FOLIA MEDICA CRACOVIENSIA
Vol. LXIV, 4, 2024: 39–46
PL ISSN 0015-5616 eISSN 2957-0557
DOI: 10.24425/fmc.2024.152181

Cognitive behavioral therapy versus supportive counseling in palliative care for caregivers experiencing bereavement: clinical trial successes and challenges

Michael Kozlov[1], Bahareh Ehsaei[2], Gabrielle Winkler[2], Joshua Fogel[3], Zarui Chopuryan[2], Lidia Moraru[2], Marina Ivanyuk[2]

[1] Department of Psychology, Brooklyn College, Brooklyn, New York, USA
[2] Department of Internal Medicine, NYC/H+H — South Brooklyn Health, Brooklyn, New York, USA
[3] Department of Management, Marketing, and Entrepreneurship, Brooklyn College, Brooklyn, New York, USA

Corresponding author: Marina Ivanyuk, M.D.
NYC/H+H — South Brooklyn Health, Department of Internal Medicine
2601 Ocean Parkway, Brooklyn, NY 11235, USA
Phone: +1 718 616 4807; Fax: +1 718 616 5360; E-mail: marina.ivanyuk@nychhc.org

Abstract: Background: Bereavement support can benefit caregivers suffering from the loss of a loved one. We report successes and challenges of a randomized clinical trial comparing cognitive behavioral therapy (CBT) to supportive care counseling for caregivers.
Methods: We recruited caregivers of individuals who previously received palliative care treatment and were now deceased. The study was conducted in a public hospital in New York City predominantly serving low-income patients. Treatments were either CBT or supportive care counseling. Treatment consisted of eight sessions over six months. Outcomes were measured at three and six months. Outcomes were the Bereavement Experience Questionnaire-24 (BEQ-24) which contains three subscales of existential loss/emotional needs, guilt/blame/anger, and preoccupation with thoughts of deceased and the Patient Health Questionnaire-9 (PHQ-9) which measures depressive symptoms.
Results: Only two people were enrolled in the trial and 101 people declined to participate. For both CBT and supportive care counseling, there were reduced bereavement symptoms for BEQ-24 existential loss/emotional needs, BEQ-24 preoccupation with thoughts of deceased, and PHQ-9 depressive symptoms from baseline to six months. For supportive care counseling, BEQ-24 guilt/blame/anger increased from baseline to six months while CBT had the same value from baseline to six months. The most common reason (87.1%) for declining to participate was that support was available elsewhere.
Conclusions: Both treatment approaches appear beneficial for improving bereavement and depressive symptoms except for BEQ-24 guilt/blame/anger. Clinicians recruiting those with bereavement from public hospitals serving low-income patients may find it challenging to recruit participants.

Keywords: bereavement, cognitive behavioral therapy, counseling, caregivers, Patient Health Questionnaire.

Submitted: 09-Sep-2024; **Accepted in the final form:** 25-Oct-2024; **Published:** 30-Dec-2024.

Introduction

Caregivers who experience bereavement related to the loss of a loved one often experience negative psychosocial outcomes including anxiety, depression, or hopelessness [1]. Bereavement can be an overwhelming and distressing experience, as six months after the loss of a loved one, 7.6% of caregivers suffer from complicated grief and 12.1% have moderate-severe depressive symptoms [2]. Bereavement support is vital for caregivers suffering from the loss of a loved one, and interventions by trained professionals in palliative care settings may reduce bereavement symptoms including grief, anxiety, and depression [3].

Cognitive behavioral therapy (CBT) targets maladaptive thought patterns, behaviors, and emotional responses, and is a potential treatment modality for bereavement [4]. There are studies on the use of CBT for bereaved caregivers of patients who passed away from a wide range of disorders. CBT decreased symptoms of depression, anxiety, and hopelessness after the loss of a loved one to cancer [5]. Additionally, CBT reduced grief experiences, anxiety, and depression after the loss of a loved one to Covid-19 [6].

Studies that compare CBT to other counseling approaches report that CBT may outperform other counseling approaches such as supportive counseling or client-centered therapy [7–9]. A meta-analysis found CBT to have a positive impact on the bereavement of informal cancer caregivers [10]. However, studies examining the use of grief interventions in families bereaved by suicide found that CBT is effective for treating aspects of bereavement such as grief, but only for those who had high initial measures for suicidal ideation [11, 12].

There appears to be a lack of research studying the use of CBT for bereavement in acute community hospital settings. We conducted a clinical trial comparing CBT to supportive care for treating bereaved caregivers of patients who died in a community hospital setting. We also describe the challenges that arose in study recruitment for our clinical trial.

Materials and Methods

Setting

The study was conducted in a public hospital in New York City predominantly serving low-income patients. The study occurred from April 2023 through February 2024. At initial pre-mortem palliative care consult, caregivers were approached and asked whether they could be contacted upon the death of their loved one. The palliative care team contacted the admitting office every two weeks for a list of deaths, and cross referenced it with the palliative care consult list. Caregivers of the deceased were contacted post-mortem through a phone call and were screened for eligibility in the study. Inclusion criteria were caregivers 18 years or greater and speaking English. Exclusion criteria were those pregnant, those with court-appointed guardianship, history of psychiatric illness, Patient Health Questionnaire (PHQ)-9 depression scores >20, suicidal ideation, and/or self-reporting anxiety symptoms including but not limited to panic attacks on initial screening [13]. Those excluded due to mental health concerns were referred to treatment at the hospital's Behavioral Health area. Ethical approval was received from the hospital institutional review board and was conducted consistent with the Helsinki Declaration of 1975, as revised in 2000. The clinical trial was registered at www.clinicaltrials.gov on April 21, 2023 with the registration number of NCT05826145. Written informed consent was obtained. Participants were randomized using

statistical software (Stata SE, Version 17, College Station, TX, 2021) into either CBT or supportive care groups.

Treatments

The control (supportive care) group received treatment through vocal expression sessions in which participants talked for 20–30 minutes about their deceased loved one [14]. The counselor provided emotional support, encouragement, and validation to study participants. Treatments were provided approximately every three weeks for a total of eight sessions over six months.

The CBT group received treatment over the course of eight 20–30 minute sessions. The approach was adapted from previous CBT and complicated grief therapy protocols [15, 16]. During session 1 (week 0), a grief monitoring diary exercise was assigned. Session 2 was scheduled for week 2 of therapy, with further treatment sessions occurring approximately every three weeks over six months. Session 2 reviewed the assigned grief monitoring diary from session 1, and reviewed grief triggers alongside patterns of grief. Another grief monitoring diary was assigned and reviewed during session 3. At session 3, participants were tasked with practicing imaginal revisiting. Session 4 reviewed the material from session 3 and taught cognitive restructuring techniques related to negative thought processes and maladaptive attitudes related to bereavement. Session 5 reviewed cognitive restructuring, taught self-monitoring techniques, and assigned a self-monitoring assignment for session 6. Session 6 reviewed self-monitoring, and reviewed techniques to think of positive memories regarding the deceased. Session 7 reviewed these techniques, and taught skills related to identifying future goals. Session 8 reviewed future goals and taught skills to assist in preventing relapse.

Variables

The Bereavement Experience Questionnaire (BEQ)-24 is a 24-item questionnaire with subscales of existential loss/emotional needs, guilt/blame/anger, and preoccupations with thoughts of deceased [17]. Each item is measured on a Likert scale ranging from 1 = never to 4 = almost always. Higher scores indicate greater levels of the bereavement subscales. The scale is reliable and valid. BEQ-24 was measured at baseline, three months, and six months.

The PHQ-9 is a 9-item questionnaire that measures depression symptoms experienced within the last two weeks [13]. Each item is measured on a Likert scale ranging from 0 = not at all to 3 = nearly every day. Higher scores indicate greater depressive levels. The scale is reliable and valid. PHQ-9 was measured at baseline, three months, and six months.

Demographic variables were age (years), sex (male, female, other), and race/ethnicity (white, Hispanic, black or African American, east Asian, southeast Asian, other). We also recorded support availability (support available elsewhere, support not available elsewhere, and decline to answer).

Results

We recruited and provided interventions to two caregivers. The caregiver in the supportive care control group was 73 years, male, and white race/ethnicity. The caregiver in the CBT treatment group was 46 years, female, and white race/ethnicity. For both control and treatment, there was

reduced BEQ existential loss/emotional needs, BEQ preoccupation with thoughts of deceased, and PHQ-9 depressive symptoms from baseline to six months. For the control, BEQ guilt/blame/anger increased from baseline to six months while the treatment had the same value from baseline to six months (Fig. 1A–D).

We obtained data from 101 consecutive people who were eligible to be recruited and declined to participate. Mean age was 77.80 years (SD = 13.04). They were 69.3% female (n = 70). Race/ethnicity of the deceased patient was 65.3% white (n = 66), 14.9% Hispanic (n = 15), 8.9% black (n = 9), 4.0% east Asian (n = 4), 3.0% southeast Asian (n = 3), and 4.0% other (n = 4). There were 87.1% (n = 88) that had support available elsewhere, 7.9% (n = 8) did not have support available elsewhere, and 5.0% (n = 5) declined to answer the question about available support.

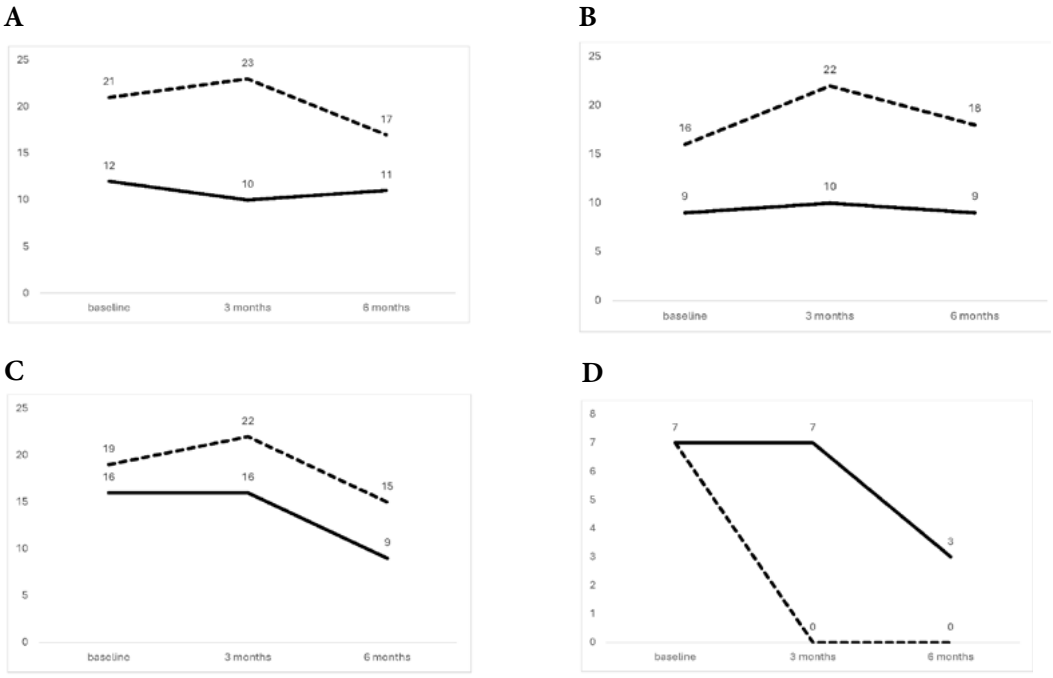

Fig. 1A. Bereavement Experience Questionnaire Existential Loss/Emotional Needs. **B.** Bereavement Experience Questionnaire Guilt/Blame/Anger. **C.** Bereavement Experience Questionnaire Preoccupation with Thoughts of Deceased. **D.** Patient Health Questionnaire-9 Depressive Symptoms.

Dashed line = supportive care counseling (control); Solid line = cognitive behavioral therapy (treatment)

Discussion

Our study followed the course of treatment of two caregivers: one in the supportive care counseling control group and one in the CBT treatment group. Both caregivers had improvement in BEQ existential loss/emotional needs and BEQ preoccupation with thoughts of deceased. BEQ guilt/blame/anger had a different pattern where the caregiver receiving supportive counseling

worsened and the caregiver receiving CBT experienced no change in symptoms. Moreover, the caregiver receiving supportive counseling reported no depressive symptoms as measured by the PHQ-9 after three months of treatment, while the caregiver receiving CBT only demonstrated reduced depressive symptoms at six months. The vast majority of those approached declined to participate, with many referencing external support through family, friends, or their community.

We found that both treatment approaches had improved BEQ existential loss/emotional needs, BEQ preoccupation with thoughts of deceased, and decreased depressive symptoms. A meta-analysis reports that CBT is effective in treating aspects of bereavement related to grief and depression [18]. Also, both supportive counseling and CBT decreased bereavement and depression [7]. Our findings are similar to these studies. We suggest that both supportive counseling and CBT provide a therapeutic environment that allows for emotional processing leading to decreased bereavement and depressive symptoms.

There was a different pattern for the BEQ guilt/blame/anger dimension in which the caregiver receiving supportive care counseling worsened and the caregiver receiving CBT experienced no change in symptoms. Caregivers more often experience grief through loneliness and thinking about the deceased rather than through guilt, blame, or anger [19]. This suggests that when caregivers do bring up guilt, blame, or anger, that supportive care counseling may be ineffective in reframing unproductive thoughts due to its passive nature and can worsen symptoms. Also, feelings of guilt surrounding the death of a loved one may not improve with CBT unless treatment is tailored specifically around guilt, blame, or anger [20]. It is possible that our CBT approach may have been ineffective in treating the guilt/blame/anger dimension of the BEQ-24, as our CBT approach focused on the general bereavement experience rather than the guilt/blame/anger subtype. Also, as our supportive care treatment was for general bereavement, this could also explain the worsening of guilt/blame/anger for the supportive care treatment.

Supportive care counseling seemingly outperformed CBT in alleviating depressive symptoms as measured by the PHQ-9. This may be an artifact of our sample size of one, as it contradicts previous research which reports CBT outperforms supportive counseling in treating grief experiences [7]. We saw that CBT appeared to lag in treating depressive symptoms where depressive symptoms were only lowered at six months for the caregiver treated by CBT. This can occur because it takes time to develop cognitive restructuring skills taught by CBT [7].

Our study experienced difficulty in recruiting caregivers with the majority reporting receiving support elsewhere. The typical caregiver contacted in our study was female (69.3%); this closely matches a previous survey which contacted bereaved Australian caregivers, who were also primarily female (70%) [21]. Previous research also found that almost all bereaved caregivers report receiving support from family (95%) and friends (88%), which is similar to our study in which 87.1% of caregivers received external support [21]. Also, previous studies examining the use of bereavement services report low interest in counseling services among caregivers who lost a loved one in hospice and palliative care settings. One study in a large metropolitan hospice and palliative care site reported that while 66% of bereaved caregivers were interested in bereavement-related mailing services, only 7% were interested in one-on-one counseling, and an even smaller 3% were interested in support groups [22]. Another reason for low recruitment is the population at our hospital, which primarily serves immigrants from low-income households, and many are Russian speaking. Those who need to work to support their family cannot afford to give up additional time in their day for counseling. Those in low-income households may not have access to or may decline therapy due to barriers such as travel costs, childcare availability, rigid work hours, or general

accessibility [23–25]. Additionally, culture can impact interest in counseling for depression which may have impacted our study recruitment. Those of Russian backgrounds are more likely to perceive those suffering from depression as "weak-willed" or as living an "immoral lifestyle" when compared to Americans, and are also less likely to seek support for mental illnesses as compared to Americans [26]. A large number of our caregivers are immigrants and Russian speaking and this may have influenced them to decline to participate in our study.

Study Strengths and Limitations

The primary strength of our study is recruitment in an acute community hospital setting with a diverse patient population. A limitation is that the small sample size of our study did not allow for inferential statistical analysis, making it difficult to determine whether CBT or supportive care counseling was more effective in treating bereavement in caregivers. Future studies that investigate bereavement treatment in acute hospital settings may opt to use alternative recruitment modalities, as our phone-based outreach had limited success. For example, an in-person pre-mortem discussion may prove to be useful, giving caregivers ample time to consider and process their support systems.

Conclusion

In conclusion, both CBT and supportive care counseling treatment approaches appear beneficial for improving bereavement and depressive symptoms except for BEQ-24 guilt/blame/anger. Clinicians recruiting those with bereavement from public hospitals serving low-income patients may find it challenging to recruit participants.

Acknowledgments, Funding, and Disclosures

Acknowledgments: None declared.
Funding: This research did not receive any specific grant from funding agencies in the public, commercial or non-profit sectors.
Conflicts of interest: None declared.

Author Contributions

M.K.: study design, data acquisition, data interpretation, manuscript drafting; B.E.: study design, data interpretation, critically reviewing manuscript for important intellectual content; G.W.: study design, data acquisition, data interpretation, critically reviewing manuscript for important intellectual content; J.F.: study design, data analysis, data interpretation, critically reviewing manuscript for important intellectual content; Z.C.: study design, data interpretation, critically reviewing manuscript for important intellectual content; L.M.: study design, data interpretation, critically reviewing manuscript for important intellectual content; M.I.: study design, data interpretation, critically reviewing manuscript for important intellectual content. All authors approved the final version of the manuscript.

References

1. *Skantharajah N., Barrie C., Baxter S., et al.*: The grief and bereavement experiences of informal caregivers: a scoping review of the North American literature. J Palliat Care. 2022; 37 (2): 242–258. doi: 10.1177/08258597211052269.
2. *Nielsen M.K., Neergaard M.A., Jensen A.B., Vedsted P., Bro F., Guldin M.B.*: Predictors of complicated grief and depression in bereaved caregivers: A nationwide prospective cohort study. J Pain Symptom Manage. 2017; 53 (3): 540–550. doi: 10.1016/j.jpainsymman.2016.09.013.
3. *Kustanti C.Y., Fang H.-F., Kang X.L., et al.*: The effectiveness of bereavement support for adult family caregivers in palliative care: A meta-analysis of randomized controlled trials. J Nurs Scholarsh. 2021; 53 (2): 208–217. doi: 10.1111/jnu.12630.
4. *Kosminsky P.*: CBT for grief: Clearing cognitive obstacles to healing from loss. J Ration Emot Cogn Behav Ther 2016; 35 (1): 26–37. doi: https://doi.org/10.1007/s10942-016-0241-3.
5. *Lacasta M.A., Cruzado J.A.*: Effectiveness of a cognitive-behavioral group therapy for complicated grief in relatives of patients with cancer: A randomized clinical trial. Palliat Support Care. Published online Feb 24, 2023. doi: 10.1017/S147895152300010X.
6. *Mirzaian N., Mirzaian B., Abbasi G.*: The effectiveness of trauma-focused cognitive-behavioral therapy (TF-CBT) on bereavement symptoms in bereaved children. AFTJ. 2023; 4 (3): 182–198. doi: 10.22034/AFTJ.2023.362941.1778.
7. *Boelen P.A., Lenferink L.I.M., Spuij M.*: CBT for prolonged grief in children and adolescents: a randomized clinical trial. Am J Psychiatry. 2021; 178 (4): 294–304. doi: 10.1176/appi.ajp.2020.20050548.
8. *Brown E.J., Goodman R.F., Cohen J A., Mannarino A.P., Chaplin W.F.*: An exploratory trial of cognitive-behavioral vs client-centered therapies for child-mother dyads bereaved from terrorism. J Child Adolesc Trauma. 2019; 13 (1): 113–125. doi: 10.1007/s40653-019-00264-2.
9. *Zisook S., Shear K.*: Grief and bereavement: what psychiatrists need to know. World Psychiatry. 2009; 8 (2): 67–74. doi: 10.1002/j.2051-5545.2009.tb00217.x.
10. *Zhou S., Wang Y., Wang Q., Yang G., Ren H., Bao Y.*: A meta-analysis of the effects of cognitive behavioral therapy on quality of life and negative emotions of informal cancer caregivers. Front Psychiatry. 2022; 13: 979158. doi: 10.3389/fpsyt.2022.979158.
11. *Linde K., Treml J., Steinig J., Nagl M., Kersting A.*: Grief interventions for people bereaved by suicide: a systematic review. PLoS One. 2017; 12 (6): e0179496. doi: 10.1371/journal.pone.0179496.
12. *de Groot M., Neeleman J., van der Meer K., Burger H.*: The effectiveness of family-based cognitive-behavior grief therapy to prevent complicated grief in relatives of suicide victims: the mediating role of suicide ideation. Suicide Life Threat Behav. 2010; 40 (5): 425–437. doi: 10.1521/suli.2010.40.5.425.
13. *Kroenke K., Spitzer R.L., Williams J.B.*: The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001; 16 (9): 606–613. doi: 10.1046/j.1525-1497.2001.016009606.x.
14. *Segal D.L., Bogaards J.A., Becker L.A., Chatman C.*: Effects of emotional expression on adjustment to spousal loss among older adults. J Aging Ment Health. 1999; 5 (4): 297–310.
15. *Bryant R.A., Kenny L., Joscelyne A., et al.*: Predictors of treatment response for cognitive behaviour therapy for prolonged grief disorder. Eur J Psychotraumatol. 2019; 8 (6): 1556551. doi: 10.1080/20008198.2018.1556551.
16. *Wetherell J.L.*: Complicated grief therapy as a new treatment approach. Dialogues Clin Neurosci. 2012; 14 (2): 159–166. doi: 10.31887/DCNS.2012.14.2/jwetherell.
17. *Guarnaccia C.A., Hayslip B.*: Factor structure of the bereavement experience questionnaire: The Beq-24, a revised short-form. OMEGA. 1998; 37 (4): 303–316. doi: https://doi.org/10.2190/l6hw-vgkf-knpt-vt3f.
18. *Komischke-Konnerup K.B., Zachariae R., Boelen P.A., Marello M.M., O'Connor M.*: Grief-focused cognitive behavioral therapies for prolonged grief symptoms: a systematic review and meta-analysis. J Consult Clin Psychol. 2024; 92 (4): 236–248. doi: 10.1037/ccp0000884.

19. *Tsaga H., Argyriadi A., Argyriadis A.*: Experiences of loss and their management by informal caregivers in the community. Perceived quality of life of people with chronic diseases. J Health Res. 2024; 10 (2): 92–104. doi: https://doi.org/10.12681/healthresj.35284.
20. *Young K., Chessell Z.J., Chisholm A., et al.*: A cognitive behavioural therapy (CBT) approach for working with strong feelings of guilt after traumatic events. Cogn Behav Ther. 2021; 14: e26. doi: https://doi.org/10.1017/s1754470x21000192.
21. *Aoun S.M., Rumbold B., Howting D., Bolleter A., Breen L.J.*: Bereavement support for family caregivers: The gap between guidelines and practice in palliative care. PLoS One. 2017; 12 (10): e0184750. doi: 10.1371/journal.pone.0184750.
22. *Ghesquiere A., Bagaajav A., Metzendorf M., Bookbinder M., Gardner D.S.*: Hospice bereavement service delivery to family members and friends with bereavement-related mental health symptoms. Am J Hosp Palliat Care. 2019; 36 (5): 370–378. doi: 10.1177/1049909118812025.
23. *Slaunwhite A.K.*: The role of gender and income in predicting barriers to mental health care in Canada. Community Ment Health J. 2015; 51 (5): 621–627. doi: 10.1007/s10597-014-9814-8.
24. *Levy L.B., O'Hara M.W.*: Psychotherapeutic interventions for depressed, low-income women: a review of the literature. Clin Psychol Rev. 2010; 30 (8): 934–950. doi: 10.1016/j.cpr.2010.06.006.
25. *Hodgkinson S., Godoy L., Beers L.S., Lewin A.*: Improving mental health access for low-income children and families in the primary care setting. Pediatrics. 2017; 139 (1): e20151175. doi: 10.1542/peds.2015-1175.
26. *Nersessova K.S., Jurcik T., Hulsey T.L.*: Differences in beliefs and attitudes toward depression and schizophrenia in Russia and the United States. Int J Soc Psychiatry. 2019; 65 (5): 388–398. doi: 10.1177/0020764019850220.