The Effectiveness of Integrated Group Therapy on Prolonged Grief Disorder of Bereaved People from COVID-19 Randomized Controlled Trial

Fatemeh Bardideh¹, Jamshid Jarareh², Mohammad Mofrad³, and Kosar Bardideh¹

Abstract
This study aimed to evaluate the integrated cognitive-behavioral group therapy and Gestalt empty chair technique on bereaved individuals with COVID-19-caused PGD (prolonged grief disease). Thirty-six patients with PGD resultant from COVID-19 were randomly assigned intervention and control groups. The intervention group underwent 16 90-minute integrated group therapy sessions twice a week. Both groups completed the BDI II depression, NAI anger, and GASP guilt scale before, after, and 2 months after the study’s conclusion. The intervention and control groups significantly differed in the depression, anger, and guilt indices after the therapeutic intervention ($p < .001$). This difference remained in the follow-up phase. Integrated group therapy in treating could help with some of the symptoms of PGD resulting from the corona-caused loss of loved ones. This reduction in symptoms was also stable over time.

Keywords
integrated group therapy, prolonged grief disease, complicated grief, COVID-19

¹Department of Counselling and Psychology, Islamic Azad University, Kish International, Kish, Iran
²Department of Teacher Training, Shahid Rajaee University, Tehran, Iran
³Department of Psychology, Khayyam Institute of Higher Education, Mashhad, Iran

Corresponding Author:
Kosar Bardideh, Department of Counselling and Psychology, Islamic Azad University, Kish International Branch, Free Zone Organization Square, Senaii Blvd., Kish Island, Kish 7941775883, Iran.
Email: kbardideh@yahoo.com
Introduction

The coronavirus has been the biggest pandemic since the Spanish influenza outbreak in 1918. Almost 6,500,000 people have died of this virus from 2019 to October 2022 (“Coronavirus 2019 Reported Cases and Deaths,” (Worldometer, 2022).

In America, it has been shown that every corona-resultant death leads to the grief of nine family members (Verdery et al., 2020). This statistic can escalate due to the intimacy of the family members in some eastern countries and the bereavement of intimate friends (Murphy, 2008). Accordingly, we can assert that this disease has made at least 58 million people suffer from corona-caused mourning. This number of grieving individuals can bring about a serious challenge to mental health worldwide. The management of these people is one of the most crucial responsibilities of psychologists.

In the past, grief and mourning were used interchangeably. However, today, with research in this field, grief is used as a concept to describe cognitive and emotional reactions, changes in performance, and behavior to the loss of a person (Schneider, 1980). In normal grief, at the beginning of loss, people usually experience extreme sadness, unfamiliar feelings, preoccupation with thoughts and memories of the deceased, difficulty concentrating, and a lack of interest in people and daily activities. Nevertheless, after a while (depending on the nature of the loss), the wounds start to heal, and the bereaved person finds a way to return to normal life. In contrast, prolonged grief is unresolved or traumatic and impairs the grieving person’s social functioning. People’s daily and social activities are disrupted by the thoughts and memories of the deceased, even after years (De Stefano et al., 2021). Recently, a new classification of grief called “Prolonged Grief Disorder” was added to the DSM-5 and ICD-11 to describe continuous and pervasive grief with longing and constant mental preoccupation for the deceased person (Szuhany et al., 2021). Based on the ICD-11 classification, PGD is usually accompanied by severe distress with feelings such as sadness, guilt, anger, denial, blame, difficulty accepting death, feeling like a part of oneself has been lost, inability to experience a positive mood, emotional numbness, and difficulty engaging with emotions. Also, PGD is usually manifested by the impairment of social activities, which goes beyond the social, cultural, or religious norms and damages the individual’s daily tasks (Eisma et al., 2020).

While PGD has been classified in ICD-11 and DSM-5TR, there are several differences between these classifications. The duration criteria for ICD-11 and DSM-5TR for the PGD are 6 months and 12 months, respectively. Also, while the DSM-5TR has 10 diagnosis criteria, the ICD-11 has two more criteria (denial and the inability to experience a positive mood). The feelings of despair, guilt, and anger are consistent in both the ICD-11 and DSM-5TR classifications. (Boelen, 2021; Eisma et al., 2020).

In their systematic reviews, Lundorf et al. and Dielantik et al. observed that the probability of prolonged grief is 9% among bereaved adults and 49% among individuals mourning in the face of unnormal deaths. However, higher statistics have been reported in non-western countries (Djelantik et al., 2020; Lundorff et al., 2017).
Furthermore, the prolonged grief of the grieving adults due to COVID-19 has been reported at 37.8%, and there were no differences between the symptoms of individuals whose loved ones had died of the coronavirus longer or shorter than the past 6 months (Tang & Xiang, 2021).

Furthermore, there is a direct relationship between guilt and an individual’s degree of grieving. In particular, concerning the grief arising from loved ones’ death due to COVID-19, the inability to take part in funerals, and the emerging feeling of guilt can be the primary factors giving rise to PGD in these people (Diolaiuti et al., 2021).

PGD could lead to avoidance behaviors, lack of control of emotions, and loss of social relationships (Stroebe et al., 2007). Prolonged grief in the long term could lead to negative outcomes that lower the life expectancy of the grieving person (Bowling, 1987; Song et al., 2019). The lack of treatment for PGD causes increased suicidal thoughts and activities, depression, and post-traumatic stress disorder (Latham & Prigerson, 2004). Suicidal thoughts and tendencies have been reported in 20–50% of PGD patients (Simon et al., 2007). Furthermore, prolonged grief disorder leads to physical and mental diseases like cancer, cardiovascular diseases, and substance abuse (Chen et al., 1999; Parisi et al., 2019; Stahl et al., 2016).

Based on Stroebe and Schut’s dual process of coping with bereavement, the person experiencing grief could go through periods of oscillation between confronting and avoiding the grief process due to the experience of loss or restoration-oriented stressors (Stroebe & Schut, 1999). Loss-oriented stressors refer to one’s feelings and experiences about losing a deceased person, such as anger, nostalgia, and longing for the return of the deceased person. Restoration-oriented stressors pertain to activities that are done to distract from the sadness and despair caused by bereavement and to deal with the stress and anxiety caused by the experience of loss (Fiore, 2021). Furthermore, the grief-to-personal growth model explains that the essence of grief remains the same, and it is the person and the life and new experiences that are added to it. Based on these models, successful treatment of grief includes gradually and continuously detaching from the decedent and building new relationships with others (Hogan & Schmidt, 2002). However, the novel treatment designs do not focus on reaching acceptance and terminating relationships with the deceased but rather on fitting feelings, awareness, and prior experiences with new realities associated with the loss (Eisma & Stroebe, 2021).

Different therapeutic methods, including CGT (Cognitive Grief Therapy) (Glickman et al., 2016), CBT (Cognitive Behavioral Therapy) (Breen et al., 2022), support group (Robinson & Pond, 2019), Gestalt (Seen et al., 2021), and pharmacotherapy are used for PGD treatment (Gang et al., 2021). It has been observed that the CBT treatment has a moderate and statistically significant effect on the alleviation of symptoms related to prolonged grief, such as anger, a feeling of guilt, and depression (Eisma & Stroebe, 2021; Szuhany et al., 2021). Individual and collective psychological therapies have been influential in grief treatment, and these effects stay until the follow-up phase (Wittouck et al., 2011).

Research has unveiled that group therapy can reduce the effects of undesirable experiences against the bereavement phenomenon rooted in the death of loved ones.
and, contrary to individual therapy, can impede the extensiveness of the social isolation, anger, and anxiety stemming from the death of these people (Para, 2009; Supiano et al., 2021).

There are different factors for accepting and adapting to the death of loved ones. One of the most significant factors constitutes the thoughts and beliefs of the person toward the death conditions of the decedent, feelings toward the decedent, relationships with and closeness to the decedent, and the attitudes of the person toward themself (Dolan et al., 2022). CBT is a method that can identify inefficient thoughts and feelings of people and examine and change them. Likewise, the embedded behavioral techniques of CBT could alter the lifestyle of grieving patients and therefore introduce restoration-oriented stressors in their daily life and help them complete their coping process.

Gestalt therapy, a humanistic-existential form of psychotherapy, is a grief treatment approach and emphasizes the personal responsibility and present experience of the person and the client-therapist relationships (Seen et al., 2021). Among the Gestalt therapy techniques, we can refer to the empty chair, which allows clients to discuss their blocked feelings and attitudes. This technique is used to help clients and reach unsolved feelings that make individuals experience difficulties (Rosner et al., 2011, 2015). Expressing suppressed feelings and examining individuals’ unmet needs can help them correctly perceive their feelings and behaviors (Greenberg et al., 2008; Roulston et al., 2018). Therefore, integrating the Gestalt empty chair technique and cognitive-behavioral interventions can be a helpful therapy for grieving individuals to express and alter their feelings. Also, Gestalt therapy has been shown to help with the personal growth of people, which, based on the grief-to-personal growth model, could help patients suffering from PGD cope with their grief (Leung et al., 2013). Combining CBT with Gestalt therapy will help patients change their destructive feelings and emotions towards the decedent and themselves by giving them a chance to say goodbye to the deceased (loss-oriented stressors). Also, this method alters their lifestyles using new behavioral habits, self-care, and personal growth (restoration-oriented stressors).

Numerous integrated therapies have examined prolonged grief; however, no study has so far, and some even addressed the integration of the group CBT and Gestalt empty chair has integrated some parts of Gestalt therapy, like the imaginal conversation, in their treatment method (Iglewicz et al., 2020). However, no integrated group therapy method has been evaluated on PGD or grief caused by COVID. Thus, the present research aimed to investigate the effectiveness of the integrated group CBT and Gestalt empty chair technique on individuals diagnosed with PGD and bereaved by the corona-caused death of their loved ones.

**Methods**

The inclusion criteria were the acquisition of >102 scores on the Grief Experience Questionnaire (GEQ-34) of Barrett and Scott (Barrett & Scott, 1989), the age range of 18–50, and the pass of >6 months from the corona-caused death of a loved person.
The exclusion criteria were substance abuse, simultaneously receiving psychiatric or pharmaceutical therapies, and possessing psychosis histories or symptoms.

**Participants**

The sample size for our study was calculated using based on the results of the BDI-II score of the study by Lacasta-Reverte (Lacasta-Reverte & Cruzado, 2021) and type I error/\(\alpha\) = 0.05 and Type II error/\(\beta\) = 0.2: \(N = 2 \times \left(\frac{1.96+0.845}{3.74}\right)^2 \times 5.43^2 = 32.7\). The sample size was calculated as 33 patients.

Participants included 18–50-year-old bereaved adults losing their loved ones due to the coronavirus. These people whose PGDs were diagnosed by psychologists or psychiatrists in their first session and were referred to us via six clinics in Mashhad city. None of these patients had received any psychiatric or psychological treatments between the death of their loved ones and the start of our study. We interviewed the selected individuals, recorded their medical histories, and administered the GEQ-34 test. The GEQ-34 (Grief Experience Questionnaire) is a self-reported measure of bereavement, consisting of subscales such as guilt, trying to justify and cope, physical reactions, feelings of abandonment, personal or other judgments, and embarrassment. The GEQ-34 test score above 102 was chosen as a measure of prolonged grief disorder based on the study by Treml et al. (Treml et al., 2021).

From the patients referred to us, the individuals scoring >102 on the GEQ test and experiencing pathological grief symptoms for more than 6 months (based on the ICD-11 classification) were included in our study. Out of 58 patients, 8 were excluded due to using psychological drugs, 11 due to not acquiring >102 scores, and 3 due to the non-fit of the intervention hours with their programs. The remaining 36 participants filled out the consent form (nobody refused to sign the form), and, finally, 36 individuals were entered into the study. Table 1 provides the demographic characteristics of the participants. If during the study, the participants developed any psychosis symptoms, suicidal tendencies, or need to use any psychological drugs, they would be excluded from the study. They would be referred to their original clinician for an emergency visit.

The participants were assigned to the experimental and control groups (18 per group) based on simple randomization through the www.randomizer.org site. Then, the experimental group was divided into two therapeutic groups (9 per group) to provide sufficient time for treatment. Both 9-subject groups (a total of 18 subjects) underwent a single treatment, and the control group received no intervention. Before the intervention, all 36 participants filled out Beck’s Depression Inventory-II, Novaco Anger Inventory (NAI), and Cohen’s Guilt and Shame Proneness (GASP) scale. Afterward, both 9-subject groups received 16 90-minute sessions of integrated therapy (Kim Paleg Grief Protocol, 2015 (Berghuis & Paleg, 2015)) twice a week. After the intervention, the experimental and control groups took the posttest and were followed up 2 months later (Figure 1). The patients in the control group also underwent integrated treatment after the study’s conclusion.
Instruments

**Beck’s Depression Inventory.** Beck’s Depression Inventory, built in 1961, consists of 21 questions comparing somatic, behavioral, and cognitive symptoms of depression and is scored based on a 5-point Likert scale (0–4) (Beck et al., 1961). It measures severe to mild depression. Its minimum and maximum scores, Cronbach alpha coefficient, and test-retest reliability equal 0, 63, 0.78, and 0.73, respectively. The validity and reliability of this questionnaire have been estimated at 0.70 and 0.77 in the Iranian context (García-Batista et al., 2018).

**Table 1.** Demographic Properties of Sample Group.

| Measure                                | Number of Participants | Percentage of Participants for Each Group |
|----------------------------------------|------------------------|------------------------------------------|
|                                        | Control | Experimental | Control | Experimental |
| Participants                           | 18      | 18            | 100     | 100           |
| Age                                    |         |               |         |               |
| 18–30                                  | 4       | 3             | 22.23   | 16.67         |
| 30–40                                  | 8       | 9             | 44.44   | 50.00         |
| 40–50                                  | 6       | 6             | 33.33   | 33.33         |
| Sex                                    |         |               |         |               |
| Male                                   | 8       | 8             | 44.45   | 44.45         |
| Female                                 | 10      | 10            | 55.55   | 55.55         |
| Academic status                        |         |               |         |               |
| Elementary school                      | 1       | 2             | 5.55    | 11.11         |
| High school                            | 2       | 1             | 11.11   | 5.55          |
| Associate degree                       | 5       | 5             | 27.78   | 27.77         |
| Bachelor degree                        | 6       | 7             | 33.33   | 38.89         |
| Master degree                          | 3       | 2             | 16.66   | 11.11         |
| Doctorate degree                       | 1       | 1             | 5.55    | 5.55          |
| Identity of deceased                   |         |               |         |               |
| Spouse/partner                         | 2       | 3             | 11.11   | 16.67         |
| Parent                                 | 9       | 7             | 50.00   | 38.88         |
| Sibling                                | 2       | 3             | 11.11   | 16.66         |
| Aunt/uncle                             | 3       | 2             | 16.67   | 11.11         |
| Grandparent                            | 1       | 2             | 5.55    | 11.11         |
| Close friend                           | 1       | 1             | 5.55    | 5.55          |
| Other                                  | 0       | 0             | 0       | 0             |
| Time since death (months) [mean ± SD]  |         |               |         |               |
| Control group                          | 13.61 ± 15.34 | Experimental group | 12.73 ± 14.87 |
Novaco Anger Inventory. This inventory, built by Novaco in 1986, is a self-report scale consisting of 30 items that measure anger and aggression. It is scored based on a 5-point Likert scale with zero and 100 as its minimum and maximum scores. Individuals acquiring scores above the mean possess higher levels of aggression. The validity and reliability of this scale have been reported at 0.86 and 0.96, and its Cronbach alpha coefficient and test-retest reliability equal 0.86 and 0.73 (Jang, 2019).

Cohen’s Guilt and Shame Proneness scale. The Guilt and Shame Proneness (GASP) scale was designed by Cohen and Wolf in 2011. It is a self-report scale with 16 items identifying shame and guilt in two subscales of negative self-evaluation and withdrawal behaviors. The scale is scored based on a 5-point Likert scale, and its Cronbach alpha coefficient for reliability has been reported at 0.61 and 0.71 (Young et al., 2021).
Therapy

The grief-treating group therapy was implemented based on the group therapy protocol of Kim Paleg (2015), which was an integration of the cognitive-behavioral group therapy and the Gestalt empty chair technique. It was provided in 16 90-minute sessions held twice a week for 8 weeks. The group sessions consisted of nine members who participated in activities collectively. The treatment for both 9-person intervention groups was overseen by the same three-clinician team with at least 4 years of grief counseling experience. F.B, with a doctorate in counseling, was the facilitator; K.B, with a doctorate in counseling, acted as the assistant, and J.J, with a doctorate in psychology, was the supervisor of the group therapy. Table 2 displays the descriptions of the sessions.

Ethical Considerations

Before the study, the researchers held a session for the subjects and explained the research procedure and its ethical issues, such as voluntary intervention leave. Then, the

Table 2. The Curriculum for Integrated Group Therapy Sessions.

| Sessions | Content |
|----------|---------|
| 1 | Share the story of the loss, including who was lost, when, and how the loss occurred |
| 2 | Describe the impact of the loss on work, family, and relationships |
| 3 | Verbalize an increased understanding of the components of grief as parts of a process that must be experienced in order to heal |
| 4 | Identify personal grief coping strategies, including the use of substances, and note those that may have interfered with the grieving process |
| 5 | Accept the need for antidepressant medication and follow through on a referral to a physician for an evaluation |
| 6 | Demonstrate the ability to ask for help in group and with significant others |
| 7 | Write a letter to the deceased person saying goodbye and expressing all the feelings experienced in the aftermath of the loss |
| 8 | Verbalize the impact of the changed identity resulting from the loss |
| 9 | Articulate a realistic picture of the lost person—both positive and negative—and of the relationship with that person, and identify ways of remembering the special qualities |
| 10 | Report an increase in self-nurturing activities |
| 11 | Develop a plan or ceremony to facilitate memorializing the lost person |
| 12 | Verbalize self-care plans to cope with anniversary reactions |
| 13 | Read books on the grief process and discuss their impact |
| 14 | Verbalize an acceptance of the unique style of grieving of others close to the deceased |
| 15 | Verbalize the desire to and beginning of the process of letting go of bitter blame for the loss of the significant other |
| 16 | Verbalize a resolution of feelings of guilt or regret over actions toward the lost loved one. (Using empty chair technique to facilitate members’ saying goodbye to the deceased and saying things that were left unsaid or asking for forgiveness for actions regretted) |
participants completed the informed consent form and were ensured that their identities would be confidential before, during, and after the release of the results. This study was approved by the ethics committee of the Iranian National Institute for Medical Research Development (NIMAD) with the registration number 4002721.

**Results**

Table 3 displays the means and standard deviations (SD) of the examined variables in the experimental and control groups in the pre-intervention, post-intervention, and follow-up phases. According to the results of this table, the intervention group’s mean scores in the anger, depression, and guilt indices are more degressive than the control group, and this degression continues until the follow-up phase. The ANCOVA test was used for testing the hypotheses. However, before running the test, the researchers investigated its basic assumptions using the Kolmogorov-Smirnov test for normality of data distribution, Levene’s test of homogeneity, box plots for the absence of irrelatable variables, Box M test for covariance, matrix’s homogeneity, and linear regression for a linear relationship between the covariate and dependent variable.

After the realization of the assumptions, the ANCOVA test was run for the comparison of the experimental and control groups in the posttest and follow-up phases (Tables 4 and 5).

The results of Table 4 show that the intervention and control groups are significantly different in the depression ($p < 0.00, f = 208.75$), anger ($p < .001, F = 76.19$), and Shame ($p < .001, F = 261.76$) indices. Likewise, according to the results of Table 5, the difference between the two groups is also significant in the follow-up phase in the depression ($p < .001, F = 63.29$), anger ($p < .001, F = 39.28$), and guilt ($p < .001, F = 150.60$).

**Table 3.** Mean and Standard Deviation for Depression, Anger and Shame.

|                      | Experimental Group | Control Group |
|----------------------|--------------------|---------------|
|                      | Pre-test           | Post-test     | Follow-up    |
|                      | M                  | SD            | M            | SD            | M            | SD            |
| BDI-II               | 42.39              | 9.54          | 34.94        | 12.64         | 33.00        |
|                      | 35.44              | 10.47         | 32.50        | 10.03         | 32.50        |
|                      | 32.94              | 12.64         | 32.94        | 12.22         | 33.00        |
|                      |                    |               |              |               |              |
| NAI                  | 73.44              | 10.77         | 51.88        | 17.46         | 68.88        |
|                      | 10.47              | 17.46         | 48.88        | 17.06         | 66.11        |
|                      | 48.88              | 17.06         | 48.88        | 17.06         | 66.77        |
|                      |                    |               |              |               |              |
| GASP                 | 24.67              | 10.77         | 18.44        | 17.46         | 16.55        |
|                      | 16.00              | 17.46         | 15.00        | 17.06         | 15.55        |
|                      | 15.00              | 17.06         | 15.00        | 17.06         | 15.55        |

Note. BDI-II = Beck Depression Inventory-Second Edition; NAI = novaco anger scale; GASP = guilt and shame proneness scale test.
After treatment, the intervention group showed lower scores for anger, depression and guilt and these results remained until the follow-up. These results show that integrated group therapy could be a promising approach for lessening the PGD symptoms, such as depression, anger, and feeling of guilt among bereaved individuals who have lost their loved ones because of the Corona Virus. Concerning the alleviation of depression symptoms, our findings are in line with the results of studies conducted by other on the subject (Boelen et al., 2007; Bryant et al., 2014; Bryant et al., 2017; Roberts et al., 2019; Rosner et al., 2015). Although the main reasons for these changes are unknown, we can claim that those individuals get acquainted with one another in integrated group therapy, learn effective social skills, and test them in the group. Group therapy aims to make individuals come to a common experience of grief, reduce the isolation stemming from their avoidance behavior and limited social support, and discover opportunities for exchanging support (Schuster et al., 2017). Likewise, in integrated group therapy, individuals decrease their depression by doing daily enjoyable activities, performing respiratory exercises, receiving cognitive restructuring techniques, and challenging and changing negative coping beliefs (107). Challenging group members, repeating exercises in the group, and witnessing positive impacts on others encourage them to continue doing these activities. In a study, Thimm et al. showed that group therapy decreased depression symptoms by 45% (Thimm & Antonsen, 2014). These effects

**Table 4. Analysis of Covariance Results for Depression, Anger and Shame Scores From the Post-Intervention Stage (Between Groups).**

|           | SS       | df | MS       | F         | Sig | Es       |
|-----------|----------|----|----------|-----------|-----|----------|
| BDI-II    | 3666.80  | 1  | 3666.80  | 208.75    | .00 | 0.69     |
| NAI       | 5922.39  | 1  | 5922.39  | 76.19     | .00 | 0.88     |
| GASP      | 3178.27  | 1  | 3178.27  | 261.76    | .00 | 0.86     |

Note. BDI-II = Beck Depression Inventory-Second Edition; NAI = novaco anger scale; GASP = guilt and shame proneness scale test; df = degrees of freedom; ES = Eta squared; MS = mean square; SS = sum of squares.

**Table 5. Analysis of Covariance Results for Depression, Anger and Shame Scores in Follow-up Phase.**

|           | SS       | df | MS       | F         | Sig | Es       |
|-----------|----------|----|----------|-----------|-----|----------|
| BDI-II    | 2382.684 | 1  | 2382.684 | 63.295    | .000| .657     |
| NAI       | 4775.315 | 1  | 4775.315 | 39.283    | .000| .543     |
| GASP      | 2830.275 | 1  | 2830.275 | 150.602   | .000| .820     |

Note. BDI-II = Beck Depression Inventory-Second Edition; NAI = novaco anger scale; GASP = guilt and shame proneness scale test; df = degrees of freedom; ES = Eta squared; MS = mean square; SS = sum of squares.

**Discussion**

After treatment, the intervention group showed lower scores for anger, depression and guilt and these results remained until the follow-up. These results show that integrated group therapy could be a promising approach for lessening the PGD symptoms, such as depression, anger, and feeling of guilt among bereaved individuals who have lost their loved ones because of the Corona Virus. Concerning the alleviation of depression symptoms, our findings are in line with the results of studies conducted by other on the subject (Boelen et al., 2007; Bryant et al., 2014; Bryant et al., 2017; Roberts et al., 2019; Rosner et al., 2015). Although the main reasons for these changes are unknown, we can claim that those individuals get acquainted with one another in integrated group therapy, learn effective social skills, and test them in the group. Group therapy aims to make individuals come to a common experience of grief, reduce the isolation stemming from their avoidance behavior and limited social support, and discover opportunities for exchanging support (Schuster et al., 2017). Likewise, in integrated group therapy, individuals decrease their depression by doing daily enjoyable activities, performing respiratory exercises, receiving cognitive restructuring techniques, and challenging and changing negative coping beliefs (107). Challenging group members, repeating exercises in the group, and witnessing positive impacts on others encourage them to continue doing these activities. In a study, Thimm et al. showed that group therapy decreased depression symptoms by 45% (Thimm & Antonsen, 2014). These effects
could also justify 75% of the changes in the follow-up phase. This study revealed that integrated group therapy reduced anger and guilt in bereaved individuals with PGD arising from the corona-caused death of loved ones. This outcome may be due to employing different techniques, such as writing letters to decedents, cognitive restructuring, and the empty chair of Gestalt therapy (Gupta, 2018).

These techniques make individuals recognize and express their hidden and suppressed anger toward the decedent or themselves. Furthermore, using the empty chair, writing a letter to the decedent, and expressing unsaid words and regrets to the decedent decrease anger and increase grief acceptance in bereaved people (Tsvieli & Diamond, 2018).

Employing cognitive restructuring techniques and identifying and challenging cognitive distortions and inefficient basic beliefs can reduce the feeling of guilt resulting from inefficient thoughts (Meichsner et al., 2020). The impact of our intervention on the withdrawal of self and other blames may be rooted in the decline of negative cognitions and avoidance behaviors and can help individuals solve their family problems (de Groot et al., 2007). As observed in the study Arslan et al. conducted on normal bereaved families, possessing opportunities to participate in groups and receiving counseling assists individuals to notice that they have made no mistakes, and their feelings of shame and guilt considerably lessen (Şimşek Arslan & Buldukoğlu, 2019). Groups create atmospheres wherein the problems related to past relationships and insecure attachments can be expressed and evaluated and provide participants with opportunities to set goals and be responsive to their progress (Larsen et al., 2021). Participating in groups and challenging the thoughts of other group members make individuals aware of their inefficient thoughts and pave the way for them to challenge and change their own thoughts (Leiderman, 2019).

In our study, we assessed three negative symptoms (depression, anger, guilt) that are associated with prolonged grief disorder. While it was concluded that integrated therapy could help reduce these variables, prolonged grief disorder is a separate construct, and the effects of this integrated therapy on this construct were not directly measured (Rosner et al., 2011). This issue should be considered when reviewing the results of our study. Furthermore, there have been several different grief treatment protocols that have utilized both elements of CBT and Gestalt therapy. These treatment protocols have shown to be effective for treatment of prolonged grief disorder and so these probably be also effective for PGD arising from COVID loss.

Compared to past studies, the merits of this design include (1) Selecting the subjects with the help of skillful psychologists and psychiatrists, (2) Assigning the subjects into groups randomly, which could enormously prevent testing errors, (3) Dividing the participants into experimental and control groups to separate the effects of the intervention from spontaneous changes in the subjects and present more reliable results; and (4). Considering a follow-up phase besides the pretest and posttest to ensure the impacts of the intervention even 2 months after the experiment.

Some of the limitations of this research were a 2-month interval for administering the follow-up test and the fewness of subjects. It is suggested that future studies use larger samples and more extended follow-up periods.
Maybe the most significant limitation of our study was the use of depression, anger, and guilt inventories because of the lack of availability of better native-translated and validated questionnaires. These measurements only evaluate some aspects of the grief process and do not assess prolonged grief disorder as a construct as a whole. Also, these inventories only measure negative variables for the effects of integrated therapy. The use of only negative variables might introduce pathology-focused bias, which is somewhat in opposition to the spirit of the dual process of coping with bereavement models and the Gestalt therapy method. We recommend that future studies use more comprehensive and positive measurement methods like Personal Growth Initiative Scale or Prolonged Grief Disorder (PG-13) questionnaire.

Furthermore, the RCT design of our study might introduce its limitations. While using a randomized clinical trial design could eliminate the selection bias and decrease the effects of confounding factors, the generalizability of the results might be more limited than varied study designs. Moreover, finally, because the control group patients were treated after the study’s conclusion, no long-term assessment of the effects of integrated therapy on the PGD of the subjects included in our study could be performed.

**Conclusion**

This study provided evidence that integrated group therapy could help with some of the symptoms of PGD resulting from the corona-caused loss of loved ones. The increasing rise of the disease statistics, besides its resultant death toll, has caused many people to experience prolonged grief derived from the coronavirus. Owing to the sudden and unexpected death of loved ones and the impossibility of mourning and grieving because of long-term quarantines, these individuals remain in the grief cycle and experience different feelings, such as grief, sorrow, helplessness, anger, anxiety, confusion, nervousness, and guilt. Hence, by applying several techniques, such as employing cognitive restructuring, deep abdominal breathing and relaxation, the empty chair, writing a letter to the decedent, and perceiving and identifying different emotions and physical states of the person, integrated group therapy can assist with accepting the death of a loved one. Moreover, groups are sources of inspiration and exemplification and increase inter-group intimacy and relationships that can overstep group boundaries. Recognizing appropriate coping strategies to manage challenging situations by applying the cognitive-behavioral and mentioned techniques can help decrease some of the depression, anger, and guilt in bereaved individuals with corona-caused PGD symptoms.

Still, further studies using integrated therapy with more encompassing inventories are needed to understand how these treatments could help patients with PGD arising from COVID.
Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

ORCID iD

Kosar Bardideh  https://orcid.org/0000-0002-8107-9894

References

Barrett, T. W., & Scott, T. B. (1989). Development of the grief experience questionnaire. Suicide & Life-threatening Behavior, 19(2), 201–215. https://doi.org/10.1111/j.1943-278x.1989.tb01033.x

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. Archives of General Psychiatry, 4(6), 561–571. https://doi.org/10.1001/archpsyc.1961.01710120031004

Berghuis, D. J., & Paleg, K. (2015). The group therapy treatment planner, with DSM-5 updates. John Wiley & Sons.

Boelen, P. A. (2021). Symptoms of prolonged grief disorder as per DSM-5-TR, posttraumatic stress, and depression: Latent classes and correlations with anxious and depressive avoidance. Psychiatry Research, 302, 114033. https://doi.org/10.1016/j.psychres.2021.114033

Boelen, P. A., de Keijser, J., van den Hout, M. A., & van den Bout, J. (2007). Treatment of complicated grief: A comparison between cognitive-behavioral therapy and supportive counseling. Journal of Consulting and Clinical Psychology, 75(2), 277–284. https://doi.org/10.1037/0022-006x.75.2.277

Bowling, A. (1987). Mortality after bereavement: A review of the literature on survival periods and factors affecting survival. Social Science & Medicine, 24(2), 117–124. https://doi.org/10.1016/0277-9536(87)90244-9

Breen, L., Greene, D., Rees, C., Black, A., Cawthorne, M., & Egan, S. (2022). A systematic review and meta-analysis of the efficacy of grief interventions for anxiety and depression in young people. PsyArXiv. Center for Open Science. https://doi.org/10.31234/osf.io/gy9ww

Bryant, R. A., Kenny, L., Joscelyne, A., Rawson, N., Maccallum, F., Cahill, C., Hopwood, S., Aderka, I., & Nickerson, A. (2014). Treating prolonged grief disorder. JAMA Psychiatry, 71(12), 1332. https://doi.org/10.1001/jamapsychiatry.2014.1600

Bryant, R. A., Kenny, L., Joscelyne, A., Rawson, N., Maccallum, F., Cahill, C., Hopwood, S., & Nickerson, A. (2017). Treating prolonged grief disorder. The Journal of Clinical Psychiatry, 78(9), 1363–1368. https://doi.org/10.4088/jcp.16m10729
Chen, J. H., Bierhals, A. J., Prigerson, H. G., Kasl, S. V., Mazure, C. M., & Jacobs, S. (1999). Gender differences in the effects of bereavement-related psychological distress in health outcomes. *Psychological Medicine, 29*(2), 367–380. https://doi.org/10.1017/s0033291798008137

de Groot, M., de Keijser, J., Neeleman, J., Kerkhof, A., Nolen, W., & Burger, H. (2007). Cognitive behaviour therapy to prevent complicated grief among relatives and spouses bereaved by suicide: Cluster randomised controlled trial. *BMJ (Clinical Research ed.), 334*(7601), 994–994. https://doi.org/10.1136/bmj.39161.457431.55

De Stefano, R., Muscatello, M. R. A., Bruno, A., Cedro, C., Mento, C., Zoccali, R. A., & Pandolfo, G. (2021). Complicated grief: A systematic review of the last 20 years. *International Journal of Social Psychiatry, 67*(5), 492–499. https://doi.org/10.1177/0020764020960202

Diolaiuti, F., Marazziti, D., Beatino, M. F., Mucci, F., & Pozza, A. (2021). Impact and consequences of COVID-19 pandemic on complicated grief and persistent complex bereavement disorder. *Psychiatry Research, 300*, 113916–113916. https://doi.org/10.1016/j.psychres.2021.113916

Djelantik, A. A. A. M. J., Smid, G. E., Mroz, A., Kleber, R. J., & Boelen, P. A. (2020). The prevalence of prolonged grief disorder in bereaved individuals following unnatural losses: Systematic review and meta regression analysis. *Journal of Affective Disorders, 265*, 146–156. https://doi.org/10.1016/j.jad.2020.01.034f

Dolan, N., Grealish, A., Tuohy, T., & Bright, A. M. (2022). Are mindfulness-based interventions as effective as cognitive behavioral therapy in reducing symptoms of complicated perinatal grief? A systematic review. *Journal of Midwifery & Women’s Health, 67*(2), 209–225. https://doi.org/10.1111/jmwh.13335

Eisma, M. C., Rosner, R., & Comtesse, H. (2020). ICD-11 prolonged grief disorder criteria: Turning challenges into opportunities with multiverse analyses. *Frontiers in Psychiatry, 11*, 752. https://doi.org/10.3389/fpsyg.2020.00752

Eisma, M. C., & Stroebe, M. S. (2021). Emotion regulatory strategies in complicated grief: A systematic review. *Behavior Therapy, 52*(1), 234–249. https://doi.org/10.1016/j.beth.2020.04.004

Fiore, J. (2021). A systematic review of the dual process model of coping with bereavement (1999-2016). *Omega, 84*(2), 414–458. https://doi.org/10.1177/003022819893139

Gang, J., Kocsis, J., Avery, J., Maciejewski, P. K., & Prigerson, H. G. (2021). Naltrexone treatment for prolonged grief disorder: Study protocol for a randomized, triple-blinded, placebo-controlled trial. *Trials, 22*(1), 110–110. https://doi.org/10.1186/s13063-021-05044-8

García-Batista, Z. E., Guerra-Peña, K., Cano-Vindel, A., Herrera-Martínez, S. X., & Medrano, L. A. (2018). Validity and reliability of the Beck depression inventory (BDI-II) in general and hospital population of Dominican republic. *Plos One, 13*(6), Article e0199750. https://doi.org/10.1371/journal.pone.0199750

Glickman, K., Shear, M. K., & Wall, M. M. (2016). Mediators of outcome in complicated grief treatment. *Journal of Clinical Psychology, 73*(7), 817–828. https://doi.org/10.1002/jclp.22384
Greenberg, L. J., Warwar, S. H., & Malcolm, W. M. (2008). Differential effects of emotion-focused therapy and psychoeducation in facilitating forgiveness and letting go of emotional injuries. *Journal of Counseling Psychology, 55*(2), 185–196. https://doi.org/10.1037/0022-0167.55.2.185

Gupta, T. (2018). Psychological management of bereavement among adolescents: A case series. *Journal of Indian Association for Child & Adolescent Mental Health, 14*(2), 117–127. https://doi.org/10.1177/0973134220180208

Hogan, N. S., & Schmidt, L. A. (2002). Testing the grief to personal growth model using structural equation modeling. *Death Studies, 26*(8), 615–634. https://doi.org/10.1080/07481180290088338

Iglewicz, A., Shear, M. K., Reynolds, C. F., 3rd, Simon, N., Lebowitz, B., & Zisook, S. (2020). Complicated grief therapy for clinicians: An evidence-based protocol for mental health practice. *Depression and Anxiety, 37*(1), 90–98. https://doi.org/10.1002/da.22965

Jang, E. (2019). The relation between temperament and anger response among prisoners: Comparison of reinforcement sensitivity theory and the psychobiological model of temperament and character. *Heliyon, 5*(7), Article e02103. https://doi.org/10.1016/j.heliyon.2019.e02103

Lacasta-Reverte, M., & Cruzado, J. A. (2021). Effectiveness of a cognitive-behavioral group therapy for complicated grief in family members of patients with cancer. Preprint. https://doi.org/10.21203/rs.3.rs-1137722/v1

Larsen, L. H., Guldberg, A., & Kring, V. (2021). A group therapy program for parentally bereaved young adults with grief complications: Rationale, method and case examples. *OMEGA - Journal of Death and Dying. Advance online publication. https://doi.org/10.1177/0030222821997705*

Latham, A. E., & Prigerson, H. G. (2004). Suicidality and bereavement: Complicated grief as psychiatric disorder presenting greatest risk for suicidality. *Suicide & Life-threatening Behavior, 34*(4), 350–362. https://doi.org/10.1521/suli.34.4.350.53737

Leiderman, L. M. (2019). Psychodynamic group therapy with hispanic migrants: Interpersonal, relational constructs in treating complex trauma, dissociation, and enactments. *International Journal of Group Psychotherapy, 70*(2), 162–182. https://doi.org/10.1080/00207284.2019.1686704

Leung, G. S., Leung, T. Y., & Ng, M. L. (2013). An outcome study of gestalt-oriented growth workshops. *International Journal of Group Psychotherapy, 63*(1), 117–125. https://doi.org/10.1521/ijgp.2013.63.1.117

Lundorff, M., Holmgren, H., Zachariae, R., Farver-Vestergaard, I., & O’Connor, M. (2017). Prevalence of prolonged grief disorder in adult bereavement: A systematic review and meta-analysis. *Journal of Affective Disorders, 212*, 138–149. https://doi.org/10.1016/j.jad.2017.01.030

Meichsner, F., O’Connor, M., Skritskaya, N., & Shear, M. K. (2020). Grief before and after bereavement in the elderly: An approach to care. *The American Journal of Geriatric Psychiatry, 28*(5), 560–569. https://doi.org/10.1016/j.jagp.2019.12.010
Murphy, M. (2008). Variations in kinship networks across geographic and social space. *Population and Development Review, 34*(1), 19–49. https://doi.org/10.1111/j.1728-4457.2008.00204.x

Para, E. A. (2009). Group counseling for complicated grief: A literature review. *Graduate Journal of Counseling Psychology, 1*(2), 10.

Parisi, A., Sharma, A., Howard, M. O., & Blank Wilson, A. (2019). The relationship between substance misuse and complicated grief: A systematic review. *Journal of Substance Abuse Treatment, 103*, 43–57. https://doi.org/10.1016/j.jsat.2019.05.012

Roberts, K. E., Walsh, L. E., Saracino, R. M., Fogarty, J., Coats, T., Goldberg, J., Prigerson, H., & Lichtenthal, W. G. (2019). A systematic review of treatment options for grieving older adults. *Current Treatment Options in Psychiatry, 6*(4), 422–449. https://doi.org/10.1007/s40501-019-00191-x

Robinson, C., & Pond, D. R. (2019). Do online support groups for grief benefit the bereaved? Systematic review of the quantitative and qualitative literature. *Computers in Human Behavior, 100*(3), 48–59. https://doi.org/10.1016/j.chb.2019.06.011

Rosner, R., Bartl, H., Pňoh, G., Kotoučová, M., & Hagl, M. (2015). Efficacy of an integrative CBT for prolonged grief disorder: A long-term follow-up. *Journal of Affective Disorders, 183*, 106–112. https://doi.org/10.1016/j.jad.2015.04.051

Rosner, R., Pňoh, G., & Kotoučová, M. (2011). Treatment of complicated grief. *European Journal of Psychotraumatology, 2*(1). https://doi.org/10.3402/ejpt.v3402i3400.7995

Roulston, A., Clarke, M. J., Donnelly, M., Candy, B., McGaughey, J., Keegan, O., & Duffy, M. (2018). Psychological therapies for major depressive disorder and prolonged grief in bereaved adults. *Cochrane Database of Systematic Reviews, 2018*(12), CD013237. https://doi.org/10.1002/14651858.cd013237

Schneider, J. M. (1980). Clinically significant differences between grief, pathological grief, and depression. *Patient Counselling and Health Education, 2*(4), 161–169. https://doi.org/10.1016/s0738-3991(80)80097-8

Schuster, R., Sigl, S., Berger, T., & Laireiter, A.-R. (2017). *Patients experiences of blended group therapy for depression: Fit and implications for the group setting*. JMIR Publications Inc.

Seen, A. T. H., Ahmad, N. S., & Khalid, N. F. (2021). Effect of empty chair technique towards psychological well-being individual experiencing grief: A case study. *Jurnal Penyelidikan Sains Sosial (JOSSR), 4*(10), 21–34.

Simon, N. M., Shear, K. M., Thompson, E. H., Zalta, A. K., Perlman, C., Reynolds, C. F., Frank, E., Melhem, N. M., & Silowash, R. (2007). The prevalence and correlates of psychiatric comorbidity in individuals with complicated grief. *Comprehensive Psychiatry, 48*(5), 395–399. https://doi.org/10.1016/j.comppsych.2007.05.002

Şimşek Arslan, B., & Buldukoğlu, K. (2019). Yasın aile üzerine etkilerini azaltmak içi şun uygulanan yas destek programları. *Psikiyatrîde Guncel Yaklasimlar - Current Approaches in Psychiatry, 11*(3), 402–417. https://doi.org/10.18863/pgy.444297

Song, J., Mailick, M. R., Greenberg, J. S., & Floyd, F. J. (2019). Mortality in parents after the death of a child. *Social Science & Medicine, 239*, 112522. https://doi.org/10.1016/j.socscimed.2019.112522
Stahl, S. T., Arnold, A. M., Chen, J. Y., Anderson, S., & Schulz, R. (2016). Mortality after bereavement: The role of cardiovascular disease and depression. *Psychosomatic Medicine, 78*(6), 697–703. https://doi.org/10.1097/psy.0000000000000317

Stroebe, M., & Schut, H. (1999). The dual process model of coping with bereavement: Rationale and description. *Death Studies, 23*(3), 197–224. https://doi.org/10.1080/074811899201046

Stroebe, M., Schut, H., & Stroebe, W. (2007). Health outcomes of bereavement. *Lancet, 370*(9603), 1960–1973. https://doi.org/10.1016/s0140-6736(07)61816-9

Szuhany, K. L., Malgaroli, M., Miron, C. D., & Simon, N. M. (2021). Prolonged grief disorder: Course, diagnosis, assessment, and treatment. *Focus, 19*(2), 161–172. https://doi.org/10.1176/appi.focus.20200052

Tang, S., & Xiang, Z. (2021). Who suffered most after deaths due to COVID-19? Prevalence and correlates of prolonged grief disorder in COVID-19 related bereaved adults. *Globalization and Health, 17*(1), 19–19. https://doi.org/10.1186/s12992-021-00669-5

Tsvieli, N., & Diamond, G. M. (2018). Therapist interventions and emotional processing in attachment-based family therapy for unresolved anger. *Psychotherapy, 55*(3), 289–297. https://doi.org/10.1037/psft0000158

Verdery, A. M., Smith-Greenaway, E., Margolis, R., & Daw, J. (2020). Tracking the reach of COVID-19 kin loss with a bereavement multiplier applied to the United States. *Proceedings of the National Academy of Sciences of the United States of America, 117*(30), 17695–17701. https://doi.org/10.1073/pnas.2007476117

Worldometer. (2022). Coronavirus, cases, reported, & deaths. https://www.worldometers.info/coronavirus/

Young, I. F., Razavi, P., Cohen, T. R., Yang, Q., Alabèrnia-Segura, M., & Sullivan, D. (2021). A multidimensional approach to the relationship between individualism-collectivism and guilt and shame. *Emotion, 21*(1), 108–122. https://doi.org/10.1037/emo0000689
Author Biographies

**Jamshid Jarareh**, Ph.D. is an assistant professor of psychological counseling at the Humanities School of Shahid Rajaee University. He is the director of the psychological clinic of Shahid Rajaee university and his research includes the studies on effects of group therapy on anxiety and anger, different methods patients use for coping with trauma, and the treatment of patients with PTSD.

**Kosar Bardideh** is a doctorate student of psychological counseling at the psychology and counseling school of Azad University. Her research focuses on cognitive behavioral therapy, Mindfulness-Based Cognitive Therapy, and group therapy for the treatment of anxiety-related disorders like nocturnal enuresis, PTSD, and grief-related disorders.

**Fatemeh Bardideh** is a doctorate student of psychological counseling at the psychology and counseling school of Azad University. Her research focuses on group CBT, existential therapy, and its effects on personal anxiety disorders and adult grief.

**Majid Monfared** is a master’s student of psychology and biostatistics at Khayam University. His research interests include panic disorders and the use of mixed-design models for evaluating psychological treatments.