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Case Study

Mourning Protocol Details and the Cognitive Behavior Therapy Applicability

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Abstract: The paper presents details of sessions taken place for a mourning female patient case study with cognitive behavior theoretical basis. The main objective is to present the clinical intervention: the list of cognitive distortions linked to the mourning process, the challenge of dysfunctional thinking, inventory scores and the coping card built along with the patient. It describes the step by step in the care of a mourning patient and proves the effectiveness of the chosen protocol for this purpose. The results show that after the application of the focused and structured protocol there was significant improvement in the patient's interpretations regarding her son's death. The evidences towards such a conclusion are the greater capacity of the interpretation's understanding and reassessing, the emission of functionally more effective behavior in producing more reinforcing consequences for the patient in face of missing her son, and more positive emotions.

Keywords: Mourning protocol; Cognitive behavior therapy; Maternal grief

Introduction

There are many ways of experiencing death, but when it comes to the mourning process is unavoidable to talk about grief. The way people live that grief needs comprehension considering mainly their civilization, culture, religion and age: the degree of kinship, gender, type of death, links and internal resources available to each individual thus influences how they experience grief and the state of mourning (Parkes, 1998).

In a historical retrospective, it is verified that death was already considered a natural and tranquil event of which all participated, and everyone felt entitled to express his or her feelings linked to the loss. The dying witnessed their departure and made their own farewell rituals. However, death was perceived as a failure towards the ending life, due to the impotence before it (Ariès, 2014).

The religious interpretations given to death vary with culture. Thus, in Buddhism death is not the end but the continuation of an existing cycle between life and death. Hinduism also interprets death as a restart in which reincarnation is the next step. Spiritism offers a likewise interpretation. Therefore, for those religions death is not regarded as "the end". In Brazil, most part of the population have its beliefs influenced by Christianity, and for those, death means the end of the earthly life, leaving only one left life to be lived after Christ come, when everyone should be judged and taken to heaven or hell. Thus, a reunion with the dead will only occur after the death of those who are in mourning, and therefore they mourn the death of a loved one, who will be absent forever from his present life. The event of death is still often interpreted as a punishment of a supreme being, as if science had not yet explained and revealed the causes of illness and death (Ariès, 2014).

Symptoms related to the loss of a person with whom one has had a close relationship (mourning) most commonly reported are: emotional (deep sadness, guilt, anxiety and loneliness), behavioral (lack of concentration, crying, dreams about the deceased, the greater attachment to objects belonging to the deceased), cognitive (disbelief, worries, hallucinations and mental confusion) and physical (lack of air, greater sensibility to noises, lack of energy and depersonalization) (American Psychiatric Association [APA] Hensley & Clayton, 2008; Zisook & Shear, 2009).

For many years, grief was associated with mental illness because of its similarity to the symptoms of depression. Currently, when grief is differentiated from a major depressive episode (MDE), it is considered that in mourning the feeling is of emptiness and loss, whereas in MDE the feeling is of persistent depressed mood and inability to anticipate positive visions of the future, including joy and happiness (APA, 2014), as described in Board 1.

Board 1 – Differences between Mourning and MDE

Mourning	MDE
Feelings of empty and loss	Depressed mood and inability to anticipate positive visions of the future, joy and happiness.
Dysphoria may subside over days and weeks, appearing in "waves" associated with memories of the deceased.	Persistent depressed mood not related to specific thoughts or memories.
The pain of mourning may come along with a positive mood.	Generalized unhappiness and distress.
Preserved self-esteem. In some cases self-depreciation is perceived, however, referring to failures associated with the deceased.	Feeling of worthlessness and aversion to oneself.
Thinking of death to be able	Feeling of death to end

to "join" the deceased.	one's life, due to the feeling of worthlessness.

The mourning experienced by a patient may, according to DSM-5 (APA, 2014), lead to great suffering, but hardly provokes an MDE. However, when a patient presents symptoms of mourning and MDE, it is a person with predisposition to emotional illness. The intense yearning, the longing for the deceased, the sadness, and the concern for the circumstances of death are expected responses in bereaved patients. However, the fear of separation is an indication of possible emotional difficulty, such as an anxiety disorder (APA, 2014). In case of mourning patients, in which the symptoms of mourning are strongly experienced and persist for longer than would be expected considering their culture, age and religion, a possible adaptation disorder, which has a worse prognosis due to greater chances of suicide attempts and consummation, should be investigated.

Normal grief is a healthy response to the loss of a loved one and implies the healthy ability of bereaved people to express this pain from the recognition of loss, readjustment, and new investments in their relationships. But when these abilities to deal with loss are scarce, according to Parkes (1998), it is possible to perceive the suffering caused by the symptoms that are manifested in denial and repression of loss, and this suffering can lead to what Malkinson (2010) calls of an irrational, or maladaptive, process of mourning.

Death is undoubtedly a stressful event in a person's life, generating much suffering and psychological, physiological, behavioral and even social changes where the mourner is inserted. The difficulties of mourning may disrupt the lives of bereaved people so much that they can not cope with such sadness (Basso & Wainer, 2011). Knowing how to differentiate the sadness of a normal mourning to the pathologic one is important for the psychology professional both for the intervention process to be adequate and avoid more suffering, and in order that the patient's symptoms are not neglected (Zisook & Shear, 2009). Understanding the patient's beliefs that were activated by the death of his or her loved one, his or her understanding of death, and how he or she has dealt with the loss situation are important elements for the practitioner in the field of psychology to identify errors in thinking and the schemes that are linked to the patient's suffering in the situation of mourning, thus helping him or her through intervention (Dattilio & Freeman, 2004).

This article presents a clinical case study of mourning in which a cognitive-behavioral psychology structured protocol was applied. The chosen protocol values three spheres of the patient's life, namely: a) the learning of new cognitive and behavioral abilities, enabling the patient to readapt to their life cycle; b) the reformulation of the social roles of the people involved in mourning; and c) the respect for the natural course of mourning.

Method

A case study was chosen for this work since it is a method capable of focusing on the understanding of different scenarios in a particular way. A protocol for the care of bereaved patients was applied, with adaptations, to a patient who sought psychotherapy for having lost her child. To describe the case and maintain the confidentiality of the patient's identity, the names have been modified and are presented in this article in a fictional manner.

Case Description

R. is a female patient, 50 years old, divorced from her second marriage, and mother of 3 children. The oldest of the children was born on her first marriage, *F.*, 34, married, died of cancer 15 days before she sought psychotherapy. She had two children in the second marriage: *N.*, 32, married, and *R.*, 27, single. At the time she sought psychotherapy, she did have neither a job nor any occupational or social activity. She reported managing the house and living with her children and some aunts. The patient has two granddaughters with whom she has little coexistence. She is overweight, reports having diabetes and observes little care with food. *R.* also has dental problems that prevent her from maintaining good nutrition.

In recent years, her activities have been confined to caring for the diseased son, *F.*, who fought a brain tumor for three years. In the last six months, the patient was living in *F.*'s house for intensified caring at night. According to the patient's account, the deceased son played a role not only as a son. She reported he witnessed the sufferings of her two divorces, as well as the suffering experienced in the second marriage, being always by her side, holding her hand in the difficult moments of her life and assuming the role of friend, comforting and playing the "father's" role, helping the patient with her self-care and personal decisions.

The patient also claims to have been dependent on both husbands to make decisions and, after the divorces, became dependent on *F.* She defines dependence as letting the child make decisions about her appearance (choosing her new clothes, deciding on her hair cut and color, as well as with the furniture for the house), her finances (whenever she needed to buy something, she would call him and ask him a blessing" – the consent for acquisition). The patient was financially dependent on all the children, who helped her with a monthly amount, but she said she could not manage that money alone. After *F.*'s death, as he left her a life insurance, she became financially independent of the children, having financial resources of her own. However, she feels unable to take care of her finances by herself because she never learned and never had to manage her money and bank account. *R.* also claims to miss the presence and affection of the other children, who moved away from her after *F*'s death. The daughter, who still lives with her, shows no affection and maintains her routine without paying attention to her mother.

Intervention Description

This section presents details of the application of the mourning protocol, clippings of the session reports, the cognitive distortions of the patient related to mourning and the tools used, so that they can serve as guides for future professionals willing to treat bereaved patients.

An evaluation was made to understand the patient's demand followed by the application of a protocol for the care of

mourning patients. At the patient's initial evaluation, information was collected on her complaint: which medications she used, who were her family and close friends, what was the current routine, and what were her expectations regarding therapy. During this evaluation, the patient's reports described a lot of suffering, with repeated verbalizations of much pain, and statements that she was asking for help in order to alleviate feelings related to mourning: "I feel much pain, help me. My other children suffer too, but it's different, no one knows the pain I'm feeling ".

The initial evaluation showed that the patient felt guilty about her son's death and was emotionally dependent on him. In addition, the intense suffering, the high hopelessness identified, and the weak support network were helping her to think of suicide as a possible outlet for her pain.

The adapted protocol of Silva's (2009) model started in the following session. The original protocol (Silva, 2009) is 12 sessions long, with space of seven days between sessions. It was adapted in its application, due to the need to stabilize the patient's mood, since she was in deep suffering and without people with whom she could share her pain.

The new protocol model, proposed in this article for *R.*'s treatment, lasted 12 sessions, with two weekly meetings until the fourth week, using the cognitive-behavioral theory as a theoretical basis. However, a suicide risk was detected, and there were, therefore, an increase of two sessions to evaluate the factors related to the risk of suicide, totalizing 14 sessions. Besides adapting the number of sessions and periodicity, procedures such as the identification of cognitive distortions, psychoeducation on the effect of emotional distortions of thought and questioning of the patients' dysfunctional thoughts were also included. The Beck Anxiety Inventory (BAI), the Beck Depression Inventory (BDI) and the Beck Hopelessness Scale (BHS) were applied. The adapted protocol can be checked in Board 2.

Board 2 – Care protocol for bereaved patients

Phase 1: Sessions 1 to 4	1.1 Application of self-report scales Beck Anxiety Inventory (BAI), Beck Depression Inventory (BDI) and Beck Hopelessness Scale (BHS), to assess the depression intensity, anxiety, and hopelessness on a weekly basis. 1.2 Suicide risk assessment. 1.3 Psychoeducation on the stages of mourning and on the cognitive, physiological and behavioral changes considered as common in this period. 1.4 Identification of the cognitive distortions of the patient related to mourning. 1.5 Help the patient to recognize the loss. 1.6 Use of techniques for anxiety and depression in acute times, if necessary.
Phase 2: Sessions 5 to 8	2.1 Physical education about the effect of cognitive distortions on emotion and behavior. 2.2 Questioning of the patient's dysfunctional thoughts related to mourning. 2.3 Resolution of outstanding problems between the patient and the lost person. 2.4 A "rescue" person's name. 2.5 Reorganization of the family system and roles redistribution.
Phase 3: Sessions 9 to 12	3.1 Propiciate the readaptation of the subjet to daily life; Weekly activity schedules' organization. 3.2 Investment in new life goals and new relationships. 3.3 Reinforce alternative thinking about distortions. 3.4 Relapses' prevention.

Phase 1: Self-report scales BAI, BDI and BHS were applied in the initial evaluation session to assess the intensity of depression, anxiety and hopelessness. The application was repeated weekly, always in the first session of the week, and the scores can be seen in Table 1.

Table 1 - Scores of self-report scales (BAI, BDI and BHS)

	Initial assessment	Week 1	Week 2	Week 3	Week 4	Week 5	Week 6	Week 7
BAI	37	28	35*	22	18	12	7	6
BDI	33	28	30*	28	20	15	10	6
BHS	11	7	9*	7	5	2	1	1

There was a significant improvement in the scores between the initial evaluation and the evaluation performed in the 7th week of care. However, there was an aggravation in the scores in week 2, which could be associated with two relevant facts: (1) it was the birthday of the deceased son and (2) the end of year celebrations were near, what was usually celebrated by the patient in the company of this son.

During the initial evaluation, the BHS showed a significant result: 11, characterizing a moderate range of hopelessness. This result became more worrying when associated to the depression score, as measured by BDI (33). It was therefore suspected that she was a patient with moderate suicide risk. Two extra sessions were then performed to identify the elements that could serve as triggers for a suicide attempt, as well as to assess this risk.

According to Serra (2006), the patient who presents the associated hopelessness and depression constructs is considered to be at risk of suicide, since hopelessness is associated with the cognitive triad related to the "future". Another risk factor pointed out by the author is the self-concept, which refers to the dimension of the cognitive triad "self", as well as the distortions in the information processing, in which the patient presents stiff thoughts.

The suicidal usually presents perfectionist and unrealistic beliefs about himself, about his expectation of others, and about the expectation he believes others have of him (Dattilio & Freeman, 2004). This perfectionist characteristic was not identified in *R*. However, in addition to the high indexes of hopelessness and depression measured by the BHS and BDI instruments, respectively, some risk factors were identified as negative self-assessment and feelings of dismay on the part of one of the children. But when talking to the patient about suicide, she commented that one of the promises she had made to her son before he died was that she would never take her own life. She also commented that at the time of his death, her son had left her with enough financial resources so that she could participate in a weight loss program, get all her teeth and implants, undergo bariatric surgery and do various plastic surgeries to feel "more beautiful". The patient reported focusing on plans to improve her self-image, and said she would work in the upcoming months, ruling out any possibility that she might commit suicide. However, even after this conversation with the patient, her psychiatrist and her two children were alerted about the risk of attempted suicide, and the therapist became aware of possible precipitators of a crisis.

After assessing the risk of suicide and the fact that the patient did not present sufficient precipitants to commit suicide, the protocol adapted for bereaved patients was followed by psychoeducation on the stages of mourning: denial and isolation, anger, bargaining, depression, and acceptance. Considering that these stages are not a script, they may change according to the personal perspective of each patient (Kübler-Ross & Kessler, 2005). Thus, the emotional, cognitive, physiological and behavioral symptoms of mourning were worked out with the patient as a response to her interpretations of death.

"What if I do not manage taking care of my money?" This thought made the patient very anxious, worried and with insomnia. "He died because he needed me and I was asleep" was a thought that caused a lot of guilt and sadness to the patient, making her feel powerless, crying a lot, feeling hopeless and wanting to die.

Board 3 – Relation between cognition and presented symptoms

Cognition	Symptoms
"What if I do not manage to take care of my money?"	Anxiety (emotional) Concern (cognitive) Insomnia (behavioral)
"He died because he needed me and I was asleep"	Guilty (emotional) Sadness (emotional) Hopelessness (cognitive) Crying (behavioral)

As it can be seen in Board 3, there is a relationship between the cognitive processes of the patient and the reported symptoms, since cognitions are mediators between the event and its consequences, and the dysfunctional emotions felt by *R*. are due to the irrational thoughts about the mourning she is experiencing (Daniel, Lynn, & Ellis, 2010). Throughout the sessions, the therapist's listening was ready to identify, in the history of mourning, the patient's negative automatic thoughts and dysfunctional beliefs about the situations involving mourning. These beliefs can be seen in Board 4.

Board 4 – Automatic negative thoughts of the patient related to mourning

"What if I do not manage to take care of my money?"
"I'm guilty of my son's death."
"What if I cannot handle loving alone?"
"I should have been more present in *F*.'s life."
"He died because he needed me and I was asleep."

In this phase, the patient showed some cognitive distortions, but the role of the therapist in this first stage was to receive and assist in the recognition of the loss. The patient was then instructed to share thoughts about her son's death with close family members and neighbors, and to elaborate the farewell rituals of the child, since, according to Wetherell (2012), it is therapeutic that the patient exposes his feeling over death, talks about it and relive it several times. The patient, in addition to writing a letter to her son as a homework assignment, paid homage in social networks by talking about her love for him and the longing she felt. During the sessions, she was able to verbalize what she would like to tell *F*. if he was still alive, and recalled the moments in which she had been caring for him in the last three years, identifying the importance of her presence and her cares. The patient stated that the birthday of the deceased was near, and that she had already begun to think of symbolic ways of celebrating it. To do so, she contacted his wife and together they arranged to bring flowers to the grave on the day of the anniversary, order a cake, sing the congratulations with the family, and then watch a movie called *"Nosso Lar*[1]*"*, of the Spiritist doctrine.

In protocol's Phase 2, psychoeducation on the effect of cognitive distortions on the patient's emotion and behavior, and the main negative automatic thoughts identified in the previous sessions regarding the grief situation were worked out. The most active thoughts were also questioned, shown in Board 4 previously presented, with the purpose of getting the patient to find alternative thoughts, that is, alternative interpretations

[1] Brazilian movie that shows life after death according to the Spiritism doctrine. A free translation of the movie's title is "Our Home".

about the death of the child. One of the dysfunctional thoughts questioned in the session with the patient can be seen in Board 5.

Table 5 - Dysfunctional thinking questioning

COGNITION	EMOTION	BEHAVIOR
"My son died because he needed me and I was asleep." How much do you believe in this cognition? (0-100): 100	Guilt and deep sadness How much do you believe in this emotion? (0-100): 100	Cry Death wish

CHALLENGE OF DYSFUNTIONAL THOUGHT

a) Evidence: What are the evidences FOR and the evidences AGAINST negative thinking?

Is is true because…

It is not true because…

- "I called the nurses when I noticed my cold son";
- "He had terminal cancer and it was not because of me that he is gone";
- "I looked after him that night alone, I woke up three times and he was still alive, sleeping";
- One of the times I woke up, I fixed the probe on his nose, because I watched over him";
- "I took care of him for many months, moved out of the house so I could help";
- "I did everything I could".

b) Alternative interpretations: What are the alternatives to the Negative Automatic Thought?

"He is gone because it was his time. If I had been awake, he would have died the same way and I would not have noticed".

What does support this alternative?

"He was asleep when he died and made no noise, not agonized".

How would someone else react?

"Similarly".

How would you advise another person in this situation?

"You are not to blame; you did everything for your son".

The patient's dysfunctional thinking which persisted was related to the guilt of F's death: "I am guilty of the death of my son". Thus, a coping card was built with it, to be read in the moments when negative automatic thinking appeared. This coping card can be seen in Board 6. The patient reported in the following session that she presented this thought still during the week, however, she said she had easily controlled her sadness and mentioned not having felt guilty.

Board 6 – Coping Card

"I'm guilty of my son's death. *F*. died because he needed me and I was asleep".

- I have no evidence that this thought is true;
- My son had terminal cancer and that is why he died;
- On the night of his death I woke up many times and he was still alive and sleeping;
- I did everything that was within my reach, I spent years caring exclusively for him, I moved from home so I could help him;
- I spent every night with my son in the last few years and I always woke up when he made noises and needed to change sides or needed something;
- **Even if I was awake, he would have died, for I would not have noticed him, since his death, according to the doctors, was quiet and he did not agonize;**

<u>Alternative thinking:</u> I am not to blame for his death; I did my best. He is gone because his time has come.

During the sessions, according to the protocol proposed in this case study, after questioning the cognitive distortions, the psychologist responsible for the care of the bereaved patient had to address this topic: "solving pending problems between the patient and the lost relative." According to *R.*, she and her son had a relationship of great companionship and nothing needed to be resolved. However, she commented that if this matter had been dealt with during some sessions, she would have apologized to the son for having fallen asleep at the moment of his death, yet now she can recognize that she was not to blame for his death and that there was only the feeling of longing left.

A close person was also chosen by the patient to be her "rescue" in times of sadness, when she needed to talk about the pain of loss with someone, or if she needed emergency help or just a "friend shoulder." The patient chose a close cousin and asked if she could play the role. After confirmation, the psychologist responsible for the care, with consent of the patient, called the "rescue" cousin and gave her guidelines regarding her role and also the risks of suicide. The therapist's contact numbers were also provide in case the patient was in crisis and needed emergency intervention.

On the family reorganization, a goal stipulated in Phase 2, *R*'s children were attended and the role that the deceased brother had exercised for years in their mother's life was exposed to them (confidant, son, caregiver, friend, Father "). They were showed the need for the patient to have support and care, mainly with health (diabetes, obesity, teeth). Also, a routine of support to *R.* in which the children would take turns to take her

to the doctor, supermarket, bank, dentist has been stipulated. Thus, the role of each of the children was established, and the youngest committed to being more present in the routine of the mother and to keep company with her every night in the upcoming months. The children also organized themselves to occupy their mother's downtime and teach her to earn her own money. They then opened space for her to work in the family factory and thus occupy the time previously devoted entirely to the deceased.

At the 8th session (still in Phase 2), the patient had her schedule filled out and needed to space the sessions for once a week. This decision was taken because it was considered that she was working for her organization, her independence, her work and occupational activities, as well as not having been observed precipitators of a crisis with risk of suicide, but rather advances in stabilizing her mood and more functional behaviors.

In Phase 3, the last phase of the protocol, the patient was readmitted to the routine without the presence of the child. A calendar was built with the patient to organize her work routine and the days when she would have logistical support of the children to go to the supermarket. The patient was also assisted in identifying the appropriate public transport to get to and from work independently and chose a form of leisure (water aerobics) so that, for two days a week, she could take care of her well-being and exercise.

The patient was identified with new short-, medium- and long-term goals to be achieved for her well-being, including: going to a nutritionist and entering a weight loss program, taking care of her teeth and implants, treating diabetes and doing bariatric surgery and plastic surgeries on the abdomen and face. It was also identified in the patient the need to donate their affection to patients suffering from pathologies similar to that of their child. Therefore, after achieving some of her personal goals, she will begin volunteering with cancer patients, believing that this way she can help people who are still alive.

Results

After the 8th session, the patient had less depressed mood (BDI = 18) and lower anxiety (BAI = 20), greater hope about her future (BHS = 5) and more functional behavior, with greater acceptance regarding the death of the child. At the end of the sessions, the patient had a significant reduction in Beck's inventory scores, from 37 to 6 in BDI, 33 to 6 in BAI, and 11 to 0 in BHS.

After questioning distorted thoughts and beliefs, identifying evidence for and against distorted thinking, and identifying more adaptive thinking, what Beck calls cognitive restructuring, *R.* has been able to reduce her sense of guilt towards the death of her son, and the fear of being alone and helpless in the face of routine difficulties. The roles that the deceased son exercised were redistributed between the other children and herself. Therefore, she became responsible for her self-care, according to the goals established in therapy (the search for a nutritionist, endocrinologist, dentist, plastic surgeon), and the children were responsible for the logistical care. The patient began to make fewer cognitive distortions and readapted to her daily life. She sought new life goals that, in addition to motivating her, distracted her and generated feelings of hope.

The patient reports having had relapses and having been sad in a few days, but says that simply by the "ring of the telephone" is distracted and can easily resume daily activities, not feeling hurt by the sadness about the memories and the homesickness of his absent son.

Conclusions

There is a limited amount of therapeutic protocols with proven efficacy for the treatment of bereavement using as theoretical support cognitive-behavioral therapy, therefore it is considered that this article may contribute with other clinicians who wish to treat bereaved patients, as it used relevant, valid and reliable instruments. From the application of this protocol, there was a significant improvement in the patient's interpretation regarding the death of the child: it showed a greater capacity for re-evaluation of the interpretations, which became more functional, reflecting on more positive emotions. It can be concluded that she had a functional adaptation regarding the loss of her child, went through mourning rationally and adaptively, which, according to Malkinson (2010), is a healthy way to deal with the loss. The patient also showed a greater ability to develop coping strategies for the child's nostalgia and to deal with her daily problems, abandoning dependent behavior and having a positive social reintegration.

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