DYNAMIC THERAPIES FOR PSYCHIATRIC DISORDERS

Relational *Therapy* for *Grief* Disorders

Tracy D. Eells

Relational Therapy for Grief Disorders

Tracy D. Eells

e-Book 2015 International Psychotherapy Institute

From *Dynamic Therapies for Psychiatric Disorders (Axis I)* edited by Jacques P. Barber & Paul Crits-Christoph

Table of Contents

Relational Therapy for Grief Disorders

Tracy D. Eells

Mourning the loss of a loved one is a common and often intensely painful experience in the human life cycle. Approximately 12 to 20 million people in the American population are newly bereaved each year through the loss of a family member (Osterweis, Solomon, & Green, 1984). Although expressions of support and sympathy are important and helpful, most of the bereaved do not need psychotherapy. Some individuals, however, have great difficulty coping with bereavement. They may experience a sustained loss of social or occupational functioning, prolonged or severe depression, or intense anger, guilt, anxiety, or self-blame. Others may appear not to grieve at all but may still show maladaptive changes in their lives, including increased alcohol consumption, social withdrawal, irritability, or a studious neglect of any reminders of the deceased. Psychotherapy can be helpful for these individuals.

In this chapter, I present a relationally focused psychotherapy model for treating grief disorders. It is relational in the sense that it focuses on the bereaved's mental representations of self and others and on the maladaptive interpersonal behavior patterns these representations are presumed to organize. For convenience, I refer to the model as relational therapy for grief

(RTG). RTG is adaptable to either a time-limited or time-unlimited format and is based on the work of Mardi Horowitz and his colleagues at the University of California at San Francisco (Horowitz, 1986; Horowitz, Marmar, Weiss, DeWitt, & Rosenbaum, 1984). The focus of this chapter is on spousal, sibling, and parental bereavement in adults; see Raphael (1983) and Crenshaw (1990) for treatment guidelines for child and adolescent grief.

At the outset, I wish to clarify how the terms *grief, mourning,* and *bereavement* are used in the chapter. "Grief" refers to the painful emotions and thoughts experienced in connection with the death of a significant other. "Mourning" is the developmental process of adapting to the loss of a loved one; it entails moving from a state of grieving to one of nongrieving. "Bereavement" refers to the social, cultural, and interpersonal status of an individual who has lost someone important to him or her.

HISTORY AND DEVELOPMENT

Freud (1917/1957) was the first to present a psychodynamic model of grief. According to Freud, the grieving individual is unable to immediately relinquish the tie to the deceased and thus maintains it through a process of identification. The bereaved directs psychic energy inward, internalizing an image of the deceased in order to maintain the relationship. With the passage of time and the expenditure of considerable psychic energy, the individual

gradually relinquishes the strong tie to the deceased and is able to initiate new love relationships. Abnormal mourning occurs when the individual is unable to accomplish the task of disengagement from the deceased. A key obstruction occurs when the relationship to the deceased was characterized by *ambivalence.* The bereaved might have loved the deceased but also might have directed feelings of anger or hatred toward him or her, consciously or unconsciously. The death catalyzes feelings of guilt as the individual irrationally blames himself or herself for the loss.

Freud's trauma theory also contributed to the model presented in this chapter. Freud (1920/1962) argued that psychological trauma, such as that incurred in mourning, is associated with an excess of stimuli that overexcite the mind. The mind's "stimulus barrier," which normally modulates the entry of external and internal perceptual information into awareness, is overwhelmed by the strong flow of energy associated with the trauma. As a result, the trauma victim may oscillate between "Re-experiencing " phenomena and denial or numbing. Re-experiencing phenomena include surges of crying, a high level of arousal, lowered threshold for a startle reaction, repeated memories associated with the event, nightmares, and the rapid onset of symptoms following an event seemingly unrelated to the trauma. Denial or numbing reflects the "binding" of psychic energy. In contrast to Freud's emphasis on transformations of psychic energy, the present model emphasizes disruptions and maladaptive distortions in the

flow of ideas and feelings that prevent resolution of the trauma and re-integrational experiences.

A second influence is the work of Bowlby (1980), who rejected Freud's emphasis on psychic energy, stressing instead the bereaved's attachment to the deceased. According to Bowlby, striving to recover the lost person is more significant in grief than is the redirection of psychic energy inward through identification with the deceased. He identified four main phases of grief. Initially, the bereaved "protests" the loss, then begins an agitated search for the deceased. When the search fails, as it inevitably will, despair and depression set in. Eventually, the bereaved forms new interpersonal attachments. Bowlby's reliance on concepts from cognitive science, such as "working models" of the self and attachment figures, is also an influence on the present model.

RTG draws as well from object relations theory (e.g., Kernberg, 1975; 1984; Kernberg, Selzer, Koenigsberg, Carr, & Appelbaum, 1989), self-psychology (Kohut, 1971), and social cognition researchers who utilize the self-schema concept (e.g., Segal & Blatt, 1993; Singer & Salovey, 1991.) For additional background on psychodynamic theories of mourning, see Abraham (1924/1948), Fenichel (1945), and Deutsch (1937).

Recent History

The more recent history of RTG originates in observations that some grief experiences are similar to those of psychosocial trauma in general. Horowitz (1986) coined the term "stress response syndrome" to label a set of intrusive and "omissive" experiences associated with psychological trauma. Intrusions are images, thoughts, or emotions that encroach on an individual's conscious experience. In grief, intrusions may take the form of intensely disturbing images of the deceased as endangered and calling out for help, as lying in state, or as physically damaged. The bereaved may also experience transient auditory hallucinations of the deceased, such as hearing his or her name called. Additional intrusive phenomena may include self-blame, searing guilt, mental replaying of events related to the death, unexpected outbursts of anger or tears, ruminations about what one might have done differently to help the deceased, and misperceiving others as the deceased. Omissions are symptoms indicating deflections of normal conscious awareness. They include emotional numbness, forgetfulness (including forgetting parts of the relationship with the deceased), distractibility, depersonalization or derealization experiences, depressed mood, poor concentration, and confusion.

Disruptions in a person's "completion tendency" also play a role in stress response syndromes. According to Horowitz, individuals are motivated to minimize discrepancies between enduring mental models, or "schemas," of self and others and current "working models" of reality. For example, a

recently bereaved individual may have an enduring schema of a deceased individual as alive. This schema contrasts with the reality of the individual as deceased. Most individuals move toward a resolution of this discrepancy, as a function of the completion tendency. Grief disorders may arise, however, when this process is disturbed.

INCLUSION/EXCLUSION CRITERIA

Most bereaved individuals with adequate motivation and verbal skills to express their thoughts and feelings are appropriate for RTG. Exclusion criteria include individuals with psychotic or dementing disorders and those with primary substance abuse or dependence disorders. Those with substance abuse disorders may be appropriate for treatment when the abuse pattern has been controlled. Many individuals with grief disorders use small or moderate amounts of alcohol or nonprescription mood-altering substances in an attempt to self-medicate for the intrusive symptoms of grief. Such patterns need not, in themselves, exclude the individual from treatment but might be explored during therapy. Individuals with prominent personality disorders have a more variable response to RTG and may do best in a time-unlimited format. Those with borderline or narcissistic personality disorders, in particular, are generally not appropriate for the time-limited format.

Symptom Patterns of Grief Disorders

There is no consensus as to the symptom patterns that distinguish grief disorders from normal grief (Middleton, Raphael, Martinek, & Misso, 1993). In large part, the lack of consensus is due to the high degree of variability in individuals' responses to bereavement. In a review of the empirical literature, Wortman and Silver (1989) show that many individuals do not experience intense distress following a loss and do not develop symptoms later in life. In fact, individuals who have fewer and less intense symptoms just after a loss show the best adaptation months and years later (e.g., Parkes & Weiss, 1983; Vachon, Rogers, Lyall, Lancee, Sheldon, & Freeman, 1982). Of course, one cannot conclude from this consistent empirical finding that the expression of intense distress following a loss is harmful to an individual.

There is also considerable variability as to the length of a grief response. Early theorists and researchers assumed that the bereaved could adjust to a loss in a matter of a few weeks or months (Engel, 1961; Lindemann, 1944). Recent research, however, shows that depression, anxiety, and rumination about the loss can extend for years. Vachon and her colleagues (Vachon, Rogers et al., 1982; Vachon, Sheldon, Lancee, Lyall, Rogers, & Freeman, 1982), for example, classified 38% of widows as highly distressed one year after the death of their spouse; 26% remained so after two years. Similarly, Parkes and Weiss (1983) found that 40% of their sample of widows and widowers were moderately to severely anxious two to four years after the loss. In a long-term study of adaptation to major life stressors, including bereavement, Tait and

Silver (1989) reported that more than half of their sample continued to ruminate about losses that had occurred decades earlier. Forty percent still searched for the meaning of the death.

Notwithstanding the variability in bereavement, most researchers and clinicians agree that deviant forms of grief exist. For example, Parkes and Weiss (1983) identified chronic, delayed, and inhibited grief. Chronic grief is characterized by intense distress beginning just after the news of the death and extending for a long period of time, perhaps years. Delayed grief, which Parkes (1991) considers relatively rare, is a pattern in which the emotional upheaval of grief begins after a period of apparent emotional quiescence. Inhibited grief, also rare, is characterized by the absence of intense emotions accompanied by other signs of maladjustment, for example, intense over-activity, somatic symptoms, lengthy social withdrawal, or depression without a sense of loss. As noted earlier, however, many individuals who show few signs of distress immediately after a loss continue to function well years later. Therefore, clinicians should not precipitously conclude that a patient with a recent loss is "repressing" his or her grief if painful affects are not experienced. Instead of psychopathology, these responses may indicate resilience to stress.

The major conclusion to be drawn from the above review is that responses to bereavement are highly individualized and variable, but that

some individuals do respond maladaptively to loss, sometimes for extended periods of time and at great cost to their well-being and to that of others. To help clinicians identify the latter group, two symptom clusters are suggested: depressive symptoms and psychological trauma symptoms. Depressive symptoms include guilt, dejected mood, loss of interest in usual activities, irritability, poor concentration, crying spells, and low energy. Positive self-esteem may be left intact more often in bereavement than it is in depression (Freud, 1917/1957). Symptoms of trauma include the psychological intrusions and omissions cited earlier as characteristic of a stress response syndrome. An additional symptom often observed in bereaved individuals is the emergence of identification processes. For example, the bereaved may take on the mannerisms of the deceased or develop physical symptoms similar to those of the deceased. When these symptoms are present in intense or prolonged forms, or when the bereaved's social or occupational functioning is significantly impaired, treatment is indicated. It is noteworthy that bereaved individuals may initially present with complaints of anxiety or depression that they do not connect to their loss. Only during the initial meeting might it become apparent to the clinician that these symptoms are related to a loss.

There is no diagnosis of "grief disorder" in the *DSM-IV,* although bereavement is listed as a V code. Most individuals who are appropriate for RTG will meet diagnostic criteria for one or more of the following Axis I

diagnoses: adjustment disorder, major depressive disorder, or posttraumatic stress disorder, depending on the circumstances of the death and the individual's response to it.

DYNAMIC ISSUES IN GRIEF DISORDERS

I will set the stage for discussing dynamic issues in grief disorders by reviewing risk factors in bereavement. Available data clearly show that the bereaved are more vulnerable than the nonbereaved to a host of psychological, social, and health problems, including increased mortality, especially among men between 55 and 74 (Helsing & Szklo, 1981; Stroebe & Stroebe, 1987); poorer physical health (Stroebe & Stroebe, 1987); increased use of alcohol and cigarettes (Osterweis, Solomon, & Green, 1984); increased rates of depression (e.g., Parkes & Weiss, 1983; Vachon, Sheldon et al., 1982); and greater risk of suicide (Bock & Webber, 1972; Carter & Glick, 1976).

What predicts a poor adjustment to loss? Researchers and theorists have implicated the age of the bereaved and the deceased, the circumstances of the death, concurrent stressors, social support, the nature of the relationship with the deceased, the personality of the bereaved, and early losses faced by the bereaved. (For reviews, see Osterweis, Solomon, & Green, 1984; Sanders, 1993; Stroebe & Stroebe, 1987.) With regard to dynamic issues in grief disorders, the latter three factors may be the most important.

Nevertheless, I will briefly review the former because they provide an important backdrop to dynamic factors.

Age has been studied primarily in the context of conjugal bereavement. Sanders (1981) and Ball (1977) showed that younger spouses had more difficulty adjusting to the loss than older spouses. As for the circumstances of the death, several studies show that adjustment is poorer if a loss is unexpected, untimely, or violent. When a person dies after a long illness, the bereaved have had time to review the impending death, to "say good-bye," and to otherwise bring the relationship to a conclusion. When the death is sudden, these opportunities are missed. Violent deaths more than nonviolent deaths may give rise to disturbing images of the deceased as suffering and needing help and of the bereaved as unable to help despite injunctions that one "should." There is also evidence that adjustment is poorer when the bereaved is facing other recent losses, is in poor health, has dependent children, faces economic hardship, or has a poor social support network.

Ambivalent and excessively dependent relationships with the deceased have long been associated with poorer adaptation to a loss. As noted earlier, Freud (1917/1957) argued that ambivalence inhibits mourning because the hostility toward the deceased is internalized and produces feelings of guilt, shame, and anxiety, as well as self-reproach. The bereaved may also minimize or deny the hostility, leading to an idealization of the deceased. Parkes and

Weiss (1983) reported that widows and widowers who report lower levels of conflict with their spouses experienced less anxiety, depression, guilt, and yearning. Horowitz, Stinson, Fridhandler, Milbrath, Redington, and Ewert (1993) associate the combination of ambivalence and "over-control" with poor adaptation to bereavement. Ambivalence is conceptualized not simply as contradictory ideas or feelings but as "simultaneous and contradictory schemas of self and other in the present, with conflicts of self-versus self, value versus value, and wish versus wish" (p. 372). Over-control is viewed as the "habitual and nonconscious intention to ward off turbulent emotionality when any topic of high importance to the self-contain[s] conflict" (p. 372).

Excessively dependent relationships may complicate adaptation to bereavement because the self-identity of the surviving spouse was not developed independently of the deceased. The "stronger" individual in the relationship may suffer just as much from a loss as the "weaker" one, because his or her identity is also enmeshed in the dependent relationship.

There is empirical evidence that personality factors such as external locus of control, emotional instability, insecurity, and chronic anxiety are associated with poorer outcome in bereavement (Parkes & Weiss, 1983; Stroebe & Stroebe, 1987). In addition, early losses, such as the death of a parent in childhood or divorce, may lead to greater vulnerability to a poor outcome.

In RTG, personality, relationship, and developmental risk factors for grief disorders are conceptualized in terms of the bereaved's schemas of self and others and maladaptive habitual controls over ideas and feelings related to the self and others. The assumption is that a grief disorder reflects the presence of unintegrated, partially conscious or unconscious, and contradictory views, or schemas, of self and others. These may relate primarily to the relationship with the deceased or to earlier relationships. For example, a middle-aged widow entered therapy after her husband, to whom she was happily married, died unexpectedly and violently. She viewed herself as a supportive, nurturing wife in a relationship with a husband who was a good provider. Her adjustment to his death, however, was complicated by a less conscious view of herself as not loving him as much as he loved her (Horowitz et al., 1993). The contradiction between these two schemas of self and other prolonged and intensified her mourning process.

The death of a loved one may also activate early schemas of the self as helpless, weak, childlike, inadequate, incapable, destructive, or evil. These "latent self-images" (Horowitz, Wilner, Marmar, & Krupnick, 1980) are assumed to form early in life as a consequence of harmful interactions with significant caretakers. Critical scenarios may have involved themes of abandonment, disappointment, betrayal, or frustrated anger. As the individual matured, more adaptive and compensatory concepts of self and other were learned and dominated personality. Additionally, latent negative

self-schemas may have been held in check through the supportive context of the relationship with the deceased.

Also critical in RTG are the habitual defensive controls an individual uses to ward off problematic themes and schemas of self and others related to a death. As noted earlier, Horowitz emphasizes "over-control" as predictive of a grief disorder. These controls may permit partial access to the emotions of grief but are rigidly maintained and prevent resolution of mourning. As reviewed below, a major goal of therapy is thus to explore the bereaved's repertoire of schemas of self and other related to the deceased and to loosen excessive inhibitory controls on these themes.

TREATMENT GOALS

The primary treatment goal is symptom reduction through an active focus on the meaning of the death to the patient's concepts of self and other. At a minimum, the goal is to restore the individual to his or her level of functioning prior to the death. A further goal is for the individual to achieve a more adaptive and integrated level of functioning than that experienced prior to the event. This is accomplished through a systematic review of the repertoire of the patient's images of and relationship schemas with the deceased and other significant others in his or her life. The patient is not asked to "give up" the relationship with the deceased but to review it and put

it in a perspective that enables the patient to continue on adaptively in life. RTG has been successful if, at the conclusion of treatment, the patient is better able to modulate his or her emotions, is functioning adaptively in interpersonal relationships, feels productive and active in life, has achieved a more stable sense of self, and has reached a more stable internal relationship with the deceased.

THEORY OF CHANGE

Relational therapy for grief is based on the assumption that mourning is an adaptive, evolution-based response to the loss of a significant attachment. Mourning thus requires a new adaptation to the self, to others, and to the world. The movement from a state of grieving to one of nongrieving represents the operation of a "completion tendency" in the individual. The work of grieving is thus a developmental process, and a grief disorder represents an incomplete mourning and a completion tendency gone awry.

To describe the theory of change in RTG, it is useful to contrast it with an idealized phase model of mourning. I present the model not as a description of normal mourning but for didactic purposes. The reader should recognize that not all individuals go through all phases and that progress through the phases is not necessarily sequential. As reviewed earlier, any phase model of mourning belies the underlying variability of individuals'

responses.

The phase model is based on the assumption that the bereaved's cognitive and emotional responses to the death of a significant other are functions of discrepancies between "enduring schemas" of the deceased and internal "working models," which include the reality of the absence of the deceased. Enduring schemas are relatively stable knowledge structures that help organize an individual's self-concept, concept of others, and dominant self-and-other relationship patterns. They result from overlearned and generalized interpersonal experiences—as well as from constitutional, genetic, and intrapersonal sources—that become ingrained in an individual's psychological makeup. Enduring schemas are not consciously experienced but influence conscious experiences.

Working models represent a combination of the activated schema organizing the individual's current state of mind and perceived and subceived environmental stimuli. A working model may not be congruent with "reality," owing to the effect that enduring schemas can have on perceptual processes. Similarly, working models may be incongruent with enduring schemas, owing to the influences of reality. When either form of incongruence occurs to a marked degree, intense emotional experience may result.

The phase model, initially presented by Horowitz (1990), includes the

following five phases: outcry, denial, intrusions, working-through, and completion (see Table 12.1). Each phase is assumed to reflect the activation of schemas and working models that organize the individual's dominant states of mind during mourning. For example, the initial "outcry" phase of grief is marked by a wrenching outpouring of sadness and tears. In schematic terms, this phase reflects the discrepancy between a working model involving the potential loss of an intimate relationship and an enduring schema representing continuity in the intimate relationship. Columns 1 and 2 of Table 12.1 illustrate the difference in schematic terms before and just after the news of a death. In the first column, "before grief," the working model of the current situation matches an enduring schema of the relationship. The state of mind is calm because the relationship is undamaged. Just after the death, as shown in the second column, a mismatch exists between the working model and the enduring schema. The news of loss changes the working model to one representing harm to the relationship, but the enduring schema expects stability and episodic togetherness. This mismatch between the working model and enduring schemas leads to an alarm reaction, resulting in a sudden, sharp emotional expression, or outcry. The outcry is the result of both the news of the harmful event and the discrepancy between working models and enduring schemas. The discrepancy can be so marked and "inconceivable" that the bereaved enters the "denial" phase of mourning.

TABLE 12.1

Relationship Between Enduring Schemas and Working Models During Grief

Stage of Grief	Before Grief	Outcry	Denial	Intrusive	Working-through/Completion
Current Working Model of Relationship	Self ↔ Mutuality ↔ Other	Self → Need / Help → Harmed Other	Self → Deny → Absent Other	Self → Need → Absent Other	Self → Need → Absent Other
Enduring Schema of Relationship	Self ↔ Mutuality ↔ Other	Self ↔ Mutuality ↔ Other	Self ↔ Mutuality ↔ Other	Self ↔ Mutuality ↔ Other	Self → Need → Absent Other
Accord of Working and Enduring Schemas	Match	Mismatch	Mismatch	Mismatch	Match
Emotional Systems	Equilibrium	Alarming Rate of Arousal	Blunted	Alarming Rate of Arousal	Equilibrium
Predominant States of Mind	Calm	Fearful Outcry	Depressed	Agitated Sadness	Poignant Sadness or Resignation

Source: Adapted from Horowitz, 1991, pp. 18, 20. Reprinted with permission.

During the denial phase (see column 3), the bereaved is unable to fully accept news of the death and consequently dampens his or her emotions. Schematically, this may represent an attempt to maintain the enduring

schema of the other as alive, but the bereaved is unable to do so, owing to knowledge of the death and, consequently, a response of suppressing higher order sensory and perceptual systems altogether. Within limits, the denial functions adaptively, protecting the bereaved from the devastating psychological impact of the death.

The fourth column depicts the "intrusive" phase of mourning. During this phase, turbulent ideas and pangs of intense sadness occur upon encountering familiar situations in which the bereaved person was usually with the deceased. Now, however, the situation is painfully empty. As indicated, the working model of being alone is discordant with an enduring schema of being together in a mutual relationship. The result of this mismatch is a sharp emotional arousal, leading to a state of agitated sadness.

Gradually the bereaved individual enters the "working-through" phase of mourning and develops an enduring model of the deceased as permanently absent. With repetitions of new situations and their working models, new enduring person schemas gradually develop. The fifth column of Table 12.1 illustrates the working-through process as it is played out in empty situations. The lonely situation, while still evoking sadness, no longer arouses the anguish it did during the intrusive phase. A mood of poignant sadness replaces one of agitated sadness. New enduring schemas have developed, and mismatches between working models and activated enduring schemas are

lessened. When the new enduring schemas are well established, the bereaved individual has entered the "completion" phase.

In RTG, the therapist intervenes at points in this phase model of mourning where progress appears to be suspended. For example, if an individual is in a denial phase, the goal would be to facilitate greater emotional expression. If the individual is in an intrusive phase, the goal is to help the patient modulate his or her emotions and to encourage an exploration of their meaning. The assumption is that interventions of this type will free up the individual to move toward fuller completion of the mourning.

TECHNIQUES

As noted, RTG is adaptable to either time-limited or time-unlimited formats. For a time-limited format, general treatment principles offered by practitioners such as Mann (1973) or Malan (1976) are appropriate. Weekly sessions are recommended.

When patients experience the painful effects of grief, some therapists may consider the concomitant use of antidepressant, antianxiety, or sleep medications with RTG. In general, these agents are not needed. The therapist will usually see positive changes in a patient's state of mind within four to six weeks. If a patient does not experience significant symptom reduction after

this length of time, consideration of a medication may be warranted. Medication should also be considered if the patient becomes suicidally depressed or otherwise presents a danger to self or others. When considering a pharmacological intervention, it is important to explore the patient's thoughts and feelings about it.

Treatment Phases

RTG is organized as five treatment phases: (1) initial formulation; (2) establishment of a therapeutic relationship and treatment frame; (3) labeling schemas of self and others; (4) learning schemas of self and other; and (5) termination. In actual practice, there are no clear boundaries between these phases, and the therapist may move back and forth across them.

Initial Formulation

A psychotherapy case formulation differs from therapy techniques. The formulation provides a blueprint for the treatment process; it guides the therapy, facilitates the therapist's conceptualization of the patient, and serves as a marker for progress. It is not static but is elaborated and refined as the therapist comes to understand the patient better. Therapy technique, on the other hand, refers to the therapist's interventions and tactics during the treatment hour that are directed at helping the patient. A provisional formulation can often be completed by the end of the first or second session.

The goal in constructing the formulation is to provide links between biographical information gathered from the patient, behavioral observations made by the therapist and patient, and inferred psychological structures and processes. Biographical information that is particularly important for bereaved patients is presented in Table 12.2. Regarding inferred structures and processes, RTG focuses on the patient's prominent states of mind, schemas of self and others, and habitual strategies for controlling ideas and affect (Horowitz, 1987).

Cognitive/affective states. A state of mind is a recurrent pattern of experience that is revealed by verbal and other behavioral cues. Indicators of a patient's current state of mind may include abrupt changes in facial expressions, intonation and inflection in speech, general arousal level, shifts in the expression of or apparent capacity for empathy, affective display, and posture. It is often convenient to label a state of mind. Common state labels for bereaved individuals include "intrusive crying," "frozen," "scared and disorganized," "businesslike and together," "plodding on," "vindictive and angry," and "self-reproaching." When inferring a patient's states of mind, begin with those that comprise the major symptomatic phenomena. The therapist should include states over which the patient has greater emotional and cognitive control (e.g., "compulsively overworking"), as well as less well controlled states (e.g., "overwhelmed by grief").

Schemas of self and other. Patients may have multiple and contradictory concepts of self and significant others. For example, a young widow may see herself as a "loyal wife" in relation to her deceased husband, but also as a "betrayer" as she begins to date again. The patient's concepts of self and others are revealed in statements such as "I'm a *shy* person," "My [deceased] father loved me but got mean when he drank" (suggesting a schema of father as *loving* and *mean),* and "I'm the sort of person who looks after himself" (suggesting a self-schema as *self-reliant).* The therapist can also identify schemas in the narratives a patient tells in therapy.

Schemas of self and other can be linked in transactional scripts to form "self-other schemas." As shown in Table 12.3, a self-other schema can involve a woman who views herself as a "depressed mourner" "seeking comfort" from an individual she views as a "selfish partner." He "withholds" comfort, and she responds by "withdrawing." We will return to this case later. Some self-other schemas are more adaptive than others, and some reflect predominantly feared or wished-for interactions.

TABLE 12.2 Information to Gather Early in Relational Therapy for Grief

Signs and Symptoms
• Symptoms? Intrusions? Omissions? Are there fantasies of joining the deceased? Insomnia? Mood? Appetite? What gives you pleasure in life now?
• How is your physical health at present?

- Are you currently taking any prescription drugs?

- Do you drink alcohol? If so, how much? Has this amount changed since the death? Illicit drug intake?

- Why are you seeking help now?

- Anniversary reactions?

Circumstances of the Death

- When did the death occur? How did you learn of the death? Where were you? What were you doing? What thoughts or experiences did you have as you heard the news? What did you do next? Did you tell others? How did they respond?

- How did [deceased] die? Was the death expected?

- Was there a funeral? How was that decision made? Did you go? If so, did going provide any relief? Do you visit the grave now? If not, why not? If so, does it provide relief?

- What became of [deceased's] belongings?

- What about his or her room?

- Was there a will? How was it handled? What role, if any, did you play? How was it decided that [person] would make these arrangements? What are your thoughts about how the will was handled?

Nature and History of the Relationship

- Tell me about your relationship with [deceased].

- *(If deceased was a spouse):* How did you meet? How did you decide to get married? How long did you know each other before marrying? Did you have children? How was that decision made? How old are your children now?

- How did you and [deceased] support yourselves?

- How were decisions in the relationship made?

- What problems were there in the relationship?

- How about other important past relationships in your life?

Circumstances Since the Death

- How have you managed your life since [deceased's] death?
- Since the death, have you sought other professional help? Psychotherapy? Medication? Was it helpful?
- How has your life changed as a result of the death?
- What other stressors are you facing?
- Financial? Interpersonal? Legal? Dependents? Recent moves?
- Have you been able to express your painful feelings to others in your life?
- Are you working now? Does work provide relief or add to your stress?
- How do you spend your days? Do you leave home often? How often do you see others?
- Where do you see your life going from here? What would you like to be doing a year from now? Five years?
- *(If deceased was a spouse)*: Have you developed any new relationships since the death? If not, why haven't you? Would you like to?

Habitual style of controlling ideas and affect. "Habitual style" refers to the processes employed to control the flow of ideas and emotions. The therapist can begin to complete this component of the case formulation by labeling the previously identified states and schemas as relatively available or relatively unavailable to conscious awareness. The woman who saw herself as a "betrayer" of her deceased husband was relatively less aware of this self-schema than she was of the view of herself as a "loyal wife." Similarly, many grieving patients may be better able to elaborate on thoughts associated with a state of "intrusive crying" than those that go with a "vindictive and angry" state. Indicators of a patient's style of controlling ideas and affect include

rapid shifting of topics, overly vague or excessively precise presentation of thoughts and feelings, disavowal of previously offered information ("My [deceased] father was mean to me but really loved me"), and denial. Benjamin's (1993) "wrong-patient syndrome" illustrates a pattern of control seen in some narcissistic patients who discuss the problems of others more than their own problems. A list of defense mechanisms, such as that provided in the *DSM-IV,* can be useful in identifying control processes.

TABLE 12.3
Case Formulation of Ms. Everett. Schemas of Self and Other, Aims, and States of Mind

Schemas of Self	Aims	Schemas of Other	States of Mind
	Problematic Relationship Schema		
Depressed mourner	Seek comfort →	Selfish partner	Sad, tearful, anxious
	← Withhold		
	Withdraw →		
	Adaptive Relationship Schema		
Responsible, healthy person	← Control	Irresponsible boyfriend	Well-modulated, controlled
	Resent →		
	Compulsively discuss, subtly blame →		
	Feared Relationship Schema		
Weak, helpless victim	← Exploit, control	Powerful, cruel manipulator	Panic, guilt
	Submit →		
	← Destroy, abandon		
	Wished-for Relationship Schema		
Talented daughter/protégée	Admire →	Powerful, principled father/mentor	Enthralled
	← Guide		
	Idealize →		
	Habitual Controls of Thought and Affect		
	"Wrong-patient syndrome" Splitting Devaluation Omnipotence Idealization Role reversal		

Once the elements of the case formulation are gathered, the therapist assembles them to make a coherent story. It is useful to think in terms of cyclical wish-fear-defense triads. To illustrate, a young widow may *wish* to let go of her strong attachment to her husband who died years earlier, but she

fears that letting go will lead to painful states of abandonment and the view of herself as a betrayer. As a *defensive* compromise, she may withdraw from people and compulsively throw herself into states of distraction and overwork. Her compromise, however, may lead to states of loneliness and back to the *wish* to let go.

Establish a Therapeutic Relationship and Treatment Frame

As with most forms of psychotherapy, it is important in RTG to establish a positive and structured working relationship with the patient. This is accomplished in part when the therapist takes a collaborative and affirming stance with the patient. It is also accomplished by actively listening to the patient, by preserving the patient's sense of autonomy, and by striving to understand the patient's world as she or he sees it. Each of these actions helps the patient to see that the therapist is a potentially helpful individual.

Establishing a therapeutic contract and treatment focus, or "frame" (Langs, 1981), is also critical to forming and maintaining the therapeutic relationship. The treatment frame includes arrangements as to the frequency of meetings, length of treatment, length of sessions, fees and the method of their payment, treatment goals, and the respective roles of the patient and therapist in pursuing the goals. The frame provides a context for the ongoing relationship that therapy requires; it also provides a point of orientation from

which the therapist may understand the patient. For many bereaved patients, the frame represents a comforting and predictable structure in an otherwise out-of-control world. It provides a safe environment in which the patient's contradictory views and powerful feelings toward the self and the deceased can be understood.

The frame is set during the first or second session, always after the therapist has made an initial formulation and determined that psychotherapy can be helpful. The frame is established knowing that it may be challenged or broken at some point during the therapy, perhaps at many points, especially when the patient is angry, frightened or threatened or has prominent Axis II psychopathology. When the frame is violated, the first treatment priority (barring imminent threats to the patient's safety or that of others) is to reestablish it and to understand the reasons it was broken. These reasons often relate to the patient's feelings about the therapist, the treatment, and the deceased.

Consider a young man who entered therapy several months after the unexpected death of his twin brother, toward whom he had often felt jealous and submissive. Several sessions into the therapy, the patient accused the therapist of overbilling him and refused to pay for one session. On further review, it became apparent that the patient had misread his bill. Without accusing the patient of wrongdoing, the therapist invited him to explore any

possible meanings in the misunderstanding. Upon further discussion, it became apparent to the patient and the therapist that the mistake reflected the patient's displaced aggression toward his brother. In the following sessions, the patient reported greater assertiveness in his interpersonal relationships and less preoccupation with the death of his brother.

As in this example, the breaking of the treatment frame can often be interpreted in light of a patient "acting out" thoughts and feelings toward the deceased, as represented by the therapist, rather than talking them out with the therapist.

Labeling Schemas of Self and Others

Once the initial formulation is made and the frame is established, therapy proper begins. Usually, symptom control is an initial focus of work. Symptom reduction is often significant during the first four to six sessions as the patient experiences the comforting structure provided by the therapist and the treatment frame. Once symptoms are under better control, it may appear that a focus on the deceased is no longer necessary or that treatment can end. Early symptom reduction, however, may reflect movement into a denial phase of mourning rather than into a completion phase. Further, treatment goals are usually broader than symptom reduction alone; they may include adaptive changes in the patient's social and occupational functioning.

At this point, therapists need not be overly concerned with encouraging abreaction. Denial can have an adaptive function, permitting the patient to prepare for the hard work ahead. The therapist should patiently allow the patient to recover at his or her own pace but at the same time should intervene if the patient seems stuck in the denial phase.

When symptoms are better modulated by the patient, the treatment should refocus to when and why the patient enters the painful, intrusive states of mind. Doing so involves identifying and labeling the patient's schemas of self and other, particularly of the deceased but also of other significant individuals in the patient's life. The primary strategy is to encourage the patient to relate detailed and concrete narratives about his or her relationships. Psychotherapy narratives have four components: (1) a temporal sequence from beginning to middle to end; (2) initiating actions, thoughts, and feelings of the self; (3) imagined and/or actual responses of the other; and (4) responses of the self to the responses of the other (Luborsky & Crits-Christoph, 1990). The therapist can elicit narratives by using questions from Table 12.2, framing them according to the details of the patient's life. When a patient offers part of a narrative, the therapist can ask for other parts. One patient expressed anguished guilt and self-condemnation about not saying "I love you" to his father, who was gravely ill in the hospital and about to die. With the aim of exploring this narrative further, the therapist asked what the father might have experienced during the meeting, and what the

patient wished the father had said and done. This exploration enabled the patient to better understand his father's capacity for forgiveness as well as his weaknesses.

As narratives are elicited and evaluated, the patient's repertoire of schemas of self and other will emerge. The therapist then uses the stories to point out these concepts to the patient.

Learning Schemas of Self and Other

Labeling is only the first step in understanding and correcting maladaptive views of self and other. Without a fuller appreciation of the meaning of these concepts, the patient risks using them in an intellectualized and defensive manner. Learning one's maladaptive schemas of self and other means appreciating the consequences they have had on one's life, reappraising their significance, and developing the capacity to choose alternative interpretations or actions. As more narratives are told, the therapist and patient may explore them as variations on themes that emerged earlier. The patient-therapist relationship may become a more important focus during this portion of the therapy as the patient tests out maladaptive beliefs on the therapist. An emergence of previously warded-off thoughts and feelings toward the deceased may also occur. As patients gain greater familiarity with previously unacknowledged aspects of self, many show an

improvement in social and work functioning. They may initiate new relationships or undertake new activities to fill the void left by the deceased.

Termination

The goals of the termination phase are to prepare for continuing the mourning process without therapy and to achieve a successful ending of the relationship with the therapist. It is important for the therapist to set the stage early in treatment for its termination. Termination is first discussed as part of the frame; if the patient does not bring it up in later sessions, the therapist should. During the termination phase, goals are reviewed with respect to whether they were achieved. If goals have not been achieved, the impediments to greater change are discussed. Termination provides the opportunity to end an important relationship in a different and more fulfilling manner than that in which the bereaved may have ended the relationship with the deceased. Just as the patient begins to form a healthy identification with the deceased, he or she can do the same with the therapist. There may be discussions of continuing the mental relationship with the deceased, as well as with the therapist, in a supportive and nonintrusive manner. Sometimes intrusive symptoms will reemerge during the last sessions as the patient prepares for another loss. The therapist should frame these as expressions of the impending loss rather than as a setback.

The termination phase might also include a discussion of future contacts. If therapy was conducted in a time-limited format and additional work is deemed important, an interim period of one to three months is recommended prior to reinitiating treatment. This interval will give the patient time to test out and consolidate any therapy gains.

Specific Techniques

As with most forms of psychodynamic treatment, the specific techniques used in RTG can be classified as supportive or expressive (Luborsky, 1984; Wallerstein, 1986). The goals of supportive techniques are to maintain the therapeutic alliance and to strengthen a patient's current adaptive strategies. Expressive techniques, on the other hand, are aimed at helping the patient understand obscure, contradictory, or otherwise puzzling aspects of self and others, usually through encouraging the expression of thoughts and feelings. In RTG, adaptive changes outside of therapy are also monitored regularly. Primary exploration focuses on the relationship with the deceased and other significant others, although the therapist-patient relationship is a secondary focus.

Below are specific techniques that can facilitate the explorations required in RTG. The therapist should use them in a manner crafted to the specific problems of the patient rather than in a stereotyped manner. The

selection of techniques is guided by the patient's personality style, the therapist's case formulation, and his or her assessment of where in the mourning process the patient is impeded.

Not Taking Sides

It is important to create an atmosphere that facilitates the exploration of negative as well as positive images of self and other. This goal is facilitated when the therapist avoids "taking sides" with respect to the patient's repertoire of schemas of self and others. The therapist's goal is neither to endorse nor to dispute a patient's "version" of self or other, but to invite the bereaved patient to explore all aspects of his or her significant relationships. It is particularly important to take this stance in grief work because it counters denial processes and facilitates the exploration of latent negative self-images that may be complicating the mourning process. If the therapist precipitously reassures the patient that he or she is not "unforgivable," "weak," or "destructive," these aspects of the patient's self-organization are not explored and integrated. The therapist's stance, instead, is to remain a stable, consistent, and predictable presence as the patient explores these frightening self-schemas. Not taking sides also provides a framework through which the patient's thoughts and feelings about the therapist can be explored. "Not taking sides" does *not* mean that the therapist is consistently silent or non-interactive during the therapy. On the contrary, the RTG therapist is

quite interactive with the patient.

Stating the Core Conflict

The core conflict, as summarized in the case formulation, should be communicated to the patient during the course of treatment. It is preferable for the therapist to speak in short, simple sentences and to communicate the formulation in pieces at appropriate moments in therapy rather than as a single intervention. Suitable opportunities to communicate the formulation occur after the patient has engaged in a topic that relates to the core conflict. A skilled therapist avoids using a didactic style, aiming instead at crafting questions that lead the patient to portions of the core conflict. A short, clearly stated intervention is more likely to be effective than lengthy interventions, which can deplete the emotional charge of a session. It is preferable for the therapist to speak in terms intended to match or mismatch the patient's current state of mind, depending on the therapist's goals for the intervention. If a histrionic patient is in an intrusive, tearful, childlike state of mind and the therapist wants to help the patient gain more control, she or he can use "adult" language with more abstract concepts. Similarly, if an obsessive patient is intellectualizing, the therapist can use simpler, more emotionally evocative language. On the other hand, if a histrionic patient is emerging from a denial phase of mourning, the therapist may match the patient's childlike language to encourage the expression of genuine affect. Similarly, if an

obsessive-compulsive patient has expressed considerable affect toward the end of a session and is moving into a well-modulated, "defended" state of mind, the therapist can facilitate this state transition by matching the patient's intellectual style.

Supportive Techniques

The support conveyed by a therapist can go a long way in comforting the bereaved. Supportive techniques range from nonspecific to highly specific. Nonspecific aspects of support include the structure and regularity provided by the weekly sessions, the therapist's availability and punctuality, and the therapist's conviction that the patient is capable of overcoming his or her pain and moving on meaningfully in life. The therapist need not convey this conviction in an overt statement, which may strike a patient as trite or stereotypical. Rather, the therapist expresses this conviction through tone of voice, respect for the patient's autonomy and natural healing process, and appreciation of the pain the patient is experiencing; that is, the therapist expresses the conviction through his or her entire stance toward the patient.

Specific supportive techniques include educating the patient about normal processes of grief and making suggestions that encourage greater activity in the world, increase social support, or encourage acts of kindness toward the self. Suggestions may be expressed in the form of questions, such

as, "How are you staying busy during the day?" "Do you have religious convictions or another belief system that provides some comfort?" "Have you considered volunteering or working to help fill your days?" and, "Have you treated yourself to anything special lately?" The therapist can also use supportive techniques as a form of "permission" for the patient to reengage in the world at a pace he or she chooses.

Use of Normalizing Interventions

Normalizing interventions communicate to the patient that the haunting, intense symptoms of grief are within the normal range of human experience and are understandable in light of the patient's loss. It is helpful to frame symptoms as attempts to cope with a major life stressor, rather than as reflecting "mental illness." For example, the therapist might say, "It's not surprising that you feel out of control in light of all you've been through."

Encourage Elaboration

Some patients, particularly those with histrionic or avoidant styles or those in a denial phase of grief, will give very few details in relating narratives. They may speak in a highly impressionistic or global manner (Shapiro, 1965) or prematurely sum up relationships, as if they have said all there is to say about the topic. These styles of self-presentation can be understood as attempts by the patient to modulate the expression of thoughts

and feelings. Often, although not always, the patient is unaware of the function his or her behavior is playing. The therapist can encourage elaboration by asking detailed questions about specific events or by asking for examples of patterns the patient identifies. Not infrequently, the impression that emerges from a detailed inquiry about a relationship sequence is quite different from the patient's original description.

To illustrate, one patient summed up his deceased father's problems by describing him as a "peacemaker" who tried to please too many people. When asked for specific examples, it emerged that the father was much more manipulative and cruel than one would infer from the descriptor "peacemaker." Sometimes patients will seem unable to communicate more details about relationships. They may repeatedly say, "I don't know," when asked open-ended questions. In these cases, the therapist can focus on the patient's lack of elaboration, perhaps expressing curiosity or puzzlement, since the relationship problems communicated earlier by the patient suggested that there was much to talk about. It may turn out that the patient's lack of elaboration is a response to overlearned family injunctions or taboos about certain topics.

Explore Dyselaboration

Some patients' use of language reveals how emotional content is

avoided. For example, a patient might refer to himself as "a little angry," "bothered," or "sort of mad" at his deceased father for belittling him in life. Exploring the meaning of these topic-avoiding verbalizations facilitates emotional expression in patients who are in a denial state of mourning. It also helps reveal warded-off concepts of self and other. One widower offhandedly referred to his former marriage as "the relationship." When the therapist pointed out this unusual form of reference, the patient became more aware of feeling emotionally distant from his wife.

Explore Behavioral Leakage

Behavioral leakage refers to indicators of over-controlled emotion. It is often observed only briefly. For example, when discussing a seemingly nonconflictual topic, a patient's face may suddenly redden, his or her eyes may briefly tear up, or there may be a transient flash of anger. Exploring behavioral leakage is particularly helpful for patients in denial states of mourning. The therapist does so by first calling the patient's attention to the behavior and inquiring whether the patient was aware of it. The therapist then invites the patient to explore the meaning of the leakage.

Name States of Mind and Schemas

Referring to patterns in a shorthand way enables both therapist and patient to identify them efficiently later. For example, one histrionic patient

referred to her style of frequent topic changes with the term "cliffhanger," indicating that she shifted a topic before bringing it to a conclusion. Later in the therapy, she and her therapist were both able to identify this pattern with this term. It is preferable if the shorthand term is first coined by the patient.

Explore Topic Flow

The patient's control of the topics discussed in therapy can be a means of understanding areas of conflict. For example, one patient with an obsessive-compulsive personality style rapidly changed topics. The therapist commented, "I've noticed today that each time we approach the topic of your mother's death, we quickly end up on a different topic. Have you noticed that?"

Facilitate Compassion for the Self

Grieving patients are often highly self-condemning and guilt-ridden. Many may be tormented with questions such as, "Why didn't I call him that last night in the hospital?" and, "Why wasn't I kinder?" The therapist's eliciting of narratives can bring these evaluative schemas of the self to the foreground. At such times, it is helpful to ask the patient whether he or she is able to find any compassion for the self in the midst of the self-condemnation. Such a question often surprises patients, who may not consider themselves "worthy" of compassion. Sometimes patients will answer, "No. I do not have

any compassion for myself. I don't deserve it." At this point, the therapist should avoid overt reassurances that the patient does, in fact, deserve compassion. Such a response may leave the patient feeling more criticized or helpless. A more productive tactic is to ask *why* the patient is unable to generate self-compassion, what prevents it, what its consequences might be, and what must happen for the patient to experience it. The therapist might also ask whether the deceased would be more forgiving of the patient, and what the deceased would think of the patient's self-condemnation. Finally, the therapist might consider whether the self-condemnation reflects an identification with past critics in the patient's life, perhaps including the deceased. Inquiries of this nature demonstrate an appreciation for the patient's value system and view of the self without endorsing them as adaptive. It also invites the patient to consider self-forgiveness and compassion as a worthwhile aim.

CASE EXAMPLE

Pamela Everett was a 25-year-old graduate student when she sought treatment for depression 18 months after her father died of heart disease. Ms. Everett's symptom presentation included insomnia, irritability, feeling "empty," recent weight gain, and crying spells that seemed to "come out of nowhere." She dated the onset of these symptoms to six months after her father's death, although she had had similar symptoms to a lesser extent prior

to his death. Ms. Everett reported that she felt unsupported by her boyfriend of three years and unable to discuss her thoughts and feelings about her father with him. Unable to sleep, Ms. Everett frequently leafed through photographs of her father late at night. Although she felt more connected to him through this activity, it always precipitated deep sobbing and feelings of abandonment and loneliness.

During the initial consultation, Ms. Everett discussed her relationship with her father and reviewed the circumstances of his death. She had great admiration for him but was also acutely aware of his limitations. She described him as an emotionally constrained, taciturn, and principled man. He seldom spoke about his feelings and took a highly guarded and superior stance toward others. He took great interest in his daughter's career choices, occasionally offering her advice, which she treasured. He advised her to pursue her dreams and not sacrifice them for either him or her mother, as he felt he had done for his parents. During her childhood, Ms. Everett idealized her father and felt much closer to him than to her mother. As an adolescent, she was shaken upon realizing that his belief system may have been based on irrational prejudice rather than logic. Ms. Everett recalled that her parents were coldly hostile toward each other but seldom argued openly. When in public, they became painfully shy. Early in her life, Ms. Everett was cast in the role of "family spokesperson." She became highly talkative and often the primary source of entertainment when adult friends of her parents visited.

Ms. Everett remained in regular contact with both her parents throughout her early adulthood.

The death of Ms. Everett's father was expected, coming after a long illness. Ms. Everett took an active role with her father's physicians during his last days. A week before he died, they told her that little could be done for him. Ms. Everett considered seeking an outside opinion, but her father died before she carried out her plan. Despite his terminal illness, Ms. Everett's father refused to discuss the possibility of death. This refusal played a significant role in Ms. Everett's last visit with her father. The two did not discuss the possibility of his death and the fact that this might be their last opportunity to talk. Ms. Everett said she "lacked the courage" to bring up the topic on her own. Instead, the two carried on a rather superficial conversation. As she was ready to leave, she wanted to tell her father she loved him but did not. The two rarely exchanged such words.

Although the death was expected, Ms. Everett felt unprepared when it came. She rapidly oscillated between overwhelming tears, pangs of guilt that she had not done enough for him, feelings of paralysis, and dutifully carrying out funeral arrangements and making necessary arrangements for her father's estate. In the face of these stressors, Ms. Everett took no time off from school except to attend the funeral. She settled back into her life after this initial "outcry" but gradually sank into a depression.

Ms. Everett and her therapist agreed to meet for once-a-week therapy on a time-unlimited basis. They set the following three goals: (1) to eliminate symptoms of depression, particularly insomnia, sad mood, and crying spells; (2) to improve understanding of her relationship with her father; and (3) to better understand and reduce current stresses with her boyfriend. The therapy lasted one year.

Table 12.3 summarizes the case formulation, which was constructed during the first weeks of therapy as relevant information emerged. I will refer to the formulation as I describe the "labeling schemas of self and other" step of the treatment.

During the early sessions, Ms. Everett presented herself primarily in one of two ways. First was as a sad and tearful mourner who was seeking comfort through disclosing her feelings. She complained that her boyfriend was not receptive to these feelings and "withheld" comfort. In turn, she withdrew from him. The therapy sessions seemed to serve as a substitute for the comfort she sought from her boyfriend. This relationship is depicted in Table 12.3 as a "problematic relationship schema" because it depicts Ms. Everett's primary presenting complaints. During these sessions, the therapist encouraged the expression of sadness and tears.

After the initial sessions, a brighter side of Ms. Everett came forth. She

presented herself as a responsible, healthy person who straightforwardly discussed problems with her boyfriend, particularly feelings of being controlled by him. She avoided talking about distressing states of mind and seemed motivated to give the impression that most of her relationship problems resided in her boyfriend. This relationship scenario is presented as an "adaptive relationship schema" in Table 12.3 because it was inferred to reflect an attempt to cope adaptively with an underlying wish-fear conflict, which at this point in the therapy was obscure.

A significant state of mind during these early sessions was revealed in a forced, compulsive quality to Ms. Everett's speech and a style of laughter that seemed designed to elicit laughter from the therapist. When the therapist commented on these observations, Ms. Everett became tearful and pointed out how important it was for her to maintain self-control. She linked her behavior to her efforts as a child to entertain her parents and others. A similarly noteworthy state occurred during the brief moments of silence Ms. Everett allowed during the therapy. At these times, she was seized with a sense of impending panic. She did not understand these feelings and fought strongly to ward them off.

In the next several sessions, Ms. Everett experienced increasing fears of panic and loss of emotional control. In a tearful session, she related feelings of "unforgivable" guilt because she had not followed through on getting a second

medical opinion on her father's condition. She castigated herself for lacking initiative and placing "false trust" in his physicians. Her therapist suggested that she might also feel that she had placed false trust in him, considering the intensity of her panicked states of mind. This interpretation precipitated a series of significant narratives during the following sessions. They involved themes of powerful manipulators who exploited innocent or not-so-innocent victims. Themes of greed and exploitation also emerged in these stories. In some stories, Ms. Everett played the role of manipulator; in others, she was the victim of others. Although the stories were not ostensibly about her father, the themes seemed to reflect an unconscious identification with him in two ways: as a powerfully cruel, emotionally sterile, and controlling person, but also as a weak and helpless man who feared others and felt inferior to them. These narratives are represented in Table 12.3 as "feared relationship schemas." These disclosures, along with Ms. Everett's complaints of emptiness and her efforts to focus the treatment on her boyfriend's problems, suggested a narcissistic personality style.

The narratives about other men led to disclosures about Ms. Everett relationship with her father. She tearfully related how he had suffered abuses at the hands of his parents. She related pride in his accomplishments but also seemed to share his sadness and disappointment that he had not accomplished more. His sullen, angry, and emotionally sterile side seemed to have a more human face after these narratives were told and discussed. The

"wished-for relationship schema" in Table 12.3 depicts Ms. Everett's major, childlike hopes for her relationship with her father. During these sessions, the therapist pointed out the roles that Ms. Everett cast herself and others into, as well as the relationship scenarios that played out between the "actors" of these roles.

After the significant schemas of self and other were presented, the therapy moved from the step of labeling schemas to that of learning their significance. The sessions increasingly focused on the relationship between Ms. Everett and her therapist. When he permitted periods of silence, Ms. Everett accused him of "withholding" help. She expressed fantasies that he was as manipulative and controlling as others in her life, including her father. In contrast, she saw herself as weak and out of control. At other times, Ms. Everett saw the therapist as a potential victim of her own seductive power. These themes were also expressed in the form of violations of the therapeutic frame. Ms. Everett canceled a number of sessions and requested changes in appointment times on short notice, all on ostensibly extra-therapeutic grounds. When these behaviors were framed in terms of deviations from the treatment contract, which specified weekly sessions, a deeper meaning emerged. Ms. Everett acknowledged that her canceled sessions were a test of whether the therapist would reject her. They also seemed to express Ms. Everett's strong motivation to control the therapist. Since she felt powerless to control him during the sessions, she expressed control by canceling

sessions.

After these "violations" were discussed, Ms. Everett resumed her earlier pattern of keeping her weekly appointments. The therapy moved more fully into a "learning schemas" phase. Ms. Everett gradually felt more comfortable in the therapy sessions and more assured that the therapist would not overstep his professional role. She felt more comfortable with silence and was not as compelled to fill all silences with talk. She discussed with pride that she was much better able to tolerate silences outside of the therapy sessions.

Further discussion about relationship difficulties ensued. It became clear to Ms. Everett that her relationship problems resembled those of her parents. She was at risk of having a similarly "paralyzed" relationship with her boyfriend. She made a commitment to being more assertive with him, to communicate more clearly, and to be more accepting of his "laid-back" lifestyle. His commitment to their relationship was reflected in his decision to enter psychotherapy.

Ms. Everett developed a more balanced image of her father. She expressed appreciation of his positive qualities, such as his intelligence and commitment to family. She was also more able to accept those qualities that she had criticized earlier, especially his difficulty with emotional expression. Ms. Everett began to struggle with the notion that forgiveness of self is

possible. She showed greater compassion and objectivity toward her own behavior at her father's death.

As Ms. Everett developed a stronger sense of self, as her relationships strengthened, and as she sustained a period of significantly reduced symptoms (including the absence of panic), she brought up the topic of termination. She and her therapist reviewed the past year's work. Ms. Everett expressed appreciation for minor qualities in the therapeutic interaction, for example, starting sessions on time. She felt increasingly secure in her capacity to form a close relationship that did not have the exploitive qualities of other relationships in her life. Although reporting increased satisfaction in her relationship with her boyfriend, she also recognized the need for further work. The topic of her father played a less central role in the sessions as she spoke more about current relationships and goals.

To summarize the case description, Ms. Everett developed a grief disorder following the death of her father. Her highly ambivalent relationship with him was complicated by a narcissistic personality style and concurrent relationship stressors. Prominent defenses were splitting, idealization, devaluation, omnipotence, and role reversal. The death of Ms. Everett's father activated feared latent schemas of the self as a helpless victim and as a powerful and merciless exploiter. These schemas seemed to develop out of Ms. Everett's intense frustrations and anger in not receiving the love she

needed from her father, whom she viewed as powerful but also as cripplingly flawed and vulnerable. The therapy focused on eliciting and reviewing Ms. Everett's repertoire of relationship schemas, including those that were most strongly warded off. The use of the patient's thoughts and feelings toward the therapist provided the opportunity for a here-and-now exploration of these conflicts. The establishment of an explicit therapeutic frame, and the therapist's stance of not taking sides, provided a context that permitted a fuller range of Ms. Everett's relationship schemas to emerge.

TRAINING

RTG is best taught with a manual guide (Horowitz, Marmar, Krupnick, Wilner, Kaltreider, & Wallerstein, 1984) in a format that permits close observation of the therapy process. A detailed review can be accomplished with videotape, audiotape, or process notes or through live supervision. Group supervision may be a more efficient form of training. Typically, one member's psychotherapy session is discussed during a single meeting. A close review of the session facilitates the observation of the effects of different types of interventions, unconscious meanings, the flow of the session, and shifts in a patient's state of mind and therapeutic responses to such shifts.

EMPIRICAL EVIDENCE FOR THE APPROACH

Surprisingly few controlled studies have been conducted assessing the efficacy of psychotherapy for the bereaved. Marmar, Horowitz, Weiss, Wilner, and Kaltreider (1988) compared time-limited (12 sessions) psychodynamic psychotherapy and mutual-help group treatment in a female conjugal bereavement sample. Women in both treatments experienced significant symptom reduction as well as improvement in social and work functioning. In a noncontrolled study of 52 bereaved patients treated in time-limited (12 sessions) psychodynamic psychotherapy, Horowitz, Marmar, Weiss et al. (1984) found statistically significant reductions of intrusive and avoidance symptoms, depression, and anxiety from pre-therapy to post-therapy status. In addition, subjects demonstrated a greater capacity for intimacy, although work capacity did not change. One of the more intriguing findings from this study was that exploratory actions on the part of the therapist were more suitable for highly motivated patients with a relatively stable sense of self and less suitable for patients with lower levels of motivation or a less stable sense of self. That is, therapist actions aimed at changing the patient's understanding of self-concepts in relationship to significant others involved in the bereavement were associated with better outcome only in the more highly functioning and motivated patients. Conversely, supportive actions were more predictive of a positive outcome in more poorly functioning patients. In their review of outcome studies of bereavement, Windholz, Marmar, and Horowitz (1985) conclude that psychotherapy "is of value in

selected cases but is only warranted for subjects who show either high manifest distress or potential for distress because of specific risk factors" (p. 445). Further controlled outcome studies are needed to better assess the efficacy of RTG.

REFERENCES

Abraham, K. (1948). A short study of the development of the libido, viewed in light of mental disorders. In E. Jones (Ed.), D. Bryan & A. Strachey (Trans.), *Selected papers on psychoanalysis* (pp. 418-501). London: Hogarth Press. (Original work published 1924)

Ball, J. F. (1977). Widow's grief: The impact of age and mode of death. *Omega,* 7, 307-333.

Benjamin, L. (1993). *Interpersonal diagnosis and treatment of personality disorders.* New York: Guilford Press.

Bock, E. W., & Webber, I. L. (1972). Suicide among the elderly: Isolating widowhood and mitigating alternatives. *Journal of Marriage and the Family*, 34, 24-31.

Bowlby, J. (1980). *Attachment and loss. Ill: Loss: Sadness and depression.* New York: Basic Books.

Carter, H., & Glick, P. (1976). *Marriage and divorce: A social and economic study.* Cambridge, MA: Harvard University Press.

Crenshaw, D. A. (1990). *Bereavement: Counseling the grieving throughout the life cycle.* New York: Continuum.

Deutsch, H. (1937). Absence of grief. *Psychoanalytic Quarterly*, 6, 12-22.

Engel, G. L. (1961). Is grief a disease? *Psychosomatic Medicine,* 23, 18-22.

Fenichel, O. (1945). *The psychoanalytic theory of neurosis.* New York: Norton.

Freud, S. (1957). Mourning and melancholy. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 14, pp. 243-258). London: Hogarth Press. (Original work published 1917)

Freud, S. (1962). Beyond the pleasure principle. In J. Strachey (Ed.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 18, pp. 1-68). London: Hogarth Press. (Original work published 1920)

Helsing, K. J., & Szklo, M. (1981). Mortality after bereavement. *American Journal of Epidemiology,* 114, 41-52.

Horowitz, M. J. (1986). *Stress response syndromes* (2nd ed.). Northvale, NJ: Jason Aronson.

Horowitz, M. J. (1987). *States of mind: Configurational analysis of individual psychology* (2nd ed.). New York: Plenum.

Horowitz, M. J. (1990). A model of mourning: Change in schemas of self and other. *Journal of the American Psychoanalytic Association*, 38, 297-324.

Horowitz, M. J. (1991). Person schemas. In M. J. Horowitz (Ed.), *Person schemas and maladaptive interpersonal patterns* (pp. 13-31). Chicago: University of Chicago Press.

Horowitz, M. J., Marmar, C., Krupnick, J., Wilner, N., Kaltreider, N., & Wallerstein, R. (1984). *Personality styles and brief psychotherapy.* New York: Basic Books.

Horowitz, M. J., Marmar, C., Weiss, D. S., DeWitt, K. N., & Rosenbaum, R. (1984). Brief psychotherapy of bereavement reactions: The relationship of process to outcome. *Archives of General Psychiatry*, 41, 438-448.

Horowitz, M., Stinson, C., Fridhandler, B., Milbrath, C., Redington, D., & Ewert, M. (1993). Pathological grief: An intensive case study. *Psychiatry,* 56, 356-374.

Horowitz, M. J., Wilner, N., Marmar, C., & Krupnick, J. (1980). Pathological grief and the activation of latent self-images. *American Journal of Psychiatry*, 137, 1157-1162.

Kernberg, O. (1975). *Borderline conditions and pathological narcissism.* New York: Jason Aronson.

Kernberg, O. (1984). *Severe personality disorders.* New Haven, CT: Yale University Press.

Kernberg, O. F., Selzer, M. A., Koenigsberg, H. W., Carr, A. C., & Appelbaum, A. H. (1989). *Psychodynamic psychotherapy of borderline patients.* New York: Basic Books.

Kohut, H. (1971). *Analysis of the self.* New York: International Universities Press.

Langs, R. (1981). *Resistances and interventions: The nature of therapeutic work.* Northvale, NJ: Jason Aronson.

Lindemann, E. (1944). Symptomatology and management of acute grief. *American Journal of Psychiatry,* 101, 141-148.

Luborsky, L. (1984). *Principles of psychoanalytic psychotherapy: A manual for supportive expressive (SE) treatment.* New York: Basic Books.

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding transference: The CCRT method.* New York: Basic Books.

Malan, D. H. (1976). *The frontier of brief psychotherapy.* New York: Plenum.

Mann, J. (1973). *Time-limited psychotherapy.* Cambridge, MA: Harvard University Press.

Marmar, C. R., Horowitz, M. J., Weiss, D. S., Wilner, N. R., & Kaltreider, N. B. (1988). A controlled trial of brief psychotherapy and mutual-help group treatment of conjugal bereavement. *American Journal of Psychiatry,* 145, 203-209.

Middleton, W., Raphael, B., Martinek, N., & Misso, V. (1993). Pathological grief reactions. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 44-61). New York: Cambridge University Press.

Osterweis, M., Solomon, F., & Green, M. (Eds.) (1984). *Bereavement: Reactions, consequences, and care.* Washington, DC: National Academy Press.

Parkes, C. M. (1991). Attachment, bonding, and psychiatric problems after bereavement in adult life. In C. M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), *Attachment across the*

life cycle (pp. 268-297). London: Tavistock/Routledge.

Parkes, C. M., & Weiss, R. S. (1983). *Recovery from bereavement.* New York: Basic Books.

Raphael, B. (1983). *The anatomy of bereavement.* New York: Basic Books.

Singer, J. L., & Salovey, P. (1991). Organized knowledge structures and personality. In M. J. Horowitz (Ed.), *Person schemas and maladaptive interpersonal patterns* (pp. 33-80). Chicago: University of Chicago Press.

Sanders, C. M. (1981). Comparison of younger and older spouses in bereavement outcome. *Omega,* 11, 217-232.

Sanders, C. M. (1993). Risk factors in bereavement outcome. In M. S. Stroebe, W. Stroebe, & R. O. Hansson (Eds.), *Handbook of bereavement: Theory, research, and intervention* (pp. 255-267). New York: Cambridge University Press.

Segal, Z. V., & Blatt, S. J. (Eds.). (1993). *The self in emotional distress: Cognitive and psychodynamic perspectives.* New York: Guilford Press.

Shapiro, D. (1965). *Neurotic styles.* New York: Basic Books.

Stroebe, W., & Stroebe, M. S. (1987). *Bereavement and health: The psychological and physical consequences of partner loss.* New York: Cambridge University Press.

Tait, R., & Silver, R. C. (1989). Coming to terms with major negative life events. In J. S. Uleman & J. A. Bargh (Eds.), *Unintended thought* (pp. 351-382). New York: Guilford Press.

Vachon, M. L. S., Rogers, J., Lyall, W. A. L., Lancee, W. J., Sheldon, A. R., & Freeman, S. J. J. (1982). Predictors and correlates of adaptation to conjugal bereavement. *American Journal of Psychiatry,* 139, 998-1002.

Vachon, M. L. S., Sheldon, A. R., Lancee, W. J., Lyall, W. A. L., Rogers, J., & Freeman, S. J. J. (1982). Correlates of enduring stress patterns following bereavement: Social network, life situation, and personality. *Psychological Medicine,* 12, 783-788.

Wallerstein, R. S. (1986). *Forty-two lives in treatment: A study of psychoanalysis and psychotherapy.* New York: Guilford Press.

Windholz, M. J., Marmar, C. R., & Horowitz, M. J. (1985). A review of the research on conjugal bereavement: Impact on health and efficacy of intervention. *Comprehensive Psychiatry,* 26, 433-447.

Wortman, C. B., & Silver, R. C. (1989). The myths of coping with loss. *Journal of Clinical and Consulting Psychology,* 57, 349-357.