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Guided Mourning for Morbid Grief: A Controlled Study

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Summary: During 2 weeks on a waiting list 12 patients with morbid grief did not improve significantly. They were then randomly allocated either to guided mourning treatment, in which they were encouraged to face cues concerning their bereavement, or to control treatment in which they were asked to avoid such cues. Each treatment comprised six 1½ hour sessions over 2 weeks. At week 4 guided mourning patients had improved significantly more than had controls on 3 measures, with a supportive trend on 4 measures. Improvement, though modest, was maintained to 10-28 weeks follow-up. Control patients did not improve significantly or show any trend to do so.

The concept of loss occupies a central position in psychiatry (Freud, 1917; Lindemann, 1944; Bowlby, 1960). Earlier interest focussed on the mother-infant relationship but more recently attention has been paid to the effect of other losses; for example of a home (Fried, 1962) or a limb (Parkes, 1972). Loss of an important relationship through death appears to have the most extensive sequelae, both to physical (Maddison and Viola, 1968; Rees and Lutkins, 1967) and to mental health (Parkes, 1964).

Much has been written on the process of mourning following such a loss (Parkes, 1964; Averill, 1968; Lindemann, 1944) but few studies have described or compared treatments for those whose distress is unduly protracted or profound. Recent descriptions of a behavioural treatment for morbid grief have been promising (Ramsay, 1976; 1977; 1979; Gauthier and Marshall, 1977; Gauthier and Pye, 1979). The approach (which we call 'guided mourning') likens unresolved grief to other forms of phobic avoidance, which have been treated successfully by exposure to the avoided situation, as in the treatment of obsessive-compulsive and phobic patients (Marks, 1978). In one series (Liebermann, 1978) most of the 19 patients treated with this approach improved with an unspecified amount of treatment; this study indicated the need for a controlled investigation which this paper reports.

The present study compared guided mourning with a control treatment in 12 patients with morbid grief (6 per condition).

Design and Treatments

After two weeks on a waiting list twelve patients were randomly assigned to one of two treatments. Each treatment consisted of 1–1½ hour long sessions given three times weekly for two weeks, with subsequent follow-up until 28 weeks after entering the trial.

There were five therapists: one (psychiatrist) treated six patients (three per condition); two (psychiatrist, nurse therapist) treated one patient each in each condition; two further therapists (psychiatrist, nurse-therapist) treated one patient each in the different conditions.

Psychological treatments

Between weeks 2 and 4 patients received either (a) guided mourning or (b) control treatment.

(a) *Guided mourning* (6 patients). During treatment sessions the patient was exposed to avoided or painful memories, ideas or situations, both in imagination and real life, related to loss of the deceased. After initial explanation of treatment aims, the events surrounding the loss or its consequences were discussed and the therapist then focussed on those areas which the patient found difficult to describe, for example a situation associated with great sadness or guilt. The patient was then encouraged to describe repeatedly such situations until his initial distress was diminished, which was then pointed out to him. Patients who avoided places such as the hospital where the deceased died, the cemetery or that person's last town of residence were encouraged to visit those places.

When phobic avoidance mainly concerned the loss itself the patient was encouraged to say "goodbye" to the deceased aloud in the sessions, in writing during

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homework, and sometimes at the cemetery where the deceased was buried.

Throughout treatment the therapist aimed to maximize exposure to stimuli at a pace tolerable to the patient, and to minimize discussion of issues not immediately relevant to this task.

During the first 4 sessions, all patients were given an instruction card on which was written: "Write at least one page daily about your relationship with the deceased, and think about that person as often as you can. *Force yourself* to face the grief and you'll feel better. Also look at a photo each day of the deceased".

(b) *Control treatment* (6 patients). In contrast to guided mourning, the patient was encouraged to avoid thinking of the deceased, and to give as little attention as possible to such painful memories or thoughts as emerged spontaneously. Methods of distraction were suggested, and techniques of thought-stopping or relaxation between sessions were also sometimes used. Emphasis was placed on current issues and on the need to carry on with life in an industrious and positive fashion. Advice was given on how this might be done with as little reference as possible to the deceased. In some cases, the subject of the loss was repeatedly re-introduced by the patient; this was dealt with by pointing out the distress caused and the need to concentrate on less distressing and more positive topics. The patient was then advised to put out of sight all painful reminders of the deceased such as photographs or possessions.

During the first 4 sessions all patients were given an instruction card on which was written: "Write at least one page daily about your relationships to friends or relatives who mean a lot to you, and think about them as often as you can. *Give yourself a break* and you'll feel better. Also look at photos of your friends or valued relatives each day'.

The two treatments were both directive, and had in common the joint co-operation of therapist and patient, and each step was made at a mutually acceptable pace. Each involved outpatient treatment (except in two cases, one per condition), sessions of similar duration and number, and tasks to be carried out at home or elsewhere after the sessions. All patients were given a relevant instruction card at session 1.

Patient Selection and Characteristics

All patients complained of persistent distress of over one year's duration which dated from the loss, or which had been greatly exacerbated by the loss. In addition, suitable patients had to have two or more of the features listed in Appendix 1 and not have had behavioural treatment for them. Suitable patients were then randomly allocated into guided mourning or control conditions within two weeks of initial assessment. Of the 12 patients selected, 11 were women, age range was 28 to 61 (median for guided mourning 42, and for control 54). The loss had occurred between 1 and 10 years prior to treatment (median for each condition 3 years). Seven patients had lost their husband, four their mother and one her aunt. Cause of death was neoplasia in 11 relatives and heart attack in one. Four patients in each condition were on antidepressant medication throughout the study, having been on it for at least 6 months previously.

Case examples: Two case histories are given to illustrate the type of patient involved in the trial. Neither did well.

(a) *Guided mourning.* A woman of 58 had been depressed and lonely since the death of her second husband from Hodgkin's disease nearly two years previously. Since the death she had taken two small overdoses, and often thought of suicide. Alcohol and cigarette consumption had increased. Sleep and appetite were poor, and her sleep was often disturbed by nightmares of her husband's illness. She avoided one of the hospitals he had been treated at, and could not look at his glasses, although none of his other possessions distressed her. She felt extremely bitter and angry about the way her husband had been treated in hospitals and by various doctors, who were almost uniformly regarded as callous and incompetent.

She was the oldest of three children, and described her childhood as very unhappy. Following a row with her father she left home at 14. She took various secretarial posts and was married at 20. The marriage was unhappy and ended after 10 years in divorce. In contrast, her second marriage was recalled as ideal.

At assessment she was depressed, tearful, and very angry about her husband's treatment. She said she could sometimes feel her husband's presence, often talked to him and had once since his death felt his hand.

From the first session she was encouraged to describe some of the more painful memories of his illness, e.g. his difficulty walking, the brusque treatment by one hospital, the late diagnosis. In this and subsequent sessions she was gently asked to describe repeatedly one particularly distressing episode. This occurred when her husband's legs became paralysed and he asked her for help. She recalled his fear and her feelings of powerlessness to help him.

Another distressing image was of her husband's face near the end of his illness when it was bloated and ugly. These and similar memories were repeatedly presented to her disgust and she was asked to describe the feelings they evoked. She felt extremely angry with the doctors who had, in her view, treated him casually and perhaps even experimentally. Again, she was encouraged to talk of her anger towards them, as well as towards his relatives whom she thought had neglected her in her loneliness.

At the end of each session she was given homework. This consisted of looking at photographs of her husband, of writing letters (not to be sent) to the various doctors who had treated him, and of letters to her husband, talking of her feelings. The last she found impossible to begin with but

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later managed to write to him of her loneliness and sadness at his loss. She could never write a final "goodbye", despite much encouragement to do so.

During follow-up the sessions gradually became more supportive and less concerned with the bereavement. Although some of the distress evoked by talking about her husband was now lessened she remained lonely and embittered when discharged at 10 months follow-up.

(b) *Control treatment.* A woman of 58 described herself as a lifelong worrier. She became depressed three months after her husband's death from lung cancer two years before entering the trial. In his final illness, which lasted six months he became cachectic and hallucinated. She fed him with food she prepared. One day after feeding him he vomited blood and died subsequently during gastroscopy. When she saw the body, she thought she saw his face move, and ran out to tell the nurses there had been a mistake.

During her depression she became insomniac, anorexic and lost weight. She lost interest in life, and was emotionally labile, with frequent crying spells. A year before entering the trial she was admitted for two months and improved slightly. At assessment she was still mildly depressed, and felt guilty if she ever began to enjoy herself. He was rarely far from her thoughts and, even in the simplest task such as threading a needle, often asked him for help in her mind or aloud. She often saw him in her flat when alone and talked to him, but knew the experience was imaginary. She also saw his cat which had died shortly after her husband.

At the first session it was explained to her that she had suffered a great deal and that therapy would concentrate, with her co-operation, on her resuming a normal, active life. This would comprise resuming previously neglected interests and tasks, and perhaps involve new ones. She agreed to this and in her homework she made plans for a holiday, wrote a diary of daily activities and undertook more of the household chores.

In treatment she showed a marked tendency to return to the subject of her husband which, although said to be comforting, usually made her tearful. This was pointed out to her and ways of distracting herself from sad or painful memories were discussed. Again, she understood this but found it hard to comply. On many occasions the opportunity arose in the sessions to practise such self distraction by talking of neutral topics, but the effect was usually shortlived.

During one session family photographs were looked at. She was encouraged to talk about those of her niece's family, but the briefest attention possible was given to those of her husband. All mention of him met with a gentle reminder that the subject was distressing for her and therefore best avoided.

Follow-up sessions were supportive, with continued emphasis on pursuit of an active life and discouragement of introspective reflection. She improved slightly overall with greater interest in her job and several activities.

Measures

Patients rated themselves at weeks 0, 2, 4, 8, 12 and 28 (Fig 1). There were no observer ratings. Ratings at week 4 occurred 2 days after the last treatment session. As a few ratings were lost at weeks 8 and 12 the two points were pooled to give a score for 'week 10'. Measures were designed to cover four areas of function which are currently of theoretical interest in the treatment of morbid grief. This facilitated study of the interrelationships among different areas of pathology when treatment led to change.

1. *Pathology of grief itself*

(a) *Bereavement avoidance tests:* Five tasks concerning bereavement were given to every patient to complete at home, each task to take 2 minutes timed on the patient's watch. The 5 tasks were: to look at a photograph of the deceased; to hold a possession of the deceased's and then throw it in the dustbin; to think about those qualities of the deceased they liked most and least; and finally to write a letter to the deceased. Each was rated according to (i) Performance —whether or not each task could be done (score range 0–5) and (ii) *Distress*—if each task could be done, how much distress it caused, by marking a cross on a 10 cm line between the two extremes of 'no distress' and 'great distress'. (Mean of 5 scores range 0–10).

(b) *Physical symptoms of grief:* Score range 0–39. Thirteen symptoms commonly reported during mourning (Maddison and Viola, 1968) were selected for this newly devised scale, and each item was scored from 0 ("I almost never have this") to 3 ("This is a severe problem"). (See Appendix 2).

STUDY DESIGN

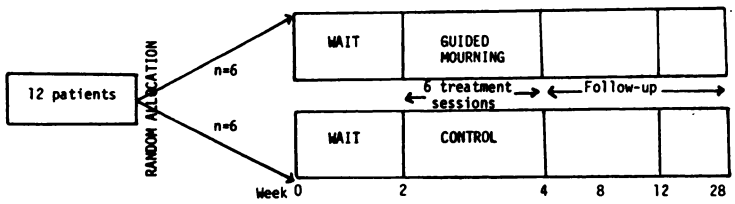


FIG 1.—Study design.

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(c) *Hostility-anger-guilt:* Score range 0–10. This newly devised scale comprised 7 questions concerning affective manifestations of grief. (See Appendix 3).

(d) *Texas inventory of grief:* This consists of 7 commonly-encountered features of normal grief each rated 0–4 (score range 0–28) (Faschingbauer *et al*, 1977. Appendix 4).

(e) *Attitude to self and to the deceased:* Two concepts (MYSELF and the DECEASED specified by name) were rated on bipolar 0–6 semantic-differential scales. MYSELF was rated on *evaluative* scales (good–bad, unpleasant–pleasant) and two *anger* scales (angry–calm and placid–irritable). The DECEASED was rated on 2 *evaluative* scales (unpleasant–pleasant, good–bad) and one *thought-difficulty* scale (easy to think about–upsetting to think about). Each concept yielded 2 factor scores (*evaluative* and *anger* for MYSELF and *evaluative* and *thought-distress* for the DECEASED).

2. Depression

(f) *Wakefield depression questionnaire*. Score range 0–36. This self-rating questionnaire (Snaith *et al*, 1971) comprises 12 0–3 items. It has a test–retest reliability of r = 0.68 and correlates r = 0.87 with the Hamilton depression scale (Marks *et al*, 1980).

3. Anxiety, fear, compulsions

(g) *Anxiety* was rated on a 0–8 scale (Watson and Marks, 1971).

(h) *Fear questionnaire* (*FQ*). This lists 17 phobic situations each to be rated on a 0–8 scale of avoidance (Total *phobia* score range 0–136), 6 anxiety–depression feelings each rated on a 0–8 scale (*anxiety–depression* score range 0–48), and a single overall global phobia 0–8 scale (Marks and Mathews, 1979).

(i) *Compulsive activity checklist*. Score range 0–117. This consists of a series of 0–3 scales concerning avoidance, repetition and duration of 39 everyday activities (e.g. having a bath, washing clothes). The scale was modified from that devised by Hallam (see Philpott, 1975 and Marks *et al*, 1977).

4. Social adjustment (j-n)

Five items (work, leisure, sex, relationships with family, relationships with friends or neighbours) were each rated on a 0–8 scale (Watson and Marks, 1971).

Results

Table I and Fig 2 summarize the results. All scores are arranged so that the lowest score of 0 indicates absence of pathology. All 12 patients completed treatment to week 4. One control patient did not return at week 10. At week 28 six patients failed to attend for follow-up (two from guided mourning, four from control). All t-tests reported are two-tailed.

The 2 groups combined: overall change

From weeks 0 to 2 the 12 patients did not improve on any measure; in fact at week 2 they rated the deceased as significantly *less* good and pleasant than at week 0 ($P < .02$ on analysis of variance). Pooling the scores for weeks 0+2, (i) analysis of variance of the change to week 4 showed that the 12 patients taken together improved on 5 measures: Wakefield Depression ($P < .03$); hostility–anger–guilt ($P < .02$), global phobia ($P < .06$), bereavement avoidance–task performance ($P < .001$), difficulty thinking about the deceased ($P < .01$). (ii) t-tests showed improvement on 7 measures at week 10 Wakefield Depression ($P < .03$); physical symptoms of grief ($P < .1$); hostility–anger–guilt ($P < .1$); Texas inventory of grief ($P < .08$); anxiety ($P < .08$); fear questionnaire, anxiety–depression ($P < .05$) and work ($P < .08$). There was no worsening on any measure.

Between-groups analysis

Guided mourning was compared with the control treatment by analysis of covariance, which covaried the pooled means of each condition's scores at weeks 0+2, and compared these with scores at week 4: After guided mourning, patients improved more than did control patients on total phobic avoidance ($P < .03$), bereavement avoidance–task performance ($P < .02$) bereavement avoidance task–distress (the guided mourning patients did not improve, while control patients became significantly *worse*) ($P < .03$), difficulty in thinking about the deceased ($P < .07$), Texas inventory of grief ($P < .06$), anxiety–depression ($P < .08$), and global phobia ($P < .1$); at week 10 t tests comparing raw scores found guided mourning to be better than control on the Texas inventory of grief ($P < .05$).

Control patients did not improve more than guided mourning patients on any of the measures at weeks 4 or 10.

Within-group change

From weeks 0 to 2, 2 to 4, and 2 to 10 change was examined within each condition separately by t tests (2-tailed). Neither group changed significantly from weeks 0–2. From weeks 2–10 guided mourning patients improved on the Texas inventory of grief ($P < .05$). No significant improvement or trend to do so was found on any measure for the control condition. At 28-week follow-up the 4 guided mourning and 2 control patients who attended had improved slightly further on most measures.

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TABLE I
Means and standard errors of scores

	Score range	Weeks	Mean	SE	Mean	SE	Mean	SE	Mean	SE
			0		2		4		10	
Pathology of grief itself										
(a) Bereavement avoidance tasks										
(i) Performance	0–5	GM	2.2	0.3	1.5	0.3	0.2	0.2	0.8	0.3
		C	2.8	0.6	1.7	0.3	1.7	0.4	1.8	0.5
(ii) Distress	0–10	GM	6.2	1.0	5.7	1.4	6.5	1.3	4.8	1.0
		C	4.7	1.8	4.8	1.4	6.5	1.3	7.8	1.3
(b) Physical symptoms of grief	0–39	GM	10.0	2.6	9.3	1.8	7.0	1.2	5.8	1.4
		C	9.5	3.0	9.5	3.0	9.0	1.8	8.7	1.6
(c) Hostility-anger-guilt	0–10	GM	4.5	0.3	5.0	0.7	3.3	0.5	3.3	0.6
		C	4.5	1.0	3.8	0.9	3.5	1.0	3.6	1.3
(d) Texas inventory of grief	0–35	GM	18.2	1.4	19.3	1.3	14.3	1.7	11.6	2.9
		C	19.7	2.0	20.0	1.9	19.6	1.6	19.5	1.9
(e) Attitude to:										
MYSELF	0–12	GM	6.5	1.4	9.0	1.1	6.8	1.9	7.0	2.1
(i) Evaluative		C	5.0	0.8	4.5	1.0	4.3	0.7	5.0	1.6
(ii) Anger	0–12	GM	8.7	1.1	9.1	1.0	8.3	1.3	7.0	1.9
		C	5.2	2.1	6.0	1.9	6.3	1.6	4.5	0.9
DECEASED	0–12	GM	3.7	2.0	5.8	1.6	3.6	1.8	4.2	1.4
(iii) Evaluative		C	1.3	0.6	5.7	2.0	4.8	1.9	1.9	0.7
(iv) Thought-difficulty	0–6	GM	5.8	0.2	4.3	1.0	2.2	1.1	2.9	1.2
		C	2.7	1.1	3.5	0.9	2.7	1.1	3.4	1.5
Depression										
(f) Wakefield	0–36	GM	25.5	2.4	27.0	2.0	20.8	3.8	18.8	4.6
		C	24.5	3.0	24.7	2.8	21.8	2.2	22.2	3.3
Anxiety, Fear, Compulsions										
(g) Anxiety	0–8	GM	5.5	1.2	5.8	0.8	5.0	0.8	4.2	1.0
		C	5.0	1.1	5.0	1.1	4.3	1.1	4.5	1.4
(h) Fear questionnaire (FQ)										
(i) Total phobia: avoidance	0–136	GM	36.8	8.6	44.7	11.7	32.2	8.2	29.2	0.5
		C	34.8	13.0	29.2	10.3	34.2	12.0	34.9	15.6
(ii) Anxiety-depression	0–48	GM	26.5	1.6	25.3	2.1	17.8	3.8	14.2	4.3
		C	20.3	6.1	19.3	5.7	21.5	5.9	20.8	6.4
(iii) Global phobia	0–8	GM	4.7	1.2	2.7	1.0	2.2	0.7	1.7	0.7
		C	3.7	1.5	3.7	1.5	3.5	1.5	4.5	1.6
(i) Compulsive activity checklist	0–117	GM	20.0	5.4	20.3	5.9	18.8	6.3	13.5	5.6
		C	22.5	7.7	28.0	10.0	32.5	13.0	23.2	12.1
Social adjustment										
(j) Work	0–8	GM	2.8	1.4	3.8	1.1	2.8	1.1	2.7	1.0
		C	4.3	1.1	2.8	0.9	4.3	1.2	4.1	1.5
(k) Leisure	0–8	GM	3.7	1.4	4.8	1.0	3.3	1.2	4.1	1.4
		C	4.3	1.3	2.8	0.9	4.3	1.2	4.8	1.4
(l) Relationship with family	0–8	GM	4.0	1.8	2.3	1.2	2.5	1.3	2.8	1.1
		C	1.3	1.0	1.8	1.0	2.0	1.0	1.4	0.9
(m) Social relationships	0–8	GM	2.2	1.2	3.3	1.6	1.8	0.9	2.2	1.2
		C	2.0	1.0	2.0	0.5	2.3	0.9	3.0	1.3

GM = Guided mourning; C = Control treatment.

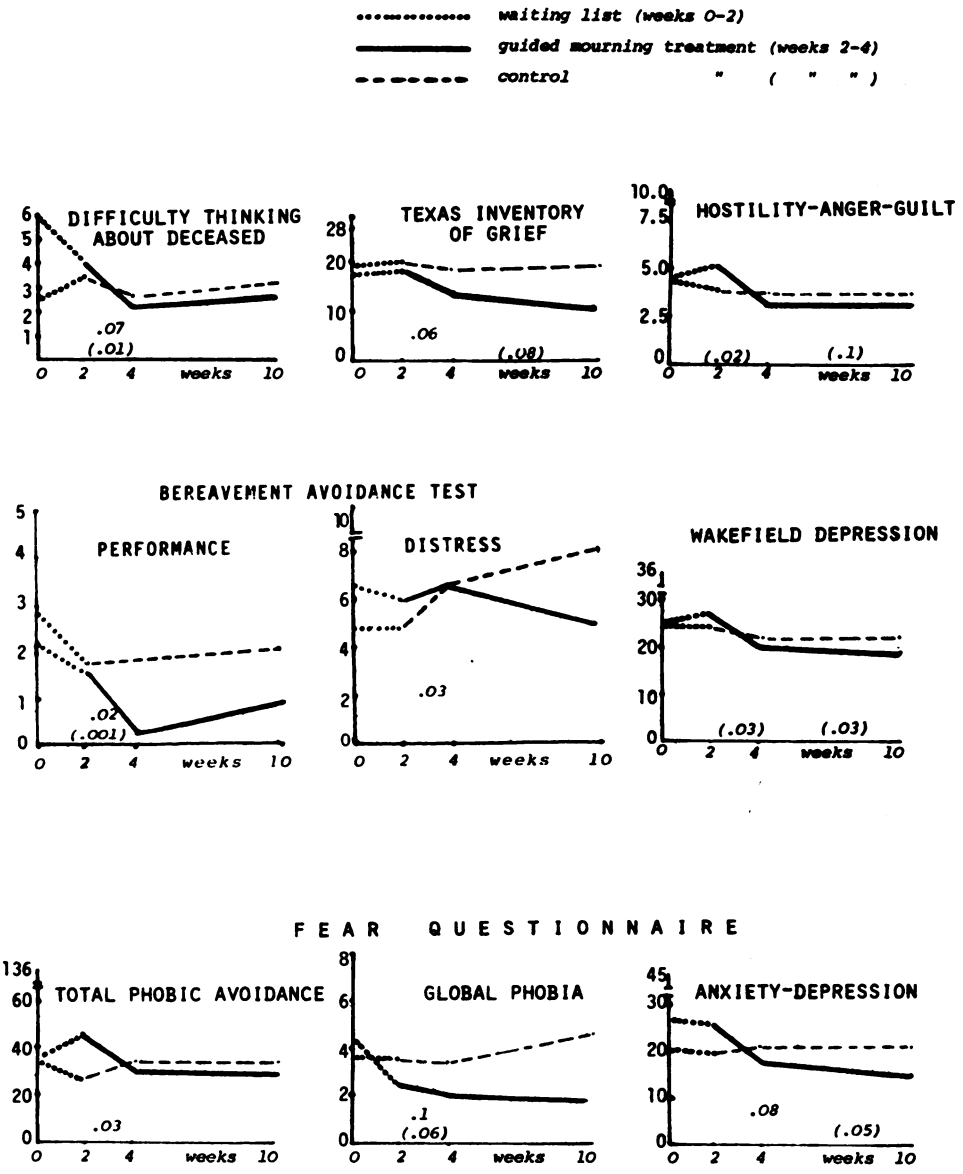
Therapist effects

The therapist who had most experience with guided mourning, in that he treated half the sample, for each treatment obtained no better results than those of the other 4 therapists combined.

Relationships among the measures

The sample was too small for factor analysis. Product-moment intercorrelations showed no clear clusters among the 4 main areas of interest. At weeks 0, 2 and 4 significant intercorrelations on all 3

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.07, .02 etc. = sig. of diff. between guided mourning and control, weeks (0+2) v. 4

(.07), (.001) = " " " for improvement of both groups combined, " " " " or 10

(n=6 for all points, except n=5 for controls at week 10)

FIG 2.—Morbid grief: mean improvement to 10 weeks.
Trends and significant effects; lower scores = less pathology.

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occasions were found among the following measures ($n = 12$ for each, P at least $<.05$). Wakefield depression with: hostility–anger–guilt, anxiety–depression (FQ-fear questionnaire), anxiety, relationships outside the family. Physical symptoms with: hostility–anger–guilt, global phobia (FQ). Hostility–anger–guilt with: anxiety–depression (FQ), global phobia (FQ), anxiety, Wakefield depression, physical symptoms.

Total phobic avoidance (FQ) with: global phobia (FQ) and compulsion checklist. Anxiety with: leisure. Leisure with: anxiety, relationships outside the family. Two versions of the hostility–anger–guilt scale (linear analogue versus anchor points) correlated significantly with one another at weeks 0, 2 and 4 respectively, ($r = .68, .72, .75$, $P < .007$).

Discussion

During 2 weeks on a waiting list patients with morbid grief did not improve significantly on any measure. Over the next 2 weeks those who received guided mourning showed significantly more improvement than did controls on 3 measures (behavioural avoidance tests concerning the deceased and distress during them, and total phobic avoidance), with a supporting trend in the same direction on 4 measures (difficulty thinking about the deceased, Texas inventory of grief, anxiety–depression, global phobia). This improvement was maintained at 10 and 28 weeks.

In contrast, control patients showed no significant improvement or trend to do so on any measure. The control treatment might be construed as having contained an element of paradoxical intention, but if so this was not therapeutic.

All measures in this study were self-ratings, but changes were consistently in the same direction, all favouring guided mourning over control treatment. Observer ratings were not used in this pilot study, but other systematic comparisons of observer with self-ratings for depression, phobias and rituals have found these to correlate highly significantly (Marks and Mathews, 1979; Marks *et al*, 1980).

The results suggest that guided mourning is a useful ingredient in the management of morbid grief, although the effect was not as potent as might have been hoped from some earlier reports (Ramsay, 1977; Gauthier and Pye, 1979; Lieberman, 1978). Our patients had only 6 treatment sessions over 2 weeks. Perhaps more sessions of treatment over a longer period would have had greater effects, and this is being investigated.

Whether guided mourning is especially worthwhile in any particular variety of morbid grief could not be ascertained from our small sample of patients. Parkes (personal communication) suggested that guided mourning is indicated where grief has been avoided, repressed or delayed, but is not especially useful where patients can readily express their grief either in self-punitive fashion or as an excuse to avoid developing a new life style. For the latter a goal-oriented programme may be helpful.

Though the overall effects of guided mourning were modest, in some cases marked improvement occurred, as in a 48 year old woman who since the death of her mother 3 years before had become almost housebound, had drinking episodes and become socially isolated. During guided mourning she was encouraged to visit places associated with her mother and to write letters to her about her mother's irritating habits. The patient carried out these activities and in her last week of treatment visited her mother's grave daily and said goodbye to her. At 28 weeks follow-up she was socially more active, was no longer drinking excessively, was driving a car for long distances, and was looking for a job.

Bereavement is a normal and important cause of physical and mental distress. Grief is regarded as morbid when unduly prolonged or severe, and this study investigated the alleviation of morbid grief by brief intervention of two sorts. Guided mourning assumed that morbid grief is to some extent maintained by phobic avoidance of an aspect of cues concerning the deceased, and concentrated on encouraging approach (exposure) to avoided cues. The control treatment was the opposite approach which discouraged exposure and resembled the reassurance frequently given by friends or relatives of bereaved individuals, although the control treatment was more intensive, structured and administered in a therapeutic setting.

Guided mourning involved intensive reliving of avoided painful memories and feelings associated with bereavement, and did not attend to social and biological features of morbid grief, though the latter were often a more obvious aspect of psychopathology. Other important features concerned depressed mood and general anxiety, and these were less improved by guided mourning than was avoidance of the deceased. This is in keeping with the nature of the treatment, but the generalization of improvement from increased approach to cues about bereavement to lightening of depression was much less than might have been hoped for. At the end of treatment the sample still had abnormally high Wakefield depression scores.

The superiority of guided mourning was most evident on measures of approach to bereavement cues, and less evident on measures of depression like the Wakefield and other measures which correlated significantly with the Wakefield. This suggests that the

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mood disturbance and the avoidance of bereavement cues are less intimately linked than is commonly thought to be the case. This idea is borne out by the few significant correlations among measures of these two problem areas, though our sample was too small for systematic appraisal of this issue. A related phenomenon is the relative independence of depressed mood on the one hand and phobic-obsessive problems on the other. The latter responds well to exposure treatment and the former does not (Marks *et al*, 1980).

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Appendix 1

Additional selection criteria: 2 or more of the following:

1. Delayed or abnormal onset of grief after the death.
2. Increased alcohol, drug or cigarette consumption since bereavement.
3. Identification with deceased.
4. Psychoneurotic reactions arising since death.
5. Anniversary reaction.
6. Avoidance behaviour concerning the deceased.
7. Excessive guilt or hostility towards the deceased, or those involved with the deceased.

Appendix 2

Physical symptoms

1. Headache.
2. Chest pain.
3. Vomiting.
4. Eat too much.
5. Palpitations.
6. Shortness of breath.
7. Nightmares.
8. Nausea.
9. Drowsiness.
10. Unsteadiness of hands.
11. Dizziness.
12. Sweating more than usual.
13. Sexual difficulties

Appendix 3

Hostility-Anger-Guilt

1. I have let people down since the death.
2. Everyone did all they could at the time of death.
3. I did all I could for the deceased.

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4. I get cross at my friends and relatives more than I should.
5. I blame myself for the death.
6. Certain people are to blame for the death.
7. Since the death I have got on with life quite well.

Appendix 4

Texas inventory of grief

1. At times I still feel the need for the person who died.
2. I still get upset when I think about the person who died.
3. I am preoccupied with thoughts about the person who died.
4. I am unable to accept the loss of the person who died.
5. I have pain in the same area as the person who died.
6. Sometimes I feel just like the person who died.
7. I seem to get upset each year at about the same time that the person died.

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