

"I OFTEN THINK THEY JUST WENT OUT ..." IDENTIFYING, UNDERSTANDING AND TREATING COMPLICATED GRIEF IN SCHEMA THERAPY

Friedrich is 44 years old, internationally successful as author and scientist. He has a university chair in Oriental Studies, speaks over 40 languages and is a celebrated poet. After many years of relationship difficulties, he finally manages to have a family with five children. He seems to be happy. All of a sudden, all of them fall ill with an insidious disease. Two and a half year old Luise dies on December 31, her little brother 2 weeks later.

The man will never recover again. His career is over. He loses his job. He just sits at home and writes poems to his dead children. One after the other, more than 400 in total. He decides to never publish them. "I often think they just went out ...," and: "she took my word from me...," and "you're my shadow during days, and in the night my light".

The 'Kindertodtenlieder' (Children Death Songs) by romantic writer Friedrich Rueckert, written between 1833 and 1834 (Rueckert 2017), published many years later, have been considered 'perhaps the greatest lamentation in world literature' (Wollschlaeger in Rueckert 2017).

SYMPTOMS

On the question of what goes beyond "normal" grief, there are ideological and cultural differences. Although the diagnosis is still occasionally questioned (Cacciatore & Frances 2022), there is a well-founded database for Complicated Grief (CG) or Prolonged Grief Disorder as an independent diagnostic entity, which has consequently recently been included in the diagnostic systems ICD-11 and DSM5-TR. Mostly related to the death of a person (but also to other losses, such as the loss of home or - also imminent - loss of physical integrity (Wellisch & Cohen 2010), it is characterized by symptoms of an insatiable and painful longing for the deceased, the avoidance of references to the fact of loss, a persistently intense and ruminating-fantasizing preoccupation with the deceased, feelings of anger and bitterness - or, complete emotional numbness as well as



considerable difficulties and rejection of accepting the loss (Prigerson & Maciejewski 2022). CG is characterized by the simultaneous presence of both approach and of avoidance (Kakarala et al. 2020).

ON RISK FOR COMPLICATED GRIEF

Well-documented intrapersonal risk factors for the development of Complicated Grief are:

1. Insecure attachment
2. Dependent personality traits
3. Increased emotional instability/neuroticism
4. Reduced ability to provide meaning, especially meaning to disruptive life events and to integrate them into a coherent structure of meaning (Mason et al. 2020).

Childhood separation anxiety is highly correlated with the development of CG in adult life but not with the development of MDD, PTSD, and GAD (26). Previous losses and a lack of social support are further risk factors (Vanderwerker et al. 2006). "Disenfranchised grief" may become a complicating factor if the grieving process is or seems to be not (longer) accepted by the social environment ("you should be able to let go sometimes"), or if the deceased person is socially not accepted, or a loss of pets or even precious objects (Doka 2016).

If we have a look at the underlying schemas in CG, we typically find:

1. Abandonment
2. Vulnerability to harm
3. Self-sacrifice

as the most common ones (Thimm & Holland 2017), whereof "self sacrifice" seems to be a secondary, conditional schema. Insecure attachment styles are significantly correlated with several schemas of all domains (Karantzas et al. 2023), wherefrom the abandonment schema plays an outstanding role in anxious attachment.

These schemas are activated towards Complicated Grief especially in cases when a reduced ability for creating meaning and coherence works as a mediating factor (Mason et al. 2020).

Interestingly, religious affiliation in itself does not necessarily cause reduced grief. It can also lead to an increase in Complicated Grief, presumably due to greater experience of guilt (Stroebe et al. 2013) or higher psychological inflexibility (Algauer 2021).

There are also risk factors associated with the context in which the deceased died: if the person died without being able to prepare for death, without being able to accept death and say goodbye, or if they died in hospital instead of hospice or at home.

32-year-old Rewan grew up with his aunt. His mother died shortly after he was born, his father married again and died when he was ten years old. He has no siblings. Due to his ADHD, he has difficulty completing his thesis as a language teacher. Despite his impulsiveness, he is very popular with his large circle of friends because of his great willingness to help. When his aunt developed an anxiety disorder 10 years ago, Rewan completely geared his life to meet her needs. 1.5 years ago she died unexpectedly at home as a result of a heart attack. Rewan was the first to find her. From this moment on everything became dark for him. He broke off all social contacts, he no longer meets anyone, and can only work sporadically. When friends try to contact him, he reacts irritably and angrily, so that after a while they turn away, which increases his anger even more. He agonizes over the thought that he could have prevented her death if he had come earlier. Several times a week he spends hours at his aunt's grave. When not there, he sits in the dark, cries and talks to his uncle about the deceased. He looks at pictures and old videos of her. He feels like he is being "buried by an avalanche".

NEUROBIOLOGICAL FINDINGS - AN ADDICTION DISORDER?

In the "normal" grief reaction, the stages of protest, anger, despair and reorganization are passed through over time.

In CG, a pseudo-attachment—not exactly hallucinated, but imagined—is maintained while at the same time avoiding and not accepting the actuality of the loss. This goes so far that, for example, the table is set for the deceased, cooking is done for them and things are bought as if they were still there.

A well-documented finding is that the reward system plays a central role in the development and maintenance of CG (Kakarala et al. 2020). The activation of the reward system is visible in a functional MRI when looking at photos or when thinking about the deceased (O'Connor et al. 2008). Different from PTSD and depression, in CG there are strong neurobiological correlates of an addiction. While emotions and drive are reduced in depression and the avoidance of triggers is typical for PTSD, the pain in CG is severe and excruciatingly experienced (activated pain system). Clients are longing and craving constantly for internal and external stimuli to deal with the lost person.

It is well known that the feeling of security and well-being in an attachment is induced by the neuropeptide oxytocin. Regarding CG there is an interesting finding: After the initial drop of oxytocin after the loss of a beloved person, oxytocin increases again during grief and increases probably even more in complicated grief (Bui et al. 2019).

Since it is still lower than before the loss, presumably this (relatively) increased oxytocin level goes hand in hand with the exclusivity of the attachment with the dead person, while other social contacts are largely discontinued.

So CG somehow resembles an emergency generator of self-sufficiency, which provides a rekindling of a ghostly relationship and is fueled with oxytocin and endogenous opioids.

Holly Prigerson, one of the leading CG researchers, describes an anecdotal observation on opioids (Kakarala et al. 2020): Three patients to whom she administered the opioid antagonist naltrexone showed an almost complete remission of the symptoms within 2 days! Currently (April '23) she recruits clients at the Weill Cornell Institute for the first systematic naltrexone trial in Complicated Grief (endoflife.weill.cornell.edu).

THE COMPLICATED GRIEF MODE MODEL

Self-blame and guilt, easily activated irritability and anger as well as continuous ruminating ideas often form the visible side of the disorder. They correspond to the coping modes of submission (to the inner critic) and to the angry protector mode. The ongoing preoccupation with the dead person, with memories and thoughts about them can be seen as a self-soothing mode.

In the vulnerable child mode, we find two core emotions: 1. sadness/despair and 2. anxiety/panic.

THE TREATMENT PROCESS

In our opinion, the treatment algorithm for Complicated Grief follows a two-stage approach:

1. Overcoming coping modes and experiencing and verbalizing grief and despair.
2. Reparenting anxiety that is underlying the abandonment schema and insecure attachment while implementing positive schemas and forming a secure attachment with the client.

HOW TO REACH SADNESS AND DESPAIR?

Depending on the patient's structuredness, i.e. the extent of her/his healthy adult mode, chair dialogues with changing chairs can be used, as well as imagining the deceased person (Gladstone 2018). Overcoming coping modes, a relief from guilt/self-criticism and removing the burden of responsibility for "maintaining" the memory of the dead person can often be achieved in one or within a few sessions. "Giving voice" as described by Scott Kellogg (Kellogg 2014) may lead to a rapid initial relief.

HOW TO REACH AND TO REARENT THE ANXIOUS CHILD

This is where treatment gets a bit more complicated and longer term, since we now are concerned with changing maladaptive schemas, and establishing a secure bond and positive schemas.

First we need to reach the scared, lost and panicked child that underlies any addictive or self-soothing behavior.

Imagery rescripting of the recent past or a "present-focused imagery" (Maurer &



Rafaeli 2020), for example based on the situation in which the client found the dead person, is powerful enough but not too hurtful to reach the primary emotions of the child. When the gallery of recent modes is activated (Maurer & Rafaeli loc. cit.), the anxious child will also appear and will function as a basis for the coming re-parenting work. In the further course of therapy we should reach one or more childhood scenes, in which the therapist first takes on the role of the re-parenting agent before the client is later coached to rescript by himself. The therapist, as a good parent, in the childhood scene is an indispensable authority, because in the re-parenting part of the rescripting, when the therapist provides security and autonomy for the child, positive schemas and secure attachment are generated. Therefore, a significant time should be spent in this part of the imagination.*

Another technique to reach the frightened, distressed or even frozen or "buried" child and to strengthen the healthy adult as a good inner parent, is the so called "emotion-focused resonance chamber" technique (inspired by Nissen & Sturm 2014). At the outset of this exercise, the healthy adult should be empowered to be "strong enough" to be a healing force in the imagery work. For this purpose we may use the "Moment of Power" image with bodily anchoring (developed from an idea presented by A. J. Popky on an EMDRIA conference 1995, quoted in Rost 2008).

"Get an image of that moment when you felt so proud after contradicting your boss. What do you feel right now, where is it in your body? Now change your posture into a posture that matches this feeling. Very good! Now make it a little bit "stronger", exaggerate it a bit ... and then anchor that posture with a "body flash".

For the following imagery work the client first has to get an image of the child ("where do you find the child?") and then to imagine the powerful healthy adult is entering the scene. From then on, there is a constant and wordless exchange of perspectives between the child and the adult. It's assumed, because in the end they both belong to the same person, that one of them is able to realize the emotions, thoughts and impulses of the other one, and react to them, so that the non-verbal exchange works is directed back and forth like a ping pong ball. The goal is that a kind of emotionally communicating tubes are created between the child and the adult, while the adult provides a compassionate containment for shared emotions:

*"When you (adult) realize that the child doesn't trust you yet and is afraid that you could leave again any moment, how do you feel? What is your impulse to do? (...)
- When the child realizes that the adult feels sorrow and wants to protect it, how does the child feel? What does it want the adult to do ...?"*

With this technique the child might be step-by-step "awakened" from its torpor and drawn from its burial into life and into the emotions of sadness, despair and anxiety, while healthy adults can contain and integrate them.

Kellogg (Kellogg 2014) argues that sooner or later it takes a "decision" whether or not to let the deceased go - emphasizing that any choice is an acceptable option, but it is a choice. This also fits with the dynamics of addiction – the decision to become autonomous plays a major role in addiction treatment.

Therefore, we believe that any "say-hello-again" concepts, presented by some therapists (f.e. Ruskay 1996), i.e. fantasizing a continued virtual bond with the deceased person, runs the risk of continuing what the client already excessively does. This does not mean though that one should not integrate the deceased as an "inner guide" or inner mentor who changes from being an addiction object towards becoming a part of the good inner parent.

CULTURAL DIFFERENCES

Especially when doing schema therapy with members of other cultures or religions, we need to be aware of cultural differences in relation to family members. In Islamic cultures, for example, there is almost unconditional reverence for parents. The soul of the deceased remains in the tomb until the resurrection, awaiting the future, where it can already be rewarded for its good deeds or punished for its bad deeds (al-Jabali 2006) so that a constant concern and intercession for the soul appears necessary and meaningful from this point of view. In therapy, it would not be important to "let go", but to enable the client to draw a helpful boundary between himself and the soul of the deceased.

*Of importance for schema therapy and its relation to attachment theory are the findings (Louis et al. 2018, Paetsch et al. 2022) that in the same schema domain we can hold contradictory, i.e. positive and negative schemas on the same issue in the same person, which are activated in different contexts. As far as we are aware, the question of whether only already existing positive schemas can be reinforced or positive schemas can be created again has not yet been investigated.



CHRISTOPH FUHRHANS studied medicine, philosophy, art history and comparative literature in Kiel, Vienna and Berlin. As a psychiatrist and psychotherapist he worked as a DBT trainer and since 2008 as Schema Therapist, Schema Therapy and Group Schema Therapy trainer and supervisor (ISST).

He is the founder and leader of the "Schema Therapy Institute East Switzerland" and president of the Swiss Schema Therapy Network.

International presentations and trainings, leader of the Schema Therapy certification training programs in Palestine (since 2018), Egypt (since 2020) and Tunisia (since 2022).

His major regions of interest are psychotherapy and cultural sciences, current developments in psychotherapy (especially in trauma therapy) and Schema Therapy in Arab countries. He lives and works in Winterthur/Switzerland.

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