



# A randomized controlled trial of an internet-based therapist-assisted indicated preventive intervention for prolonged grief disorder<sup>☆</sup>



Brett T. Litz<sup>a, b, \*</sup>, Yonit Schorr<sup>a</sup>, Eileen Delaney<sup>c</sup>, Teresa Au<sup>d</sup>, Anthony Papa<sup>e</sup>,  
Annie B. Fox<sup>f</sup>, Sue Morris<sup>g</sup>, Angela Nickerson<sup>h</sup>, Susan Block<sup>g, i</sup>, Holly G. Prigerson<sup>j</sup>

<sup>a</sup> VA Boston Healthcare System, Massachusetts Veterans Epidemiological Research and Information Center, USA

<sup>b</sup> Boston University School of Medicine, USA

<sup>c</sup> Naval Center for Combat & Operational Stress Control, Bureau of Medicine and Surgery, USA

<sup>d</sup> Boston University, USA

<sup>e</sup> University of Nevada at Reno, USA

<sup>f</sup> VA Boston Healthcare System, USA

<sup>g</sup> Dana Farber Cancer Institute, USA

<sup>h</sup> University of New South Wales, Australia

<sup>i</sup> Harvard University School of Medicine, USA

<sup>j</sup> Weill Cornell Medical College, USA

## ARTICLE INFO

### Article history:

Received 27 September 2013

Received in revised form

30 March 2014

Accepted 15 July 2014

Available online 24 July 2014

### Keywords:

Internet-based intervention

Prolonged grief

Prevention

Cognitive behavior therapy

## ABSTRACT

This trial assessed the feasibility, acceptability, tolerability, and efficacy of an Internet-based therapist-assisted cognitive-behavioral indicated prevention intervention for prolonged grief disorder (PGD) called *Healthy Experiences After Loss* (HEAL). Eighty-four bereaved individuals at risk for PGD were randomized to either an *immediate* treatment group ( $n = 41$ ) or a *waitlist* control group ( $n = 43$ ). Assessments were conducted at four time-points: prior to the wait-interval (for the waitlist group), pre-intervention, post-intervention, 6 weeks later, and 3 months later (for the immediate group only). Intent-to-treat analyses indicated that HEAL was associated with large reductions in prolonged grief ( $d = 1.10$ ), depression ( $d = .71$ ), anxiety ( $d = .51$ ), and posttraumatic stress ( $d = .91$ ). Also, significantly fewer participants in the immediate group met PGD criteria post-intervention than in the waitlist group. Pooled data from both groups also yielded significant reductions and large effect sizes in PGD symptom severity at each follow-up assessment. The intervention required minimal professional oversight and ratings of satisfaction with treatment and usability of the Internet interface were high. HEAL has the potential to be an effective, well-tolerated tool to reduce the burden of significant pre-clinical PGD. Further research is needed to refine HEAL and to assess its efficacy and mechanisms of action in a large-scale trial.

Published by Elsevier Ltd.

The death of a loved one can trigger *prolonged grief disorder* (PGD; Prigerson et al., 2009). Symptoms of PGD are distinguishable from normal, uncomplicated grief, bereavement-related depression and anxiety symptoms, and posttraumatic stress disorder (e.g., Barnes, Dickstein, Maguen, Neria, & Litz, 2012; Boelen & van den Bout, 2005; Bonanno et al., 2002; Golden & Dalgleish, 2010; Prigerson et al., 1995, 1996). Bereavement is a well-established risk factor for illness, disability and death (Buckley et al., 2012; Kaprio, Koskenvuo, & Rita, 1987; Mostofsky et al., 2012).

Specifically, among the bereaved, those with syndromal level PGD have been shown to have heightened levels of suicidal thinking and behaviors, poor sleep, reduced quality of life, impaired social functioning, more health complaints, and days of work missed compared to those without syndromal level PGD (Boelen & Prigerson, 2007; Bonanno, Moskowitz, Papa, & Folkman, 2007; Chen et al., 1999; Lannen, Wolfe, Prigerson, Onelov, & Kreicbergs, 2008; Latham & Prigerson, 2004; Lichtenthal et al., 2011; Prigerson et al., 1995, 1996, 1997, 2009). Consensus criteria for PGD have been validated (Prigerson et al., 2009) and will be used in the ICD-11 (Maercker et al., 2013).

Although there are specialized evidence-based psychotherapies for PGD (e.g., Shear, Frank, Houck, & Reynolds, 2005), there are no evidence-based approaches to prevent PGD, nor to address the suffering of individuals with clinical levels of distress and

<sup>☆</sup> This research was supported by a grant from the National Institute of Mental Health (MH079884) awarded to the Brett Litz.

\* Corresponding author. VA Boston Healthcare System (116B-4), 150 South Huntington Avenue, Boston, MA 02130, USA.

E-mail address: [litzb@bu.edu](mailto:litzb@bu.edu) (B.T. Litz).

impairment in the early months post-loss. If PGD can be prevented, substantial pre-clinical suffering and functional impairment can be alleviated. Further, intervening early, when many bereaved are still interacting with caring family members or care-providers and actively processing the loss, may be more palatable and less distressing than waiting until enough time has passed for a PGD diagnosis (see Maercker et al., 2013), at which point most will be more isolated and not seek or receive the care they need (Lichtenthal et al., 2011).

Yet, there is good reason to be cautious about early interventions applied across too wide a range of bereavement-related distress (Litz, Gray, Bryant, & Adler, 2002; Schut, Stroebe, van den Bout, & Terheggen, 2001; Wittouck, Van Autreve, De Jaegere, Portzky, & van Heeringen, 2011). Concerns have been raised that bereavement interventions may interfere with the natural healing processes required for healthy adjustment to loss (e.g., Kleinman, 2012), and some have argued that any early degree of distress and impairment associated with bereavement is normative and should not trigger intervention (Bonanno, 2005). Indeed, most bereaved do not need or want, nor will they benefit from, interventions designed to ameliorate normative grief. *Selective prevention* (see Muñoz, Mrazek, & Haggerty, 1996) efforts (chiefly *grief counseling*) assume that in many loss contexts, especially mass-casualty events, all bereaved persons need help to recover. This can be intrusive, presumptuous, and wasteful of time and effort because most grief reactions do not entail serious and impairing distress (see Litz, 2006).

By contrast, *indicated prevention* strategies, which target individuals with significant and impairing pre-clinical symptoms, are more efficacious and a better use of limited resources (see Litz & Bryant, 2009; Litz et al., 2002). Indicated prevention only targets individuals with significant and impairing grief symptoms who are at the greatest risk for enduring distress and dysfunction and PGD. Indeed, individuals at significant risk for PGD can be reliably identified in the first few months following loss. For example, in a study of caregivers of terminally ill patients, severe PGD symptoms three months prior to the death predicted PGD six months following the loss (Lichtenthal et al., 2011). Prigerson et al. (2009) also demonstrated that grief severity prior to six months following bereavement predicted morbidity at 6–12 and 12–24 months after bereavement. Similarly, high levels of psychiatric morbidity and aversive emotions are predictive of a more protracted course of grief reactions (Bonanno, Moskowitz, Papa, & Folkman, 2005; Coifman & Bonanno, 2010). This convergent evidence shows that severe grief reactions that will not abate with time are detectable early on. In spite of this, to date, there are no indicated prevention programs for early PGD symptoms and impairment.

To address the need to target PGD in an indicated preventive framework, we developed and pilot tested an Internet-based therapist-assisted indicated prevention intervention called *Healthy Experiences After Loss* (HEAL). Internet-based interventions are scalable, cost-effective, and avoid draining scarce specialty care resources. The Internet also obviates barriers to seeking and receiving care (e.g., shame, stigma, logistical challenges such as impaired mobility and time constraints; Rochlen, Zack, & Speyer, 2004) that may be particularly relevant to older adults, the vast majority of bereaved individuals in the US (e.g., Hoyert, Kung, & Smith, 2005). Additionally, individuals who use technology to maintain connectedness have shown increased energy levels and quality of life following bereavement (Vanderwerker & Prigerson, 2004) suggesting that this may be a medium particularly well-suited for addressing PGD. The efficacy of Internet-based interventions for prolonged grief problems has recently been explored with encouraging initial findings (Kersting et al., 2013; Kersting, Kroker, Schlicht, Baust, & Wagner, 2011; Van der

Houwen, Schut, van den Bout, Stroebe, & Stroebe, 2010; Wagner, Knaevelsrud, & Maercker, 2006; Wagner & Maercker, 2008) suggesting that the Internet is indeed a promising medium for the delivery of care in a bereaved population.

HEAL employs cognitive and behavioral self-management strategies designed to ameliorate core prolonged grief symptoms, namely psychological, behavioral, and social disengagement from the present in favor of yearning for the deceased and focusing on the past. HEAL targets the common complaints that PGD sufferers describe about the difficulties of adjusting to life in the absence of the deceased. These challenges include impaired capacity for enjoyment and self-care, low productivity and difficulty engaging and finding meaning in work or leisure activities, and difficulties forming new emotional bonds and relationships (e.g., Boelen, van den Hout, & van den Bout, 2006). HEAL emphasizes reengagement in positive self-care and wellness activities and reattachment to social resources (see Stroebe, Abakoumkin, & Stroebe, 2010). HEAL builds upon our prior successful Internet-based therapist-assisted self-management approach to PTSD (Litz, Engel, Bryant, & Papa, 2007). In a similar vein, HEAL sessions and homework exercises are designed to be easily self-navigated, with little if any, need for professional assistance or intervention. However, as was the case in our earlier work, HEAL is therapist-assisted in that each participant receives an initial brief telephone call to introduce HEAL and provide logon information. In addition, the therapist contacts participants (via email or, if need be, telephone) who are not regularly logging on to help troubleshoot any obstacles to completing the intervention in a timely fashion. The primary goals are to promote and reinforce completion of assignments and to intervene in the event of a clinical crisis. The therapist contact in HEAL is supportive and limited – the therapist neither provides intervention content nor delivers feedback on specific assignments completed by the participants (in contrast to Kersting et al., 2011, 2013; Wagner et al., 2006; Wagner & Maercker, 2008). In addition to the benefit of monitoring and addressing clinical considerations in the event of a downward course or crisis, therapist-assistance has been associated with improved outcomes (Andersson & Cuijpers, 2009; Spek et al., 2007) and increased compliance and retention in internet-based interventions (Newman, Szkodny, Llera, & Przeworski, 2011).

The HEAL research occurred in three phases. Phase 1 was a content and website development phase, which entailed an extensive literature review, consulting with bereavement experts, and informed by our prior Internet-based intervention experience. Phase 2 entailed a program evaluation of HEAL to validate and standardize the protocol using feedback from clinical experts in bereavement as well as input from bereaved family members. Phase 3, described here, was a pilot randomized waitlist-controlled trial to examine HEAL's efficacy as well as its feasibility, acceptability and tolerability. We also aimed to examine the extent of professional oversight required and its impact on efficacy.

## Method

### Participants

This study was approved by the Internal Review Boards of the institutions affiliated with the study; participants provided verbal consent over the telephone and returned a signed consent form by mail. Participants were bereaved caregivers of recently deceased patients who had been treated at the Dana-Farber Cancer Institute in Boston, Massachusetts. Information about the study was distributed to family members as part of a routine informational mailing distributed by the hospital's Department of Psychosocial Oncology and Palliative Care between three- and six-months post-

متن کامل مقاله

دریافت فوری ←

**ISI**Articles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات