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Remotely Delivered Cognitive Behavior Therapy for Disturbed Grief During the COVID-19 Crisis: Challenges and Opportunities

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ABSTRACT

Cognitive behavior therapy (CBT) interventions are effective in alleviating disturbed grief. CBT is typically delivered face-to-face. Government policy during the coronavirus (COVID-19) pandemic (quarantine and social distancing) may impede access to face-to-face therapy. Psychotherapy is now widely delivered remotely. In this article, various points of attention related to the application of CBT for disturbed grief using telephone or videoconferencing (or video calling) services are discussed. Additionally, we explore possible ways in which individual risk factors and stressors connected with COVID-19 can be addressed in treatment. Remote treatment brings challenges but also opportunities to help people in shifting from unhealthy to healthy grieving.

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Introduction

Cognitive behavior therapy (CBT) interventions, including exposure, cognitive restructuring, and graded activation are effective in alleviating disturbed grief, that is, persistent, severe, and disabling grief (see, Currier et al., 2010; Johannsen et al., 2019). Within the 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, American Psychiatric Association, 2013), disturbed grief is conceptualized as persistent complex bereavement disorder included in Section III as a diagnosis for further study; the 11th edition of the International Classification of Diseases (ICD-11) of the World Health Organization (WHO) newly included prolonged grief disorder (WHO, 2018). CBT is typically delivered

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face-to-face. Government policy to curb COVID-19 (quarantine and social distancing) can impede access to face-to-face therapy.

Therefore, psychotherapy is now widely delivered remotely, using telephone or videoconferencing (or video calling) services including Apple's FaceTime, Google Meet, Microsoft's Skype, MS Teams, and Zoom. Similar to colleagues treating patients with other disorders, health care providers treating disturbed grief face major challenges in delivering such care (Wright & Caudill, 2020). These challenges concern necessary preconditions for treatment, such as the availability of adequate technology and internet access (which may be unavailable for lower resourced or elderly people). Other challenges relate to the fact that therapists do not have access to social resources (e.g., easy consultation with colleagues) and tools (a whiteboard, questionnaires, worksheets, and forms) they are accustomed to. More importantly, they may be less well able to respond accurately to the patient's emotional state (e.g., offering comfort to help regulate sadness, fear, or anger) because they are not in close proximity to their patient. In this brief article, we aim to give advice on how to remotely apply CBT-interventions for disturbed grief using videoconferencing. For the sake of clarity, in referring to remotely delivered CBT, we are not referring to internet therapy with structured assignments (asynchronously) supervised by a therapist, but therapy delivered synchronously with a two-way audio-visual link between a patient and therapist.

Six steps in remotely delivered CBT

Drawing from our work on face-to-face CBT (e.g., Boelen, 2006; Smid et al., 2015) and internet-based CBT (Eisma et al., 2015), and our own recent experiences in applying CBT remotely, treatment can be structured according to six steps.

Step 1 is to "set the scene" and make sure the preconditions are met. Therapist and patient should agree on the platform used for videoconferencing (e.g., with high-quality video transmission and optimal security). Using a wired connection may be preferred over a wireless connection, because wired connections have better speed, latency, stability, and security. Confidentiality of the contact must be guaranteed and the session can, obviously, not be recorded unless patients give explicit consent to do so. It is important for therapists to explain that patients should preferably seek a quiet place for the sessions, that sessions have the regular (e.g., 45 minutes) duration, and that a session will be resumed as quickly as possible when disrupted by technical problems; phone numbers may be exchanged to quickly get back in touch when the internet is down for more than a few minutes.

Step 2 is to encourage the involvement of a supporting person; a friend or family member may be invited to join one of the initial sessions—either remotely or “live” from the patient’s home (when that is in line with the corona measures). This person’s role is to act as a sounding board, advisor, and companion, while the patient moves through therapy and completes his/her assignments. The patient is advised to inform the supporting person about the planning of sessions and to contact him or her after a very emotional session, to reflect on the session, summarize lessons learned, and go over homework assignments and plans and activities for the days before the next session

Step 3 involves the explanation of the rationale for CBT-interventions. Key elements of this rationale are that facing the reality of the loss (and internal and external cues connected with the reality), facing the pain of the loss, maintaining an adaptive view of the self, life, and the future, and continued engagement in activities valued before the loss are key challenges or tasks of coming to terms with loss. Anxious and depressive avoidance strategies as well as rigid, maladaptive thought patterns interfere with the achievement of these goals and are targeted in treatment (Boelen et al., 2006).

Step 4 includes exposure and, as such, is at the heart of the treatment. Exposure involves the gradual confrontation with specific internal and external loss-related stimuli (e.g., memories, objects, and situations) avoided by the bereaved person; this is done to reduce this avoidance and to confront and elaborate the reality of the loss and the pain connected with this reality. General exposure exercises include encouraging patients to recount the circumstances of the loss, to articulate and elaborate the consequences of the loss for the self, the future, and the relationship with the deceased, and to experience and express the separation distress connected with this reality. Moreover, therapists can show material from the internet to foster exposure to the circumstances of death, increasing the confrontational content thereof step-by-step. For example, one may gradually zoom in on the surroundings of the place where the loved one died, using Google Earth. Similarly, when a loved one has died from COVID-19, one could show increasingly explicit images reminding of the death, ranging from neutral images of medical staff to images of coronapatient in an overburdened intensive care unit during the coronacrisis. Videoconferencing brings opportunities to promote exposure to specific avoided objects. Patients can, for instance, be asked to show pictures or video footage of the deceased, to walk around the house showing places or objects with a specific significance. Exposure assignments can also be performed outside the patient’s house. For instance, patients can be encouraged to visit the grave of the deceased or the location of the death with the therapist providing guidance

and support via videoconferencing. These real-life exposure assignments can, of course, only be carried out while taking into account safety and privacy measures. Patients may be advised to do these exercises in the presence of a support figure and using telephone instead of video calling to ensure privacy in public places and avoid Internet connection issues. Chat functionality may be used to monitor distress levels (e.g., the patient may be asked to score his/her distress level on a 0–10 scale, every 15 minutes). Exposure interventions during the sessions can be supplemented with writing assignments, as described below.

Step 5 encompasses cognitive restructuring; this is aimed at identifying and altering pervasive maladaptive cognitions that hamper confrontation with the reality of the loss and orientation toward the future, and maintain negative emotions and unhelpful coping behaviors. Maladaptive cognitions include negative cognitions about the self, life's meaning, and the future, as well as catastrophic misinterpretations of grief-reactions, and, specifically after unnatural loss, the world's safety, predictability, and controllability, and self-blame and mistrust. The aim of cognitive restructuring is not to help patients to think positively about these issues or to convince them that their cognitions are incorrect. Instead, the aim is to help patients accept that the loss has shattered some certainties and that, in order to make a switch from unhealthy to healthy grief, it is important to alter maladaptive beliefs into helpful beliefs—reflecting confidence, trust, and hope. In videoconferencing, screen sharing can be used to explain thought records, that is, forms patients may use to record and challenge unhelpful thoughts. Shared workspace options (like whiteboarding) can be used to articulate the patient's negative cognitions very precisely and to support the application of techniques to challenge cognitions. Examples of these include the two-column technique (focused on distinguishing between evidence in favor, and evidence against a specific cognition) and the pie-chart technique (focused on targeting a patient's inflated responsibility for an unwanted event—for example, a relative getting infected by corona—by listing all possible causes for the event and then weighing and graphically presenting these causes).

Step 6 is graded activation. This involves helping patients to gradually increase their engagement with usual activities that offered joy, meaning, and fulfillment before the loss occurred. In case the mutual dependency with the deceased person was strong, emphasis should be placed on developing new goals and roles unrelated to the deceased. In this case, the patient should be aided in becoming aware of personal values in, for example, social, recreational, and education/occupational areas of functioning, as well as in formulating specific goals connected with these values and steps to achieve them. In this part of the treatment, videoconferencing

offers opportunities to exchange goals via screen sharing, to design and share steps for achieving the goals together via whiteboarding, to involve the supporting person (or others) directly in thinking up and planning activities, and to record planned activities directly with the agenda-setting and planning tool.

Importantly, in all steps of treatment, patients can be asked to record sessions and review them a few times to increase the learning effect. For example, sessions in which imaginal exposure is used may be watched repeatedly to foster processing of emotional memories. Sessions where cognitive diaries are used to identify and alter negative thoughts may be watched more than once to obtain a good grasp of the subtleties of cognitive restructuring.

Writing assignments

Parallel to these steps in treatment, writing assignments may be used. These are powerful interventions that may be employed to (a) help patients expose themselves to distressing elements of the loss (e.g., by writing increasingly detailed accounts of painful moments surrounding the loss, or a letter to the deceased in which patients articulate what is missed most), (b) help patients get an alternative perspective to their own maladaptive beliefs (e.g., by writing an encouraging, optimistic letter to a hypothetical friend when they themselves have a pessimistic view of the future), and (c) help patients consolidate the lessons they have learned during therapy (e.g., by encouraging them to make minutes of each session and eventually to summarize the lessons they learned that may be used when the pain returns; Cummings et al., 2014; Wagner et al., 2006). Patients can easily share their writings via email or share screen options. When patients have trouble to get started with a letter, therapists and patients may use whiteboarding to start writing together.

Tailoring treatment to the patient's circumstances

Where possible, interventions should be tailored to the patient's vulnerability factors that are known to complicate grief. These factors include: losing a partner or child (generally bringing more harm to basic attachment needs and increasing the need to deal with unfulfilled attachment needs), more traumatizing circumstances surrounding the loss (meaning that emotionally processing these events requires more attention), a history of separation anxiety (requiring extra attention for negative views of self and others and for building interpersonal trust), and history of psychiatric illness (necessitating attention for broader vulnerabilities, alongside the grief).

In times of COVID-19, interventions must also be tailored to the fact that patients have lost relatives *during* the coronacrisis, and sometimes, also, as *a result of* COVID-19. This brings additional challenges over and above those resulting from the fact that treatment is offered remotely (Eisma et al., 2020; Kokou-Kpolou et al., 2020; Morris et al., 2020). Factors complicating the grieving process when relatives die *during* COVID-19 include isolation of the dying relative in the last stage of life, limited opportunities to say goodbye, restrictions placed on funerals, and lack of (physical) support following the death. Recovery may further be hampered by stressors associated with quarantining/confinement (e.g., restriction of usual social, recreational, and occupational activities, intra-household tensions), fears and worries about infection, and economic losses (e.g., loss of financial security). Additional possible risk factors faced when relatives die *due to* COVID-19 include (but are not limited to) treatment and death in the intensive care unit (which, in itself, places an extreme burden on family members, Downar et al., 2018), isolation of the dying relative, vicarious guilt, anger or moral distress connected with suboptimal care provision caused by resource scarcity, lack of (emotional and practical) preparation for the death, multiple losses because of the spread of infection, and worries about one's own disease status.

What can be done during treatment to mitigate the impact of these factors? In order to facilitate processing of specific stressful/traumatizing circumstances surrounding the loss, it is important for therapists to help patients in mapping out and reconstructing these circumstances, zooming in on the most distressing elements, while acknowledging, validating, and normalizing the impact of these events on the grieving process. Therapists should be sensitive to distressing thoughts and images that patients might have about what their relative(s) experienced, thought, and felt during the last moments of life. For instance, therapists can help patients to articulate patient's thoughts and images to relieve emotional pain, correct cognitions that this pain is unbearable, and foster emotional processing. Imaginal conversations with the deceased may be used to say goodbye to the deceased—when this was insufficiently possible during the time of the funeral, or to settle “unfinished business.” Helping patients to envision an interaction with the deceased, encouraging them to say (in their own minds or out loud) what still needs to be said, may help to relieve pain. It may also help to counter traumatic images (when patients have images of the deceased suffering pain, these can be replaced by images of the deceased at peace), to alleviate feelings of guilt (when the envisioned interaction with the deceased helps to alter cognitions about responsibility for the death), and to reduce a sense of betrayal (when the deceased expresses understanding or forgiveness for the patient's alleged mistakes).

What can be done to make up for funeral rituals that could not take place? This is not easy, but apart from giving space to feelings of regret, therapists can aid patients in searching for means to organize a ceremony online, and in making plans for more traditional rituals or ceremonies (where farewells can be said) to be held when allowed. Drawing from the literature on ambiguous loss (e.g., after the disappearance of a loved one; Boss, 2006) farewell ceremonies could be held. For instance, art or music could be used as a farewell ritual in a way that meets the needs of the bereaved, for instance by listening to the favorite song of the deceased. Culturally appropriate rituals may be explored using the cultural assessment of bereavement and grief (Smid et al., 2018). To mitigate feelings of social isolation and grieving in isolation, it is important to encourage patients to continue communicating with friends and loved ones, online or—once allowed—in person.

Conclusion

To our knowledge, no studies have systematically evaluated the effects of CBT for disturbed grief using telephone and/or videoconferencing. However, a meta-analysis of randomized controlled trials, has shown moderate to large treatment effects of web-based CBT for bereaved people (Johannsen et al., 2019). This gives reason to be cautiously optimistic about the effects of CBT for disturbed grief offered through telephone and videoconferencing rather than in a conventional therapeutic setting. Nevertheless, despite great similarities between therapy delivered face-to-face and through videoconferencing, we need to acknowledge that this type of delivery is in need of further empirical scrutiny. Looking ahead, after the coronacrisis is over, remotely delivered CBT may remain an alternative for face-to-face therapy, when such face-to-face help is less accessible because of time constraints, transportation problems, or stigma. In addition, it is exciting to think about its wider application, given the (expanded) and novel real-life options for exposure. We hope that the coronacrisis will soon be over so that developments of remotely delivered CBT will no longer be primarily driven by need but rather by the larger mission to improve treatment options for the small but significant group of people who “get stuck” in grief.

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