Prolonged grievers: A qualitative evaluation of a support group intervention

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ABSTRACT

Objective: The aim of this project was to study prolonged grievers psychosocial processes and experience during participation in a group intervention and 6–8 weeks after discontinuation. The intervention in this study was a group therapy with the aim of getting in contact with their pain and loss and confronting and working with this loss.

Methods: Data was collected by using diaries and tape-recorded interviews, analyzed with grounded theory. The participants were 11 females between the ages of 33 and 71.

Results: The main process that was found in the qualitative data was: Ambivalence when struggling and learning through work and rest towards a balance. Sub-processes were: To share and be confirmed in the group through sense of cohesion; To dare/venture to discover problems and solutions; To react when you get emotionally involved, and to compare and discover.

Significance of results: This study gives insight into prolonged grievers' thinking, which is valuable knowledge. Rather than assuming that all individuals suffering from prolonged grief need the same treatment, we suggest that there should be a range of different therapies.

KEYWORDS: Prolonged grieving, Complicated grieving, Females, Grounded theory

INTRODUCTION

Although the loss of a close person or a family member is often experienced as one of the most distressing events in a person's life, most individuals manage to cope with their grief with support from their families and friends (Stroebe et al., 2007; Milberg et al., 2008). There is however a fraction who suffer from a more problematical grief, previously named complicated grief (CG) (Boelen et al., 2007) and today, prolonged grief disorder (PGD). PGD reactions are maladaptive extensions of normal bereavement. These maladaptive reactions overlap with psychiatric disorders and require more complex, multimodal therapies than uncomplicated grief reactions (National Cancer Institute et al., 2008). This paper will give a background for PGD and empirically explore a support group intervention for individuals suffering from PGD.

The prevalence of PGD varies greatly, depending on research design, instruments, culture and context, and figures between 10–30% have been reported (Prigerson et al., 1996; Piper et al., 2001; Prigerson et al., 2002). Women have been shown to suffer from PGD to a higher extent than men (Johannesson et al., 2011; 2012). Despite the fact that PGD is associated with an increased risk of depressive disorders, it has been described as a particular bereavement-related psychopathology (Bonanno et al., 2007) clearly distinguished from depression (Boelen & van den Bout, 2008) including maladaptive extensions of normal bereavement, that overlap with psychiatric disorders. In contrast to depression and anxiety,

PGD is characterized by being overwhelmed by emotions, changes in all personal relationships, a rupture in personal beliefs, a feeling of meaninglessness, as well as a prolonged searching for the deceased (Worden, 2002; Shear et al., 2005). The proposed criteria for DSM-V require that the bereaved person has at least one symptom of separation of distress, and five out of nine cognitive, emotional and behavioral symptoms, symptoms of depression and anxiety (Boelen et al., 2007). More precisely this means; trouble accepting the loss, inability to trust others since the death, excessive bitterness related to the death, discomfort with moving on with life, detachment from other people to whom the person was previously close, the feeling that life is now meaningless, the view that the future holds no prospect for fulfillment, and agitation since the death (Boelen & van den Bout 2008). These symptoms should have been causing significant impairments in functioning for at least 6 months (Zhang et al., 2006). Other suggested symptoms that are reported are also avoidance and an indirect self-destructive behavior; in one study the wish to die following the death of a loved one was as high as 65% among the PGD participants (Szanto et al., 2006; Shear et al., 2007). PGD may also occur pre-death in caregivers of cancer patients (Tomarken et al., 2008) were pessimistic thinking, severity of stressful events in caregivers and the age under 60 years old were important factors for developing CG pre-death. Childhood separation anxiety and lower self-concept clarity uniquely predicts PGD (Vanderwerker et al., 2006; Boelen et al., 2012).

There are also more theoretical models to explain PGD. For example, Shear et al. (2005; 2007) state that a person suffering from PGD has an imbalance between the mental representation of the beloved individual and the dramatic change in the current relationship with that person, that leads to consequences in terms of the symptoms described earlier. PGD is seen as a stress response syndrome that cannot integrate the present reality into an effectively secure and functioning daily life with an inability to re-engage in the exploratory system in a world without the deceased. Reality continues to fail to match the imaginary world. The motivation is inhibited, which results in a feeling of drifting apart from the world. The person's thoughts about giving care, providing comfort, etc. (e.g., attachment behaviors) may create feelings of incompetence. This, together with the mismatch with reality creates a persistent feeling of failure to protect the deceased. A recent study (O'Connor et al., 2008) supports Shears et al. theory, in persons suffering from PGD who were reminded of the deceased loved person, neurons were activated in the nucleus accumbens

in the reward centers of the brain. This may interfere with adapting to the loss in the real world. Parkes (2008) states that loving and grieving are two dichotomies, two sides of the same coin. One cannot have one side of the coin without jeopardizing the other. Parkes claims that the nature of attachment developed in childhood, has an effect upon the capacity/incapacity to trust oneself and others. This influences adult relationships and responses to bereavement, for example PGD.

Different therapies have been used as treatments for PGD patients, but still there is limited knowledge. There is also a gap between the knowledge to why some treatments work for PGD and why some do not. One study (Boelen et al., 2007) reported that exposure was more effective than cognitive restructuring. Another study investigated changes in perceived social support after group therapy (Ogrodniczuk et al., 2003). The bereaved individuals undergoing CG treatment (CGT) who revisited the story of the death, described helpfulness of others as not sufficient to protect against developing PGD. But absence of others or unhelpful individuals (being rude, aggressive) distressed them (Wilsey & Shear, 2007). A three year targeted psychotherapy was developed by Shear et al. (2005), in order to manage related symptoms. This therapy was found to be significantly more effective compared to interpersonal psychotherapy in the treatment of CG. Patients also responded significantly faster to the therapy. But three years in therapy is expensive and time-consuming, and does one size of therapy fit all?

Established relationships seem to be important (Piper et al., 2007) and even internet-based cognitive behavioral therapy has been shown to improve CG (Wagner et al., 2006; 2007). Hence, a lot of studies have been performed on treatment but still there is limited knowledge, and only a few studies have used a qualitative approach following persons suffering from PGD over a period of time. Therefore, in this study we wanted to apply a qualitative approach to show individuals' own perspective and thinking, by using their own words as illustrations, by using diaries and individual interviews. Our intervention was inspired by the work of Davidsen-Nielsen and Leick (2003), psycho- therapists at Copenhagen University who claim that persons suffering from PGD need to get in contact with thoughts that give rise to their experiences of pain and loss, and confronting these experiences to be able to go on in life. Their theory includes a relationship between the child's attachment to its parents and PGD. They mean that people suffering from PGD have problems with attachment to other people. According to Verena Kast's theory (Kast, 1988) every person wants symbiosis but is forced to cope with losses, separation, and grief.

When someone who has a fundamental influence on our life, dies — paradoxically the symbiosis get stronger, instead of the opposite. Working with PGD is about gradually helping the person out of this symbiosis. Group intervention based on these thoughts might be useful as it prevents isolation and loneliness provides multiple perspectives on previously introvert issues. The aim was to study how a PGD intervention influenced persons suffering from prolonged or CG by qualitatively studying their psychosocial processes and experience during the participation in the group intervention and 6-8 weeks after discontinuing.

MATERIAL AND METHODS

Sampling

The study was performed in the south-east of Sweden. A convenience sampling was used. Participants were recruited by an advertisement in the local press and by contacts between social workers in the county. Thirty eight persons applied and 29 of these were still interested in participating after receiving a short informing telephone call. The group leaders then interviewed these 29 persons for 45 to 90 minutes and informed them about the group therapy, discussed their individual loss and needs as well as discussed their motivation to participate. Thereafter a judgment was made by the group leaders, according to the inclusion and exclusion criteria (Table 1), whereby 13 persons were excluded (Table 2) (directed on an individual basis to apply for help to other instances). As prolonged grief was not as well studied in 2004, the group leaders' judgment was also based on the recommendation given by Prigerson et al. (1995) and Lichtenthal et al. (2004). Sixteen persons started in the group and 14 completed their participation in the group. One chose to discontinue due to problems with the group constellation and fatigue. Thirteen of those persons participated by answering the TRIG "The Texas Revised Instrument of Grief" questionnaire, but 11 completed their diaries and interviews after discontinuing with the group. Three persons declined to participate in the interviews and to send in their diaries due to illness and limited capacity, not accepting tape-recording and problems to find time.

The Intervention

The intervention in this study was a group therapy with a strong individual influence, i.e., one individual was in focus in one group session where the group leaders and later on the group participants confronted and discussed her grief. In each group, there

Table 1. *Inclusion and exclusion criteria*

Inclusion criteria

- Fulfilling the proposed criteria for CG according Prigerson et al. (1995) and Lichtenthal et al. (2004)
- Being over 18 years of age
- Applying to the group of their own free will and be interested in working with their grief through this model
- At least one year since the last experience of loss of a person
- The person should experience his/her own grief as complicated, prolonged and difficult to handle
- Able to work in a group according to the person's own judgment
- At least two aggravating circumstances such as
- The loss of a child
- Loss through suicide
- Dramatic or unexpected death
- Complicated relationship to the deceased
- Unresolved loss that has been brought to the light again
- Weak social network
- Double losses within a three year period

Exclusion criteria

- Cannot speak Swedish
- Being in a crisis without any relation to grief
- Ongoing psychotherapy, support or psychiatric care
- Ongoing drug abuse

was place for eight individuals. These individuals changed during time depending on their own needs, but had to stay for at least 2 months and at longest for 6 months. When an individual ended her participation in the group another new individual started in the group. Before an individual discontinued the group, this was openly discussed and prepared in the whole group. There were three group leaders, all trained in the above mentioned theory and practice (Davidsen-Nielsen & Lieck, 2003); one male social worker and deacon, one female physiotherapist and one female physician, all trained in and experienced in palliative care. The group leaders worked together two at a time. The aim of the group was to help participants to accept the loss of one or several dead persons, identifying obstacles for the adaptation to the loss (i.e., what do they avoid telling the group), helping them to look to the future and go on with their life. They assisted them to verbalize their thoughts and emotions that give rise to their pain and loss and work through their pain, and help them recreate a social network, be more self-confident and accept challenges. A kind of reflective conversation was used and the group members listened

Table 2. *Sampling process*
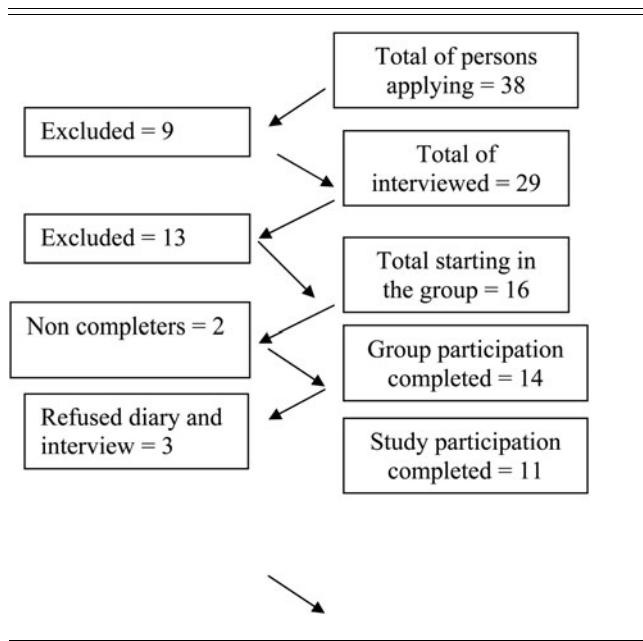
to everything that was expressed in the room; words, crying, anger, laughs. Every meeting, held once a week, lasted 3 hours in a parish house. Every meeting started with a short relaxation period. The first two hours had a specific focus on grief work and the last hour was a relaxing coffee time without the group leaders in order to strength the individuals' social network and to allow group leaders to evaluate the current group session and prepare for the next one. Each participant worked with their individual experience of loss in front of the group by talking about their memories and experiences and listening to and comment on others. The group leaders asked questions depending on what the individual expressed, explicit or implicit. Examples of their work at the sessions and at home were writing and then reading letters to the dead person or others, showing photos or things that belonged to the dead person, showing paintings, reading lyrics, visualizing and listening to music. The aims of this work were both to confront, accept and to go on.

Data Collection

Data collection was conducted with diaries and tape recorded interviews. The participants were given a diary (for research use only), a folder with a number of blank pages, where they could write their own experiences of each group session. They were asked to do this within 24 hours of each meeting and concentrate their notes on experiences related to how each session had affected them, what kind of feelings had

come up and if they had learned anything. Each diary had questions on the first page to guide participants writing: What happened during the meeting today? Has the meeting influenced you? If yes, in what way? Why do you think so? What kind of feelings do you have after the meeting? Why do you think these feelings had come up? Has the meeting given you anything? If yes, please explain. Tape-recorded interviews were conducted 6–8 weeks after the support group in order to evaluate it. A registered nurse experienced in palliative care and not involved in the support group conducted these interviews in order to follow-up the diaries and further deepen the area. This interview guide was thematic and focused on the experiences of participating in the group, such as the perceived aim, content, and outcome. The interviewees chose a place for the interviews; five were performed in their own home, five in hospital, and one in the participants' office at work.

A self-constructed questionnaire was used to collect information on age, gender, education level, etc. (see Table 3). All the participants filled in the questionnaire "The Texas Revised Instrument of Grief" (TRIG) at the first interview before starting in the group. TRIG was developed by Faschingbauer et al.

Table 3. *Demographic data*

Gender	
Female/male	13/0
Age	
Median; min-max	58; 33–71
Education*	
Elementary	5
High school	3
University	3
Other	4
Relationship to the deceased*	
Partner	7
Child	3
Parent	3
Sibling	3
Relative/friend	2
Occupation*	
Student	2
Working full-time	0
Working part-time	2
Sick leave, half or full-time	4
Person on a disability pension	2
Old-age pensioner	5
Time from loss (in months)*	
Median; min- max	$md = 49; 12–348$
Cause of death*	
Disease	12
Trauma	3
Previously participating in support groups	
Yes/no	8/5

*More than one alternative could be chosen.

(1977) and is a three-part self-administered 26 item questionnaire. This study has used the second part of this questionnaire (13 items), which focuses on grieving, such as thoughts, feelings, and memories at the present. TRIG have been translated to Swedish and validated (Lundin, 1984; Lindqvist & Sjödén, 1998). It consists of 13 statements by using a five-point Likert scale ranging from $1 =$ completely true, to $5 =$ completely false.

Analysis

This study has used a modified version of grounded theory (GT) when designing the study and analyzing the results. GT is a research process that allows participants' views to be explored (Strauss & Corbin, 1998) by studying experiences of the phenomenon and psychosocial processes. The analysis requires both description and interpretation. The participation in this support group is seen as a psychosocial process where different actors interact and influence each other. Researchers start with a research question, investigate it and then develop a theory or explanation for what they have found out. Usually the data analysis is integrated with data collection in GT. This was not the case in this study as participants kept the diaries from the beginning to the end of the study. Therefore, the data was analyzed after data collection and saturation was not reached by the usual way of constant comparison. However, the interviews were analyzed after the diaries in order to deepen the analytical process.

The diaries and the interviews were transcribed verbatim and read carefully. The applied GT approach consisted of isolating, investigating, comparing, conceptualizing, categorizing, and relating the data with other data. We searched for phenomenon, causal and intervening conditions in the context, action strategies and consequences. We have also used theoretical memoing as an aid in the analyzing process. The data from the diaries was mainly analyzed by two authors (MF, AM) and the interview data mainly by a third author (YH). Both analysis and the raw data were then added together for constant comparison and re- analyzed by the first author. The analysis was then questioned by the other authors. The text from the diaries and the interview transcripts were read several times. Significant statements and paragraphs were marked and coded separately. We coded these statements initially using the participants' phrasing and terms — looking for similarities and differences then comparing these statements and paragraphs. Then they were organized into preliminary themes by sorting them. The themes referring to the same content of the data were grouped into categories. Subcategories were combined into categories and further into main categories. Relationships between the categories were sought for as well as the process.

Researchers undertaking an original form of grounded theory study seek to develop a theory grounded in the data (Strauss & Corbin, 1998). Our aim was not to rigorously develop a theory. Instead, we created a set of themes and made possible connections between them in order to achieve a grounded explanation of the data. Researcher triangulation was used in this study to create trustworthiness; two researchers are nurses and one is a physician. Discussions about each step in the analyzing process were performed mainly by the first, second, and the last author. The study was conducted in accordance with principles in the Declaration of Helsinki (Code of Ethics of the World Medical Association). The regional Research Ethical Committee approved the study.

RESULTS

Socio-Demographic Data

The participants were 11 females between 33 and 71 years. The time since the loss varied between 1 year and 23 years ($m = 8.1$ $SD = 10.5$). Eight persons had tried other types of support like social workers, the church, individual — or group therapy but according to their own judgment without success.

In the current study, each person participated once a week for 2–6 months. In total, 43 meetings were held during 2004–2005 with a group size between 4–8 participants/group, ranging from 8 to 24 meetings/person ($m = 15$). Demographic data and the self-chosen most distressing situations are presented in Tables 3–4. The measurements with TRIG showed that item 4 "Sometimes I very much miss the person who died" and item 8 "No one will ever take the place in my life of the person who died" were perceived as most true before the intervention (Table 5).

Table 4. *Self-reported most distressing situations for the participants* n = 13*

Feeling of loneliness and being unloved	2
The feeling of not being able to manage the situation by myself	4
The feeling of not being able to manage distressing situations	4
Feelings of guilt towards the deceased	1
Feelings of being dependent on others	1
Feelings of uncertainty	1

*More than one alternative could be written.

Table 5. *Grief reactions (TRIG) before group start (1 = completely true, to 5 = completely false) n = 13*

TRIG statement n = 13	Before group start			TRIG statement n = 13	Before group start		
	m	md	SD		m	md	SD
1. I still cry when I think of the person who died.	2.2	2.0	1.2	8. No one will ever take the place in my life of the person who died.	1.2	1.0	0.6
2. I still get upset when I think about the person who died.	2.5	3.0	1.3	9. I can't avoid thinking about the person who died.	1.8	1.0	1.0
3. I cannot accept this person's death.	2.4	3.0	1.0	10. I feel it's unfair that this person died.	1.4	1.0	0.8
4. Sometimes I very much miss the person who died.	1.2	1.0	0.6	11. Things and people around me still remind me of the person who died.	1.5	1.0	1.1
5. Even now it's painful to recall memories of the person who died.	1.5	1.0	0.9	12. I am unable to accept the death of the person who died.	2.3	2.0	1.3
6. I am preoccupied with thoughts (often think) about the person who died.	1.4	1.0	0.8	13. At times I still feel the need to cry for the person who died.	1.3	1.0	0.5
7. I hide my tears when I think about the person who died.	2.7	3.0	1.3				

Qualitative Results

Main Process: Ambivalence When Struggling and Learning through Work and Rest towards Balance

The main process was described as an inner fight, a struggle that the participants felt they had to go through. This started immediately when they knew they could apply to the group and continued afterwards. Participants experienced ambivalence where they sometimes wanted to stop attending the group while at the same time they wanted to continue. Some even questioned the "normality" in the group and had to convince themselves of the benefit of continuing (numbers after quotations represents each participants code number).

> It sounds strange but I'm frightened every time before I go to the meeting. On the other hand I long to meet the group and cry. 22.

> I've had a headache and felt upset all week. Yesterday there were two participants who weren't there because of illness and headache. Who takes care of that? All the reactions that this starts, that makes my heart pound and my body ache. All Friday long I had the feeling that I don't want to go.// Even though it's so tough to go through I don't have any thoughts about stopping. I just have to do it for my family and myself. 08.

It was also necessary to rest because of all energy-consuming fear and anxiety that came up. Resting was sometimes possible during group meetings, while listening to someone else in focus, and afterwards during the coffee time or back at home. Some described that they needed a vacation from the group to get some relief to be able to come back with new strength and continue their struggle.

The group members described that they learned a lot, emotionally and cognitively, and this started early on in the process. By hearing oneself talking and discussing with others who had their own experiences and could give advice brought about their learning process. They felt humble when working together with others' life stories and understood that they themselves could teach others by just relating their experiences. Thus they realized that their experience could be useful and of benefit to someone else, which was felt as rewarding and meaningful.

> Hopefully I can help the other group members by telling them about my own grief, so that they can learn something and that's nice. 15.

They also learned that there were still things in their life to appreciate and to take advantage of. They also

felt that they learned how to be more balanced for example to control their feelings and by not being too emotionally involved in other people's emotions. They described how they became more balanced and developed healthy neutrality and could focus on other things than their own grief.

Sub-Processes

To Share and Be Confirmed in the Group through Sense of Cohesion

One important step for the participants was to start in the group. Some were afraid of this while others looked forward to such an opportunity. Hearing other people's stories gave them an insight that they were not alone with their grief, which reduced their feelings of being unusual. Instead they felt confirmed and were moved by the others' stories and felt that they had something important in common. This made it possible to expose their inner wounds and guilt and share them with others, while at the same time being safe and validated. This gave them a feeling of inner peace.

> It felt like I was a part of a specific kind of togetherness, even though I had never met the others before, especially after they had told me their stories. It was like taking off a frozen mask that I had to wear to resist the surrounding world that I could be exactly the person that I am. 32.

> There were different flashbacks and thoughts, grief that came back. Even though we had experienced different deaths and different relationships we have thoughts, feelings and reactions around our grief that are quite the same. It's a nice feeling that we can share our grief. 1.

To Dare/Venture to Discover Problems and Solutions

One sub-process was to have the courage to speak in front of others in the group. The group leaders were an important factor for venturing into the arena and speaking. Respect was important as well as being met with humbleness when telling one's own personal story, for example, memories from the moment of death, the feelings of not being able to say goodbye, or guilt and shame. The participants described how the group leaders had to be able to identify their specific problem, respectfully confront them with it, allow them to react and make them realize that there also was another side to their problem.

> I like the meeting in the group. Every time there is something that gets released inside of me. Sometimes there are only a few words that help me turn something around, like lifting a stone. Deep down there is something that makes the indefinable becomes an insight. 25.

> The way of talking is so much different from the other grief therapies that I've participated in. In this group I was forced to decide what to do in certain areas. I just couldn't brush it aside and not decide. I always get new questions where I have to decide what to do. . . I think it's good to get these unpleasant questions and decide and try to translate feelings into words. 1.

The other group members were also a part of this process. Through the "enabling" atmosphere in the group sense of cohesion it was possible to be openminded and see things that they had not noticed before. Taboo feelings, self-reproach or things they felt uncomfortable about, such as feelings of guilt, shame, frustration or anger toward the deceased or other relatives were now questioned at the same time as they were given advice. The participants had to have the courage to see the problem and how they behaved. Some discovered problems and understood possible solutions when being the central focus in the group, when listening to others or when they were alone back home. This realization created a feeling of freedom and release.

> Today, when we listened to music I've got such a pleasant feeling inside when I shut my eyes and saw myself together with my dear sister, and we were happy. Then I got the knowledge that it's not only she that can visit my dreams. I can escape to her too. That feeling decreased my longing for her. 15.

> Today I felt that it was nice to talk about my feelings of disappointment. I didn't realize that I would feel that good afterwards. 20.
> Now I know that I'm allowed to feel anger towards the deceased. 25.

> When I read the letter I was devastated and sad because of XX (the deceased) while at the same time there was anger towards YY (a relative). Afterwards I felt a kind of release; I had been given a way of venting my anger and disappointment about her way of behaving towards my husband and me. 1.

To React When You Get Emotionally Involved

By participating in the group their own grief was brought up to the light and became more painful. This was described as physical as well as psychological, for example, nausea and shortage of breath as well as heart palpitations, different kinds of physical

aches, shaking, and worries as well as anxiety before, during, and after the group meeting.

> I was really touched by a story, so much so that I felt nauseous and my anxiety came through. I really felt that person's huge grief, her guilt and her difficulty in forgiving herself. 23.

A task to be presented in the group could also generate physical or psychological symptoms. Some of them became irritated or angry because of other members took too much space. After the meetings a feeling of exhaustion or emptiness setting in was described where they wanted to be left alone without meeting anyone else. Some of them described sleeping problems like persistent thoughts or crying.

Sometimes the group meetings were so demanding that the participants felt that they wanted to talk about positive memories about the deceased, as a contrast to the grief.

> It's very heavy to only write about our loved ones and again and again remind ourselves of what's sad. I want to write about the funny memories, because we have them too. That's how they (the deceased) can continue living. 16.

Even though the group was described as trying, there were also positive experiences, such as joy, a feeling of relaxation, or a great relief from their pain.

> This feeling of powerlessness is always there, is it never going to end? But what is good is the last hour where we all can talk to each other in a more relaxed atmosphere. Although it's hard for the first two hours, the last hour is always positive. 20.

To Compare and Discover

Another important process was to compare oneself with the other participants. They compared their similarities and differences, for example, life situations, reactions from those around them, not talking in clear terms, hiding the problems, not clearing the air, and relationships to the deceased or relatives.

From the beginning they experienced similarities in each other's stories, their own or others reactions which contributed to a feeling of companionship. Sometimes they recognized some differences, and felt that others could have had worse experiences. After a while some participants described that they recognized a feeling, but felt that they had left this feeling behind during the process. Such an evaluation made them feel stronger as they felt clear inner progress.

> When I listened to the other group members who had lost their mothers, then I thought, thank God that I at least have mummy there for me ... What if I had lost them all? I've learned that there's always something worse that could happen. 15.

> I've understood how much I've really attained. When I compared myself to these people, who were much closer in time to their grief than me, then I knew that they would also progress in time. I compare myself too often with those people who haven't experienced a close trauma, a death, and I always lose out. But when I compared myself to the participants in the group, then I felt that I've found new ways in my life to go on living and these ways are actually good for me. 23.

DISCUSSION

This study has contributed with knowledge about how persons suffering from PGD experience an intervention aimed at confronting pain and loss to be able to go on with life, individually as well as in a group. This process was regarded as very painful by the participants, which could be interpreted as a weakness of the intervention. However, previous research (Boelen et al., 2007) has shown that it is better to expose pain than to restructure it. Exposure may be painful but it will also initiate adaptation. In the qualitative data, participants described that they could go on with their life which could be interpreted as a kind of acceptance of what they previously could not accept.

Current research has contributed with knowledge about the participants' thinking, during and afterwards the process. Participants reported that it was a struggle and a learning process to participate in the group, which could be interpreted in the light of meaning. If they could not find meaning and no one in their social network or among professionals was able to help them find meaning, they had to choose what was available, in order not to be so limited in life. According to Shears et al. (2007) theory, patients with prolonged grief experience problems in finding meaning when the beloved attachment figure has gone and the change in that relationship is discontinued. A previous study (Palm & Friedrichsen, 2008) showed that closeness among partners to terminally ill patients was seen as togetherness, and this togetherness was an existence in its own terms. When one-half of this togetherness has gone then existence can no longer go on. This creates an existential crisis and thereby confusion. And the more time goes by, the expectations of a closure from those around increase, which may not be meaningful to the grieving person. One of the points in this study was to share and be validated in the group cohesion. This group

meeting was a place where they could exist on their own terms, feel "normal" even though they were only "half." This was contrary to their world in everyday life, where they were seen as a "problem," a person who cannot make a closure and stop grieving. They could even grow in the group by listening to others and/or functioning as a counselor themselves. Helping others is known to be rewarding in other contexts (Midlarsky et al., 1999; Ferguson et al., 2008). We are of the opinion that this intervention created meaningfulness in their lives. Yalom (1980) claims that in the absence of a predetermined system of ultimate meaning, individuals are forced to constantly create and recreate meaning in their own life, and maintain it in the face of the objective uncertain world.

In a conducive setting, it was possible to venture into the arena to discover both problems and solutions. Through this "enabling" atmosphere it was even possible to take criticism and be questioned. This atmosphere also contributed to the feeling of being allowed to grieve and to have an internal dialogue with the deceased, which previously was a forbidden zone. Instead of having the goal of gaining closure, grief counseling could incorporate ways of encouraging a constructive continuing bond with the deceased person, talking to the deceased person, and visualizing the person's reactions, and coping strategies with current life events and problems. Parkes (2008) suggest that PGD may be a problem starting in childhood (attachment theory), where the child do not find the world as a safe place and thereby stay close to its parents, which in later life will be extended to other close persons, which they cannot separate from. This creates a vulnerability to PGD. By using the attachment theory this intervention could be interpreted to help PGD persons to separate from the close persons. By writing and reading letters to the dead person or others, showing photos or things that belonged to the dead person they confront their anxiety but still under control and in a secure base. To share and dare is about the same, to be in a secure base in the group therapy brings the person with CG to dare things they have not dared before.

Previously several treatments (Shear et al., 2005; Wagner et al., 2006; 2007; Boelen et al., 2007 Piper, 2007, p. 794; Piper et al., 2007) have been suggested and our intervention is one among many. But we claim that rather than using a "one-size-fits-all approach" to these grievers, assuming that all of them must need the same amount of treatment, we need a range of therapies. However, we need to be humble as our study has a small material based on one specific group. This study is only based on female participants that make it impossible to transfer the results to a male context. Other limitations are that the data collection did not use constant comparison and therefore did not reach saturation. A weakness in this study is the inclusion criteria. In practice, we used TRIG to assess CG symptoms. However, ICG (The inventory of CG scale) assess CG better than TRIG, but is not translated to Swedish language in a scientific way, nor is it validity or reliability- tested in a Swedish context, but it has a high correlation with the TRIG ($r = 0.87$). Therefore, we used the TRIG, which fulfill the scientific requirements, although not the specific symptoms of prolonged grief. Further studies could include males and also follow the participants in a longitudinal design to see if these results would hold after 1–2 years. Therefore, we cannot draw any general conclusions. This study gives insight into prolonged grievers' thinking, which is valuable qualitative knowledge.

To conclude, prolonged grief is a complicated situation and should be counteracted as long as possible. However, if persons are suffering from this condition, it is important to know that this person needs a good setting where he/she has the chance to talk about this in his/her own way and still be accepted. Individuals might strive for balance, and the "struggling and learning process" is a way of achieving that. This could be done through work but also importantly through rest, which is supported in a previous paper (Stroebe, Schut et al., 2009).

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