

# A Randomized Open Trial Assessing the Feasibility of Behavioral Activation for Pathological Grief Responding

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This study investigated the feasibility of using behavioral activation to treat enduring postbereavement mental health difficulties using a two-arm, multiple baseline design comparing an immediate start group to a delayed start group at baseline, 12-, 24-, and 36-weeks postrandomization. Participants received 12–14 sessions of behavioral activation within a 12-week intervention period starting immediately after the first assessment or after 12 weeks for the delayed start group. Prolonged grief, posttraumatic stress, and depression symptoms were assessed as outcomes. Compared with no treatment, behavioral activation was associated with large reductions in prolonged, complicated, or traumatic grief; posttraumatic stress disorder; and depression symptoms in the intent-to-treat analyses. Seventy percent of the completer sample at posttreatment and 75 percent at follow-up responded to treatment with 45 percent at posttreatment and 40 percent at follow-up being classified as evidencing high-end state functioning at 12-week follow-up.

*Keywords:* behavior therapy; bereavement; complicated grief; depression; posttraumatic stress disorder

GRIEF, WHILE PAINFUL AND disorientating, does not in itself warrant psychiatric intervention. Nonetheless, a subgroup of those bereaved experience persistent reactions that interfere with functioning and necessitate psychiatric diagnosis and intervention. These reactions range from major depressive disorder (MDD) to posttraumatic stress disorder (PTSD) to a pathological grief response variously referred to as prolonged, complicated, or traumatic grief (referred to as PGD in this paper; Boelen & van den Bout, 2005; Bonanno et al., 2007; Prigerson et al., 2009). Prevalence estimates indicate that levels of disruption due to grief can be as high as 10% in the general population across diagnostic categories (e.g., Latham & Prigerson, 2004; Middleton, Burnett, Raphael, & Martinek, 1996; Ott, Lueger, Kelber, & Prigerson, 2007; Shear, Zuckoff, & Frank, 2001). Looking only at PGD, population estimates range from about 1 to 5% (Forstmeier & Maercker, 2007; Kersting, Brähler, Glaesmer, & Wagner, 2011). However, in at-risk populations the prevalence can be much higher with rates ranging from 20% in bereaved dementia caregivers (Schulz, Boerner, Shear, Zhang, & Gitlin, 2006) to over 50% in HIV+ caregivers (Bonanno, Moskowitz, Papa, & Folkman, 2005). Factors such as violent death, loss of child, and preexisting psychopathology have also been associated with rates as high as 78% (e.g., Dyregrov, Nordanger, & Dyregrov, 2003; Kersting et al., 2011; Simon et al., 2005).

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Pathological grieving is thought to develop when excessive self-regulatory focus precludes (re)engagement with the social environment and (re)establishment of psychosocial functioning (e.g., Stroebe et al., 2007). In contrast, resilience after loss appears to be contingent on the degree of flexibility in individuals' behavioral repertoire allowing engagement with an altered social landscape and access to positive reinforcement from their changed environment in self-relevant domains (Bonanno, Papa, & O'Neill, 2001; Papa, Rummel, Garrison-Diehn, & Sewell, 2013). Indeed, disengagement, avoidance, and passive coping have long been linked to symptoms of depression (Martell, Addis, & Jacobson, 2001), PTSD (Foa & Kozak, 1986), and PGD (Boelen & van den Bout, 2010; Boelen, van den Bout, & van den Hout, 2006; Shear et al., 2007; Stroebe et al., 2007). Individuals who exhibit substantial disengagement and isolation after loss are at substantial risk to develop chronic difficulties due to limited access to psychosocial resources promoting natural recovery and also present with the highest levels of comorbidity across these diagnostic categories (Simon et al., 2007).

Despite the need, the treatment efficacy literature for grief has been mixed, partially due to lack of consensus of what constitutes pathological grief. Though not wholly resolved, recent work has sharpened the distinction between normal and pathological grief and has delineated symptoms unique to pathological grief not subsumed under MDD and PTSD diagnoses. Despite these advances, there have been a limited number of well-controlled studies of tertiary interventions capitalizing on these distinctions. A recent meta-analysis of studies that used contemporary conceptualizations of pathological grief as the main inclusion criteria found only three trials of therapist-directed individual therapies (Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen, 2011). Each of these therapies approached pathological grieving as a variant of psychological trauma to be treated by emotional processing techniques, with the assumption that processing of death-related experiences will result in reductions in avoidance of reexperiencing triggers and associated emotional disruption. These studies entailed (a) complicated grief therapy that combines prolonged exposure, motivational enhancement, and interpersonal therapy techniques (Shear, Frank, Houck, & Reynolds, 2005); (b) combined prolonged exposure and cognitive restructuring (Boelen & van den Bout, 2007); and (c) the use of a therapist-directed, e-mail-delivered writing task thought to promote adaptation to traumatic events by facilitating emotional processing (Wagner, Knaevelsrud, & Maercker, 2006).

The current study was a proof-of-concept trial assessing the use of behavioral activation (BA; Martell et al., 2001) as an alternative to emotional processing approaches in treating pathological grief responses. This open trial was the first step in Stage 1 development of BA for pathological grief (Carroll & Rounsaville, 2007; Rounsaville, Carroll, & Onken, 2001), geared primarily toward establishing the feasibility of using BA to treat bereavement-related dysfunction. The goals of this pilot trial were to assess safety and acceptability, treatment and training protocols, adherence/competence measures, and recruitment procedures, as well as contribute to manual development. A second goal for our feasibility analysis was to examine clinical impact of a treatment that explicitly targets the main risk factors for postbereavement dysfunction (avoidance, rumination) underlying the diagnoses commonly seen in response to bereavement. We hypothesized that addressing loss-related reductions in environmental engagement by enhancing the flexibility of individuals' behavioral repertoire would allow individuals to secure meaningful, positive reinforcement in the postloss environment and reduce functional disruption, promote resilience, and alleviate pathology.

Modern behavioral treatments for depression, including brief behavioral activation treatment for depression (BATD; Lejuez, Hopko, Acierno, Daughters, & Pagoto, 2011) and BA, posit that psychopathology is a result of goal-directed behavior being consistently associated with nonreinforcement or punishment (Ferster 1973; Lewinsohn & Graf, 1973). A consequence of these learning histories is an overreliance on escape and avoidance responses, and passively ruminating on unmet needs, rather than actively engaging the environment. Behavioral treatments for depression employ ideographic functional analysis to identify the contingencies maintaining depressive behavior and then uses operant conditioning principles to change these behaviors in order to improve functioning by increasing active, goal-directed behavioral strategies and decreasing passive or avoidant behavior (see Jacobson, Martell, & Dimidjian, 2001). In terms of techniques, both BA and BATD have a strong focus on activities scheduling (Lejuez et al., 2011; Martell et al., 2001)—a technique with significant support as a treatment for depression across several meta-analyses (Cuijpers, van Straten, & Warmerdam, 2007; Ekers, Richards, & Gilbody, 2008; Mazzucchelli, Kane, & Rees, 2009), and is garnering support as a treatment for PTSD (Jakupcak, Wagner, Paulson, Varra, & McFall, 2010; Wagner, Zatzick, Ghesquiere, & Jurkovich, 2007), smoking cessation (MacPherson et al., 2010), negative symptoms in schizophrenia

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