Outcomes of Cancer Bereavement Therapeutic Support Groups

Hannah Jerome

D.Clin.Psy Thesis (Volume I), 2017

University College London

UCL Doctorate in Clinical Psychology

Thesis Declaration Form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature:

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Overview

This thesis examines group interventions for bereavement. It is presented in three parts.

Part I is a literature review of the effectiveness of group interventions for uncomplicated grief. Eleven studies met inclusion criteria. Overall, study quality was mixed. Ten of the 11 studies reported improvement in outcomes. Future research would benefit from greater homogeneity in theoretical approach and measurement and clearer intervention rationale.

Part II presents a pre-post study of 27 participants who attended a six-session therapeutic cancer bereavement support group. A small waiting list group (N=11) was also used to estimate changes in outcomes over time with no intervention. At intervention completion, symptoms of grief intensity, PTSD, anxiety and depression were reduced and self-compassion was increased. At three-month follow-up, improvement in symptoms remained for grief, PTSD and depression. The waiting-list control group showed no change on any measures. The study provides preliminary evidence that a brief therapeutic group is an effective intervention for cancer bereavement.

Part III is a reflection and critical appraisal on the experience of conducting the research described in Part II. It considers the strengths and limitations of conducting research in the voluntary sector and some measurement and ethical considerations of bereavement research. It concludes with reflections on researcher reflexivity and the emotional impact of conducting bereavement research.

Table of Contents

List of Tables

Part I: Literature Review

Part II: Empirical Paper

List of Figures

Part I: Literature Review

Part II: Empirical Paper

Acknowledgements

To Chris and Nancy, thank you for teaching me about perseverance and balance, and for your dependability. You went above and beyond what I had hoped for in supervisors and were unwavering in your patience and support.

To The Loss Foundation, thank you for letting me be part of such an exciting project and for trusting me; it was a privilege to be part of the groups and the incredible work that you do.

To all of my participants, thank you for your bravery in taking part in the new groups, without you this thesis would not have been possible.

To Hugh, for the endless tea, patience and reassurance- ngiyabonga.

Part I: Literature Review

The Effectiveness of Group Bereavement Interventions for Uncomplicated Grief

Abstract

Aims: The effectiveness of bereavement interventions for uncomplicated grief remains unclear despite recent reviews. This present review aimed to explore the effectiveness of group interventions for uncomplicated grief and consider the implications for clinical practice and future research.

Method: A systematic search of the literature for relevant articles published between 1991 and 2016 was conducted via a combination of electronic database searches, citation searching and manual searches of bibliographies of relevant papers. The methodological quality of the studies included for review was assessed using the Effective Public Health Practice Project Quality Assessment Tool.

Results: Eleven studies met inclusion criteria for the review. Eight used a comparison group; five of these used an RCT design, two a non-randomised design and one a preference trial design. Three did not use a comparison group and were uncontrolled cohort designs. Overall, quality ratings across the domains were mixed. Ten of the 11 studies reported some statistically significant improvement in outcomes. Effect sizes were reported in only five of the 11 studies and ranged from 0.03 to 1.68.

Conclusions: Group bereavement interventions show promise in improving psychological symptoms for people experiencing uncomplicated grief. Future research would benefit from greater homogeneity in theoretical approach and measurement and clearer intervention rationale.

Introduction

The death of a close family member, partner or friend is a painful and significant life event that is inescapable for most individuals across their lifetime. The loss of a loved one often leads to a grief reaction, a term that describes not only the emotional and cognitive responses to the loss but also behavioural and physiological response (Lev & McCorkle, 1998).

Grief Responses

Typically grief is characterised by strong negative emotions such as feelings of sadness, guilt, anger and despair; and cognitive reactions include excessive thoughts about the loved one and the loss, difficulty concentrating and a sense of unreality. Individuals may also react to bereavement by wanting to be alone and avoiding situations that may be distressing, for example not going to social events. Common physiological aspects of grief include sleep difficulties, fatigue, changes in appetite and hyper-arousal (Stroebe, Schut & Stroebe, 2007). However, grief is a complex syndrome and the above symptomology is not exhaustive and does not capture its variability across cultures, time and between individuals.

Although experiencing the death of someone significant in a lifetime is universal, bereavement experiences and grief responses to loss are more diverse. Grief responses can be conceptualised as being on a continuum. After a bereavement most individuals will experience significant distress and symptoms of grief that will disrupt social, occupational or daily functioning; but over weeks and months the impairment to functioning will usually gradually resolve (Stroebe, Hansson, Schut, & Stroebe, 2008). This grief response is considered ‘normal’ and is described as uncomplicated grief, a term that will be used throughout this review. Uncomplicated grief responses constitute most of the grief continuum but will vary in their presentation between and within individuals.

However, for approximately 10% of bereaved individuals their grief symptoms do not naturally improve, and they develop debilitating grief that impairs their everyday lives more severely (Bryant et al., 2014). The experience of grief for this group is persistent and disruptive and is now recognised as a psychological syndrome (Shear et al., 2011). There are multiple terms used to describe prolonged and intensified acute grief, such as complicated grief, prolonged grief or pathological grief (Bonanno, Wortman, & Nesse, 2004); this review will use the term Complicated Grief, abbreviated to CG.

Emotional symptoms of CG include intense feelings of loneliness, anger, shock and disbelief; emotional numbness and/or dysregulation, feeling estranged from others and that life has no meaning. Cognitive symptoms may include intrusions related to the loss, such as thoughts or images of the deceased; ruminations about the death and thoughts of dying in order to be closer to the deceased. These can lead to maladaptive behaviours such as excessive proximity seeking to feel closer to the deceased (which may include suicidal behavior) or excessive avoidance of reminders of the deceased. CG is also associated with negative physiological changes such as sleep disturbance, difficulty concentrating and fatigue (Prigerson et al., 2009).

The consequence of CG is that symptoms cause significant distress or disability for the individual. It is associated with a number of adverse outcomes such as increased risk of suicidality; poor work and social adjustment; and poorer physical health and behaviours (Boelen, 2006).

Models of Grief Responses

Theoretical approaches to understanding grief responses have changed significantly over time, with many different theories and models being proposed in an attempt to explain the continuum of grief experiences and to inform interventions.

Early theories of bereavement and interventions were based on psychoanalytic theory following Freud's (1917) publication of 'Mourning and Melancholia'. Freud proposed that the function of grief was for the bereaved to separate all attachments with the deceased in order to 'move on' with life. He described grief work as an active process of confronting memories, thoughts and painful emotions associated with the loss. Failure to engage in the process of separation between the bereaved and deceased, or conflicting feelings about the deceased were thought to result in debilitating and pathological grief.

Despite Freud's psychoanalytical approach being influential, the theoretical understanding of bereavement has advanced and multiple theories of bereavement based on attachment and cognitive approaches have developed since the 1980's. Description of these is beyond the scope of this paper but the Four Tasks of Grief Model (Worden, 1991) and Dual-Process Model (Stroebe & Schut, 1999) are currently the most comprehensive and influential grief models.

The Four Tasks of Grief Model (Worden, 1991) proposes four tasks of grieving that the bereaved should engage with but also considers protective and risk factors that account for the idiosyncratic experience of grief and range of grief reactions. For example, the strength and nature of attachment with the deceased is considered as a factor that may impede or assist ‘normal’ grief responses.

Stroebe and Schut (1999) developed the Dual Process Model of Grief from a cognitive stress perspective. This model describes grief as a process of oscillation between loss-oriented or restoration-oriented coping and proposes that grief reactions become complex as a result of extreme confrontation or avoidance of either mode of functioning (this is discussed in greater detail in Part II).

The two models have frequently been drawn upon in the design and delivery of grief interventions. They provide a framework to guide interventions whilst allowing for the complexity and diversity of grief reactions (Hall, 2014).

Interventions for Grief Responses

There is a range of bereavement interventions designed to meet the breadth of grief responses. Based on National Institute for Health and Care Excellence (NICE) guidance, these types of bereavement support have been separated into three levels. Level one is typically information about the experience of bereavement and how to access support, level two is more direct intervention from services such as a visit from a GP or voluntary support groups, and level three is targeted support for people who are experiencing or are at risk of developing complex grief reactions (University of Nottingham, 2010).

Most individuals will adjust to their grief without the need for formal or professional help. They may rely on informal support from social networks of friends and family to assist them with this process (Schut & Stroebe, 2010). Some may also choose to access low and moderate levels of bereavement support, such as grief counselling. These supportive interventions are often preventative in nature and individuals do not need to present with clinical symptoms to access services or information (Currier, Neimeyer, & Berman, 2008). They help facilitate the process of uncomplicated grief to ease suffering and support healthy adjustment, but vary in therapeutic approach and format and may be delivered in one-to-one or group settings. Level one and two type interventions are often described in the literature as grief counselling or when specifically in a group format as mutual help, support groups or grief groups, although there is no consensus on terminology.

In contrast, when grief becomes disabling and persistent, professional mental health interventions that use specialised techniques to help treat CG are most effective (Stroebe et al., 2008). These are typically delivered in one-to-one settings and vary in therapeutic approach; again there is no consensus on terminology but these interventions are commonly described as grief therapy.

Evidence for Grief Interventions

Whether grief is complicated or uncomplicated, bereavement is associated with intense distress and therefore has been a focus of psychological research. As researchers have worked to establish a clear evidence base and guidance on what treatment works best for whom, a debate regarding the efficacy of interventions for bereavement has arisen.

Following a dissertation by Fortner (1999) and a meta-analysis by Neimeyer (2000), a strong consensus developed that grief counselling was ineffective and possibly harmful. Support for this argument grew and bereavement interventions were considered less efficacious than psychosocial interventions for other emotional and behavioural problems, and causing deleterious effects for some individuals. This negative perspective of bereavement interventions became pervasive and unsettled bereavement clinicians and researchers as they tried to establish if bereavement interventions were indeed meaningless and unhelpful.

However, the basis for the pessimism about grief counselling was questioned by Larson and Hoyt (2007), who argued that the claims were developed on little or no empirical evidence. They found that the statistical methods used in Fortner's (1999) dissertation were inappropriate, and Neimeyer's (2000) meta-analysis did not follow established meta-analysis procedures. They argued that there was no evidence that bereavement interventions are harmful, or that grief counselling is less efficacious than other forms of counselling and psychotherapy. They also encouraged bereavement clinicians to think critically and skeptically about published research and to become active and involved in contributing to an evidence base.

Subsequently, the debate about the value of bereavement interventions for grief has led to a number of reviews, discussed in the following section. These attempt to synthesize the available evidence and provide guidance regarding the efficacy of interventions for bereavement.

Reviews of Bereavement Interventions

The empirical research literature into bereavement interventions has increased considerably since 2000 (Waller et al., 2016). Consequently several reviews have been conducted in order to integrate this research and develop a coherent evidence base for the treatment and support of bereaved individuals.

The most cited and thorough review is a meta-analysis by Currier, Neimeyer, and Berman (2008) who evaluated the effectiveness of psychotherapeutic bereavement interventions on outcomes. They summarised findings from 61 controlled studies that evaluated diverse interventions aimed at promoting healthy adaption to bereavement. Their criteria for interventions were broad, they could be delivered in any modality and the content and nature of the interventions were unrestricted (e.g. social activities groups and crisis intervention). They found that interventions had small effects when measured immediately at post-treatment, with stronger effects for participants who were self-referred or clinically referred compared to participants who were recruited using outreach strategies (e.g. using death records to contact participants). Interventions that targeted participants who displayed maladaptive coping to their loss had the greatest effects and outcomes that compared favorably with psychotherapies for other difficulties.

The finding by Currier et al. (2008) that bereavement interventions are most effective when grief is more complicated or at risk of becoming complicated was replicated in another meta-analysis by Wittouck, Van Autreve, De Jaegere, Portzky, and van Heeringen (2011). This meta-analytic investigation focused specifically on the prevention and treatment of CG and the results of 14 Randomised Controlled Trials (RCTs) were analysed. The authors found that there was no evidence for the effectiveness of preventative interventions for the development of CG. However, they did find that treatment interventions for CG were efficacious for symptoms, at post-intervention and also at longer-term follow-up.

The evidence base for the treatment of CG continues to grow with results from RCTs demonstrating that CBT is an effective treatment for CG symptoms and improvements are maintained long-term (Rosner, Bartl, Pfoh, Kotoučová, & Hagl, 2015). This effectiveness of this treatment has been replicated when delivered one-to-one (e.g. Shear, Frank, Houck, & Reynolds, 2005), via the Internet (Wagner, Knaevelsrud, & Maercker, 2006), and in group formats (Supiano & Luptak, 2014).

Thus, a coherent evidence base for the effective treatment of CG is developing. However, it is a different picture for interventions for uncomplicated grief.

Based on the meta-analysis by Currier et al. (2008) it would seem that there is little evidence to support interventions for uncomplicated grief (the authors found that for participants who had uncomplicated grief there was only a small effect on outcomes post-treatment with no significant benefit at follow-up). However, this meta-analysis included studies with participants experiencing a range of grief reactions, across a number of different types of treatment interventions. The authors included studies that tested heterogeneous interventions for both complicated and uncomplicated grief, for example, individual counselling sessions with a professional as well as mutual support groups. These broad inclusion criteria may therefore minimise intervention effects for uncomplicated grief (Hoyt & Larson, 2010).

Despite the limited evidence on treatment interventions for uncomplicated grief, support for this level of need constitutes the majority of bereavement services, i.e. level one and two support as recommended by NICE guidance (The University of Nottingham, 2010). Therefore whilst the evidence in support of interventions for CG grows so should the evidence for uncomplicated grief.

In addition to the meta-analyses by Currier et al. (2008) and Wittouck et al. (2011), two additional reviews that include interventions for uncomplicated grief have been conducted by Gauthier and Gagliese (2012) and Waller et al. (2016).

Gauthier and Gagliese (2012) conducted a systematic review that focused on bereavement interventions for adults who had lost a spouse to cancer. They examined eight studies that included interventions for end-of-life care (preceding the death of their spouse) and bereavement interventions (following the death of a spouse). The authors did not draw any conclusions from their review, as they believed that the methodology of their included studies was too poor to determine the effectiveness of the interventions.

A recent review by Waller et al. (2016) did not aim to determine the effectiveness of bereavement interventions for uncomplicated grief but rather to synthesize and comment on the quality of the existing evidence base. They identified 126 papers published between 2000-2013 that examined grief counselling for bereaved individuals (they used the term ‘grief counselling’ to describe any intervention that primarily targeted grief responses). They found that research outputs had increased, but studies were often of poor quality and did not include comparison groups.

The Current Review

Although other reviews of bereavement interventions have been conducted, no reviews have focused on group interventions for uncomplicated grief. Table 1 presents previous reviews that have included studies of group interventions for

Table 1. *Recent Reviews that Include Studies of Group Interventions for Bereavement*

Author	**Population**	**Intervention**	**Method of review**	**Main difference from current review**
Currier et al. (2008)	Bereaved adults	Bereavement interventions	Meta-analysis	Broad criteria for interventions including all formats; limited to controlled studies
Gauthier & Gagliese (2012)	Bereaved spouses of patients with cancer	Bereavement interventions or interventions at end-of-life (preceding the death)	Systematic review	Focused on bereavement by cancer; interventions included all formats; interventions included end-of-life before the death
Waller et al. (2016)	Bereaved adults	Bereavement interventions	Systematic review	Focused on quantifying and evaluating the quality of research; interventions included all formats
Wittouck et al. (2010)	Bereaved adults with CG or at risk of developing CG	Interventions or techniques to treat or prevent CG	Meta-analysis	Limited to the prevention or treatment of CG; focused on interventions of any format; only included RCTs

bereavement (and which have been discussed above) and how they differ from the current review.

The current review focused specifically on studies for individuals who do not present with CG, as the evidence base for uncomplicated grief remains unclear. As one criticism of previous reviews is that their inclusion criteria were too broad [see Hoyt & Larson (2010) on Currier et al. (2008)], this review examined only interventions conducted in a group modality. The rationale for this decision was that group formats are a common modality for bereavement interventions and therefore are worth examining. For example, Waller et al. (2016) found that approximately half of the bereavement interventions included in their review were conducted in a group format.

Based on findings from previous reviews it was anticipated that RCTs would be uncommon (Currier et al., 2008; Waller et al., 2016). Therefore, the current review included studies that used either a comparison group (randomised or non-randomised) or a prospective longitudinal design comparing data from two or more time points. In order to establish if group interventions for uncomplicated grief are effective, studies needed to include at least one outcome measure assessing psychological wellbeing (e.g. psychological symptoms, mood and grief). The current review was limited to publications from the last 25 years because grief interventions were more widely implemented from the 1990s (Schut & Stroebe, 2011).

In summary, the current review aimed to address the following questions:

1. What is the effectiveness of group psychological interventions for the bereaved with uncomplicated grief?
2. What are the implications for research and clinical practice?

Method

Inclusion Criteria

To be included in the review, studies had to satisfy four sets of criteria. These addressed: (1) participants, (2) characteristics of the intervention, (3) outcome measures, and (4) research design.

1. Participants: studies were included if the participants were adults who had experienced a bereavement. The nature of the bereavement was the loss of a loved one (e.g. friend or spouse) by death (i.e. not by divorce). These criteria included the loss of a child but excluded the loss of a baby or unborn child (i.e. miscarriage or stillbirth). There was no exclusion criterion on the time since the bereavement or the nature of the death (e.g. death following a terminal illness or accident).

2. Intervention: studies were included if the intervention being evaluated met all of the following criteria:

a) It aimed to provide support for people who had been bereaved by death by focusing on healthy adaption to bereavement (e.g. increasing resilience) or on reducing members' bereavement distress. It excluded studies that focused on treating complicated or prolonged grief disorders.
b) It was delivered in a group format (i.e. more than two people) and face-to-face (i.e. not on the internet or telephone).
c) It comprised more than one session (i.e. not a single workshop).
d) It was delivered by a trained facilitator (professional or peer led) and followed a structure (i.e. unstructured support groups were excluded).

Interventions meeting these criteria could be described under a variety of labels (e.g. bereavement group, support group or therapeutic group). Studies were excluded if the group intervention was only one aspect of a wider psychological intervention, which meant that the effects of group membership could not be isolated.

3. Outcome measures: studies were included if they reported at least one outcome measure assessing psychological wellbeing. Studies measuring only satisfaction with the intervention were excluded.

4. Research design: studies needed to use either a comparison group (randomised or non-randomised) or a prospective longitudinal design comparing data from two or more time points.

Search Strategy

Studies were identified via a combination of computerised database searches, citation searching and manual searches of bibliographies of relevant papers. A systematic search of the literature for relevant articles published between 1991 and August 2016 was performed using the electronic databases PsycINFO, CINAHL and MEDLINE.

A combination of the search terms was used to ensure all relevant studies were identified, and truncated terms were used in order to allow for variations in keywords and to identify both British and American-English publication. Table 2 presents an example of the search strategy. The search output was filtered to include only papers published in peer-reviewed journals.

Table 2. *Example of Medline Search Strategy*

Concept of Interest	**Free-text Search**	**MeSH Term Search**
Bereavement	bereave* OR mourn* OR grief OR griev* OR widow*	bereavement/ OR grief/
	AND	
Group Intervention	group ADJ3 (therap* OR counsel* OR psychotherap* OR intervention OR CBT OR support OR self-help)	psychotherapy, group/ OR self-help groups/

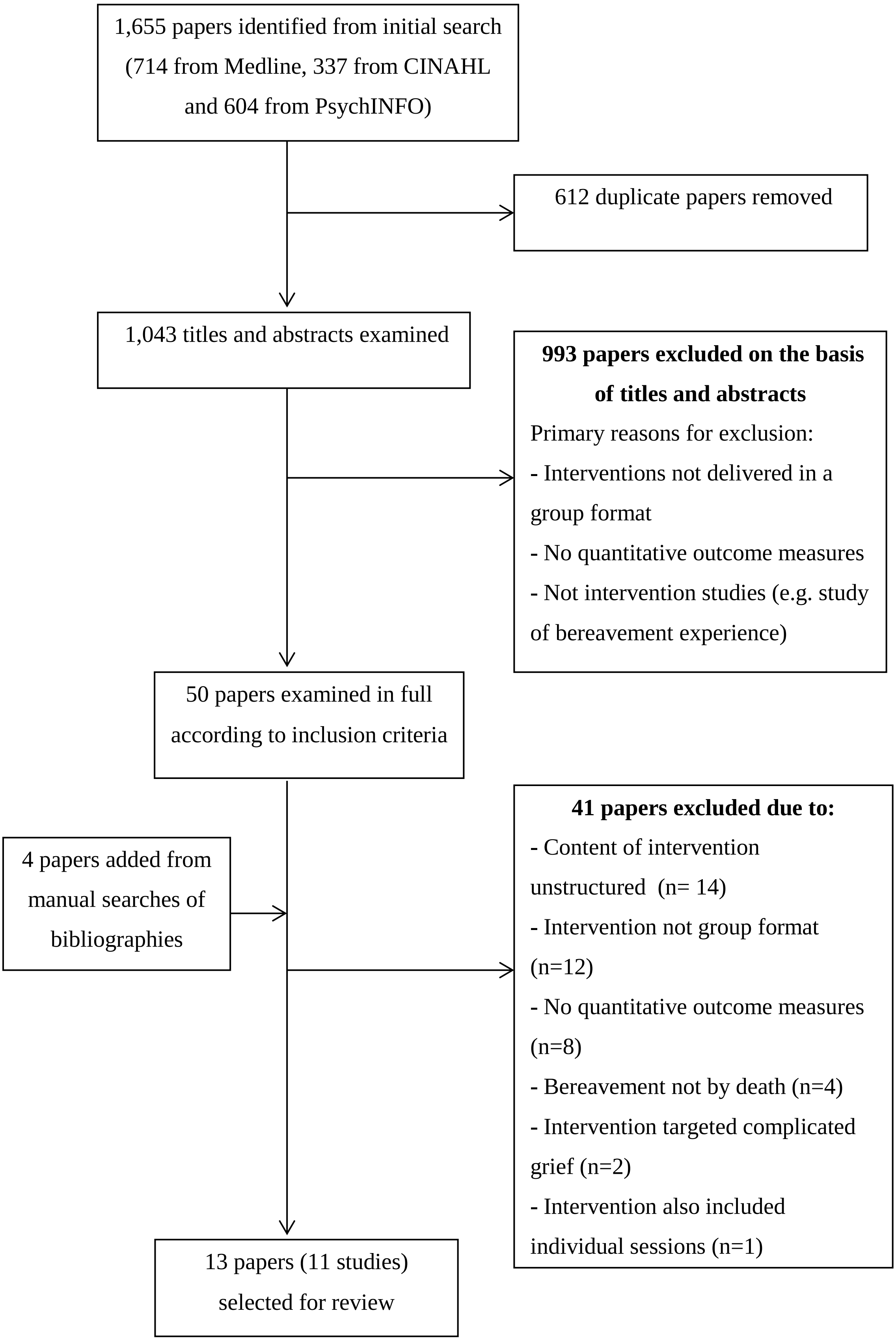
* = truncated to allow for multiple endings of term; ADJ3 = words have to appear within 3 words of each other

Study Selection

The study selection process is outlined in Figure 1. A total of 1,655 papers were returned from the search of electronic databases; 612 duplicates were removed. These papers were screened by title and abstract to compile a list of potentially eligible studies. Most studies were excluded at this first stage because they were not evaluations of group bereavement interventions.

The full-text manuscripts of the remaining 50 papers were then read and considered in detail against the inclusion criteria, and a further 41 papers were excluded. An additional four papers were identified through citation-searching,

Figure 1. *The Process of Study Selection and Primary Reasons for Reference Exclusion*



bringing the total number of papers included in the review to 13. Of these 13 papers, three reported findings from the same study but focused on different aspects (Ghebremichael, Hansen, Zhang, & Sikkema, 2006; Hansen et al., 2006; Sikkema et al., 2006), therefore the total number of studies reviewed was 11. Judgments about the eligibility of studies for the review were made by the researcher; but when this was not clear-cut studies were discussed by the research team and a decision was made.

Data Extraction

For each of the studies included in the review, key data were extracted: author, date, journal, title of study, sample size, participant characteristics, details of intervention (number of sessions, their duration and content), theoretical underpinnings of intervention, study design (details of any control group), primary outcome measures and points of data collection, and summary of outcomes.

Assessment of Methodological Quality

The quality of the studies included for review was assessed using the Effective Public Health Practice Project Quality Assessment Tool (EPHPP; Jackson & Waters, 2005; Thomas, Ciliska, Dobbins, & Micucci, 2004). This tool is suitable to be used in systematic reviews of effectiveness (Deeks, Dinnes, D'Amico, Sowden, & Sakarovitch, 2003) and has content and construct validity (Jackson & Waters, 2005). This tool was selected because it can be used to evaluate not only RCTs but also observational, cross sectional pre-post studies. It was designed for use in public health research and it provides tangible information to assess study quality, rather than subjective judgments (Deeks et al., 2003).

The EPHPP tool assesses the overall quality of quantitative studies across six domains: 1) selection bias; 2) study design; 3) the presence of confounding variables;

4) blinding; 5) data collection methods and 6) participant withdrawals and dropouts. Each of the six domains was rated as strong, moderate or weak based on information contained in the paper and following the tool guidelines. Two modifications to the guidelines were made, following Coughtrey and Pistrang (2017). For the domain of study design, in order to clarify the distinction between non-randomised controlled designs and uncontrolled designs, the former were rated as moderate and the latter as weak. For the domain of withdrawals and drop-outs, studies were rated as strong if they carried out an intent-to-treat analysis and attrition was less than 33%.

Each study was assessed and independently rated by two researchers. Agreement was generally high; but where discrepancies between ratings were identified they were discussed and consensus was reached.

Synthesis

Following the assessment of methodological quality, a synthesis of the studies was conducted. This focused on study design, participant characteristics, nature of the intervention, outcome measures and the outcomes reported. Outcomes were considered in terms of statistical significance and, where available, effect sizes and clinical significance.

Results

Overview of the Studies

A brief overview of the studies and their quality will be given before describing the nature of the interventions, characteristics of the participants, study designs and outcomes. The characteristics of the 11 studies that met the inclusion criteria are outlined in Table 3.

Table 3. *Characteristics of Reviewed Studies*

Study	**Sample**	**Time Since Loss**	**Intervention**	**Theoretical Underpinning**	**Design**	**Outcomes**	**Main Findings**
Goodkin, et al. (1999) USA	N = 166 homosexual men; loss of close friend, partner or family member; no co-morbid acute mental illness or dementia	<6 months	10 sessions (90 min) Grief resolution & stressor management techniques. Group size unknown	Based on stressor-support-coping model (Goodkin et al. 1997)	RCT; outcomes at pre & post intervention Control group continued to receive community standard-of-care	TIG; TPMS; SIGH-AD	Intervention effect for overall distress & grief (p = .004). Reduction in grief levels (p = 0.04) & secondary distress (p=0.03) was found only in the analysis that included control variables.
Kang & Yoo (2007) Korea	N = 27 Korean widows	<6 months	10 sessions (120 min) Breathing & stretching, group activity & health check Group sizes = 3-4	Traditional Korean breathing techniques (Hyun, 2001) & Worden's Four Tasks of Grief Model (1991).	Preference trial; outcomes at pre & post intervention. Control group received a pre & post health check only.	RGEI ; SS	Reductions in grief & stress for both groups, decrement was greater for experimental group (p< .001).
MacKinnon et al. (2015) Canada	N = 26; loss of close friend, partner or family member; no co-morbid mental health problems	Not specified	12 sessions (90 min) Meaning-Based Group Counselling Group sizes = 6-8	Based on a meaning-making framework of adapting to bereavement (Neimeyer & Sands, 2011).	RCT; outcomes at pre & post intervention & 3 month follow-up. Control TAU support group	RGEI; CBI; HGRC; CESDS; STAI; PIL; ISLES	Mean scores at follow-up for experimental group showed no worsening from baseline. Averages of most outcomes improved more at 3-month follow-up in the experimental than control condition.

Table 3. *Characteristics of Reviewed Studies Continued*

Study	**Sample**	**Time Since Loss**	**Intervention**	**Theoretical Underpinning**	**Design**	**Outcomes**	**Main Findings**
Maruyama, & Atencio (2008) USA	N = 47; loss of close friend, partner or family member	No criteria but 55% = < 6 months; 27% = 6 -12 months; 18% = 1> year	8 sessions (90 min) Psychoeducation & mutual aid Group size unknown	Incorporated various elements of grief models & the experience of bereavement e.g. Worden's Four Tasks of Grief Model (1991)	Cohort; outcomes at pre & post intervention	POMS-SF; TRIG; UGI	Improvements in present grief for completers (p=.005). Reduction in depression scores for women (p = .006), but not men.
McGuinness et al. (2015) Ireland	N = 20 ; loss of close friend, partner or family member	Not specified	8 sessions Creative arts activities & grief psychoeducation Group size = 10	Based on the Dual Process Model of Bereavement (Stroebe & Schut, 1999) & the dramatherapy concept of varying therapeutic distance (Langley, 2006)	RCT; outcomes at pre & post intervention & 3 month follow-up. Waiting list control	AAG; TRIG	No difference between groups on grief intensity or attitude to grief. However, when limited to participants who attended > 6 sessions a difference was found in the degree of balanced coping (p< .02; η =0.48).
Murphy et al. (1998) USA	N = 261; parents loss of a child aged 12-28 years	≥ 2 & < 8 months	12 sessions (120 min) Information giving, skill-building & emotion-focused support Group sizes = 5-10	Based on assumptive world theory (Janoff-Bulman & Frieze, 1983) & coping assistance theory (Thoits; 1986)	RCT; outcomes at pre & post intervention & 6 month follow-up Waiting list control	BSI; TES; GES; HHB; DAS	Treatment effects were found at post-intervention & follow-up in mothers for overall distress, PTSD & grief responses. Fathers showed no immediate benefits of treatment

Table 3. *Characteristics of Reviewed Studies Continued*

Study	**Sample**	**Time Since Loss**	**Intervention**	**Theoretical Underpinning**	**Design**	**Outcomes**	**Main Findings**
O'Connor et al. (2014) Denmark	N = 30 spouses	4 years post loss	8 sessions (120 min) MBCT Group size = 12	Based on MBCT for depression relapse prevention & reduction of psychological distress symptoms (Segal et al., 2004).	Controlled clinical trial; outcomes at pre & post intervention & 5 month follow-up. Waiting list control	BDI-II; HTQ ; ICG-R; CES; LNSeq	Reduction in depressive symptoms in experimental completers at follow-up (p = 0.04, Hedges' g = 0.84) Interaction between group & time (p = 0.02, Hedges' g = 0.88).
Pomeroy & Holleran (2002) Africa	N = 5; loss of partner or family member	No criteria but time since loss was < 2 years	6 sessions (90 min) Psychoeducation with support & task-centred components Group size = 5	Based on previous research of support groups for family members of people with HIV & AIDS bereavement groups.	Cohort; outcomes at pre &post intervention	BDI; STAI; GEI	Reduction in depression (p = .045), despair (p =.009) & anxiety p = .011), with medium & large effect sizes (Cohen's d values ranged from .62 to 1.18)

Table 3. *Characteristics of Reviewed Studies Continued*

Study	**Sample**	**Time Since Loss**	**Intervention**	**Theoretical Underpinning**	**Design**	**Outcomes**	**Main Findings**
Rheingold, et al (2015) USA	N = 89; loss of close friend, partner or family member; no co-morbid acute mental illness	No criteria but mean time since loss= 21 months	10 sessions (120 min) Resiliency-building stress reduction techniques, commemorative imagery & death imagery. Group sizes = 6-10	Based on separation & trauma distress theory conceptualised as Restorative Retelling intervention (Rynearson, 2001)	Retrospective cohort design; outcomes at pre & post intervention & 1-year follow-up	CGA-SR; BDI; IES-R; DIS	Reduction in depression, PTSD & death imagery from pre to post intervention, effect sizes in small to medium range (Cohen's d values ranged from .31 to .46). Sustained improvements at 1-year follow-up in depression, PTSD & complicated grief, with large effect sizes (Cohen's d values ranged from .97 to 1.21).
Sikkema, et al. (2006) [Includes findings from Hansen, et al. (2006) and Ghebremichael et al. (2006)] USA	N = 267 HIV positive adults; loss of close friend, partner or family member; no co-morbid acute mental illness or HIV related dementia	>1 month <2 years	12 sessions (90 min) CBT to reduce maladaptive coping and improve adapting coping strategies Group sizes = 6-8	CBT; stress & coping theory (Folkman et al. 1991; Lazarus & Folkman, 1984); bereavement & coping models (Rando, 1984; Worden, 1991).	RCT; outcomes at pre & post intervention, 4-, 8-, & 12-month follow-up Control group received up to 12 individual CBT sessions	GRI; SCL-90-R;FAHI; WCQ; CWI	Decrease in grief severity over time ($p < .001$) for both conditions. Significant effect for dosage ($p = .017$) on psychiatric distress and grief severity ($p = .047$). Clinical change in grief & psychiatric distress at post-intervention & follow-up in experimental group.

Table 3. *Characteristics of Reviewed Studies Continued*

Study	**Sample**	**Time Since Loss**	**Intervention**	**Theoretical Underpinning**	**Design**	**Outcomes**	**Main Findings**
Walls & Meyers (1985) USA	N = 38 widows	> 3 & < 25 months	10 sessions (90 min) Cognitive restructuring, behavioural skills or self-help. Group sizes = 8-10	Cognitive restructuring based on Beck's (1976) cognitive theory. Behavioural skills based on widowhood research & Lewinsohn's (1973) behavioural approach to social reinforcement. Self-help group based on self-help research.	Controlled clinical trial; 3 experimental conditions & waiting list control. Outcomes at pre & post intervention & 1 year follow-up	BDI; IBT; SADS; PES; LSI	Cognitive restructuring group showed pre- to posttest improvement on social anxiety ($p < 0.05$). Behavioural skills group & cognitive restructuring group reported a decrease in potential for pleasurable activities at posttest, ($p < 0.05$) & ($p < 0.01$). Increase in overall satisfaction & pleasure derived from activities in the control group ($p< 0.05$).

Note: AAG = The Adult Attitude to Grief ;BDI = Beck Depression Inventory; BSI = Brief Symptom Inventory; CBI = Core Bereavement Items Instrument; CBT = Cognitive Behavioural Theory CES= Centrality of Event Scale; CESDS = Centre for Epidemiological Studies Depression Scale CGA=SR = Complicated Grief Assessment Self-Report; CWI = Coping With Illness Scale; DAS = Dyadic Adjustment Scale; DIS = Death Imagery Scale; FAHI= Functional Assessment of HIV Infection; GEI = Grief Experience Inventory; GES = Grief Experiences Scale; GRI = Grief Reaction Index; HGRC = Hogan Grief Reaction Checklist; HHB= Health Status/Health Behaviours Scale; HTQ = Harvard Trauma Questionnaire; IBT= Irrational Beliefs Test; ICG-R = Inventory of Complicated Grief – Revised; IES-R = Impact of Events Scale-Revised; ISLES = Integration of Stressful Life Experiences Scale; LNSeq = Letter–number sequencing; LSI= Life Satisfaction Index; MBCT = Mindfulness-Based Cognitive Therapy; PES = Pleasant Events Schedule; PIL = The Purpose in Life Test; POMS-SF = Profile of Mood States Short form; ; RGEI = Revised Grief Experience Inventory; SADS = Social Anxiety & Distress Scale; SCL-90-R = Symptom Checklist-90-Revised; SIGH-AD = The Structured Interview Guide for the Hamilton Anxiety and Depression rating scale; SS = Symptoms of Stress ; STAI = State-Trait Anxiety Inventory; TES = Traumatic Experiences Scale; TIG =Texas Inventory of Grief; TPMS =The Profile of Mood States; TRIG= The Texas Revised Inventory of Grief; UGI = Unresolved Grief Index; WCQ = Ways of Coping Questionnaire

Six studies evaluated general bereavement interventions, whilst three focused on bereavement that was related to HIV (one of these was reported in three papers; the first paper will be cited to reference this study) and two where the bereavement was by violence (e.g. accident, homicide or suicide). In seven of the studies the relationship with the deceased was deemed as close but was not specified, in three studies the intervention was for the loss of a spouse and in one it was for parents who had lost a child.

The majority (73%) of the studies were conducted since 2000. Of the 11 studies six were conducted in the USA, two in Europe and one in Canada, Africa and Korea respectively. Eight used a comparison group; five used an RCT design, two a non-randomised design and one a preference trial design. Three did not use a comparison group and were uncontrolled cohort designs.

Quality Assessment of Included Studies

The quality ratings of the included studies (as rated by the EPHPP) are shown in Table 4. Overall, the quality ratings across the domains were mixed. For the domain of selection bias no studies were rated as strong. This was due to most studies recruiting participants through informal advertising (e.g. newspaper advertisements).

Two studies (Murphy et al., 1998; O'Connor, Piet, & Hougaard, 2014) were rated as very likely to be representative of the target population; but the percentage of individuals who agreed to participate was less than 80% and therefore selection bias was rated as moderate. The weak to moderate ratings in this domain were also partially due to the lack of detail in the reporting of the level of participation in some studies; for example in three studies (Maruyama & Atencio, 2008; Sikkema et al., 2006; Walls & Meyers, 1984) it was not possible to tell what percentage of

Table 4. *Quality Assessment of Reviewed Studies*

Study	**Selection Bias**	**Study Design**	**Confounders**	**Blinding**	**Data Collection Methods**	**Withdrawals and Drop-Outs**
Goodkin et al. (1999)	Weak	Strong	Strong	Moderate	Strong	Strong
Kang & Yoo (2007)	Weak	Moderate	Strong	Weak	Strong	Strong
MacKinnon et al. (2015)	Weak	Strong	Weak	Weak	Strong	Moderate
Maruyama & Atencio (2008)	Weak	Weak	NA	NA	Strong	Moderate
McGuinness et al. (2015)	Weak	Strong	Weak	Weak	Strong	Strong
Murphy et al. (1998)	Moderate	Strong	Weak	Moderate	Strong	Strong
O'Connor et al. (2014)	Moderate	Moderate	Strong	Moderate	Strong	Moderate
Pomeroy & Holleran (2002)	Moderate	Weak	NA	NA	Strong	Weak
Rheingold et al. (2015)	Moderate	Weak	NA	NA	Strong	NA
Sikkema et al. (2006) [Includes Hansen, et al. (2006) & Ghebremichael et al. (2006)]	Moderate	Strong	Strong	Moderate	Strong	Strong
Walls & Meyers (1985)	Weak	Moderate	Weak	Weak	Strong	Moderate

individuals agreed to participate.

For the domain of study design the majority of studies were rated as strong or moderate, although of the five RCTs only three described the method of randomization, all of which were appropriate (Goodkin et al., 1999; MacKinnon et al., 2015; Sikkema et al., 2006). Evaluation of studies on the confounders and blinding domains was only relevant for eight studies, as three did not use comparison groups. In four of these studies, confounders were controlled well through stratification or statistical methods and rated as strong; in the other four they were controlled poorly and rated as weak.

Ratings for blinding were generally weak or moderate. This can be attributed to the nature of the intervention; it is not feasible to blind participants to the condition or research question. No studies reported blinding the assessors and most outcomes were self-reported by participants.

The domain of data collection methods was the strongest and most consistent, as all studies received a strong rating. This reflects the availability and use of psychometrically sound outcome measures within the field of bereavement. For the domain of withdrawals and drop-outs most studies were rated as strong or moderate. Where applicable the majority of studies retained a good number of participants at follow-up; half reported an 80% follow-up rate and half a follow up rate of 60-79%. Generally the number of eligible participants at each stage of the research process was not always reported or transparent.

Nature of the Group Interventions

The number of sessions that the interventions provided ranged from six to 12 (median =10) lasting between 90-120 minutes each, although one study did not specify the length of sessions (McGuinness, Finucane, & Roberts, 2015). Nine studies reported the size of the group/s; they ranged from three to four participants per group (Kang & Yoo, 2007) to 12 participants per group (O'Connor et al., 2014).

A challenge for the included studies is that treatment for uncomplicated grief is an area of debate. There is mixed evidence regarding its effectiveness and therefore no manualised interventions or treatment guidance from organisations such as NICE. The lack of consistency and subsequent robust evidence is reflected in the content of the included studies' interventions, with only two studies using manualised-treatment interventions (O'Connor et al., 2014; Rheingold et al., 2015). No two studies evaluated the same intervention and most interventions had multiple theoretical underpinnings. Details of the treatment components were inconsistently reported across studies and difficult to identify.

Despite this, three of the studies used interventions that described incorporating elements of cognitive behavioural theory (O'Connor et al., 2014; Sikkema et al., 2006; Walls & Meyers, 1984).

O'Connor et al. (2014) used Mindfulness-Based Cognitive Therapy (MBCT), which is a manualised intervention for the prevention of depression relapse. The aim of MBCT is to help participants become aware of their thoughts, feelings and physiological sensations and then relate differently to them using mindfulness techniques. The authors described the treatment components and provided the details of the treatment manual.

The second study (Sikkema et al., 2006) evaluated an HIV-related bereavement intervention based on stress and coping theory (Lazarus & Folkman, 1984), and the format combined semi-structured cognitive–behavioural and support group approaches. The authors described the themes of each session and the techniques used such a goal setting and tasks to be completed between sessions.

Finally Walls and Meyers (1984) compared a cognitive restructuring group based on Beck's (1976) cognitive theory, a behavioural skills group based on Lewinsohn's (1973) behavioural approach to social reinforcement, and a self-help group with a control condition. Although the theoretical underpinnings of each condition were described, the content and how it was delivered across sessions was unclear.

Most of the theoretical underpinnings of the interventions were based on models or theories of grief. The most common was Worden's Four Tasks of Grief Model (1991), which was incorporated into three interventions (Kang & Yoo, 2007; Maruyama & Atencio, 2008; Sikkema et al., 2006). This is a prominent model in the planning of counselling and therapy programs and it proposes four tasks of grieving: 1) accepting reality of loss; 2) experiencing the pain of grief; 3) adjusting to life without the deceased and 4) relocating the deceased emotionally and moving forward (Worden, 1991). Other models of grief or bereavement that were used were the Dual Process Model of Bereavement (Stroebe & Schut, 1999) and meaning reconstruction following loss (Neimeyer & Sands, 2011).

In the two studies where the bereavement was a result of violence (Murphy et al., 1998; Rheingold et al., 2015), the theoretical underpinnings of the interventions were noticeably different, as they were not based on grief or bereavement models. They were based on theories of trauma and consequently were designed to address specific aspects of trauma distress.

In an intervention for parents who had lost a child by accident, suicide or homicide Murphy et al. (1998) evaluated a preventative program based on assumptive world theory (Janoff-Bulman & Frieze, 1983) and coping assistance theory (Thoits, 1986). It was a broad-spectrum group intervention that provided problem-focused and emotion-focused support. The treatment protocol was not described in detail but as part of the problem-focused support participants were taught how to develop skills such as active confrontation of problems and practicing self- care. The emotion-focused support aimed to provide feedback from group members to facilitate the reframing of some aspects of the death and its consequences.

Rheingold et al. (2015) evaluated a manualised intervention of Restorative Retelling for adults who had lost a close friend, partner or family member to death by accident, homicide or suicide. This intervention was based on a model of non-recovery from bereavement by violent death as involving separation distress and trauma distress, which results in a narrative dilemma. The intervention uses retelling of the death story to reconstruct a coherent narrative and in turn restore autonomy and meaning to the bereaved. It was designed for a group modality to help participants benefit from vicarious learning, shared experience and increased social support. The authors described the treatment components (e.g. relaxation techniques and commemorative imagery of loved one) and provided details of the treatment manual.

Sample Characteristics

The sample sizes of the included studies ranged from five to 267 and, in general, the sample sizes were largest in the RCTs (Goodkin et al., 1999; Murphy, 1997; Sikkema et al., 2006). Most of the studies provided interventions for both men and women, with the exception of two studies where the interventions were for widows (Kang & Yoo, 2007; Walls & Meyers, 1984) and a study where the intervention was for homosexual men (Goodkin et al., 1999).

Six studies included participants whose bereavement was defined as the death of a close friend, partner or family member, whilst three were specifically for the death of a spouse, one the death of a family member or partner and one the death of a child. Only four of the studies reported excluding participants with co-morbid acute mental illness; two of these studies also excluded participants if they had HIV-related dementia.

Only six studies reported time since loss as an exclusion criterion; there was no consistency in timescale and it ranged from less than six months to more than four years. Of the studies that did not specify time since loss as an exclusion criterion, three reported participants' mean time since loss, which was typically less than two years, and two studies did not report any information on time since loss.

Recruitment of participants was typically informal and opportunistic. Nearly all of the studies used advertising such as flyers and posters as a method of recruitment; the only two studies that did not use this method were the studies where the bereavement was a result of violence. Some studies utilised staff working in organisations that had contact with the bereaved (e.g. funeral directors and hospices). In addition, three studies used death registers of local hospitals or geographic locations to identify potentially eligible participants. No studies used mental health services for participant recruitment. It was not always reported what percentages of participants were concurrently receiving other sources of psychological support or had received psychological bereavement support in the past.

Study Design

Eight studies used a design where an experimental group (or groups) was compared to a control group. Four studies used a waiting-list control condition as a comparison group; two used a treatment-as-usual control condition; one compared a CBT and coping group with individual CBT sessions, and one compared a traditional Korean relaxation and activity group with a health check group. Three studies used a design where no control group was used as a comparison; instead outcomes were compared within participants between pre-and post- intervention.

All studies compared participant symptoms pre- and post- intervention. In addition, seven studies included a follow-up period ranging from three months to one-year post intervention. One study followed up participants at four, eight and twelve months post intervention (Sikkema et al., 2006); but most only followed-up participants once (mean time of follow-up = 7.2 months).

Outcome Measures

All studies reported outcomes based on reliable and valid measures that were typically self-report questionnaires. Across the studies 38 different outcome measures were used (see Table 5). Outcomes covered the following domains: grief, complicated grief, mood and psychological wellbeing, trauma, coping, physical health, memory, cognition, relationships and stress. The number of outcomes measured in each study ranged from two to seven (mean = 4); the most common domains assessed were grief and complicated grief; and mood and psychological symptoms.

The most common measure used was the original Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) which was used in three studies, and its revised version (BDI-II; Beck, Steer, & Garbin, 1988) which was used in one

Table 5. *Outcome Measures*

Domain of Outcome	**Measurement Tool**
Grief	AAG = The Adult Attitude to Grief CBI = Core Bereavement Items Instrument CES= Centrality of Event Scale DIS = Death Imagery Scale GEI = Grief Experience Inventory; RGEI = Revised GEI GES = Grief Experiences Scale GRI = Grief Reaction Index HGRC = Hogan Grief Reaction Checklist TIG = Texas Inventory of Grief; TRIG = Texas Revised IG
Complicated Grief	CGA-SR = Complicated Grief Assessment Self-Report ICG-R = Inventory of Complicated Grief – Revised UGI = Unresolved Grief Index
Mood & Psychological Symptoms	BDI = Beck Depression Inventory BSI = Brief Symptom Inventory CESDS = Centre for Epidemiological Studies Depression Scale POMS-SF = Profile of Mood States Short Form SADS = Social Anxiety & Distress Scale SCL-90-R = Symptom Checklist-90-Revised SIGH-AD = The Structured Interview Guide for the Hamilton Anxiety and Depression rating scale STAI = State-Trait Anxiety Inventory TPMS = The Profile of Mood States
Trauma	HTQ = Harvard Trauma Questionnaire IES-R = Impact of Events Scale-Revised TES = Traumatic Experiences Scale
Coping	ISLES = Integration of Stressful Life Experiences Scale LSI= Life Satisfaction Index PES = Pleasant Events Schedule PIL = The Purpose in Life Test WCQ = Ways of Coping Questionnaire
Physical health	CWI = Coping With Illness Scale FAHI= Functional Assessment of HIV Infection HHB= Health Status/Health Behaviours Scale
Memory	LNSeq = Letter–number sequencing
Cognition	IBT= Irrational Beliefs Test
Relationships	DAS = Dyadic Adjustment Scale
Stress	SS = Symptoms of Stress

study. It is considered as a ‘gold standard’ measure of depression (Cristina, Huaiyu, Albert, & Maurizio, 2010).

Anxiety was less commonly measured, with only three studies using anxiety as an outcome. In a study with HIV-positive participants the researchers used an amended version of the Hamilton Anxiety and Depression rating scale. This version excluded somatic items therefore making it more appropriate for HIV-positive populations.

There was no consistency in the measurement of grief, with various self-report questionnaires used to capture different aspects of grief. Many studies used multiple grief measures. For example MacKinnon et al. (2015) used three different grief measures: the Revised Grief Experience Inventory (RGEI; Lev, Munro, & McCorkle, 1993) which measures the grief experience; the Core Bereavement Items instrument (CBI; Burnett, Middleton, Raphael, & Martinek, 1997) which assesses frequently experienced phenomena in the bereaved; and the Hogan Grief Reaction Checklist (HGRC; Hogan, Greenfield, & Schmidt, 2001) which captures common thoughts and emotions. The variation in outcomes reflects the lack of a ‘gold-standard’ measurement tool for grief that is uncomplicated.

Similarly, there was little consistency in the measurement of trauma: the three studies that used trauma symptoms as outcomes used different measurement tools. Rheingold et al. (2015) used the Impact of Event Scale-Revised (Weiss & Marmar, 1997), which is a 22-item self-report measure that assesses distress related to trauma symptoms, whilst Murphy et al. (1998) used the Traumatic Experiences Scale, an 18-item self-report measure based on DSM PTSD criteria, and O’Connor et al. (2014) used the Harvard Trauma Questionnaire which measures symptoms of PTSD as reflected in the DSM-IV.

Outcomes

Outcome was considered in terms of statistical significance, effect sizes and clinical significance.

Statistically significant change

Ten of the 11 studies reported some statistically significant improvement in outcomes, the exception being the study by MacKinnon et al. (2015). Seven studies reported reductions on grief outcomes; two of these reported reductions only for those participants who attended more than six sessions (McGuinness et al., 2015) or completed the intervention (Maruyama & Atencio, 2008).

In a large RCT for HIV-related bereavement grief severity decreased over time for all participants regardless of condition (Sikkema et al., 2006). However, participants with higher intervention exposure had greater reductions in grief severity and psychiatric distress across time.

In a 12-session intervention for parents who had lost a child, parents in the experimental condition who had higher levels of emotional distress and grief at baseline improved more compared to wait-list controls. This was found at post-treatment and was maintained at six-month follow-up, but only in mothers and not fathers (Murphy et al., 1998).

All three studies that used an uncontrolled cohort design reported reductions in depression over time. One study of a Restorative Retelling intervention reported a reduction in depression from pre- to post- intervention that was maintained at one-year follow-up (Rheingold et al., 2015). In a study of Meaning-Based Group Counselling, reductions in depression were only found in female participants (Maruyama & Atencio, 2008). A six-session psychoeducation support group also reported a reduction in depression between pre- and post-intervention (Pomeroy &

Holleran, 2002); however, these findings should be interpreted with caution as the sample size was very small (N=5).

Reductions in depression were also found in O'Connor et al.'s (2014) controlled clinical trial of a MBCT intervention. They found that compared to wait list control participants, MBCT reduced depressive symptoms at five month follow-up but only in intervention completers.

Two studies reported reductions in PTSD symptoms over time. Following a 10-session Restorative Retelling intervention Rheingold et al. (2015) found there was a significant reduction in PTSD symptoms and death imagery from pre- to post-intervention, which was sustained at one-year follow-up. Murphy et al. (1998) found a similar treatment effect for PTSD symptoms at post-intervention and six month follow-up. However, this effect was only in mothers who had higher levels of baseline emotional distress.

One study (Walls & Meyers, 1984) reported a significant decrease in potential for pleasurable activities for participants in the behavioural skills group and cognitive restructuring group. They also found a significant increase in overall satisfaction and pleasure derived from activities but only in the delayed-treatment control group. They attributed these findings to procedural effects such as activity monitoring and over-estimation at pre-intervention.

Effect sizes

Effect sizes were reported in only five of the 11 studies; where there was sufficient information the author calculated the effect sizes for the remaining studies (see Table 6). Effect sizes ranged from 0.03 to 1.68 and were mostly moderate in size.

Table 6. *Intervention Effect Sizes of Primary Outcomes for Studies of Group Bereavement Interventions*

Study	**Measure**	**Effect Size**
Goodkin et al. (1999)[a]	TIG	0.53
Kang & Yoo (2007)[b]	RGEI	1.68
MacKinnon et al. (2015) [b]	CBI	0.46
	CES-DS	0.34
	RGEI	0.03
Maruyama & Atencio (2008)[c]	-	-
McGuinness et al. (2015) [a]	AAG	0.48 (Eta)
Murphy et al. (1998) [b]	BSI	0.03
	TES	0.11
	GES	0.16
O'Connor et al. (2014)[a]	BDI	0.88 (Hedges' g)
Pomeroy & Holleran (2002)[a d]	BDI	0.95
	STAI	0.62
	GEI	1.18
Rheingold et al. (2015)[a]	BDI	0.44
	IES-R	0.46
	DIS	0.31
Sikkema et al. (2006) [b]	GRI	0.33
	SCL-90-R	0.37
Walls & Meyers (1985) [b]	SADS	1.35

Note. [a] effect sizes reported in paper; [b] effect sizes calculated by author based on reported data; [c] information not available to calculate effect sizes; [d] based on a small sample (N=5).

AAG = The Adult Attitude to Grief ;BDI = Beck Depression Inventory; BSI = Brief Symptom Inventory; CBI = Core Bereavement Items Instrument; CES-DS = Centre for Epidemiological Studies- Depression Scale; DIS = Death Imagery Scale; GEI = Grief Experience Inventory; GES = Grief Experiences Scale; GRI = Grief Reaction Index; IES-R = Impact of Events Scale-Revised; RGEI = Revised Grief Experience Inventory; SADS = Social Anxiety & Distress Scale ; SCL-90-R = Symptom Checklist-90-Revised; STAI = State-Trait Anxiety Inventory; TES = Traumatic Experiences Scale; TIG =Texas Inventory of Grief

Reliable and Clinically Significant Change

Only one of the studies reported findings in terms of clinically significant change (Sikkema et al., 2006). This is unsurprising given that the included studies were not aimed at treating a population with clinical symptoms.

An RCT for HIV-related bereavement in HIV-positive participants reported clinically significant change on the SCL-90–R and GRI (Ghebremichael et al., 2006). They explored change by dosage and found that recovery on both outcomes was greatest for participants who attended between eight and 12 sessions and this increased over time. For these participants with high attendance on the SCL-90-R there was a 12.5% recovery post-intervention, which increased to 21.1% at 12-month follow-up. Participants with a high attendance had a 4.5% recovery on the GRI at post-intervention, which increased to 6.6% at 12-month follow-up.

Discussion

Of the 11 studies included in this review, 10 reported statistically significant reductions in relevant outcomes such as symptoms of depression and grief following a group bereavement intervention. Previous research has shown that bereavement interventions are most effective for CG, but that they have a small effect for normal grief reactions. By focusing on uncomplicated grief, the results from this review extend and support the findings that group bereavement interventions are beneficial for this population and have a small to moderate effect on outcomes

The designs of the interventions were similar in their structure (e.g. the number and length of sessions); but their content was heterogeneous. No two studiesevaluated the same intervention and only two used manualised interventions. The studies were of mixed quality, but most were of strong or moderate study design and included a comparison group or groups. All used robust outcome measures across domains such as grief and psychological symptoms; but between studies few used the same measurement tools. Despite these caveats this review shows that there is reasonable evidence that group interventions for bereavement can improve grief and psychological outcomes.

Study Quality and Methodological Considerations

Overall, the quality of the included studies was mixed, which is reflected in the variability of the quality ratings across the EPHPP domains. Although these ratings provide insight into some of the weaknesses of bereavement intervention research they may also be indicative of the challenges in conducting high quality research within the field.

For example, previous reviews have found that bereavement interventions are most effective for bereaved individuals who request and seek them out and are less effective when provided universally for all the bereaved (Currier et al., 2008). Based on these findings the most appropriate recruitment method is to make bereaved individuals aware of research interventions but allow them to initiate contact regarding participation. This was a method used by most of the included studies, but the EPHPP quality rating tool assesses this as a weak or moderate approach regarding selection bias. This provides a dilemma for researchers, as methods that are deemed to be of higher methodological quality are counter to the bereavement evidence base (Hoyt & Larson, 2010).

Despite the growing number of bereavement intervention studies there remains a paucity of guidance for the treatment of uncomplicated grief and how outcomes should be measured. This lack of a consistent evidence base was evident in the theoretical heterogeneity of the included interventions. To help address this issue researchers should include adequate reporting of the tested interventions and their theoretical underpinnings. Some of the included studies provided this information (which allows opportunities for replication studies) whilst others reported very little detail on the intervention and its rationale, which perpetuates the problem.

In the same way the between-study variation in the measurement of outcomes makes comparing studies and developing a coherent evidence base challenging. Although the measurement tools in the study were rated strong for reliability and validity, the number of measures being used makes comparisons difficult. Guidance and agreement on what tools should be used may help future research become more homogenous and thus aid the development of an evidence base for interventions for non-pathological grief.

Previous reviews of bereavement interventions (Currier et al., 2008; Forte, Hill, Pazder, & Feudtner, 2004) have consistently identified that the lack of comparison groups is detrimental to the research and limits the ability to extrapolate findings to clinical guidelines. However, a methodological strength of the studies included in this review is that most included one or more comparison groups.

Allocating bereaved participants to a control condition raises ethical considerations and has been identified by other researchers (Schut & Stroebe, 2011) as a barrier in conducting high quality bereavement research. A strategy typically used is to create a waiting list control condition, which four of the included studies implemented; but this can make comparisons difficult as grief adjustment naturally takes places over time. As an alternative to waiting list control conditions, two of the included studies used a treatment-as-usual control condition, one offered individual CBT and only one provided no intervention to control participants [Kang and Yoo’s

(2007) preference trial]. These examples suggest that it is possible to develop control conditions where ethical and research demands are balanced.

Limitations of the Review

A limitation of the studies in the review is the heterogeneity of the recruited participants. There was variability across a number of important participant characteristics that should be considered in the context of the findings. The relationship between the bereaved and the deceased, the time since the bereavement and the cause of the death are all factors that have been shown to affect bereavement outcomes (Waller et al., 2016). The review could have considered these moderating variables, but they were not consistently reported and therefore this was not possible.

This review also included only 11 studies and therefore the findings should be considered with caution. The limited number of studies partly reflects the exclusion criteria but even when including uncontrolled studies there is a lack of published interventions for uncomplicated grief.

Most of the included studies did not report effect sizes. Although the author calculated some of these, this was not always possible; thus when treatment effects were identified it remains unclear what the size of this effect was.

The EPHPP tool, which was used to assess the quality of the studies, provided a useful framework for evaluating methodological quality, but it is not without some limitations. Importantly, it does not include an assessment of statistical power; therefore studies with low power may not have been identified as being of poorer quality compared to other studies with higher power. The tool also does not make adequate distinctions regarding two other methodological issues, and was therefore modified in line with a previous review (Coughtrey & Pistrang, 2017). The domain of study design was modified so that non-randomised controlled designs and uncontrolled designs were differentiated (the former were rated as moderate and the latter as weak); the domain of withdrawals and drop-outs was modified to include consideration of intent-to-treat analysis. Although these modifications may have enhanced the rigour of the EPHPP, they also meant that the tool was not used in the prescribed way. Finally, despite the EPHPP guidelines on the criteria for the ratings, it was not always clear how a domain should be assessed and rated; although each study was independently assessed by two raters, this does not completely exclude the possibility of subjective interpretations being made.

Research and Clinical Implications

As discussed in the introduction there has been lively debate regarding the efficacy of interventions for bereavement. Some have criticised bereavement interventions as being ineffective and even harmful for people experiencing non-pathological grief (Fortner, 1999; Neimeyer, 2000). It has been argued that bereavement interventions show levels of effectiveness similar to traditional psychotherapy, but there is little evidence of them being detrimental to the bereaved (Larson & Hoyt, 2007).

The findings of this review indicate that group interventions may be effective in reducing symptoms of grief, mood and other psychological symptoms following bereavement. These preliminary findings also suggest that the interventions are most or only effective when the majority or all of the sessions are attended. However, it still remains to be demonstrated which interventions are more effective when delivered in a group and whether there are certain populations who are more likely to benefit from group interventions (e.g. women).

This review provides no evidence that group interventions are harmful or ineffective. One included study (Walls & Meyers, 1984) did find that participants in the experimental condition reported a decrease in potential for pleasurable activities, but this was attributed to procedural effects of over-estimating pleasurable activities at baseline.

The studies included in this review reflect the ‘excessive theoretical heterogeneity’ (Forte et al., 2004, p.11) of bereavement interventions, which makes it difficult to identify what aspects of the interventions are beneficial and to draw conclusions about clinical implications. In order to develop clearer guidelines for clinicians and to aid service development it may be of value to conduct research that uses dismantling designs (Ahn & Wampold, 2001). This research would help identify what components of the interventions were essential in eliciting change, for example behavioural activation or developing a coherent narrative of the loss. A commonality of all of the interventions included in this review is the group format; improvements in outcomes could well be attributed to the therapeutic factors of a group format (Yalom & Leszcz, 2005) rather than the content of the intervention.

The included studies focused on changes in pathological outcomes such as anxiety or depression, despite the study population being non-pathological. There was an absence of potentially relevant non-pathologising outcomes such as post-traumatic growth, optimism, hopefulness and the development of resilience. This focus on reducing distressing psychological symptoms may mean that changes in psychological well-being or restoration are overlooked. Future research should consider how suitable the outcome measures used in CG are for grievers who are experiencing uncomplicated grief. This may increase the possibility of detecting improvement that current measures are not able to capture.

Similarly, the studies focused on individual outcomes and did not consider the potential benefits of the interventions at a societal level. As identified by Currier et al. (2008), interventions may have wider positive effects by reducing the use of healthcare services or enabling individuals to remain or return to employment. Within the United Kingdom's health and social welfare system these benefits should not be overlooked and future studies could incorporate health economics as part of the evaluation of effectiveness of treatment.

The clinical implications of this review are limited when considered within an NHS setting and the current context of austerity. The provision of level one and two NHS support for populations who are not experiencing symptoms of CG is unlikely. However, voluntary sector organisations, hospices and private clinicians currently provide most of this support and would therefore benefit from the establishment of a clearer evidence base.

Conclusion

The current review aimed to examine the effectiveness of group bereavement interventions for individuals with uncomplicated grief. Despite identified limitations of the included studies, it does appear that group interventions are beneficial for some participants and help improve symptoms of grief, mood and other psychological outcomes. However, like traditional psychotherapy there is a dose-effect treatment response.

Clinical practice and research would benefit from greater homogeneity in theoretical understandings of uncomplicated grief, which would in turn improve continuity across research. Examining different types of symptom and treatment outcomes (e.g. resilience and economic benefits) and utilising different research designs should help develop our understanding of what interventions are most helpful for individuals with uncomplicated grief and how they work. This should translate to providing valuable support for those who seek it following the loss of a loved one.

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Part II: Empirical Paper

Outcomes of Cancer Bereavement Therapeutic Support Groups

Abstract

Aims: The loss of a loved one through cancer is associated with unique challenges that can affect the bereavement experience. Despite a strong clinical rationale for the use of therapeutic bereavement support groups, there is limited empirical evidence regarding their efficacy for cancer-related loss. This study examined outcomes of a therapeutic bereavement support group, using a longitudinal study with a waiting list control.

Method: Twenty-seven participants attended a six-session therapeutic bereavement support group, provided by a charity. Outcome measures assessed a range of domains: grief responses; psychological symptoms; self-compassion; and resilience. The Helpful Aspects of Therapy Questionnaire was administered after every session. Data were collected via online questionnaires at baseline, intervention completion and at three-months follow-up. In addition, a small waiting list group (N=11) was used to estimate changes in outcomes over time with no intervention.

Results: At intervention completion, participants' symptoms of grief intensity, PTSD, anxiety and depression were reduced and self-compassion was increased. At follow-up, improvement in participants' symptoms remained for grief, PTSD and depression. Participants reported that therapeutic group factors were most helpful in the first and last sessions and the structured content of the intervention was most beneficial during the middle sessions. The waiting-list control group showed no change on any of the outcome measures between initial assessment and end of the waiting list.

Conclusions: This study provides preliminary evidence that a brief therapeutic group may be an effective intervention for cancer bereavement.

Introduction

The death of a loved one[1] is a painful and significant life event that is inescapable for most people across their lifetime. The loss of a loved one to cancer, however, is particularly difficult and can be distinguished from other types of loss (MacKinnon et al., 2012).

In the time between cancer diagnosis and cancer-related death, family and friends are often exposed to additional sources of psychological distress. For example: there may be prolonged periods of uncertainty about outcomes and prognosis; their loved ones may undergo intensive treatments that are often invasive and lead to significant changes in physical appearance (e.g. cachexia); and they may observe the progressive deterioration of a loved one's health which may include witnessing traumatising events (e.g. emergency hospital admissions).

In addition, family and friends may take on a new role as caregiver, particularly as dying at home is encouraged (Social Care Institute for Excellence, 2016). The additional role as a caregiver can be emotionally and physically taxing. Challenges that cancer caregivers experience include caring whilst trying to manage the demands of everyday life (e.g. finances and employment); making decisions about their loved one's health and care; and trying to negotiate healthcare systems (Stajduhar, Martin, & Cairns, 2010).

Furthermore, following a cancer diagnosis friends and family may experience anticipatory grief, as they expect the death of their loved one and experience multiple losses such as the loss of roles, relationships and hopes for the future (Kacel, Gao, & Prigerson, 2011). Anticipatory grief in close relatives of terminally ill cancer patients

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[1] The term 'loved one' can be problematic as it assumes that the relationship between the bereaved and the deceased was loving in nature. However, it is commonly used in bereavement literature in order to be inclusive of the range of relationships with the deceased (e.g. spouse, friend, family member etc.).

is associated with increased use of alcohol and drugs, greater intensity of anger, and an increased risk of atypical grief (Johansson & Grimby, 2011).

Conceptual Frameworks of Coping with Bereavement

There are multiple different models and theories that attempt to explain how people respond to and cope with bereavement; these can provide a conceptual framework for considering cancer-related bereavement. They are typically focused either on tasks or on processes, but more recent models have aimed to integrate the two (Stroebe & Schut, 2008). Although the approaches offer different principles of adaption to bereavement, they all propose that adaptive coping strategies should lead to a reduction in the negative impact that grief has on psychosocial functioning and physical health, as well as the lowering of grief.

Stroebe and Schut (2008) categorise the theories and models into the following four groups:

i. General life-event theories e.g. theories of stress and trauma
ii. General grief-related theories e.g. psychoanalytic and attachment theories
iii. Specific coping with bereavement models
iv. Integrative models

Description of these models and theories is beyond the scope of this paper. However, the dual processing model of coping with bereavement (Stroebe & Schut, 1999) merits description as it attempts to integrate existing ideas, is focused on bereavement and how people come to terms with the loss of a loved one, and is evidence-based (Lund, Caserta, Utz, & de Vries, 2010).

The model proposes that there are two broad types of stressor associated with bereavement that require either loss-oriented or restoration-oriented coping.

Loss-oriented coping is described as ‘the concentration on, and dealing with, processing of some aspect of the loss experience itself, most particularly, with respect to the deceased person’ (Stroebe & Schut, 1999, p. 212). Loss-oriented coping includes the experience of a range of emotions, from intense sadness and painful longing when ruminating about the loss or thinking about the circumstances of the death, to happiness when looking at photos of the loved one and reminiscing about them. Although the model does not have stages, it recognises that immediately after bereavement most people will use loss-oriented coping which will be characterised by negative affect.

Following bereavement, not only is there grief for the loss of the loved one, but also considerable changes secondary to the loss which need to be adjusted to. Restoration-oriented coping encompasses how an individual deals with the consequence of the bereavement. For example, social isolation may be a consequence of the bereavement and seeking connection with others may be used as a strategy to cope with this stressor. Like loss-oriented coping, restoration-oriented coping also includes a range of emotions such as anger when taking on a new role, to a sense of achievement if a new task is achieved.

The model proposes that people will oscillate between loss-oriented and restoration-oriented coping. The dynamic process of confrontation and avoidance of different stressors associated with bereavement is thought to be necessary for optimal adjustment over time, including better physical and mental health outcomes. More recently, the model has provided a framework for understanding the continuum of grief responses, and in particular how more problematic grief responses are characterised by extreme confrontation and avoidance of either loss-oriented or restoration-oriented coping (Stroebe & Schut, 2010).

Grief Responses and Bereavement Support

Grief includes distressing emotional, cognitive, functional and behavioural reactions. These reactions typically disrupt normal functioning, but usually resolve over time as people adapt to their loss. While most individuals will notice an improvement in their functioning over time, for some individuals, grief symptoms do not improve naturally, and they continue to experience significant suffering that impairs their everyday lives more severely (Bryant et al., 2014). There are a number of terms used to describe prolonged and intense grief that impairs functioning, such as persistent complex bereavement disorder, complicated grief and prolonged grief disorder, and there is a current debate regarding whether or not they are substantially different disorders (Maciejewski, Maercker, Boelen, & Prigerson, 2016). The present study will use the term ‘complicated grief’ to describe ‘atypical’ grief responses that cause significant suffering and enduring functional impairment.

The National Institute for Clinical Excellence (NICE) suggests that bereavement support should meet the needs of all, and therefore span the continuum of grief responses (discussed further in Part I). As such, bereavement interventions are broad in nature and should include:

i. low level support - such as informal help from friends and family
ii. moderate level support - typically preventative in nature e.g. grief counselling
iii. high level support - specialist in nature and provided by mental health professionals

The effectiveness of bereavement interventions has been under much scrutiny (Schut, Stroebe, van den Bout, & Terheggen, 2008). The most robust evidence for the effectiveness of bereavement interventions is for formalised professional therapeutic interventions for people experiencing complicated grief reactions (referred to as targeted interventions). Weaker effects are observed for bereavement interventions that are actively sought out by individuals who believe they would benefit from additional support (selective interventions). No effects are found for interventions that are offered to anyone who has suffered bereavement (universal interventions) (Currier, Neimeyer, & Berman, 2008).

Bereavement Support for Cancer-Related Loss

Although most people adjust well to a cancer-related bereavement, the loss of a loved one to cancer is associated with negative bereavement outcomes such as higher levels of depression, anxiety, and sleep difficulties (Jonasson et al., 2009), and can place individuals at greater risk of developing complicated grief responses (Lichtenthal et al., 2015; Lichtenthal, Prigerson, & Kissane, 2010). Therefore people who have lost a loved one to cancer may require more than informal support provided by friends and family in order to help them adapt to their bereavement.

Group bereavement interventions are a popular treatment format for bereavement support (Waller et al., 2016). Their popularity can be attributed to their effective use of resources, social acceptability, and therapeutic factors that often meet the needs of bereaved individuals (e.g. reducing social isolation). Bereaved individuals also perceive bereavement groups as more acceptable and appropriate when they are specific to the type of loss experienced (Zimpfer, 1991). Group bereavement interventions tend to be either self-help groups (sometimes referred to as mutual support groups), or more formalised therapeutic bereavement groups (Rice, 2015).

Self-help groups are usually self-governing and self-regulating and offer a support network (Lieberman, 1986). Bereavement self-help groups are usually open to anyone who has experienced a loss, and members do not need to present with, or be at risk of developing, more complicated grief symptoms (Schut & Stroebe, 2010). Members of bereavement self-help groups report many positive aspects, such as social support, emotional expression, reciprocity within the group, exchanging of information and advice, and sharing of hope (Dyregrov et al., 2014).

Few studies have used objective measures to examine the effectiveness of self-help groups for cancer bereavement. The research that has been conducted presents consistent findings that participants report self-help groups as being beneficial, but changes on objective outcome measures of psychological symptoms are not found (Heiney, Hasan, & Price, 1993; Levy, Derby, & Martinkowski, 1993).

The second type of group intervention for bereavement, are therapeutic groups which differ from self-help groups in that they have structured content and are initiated and led by professionals. These groups are often based on theoretical knowledge and practice, and the professional facilitating the group is usually distinct from the group members. In addition, members' expectations about therapeutic support groups may be different to self-help groups (Lieberman, 1988).

Therapeutic bereavement groups specific to the type of loss (e.g. HIV-related death) have been shown to be an effective intervention for grief reactions (e.g. Sikkema, Hansen, Kochman, Tate, & Difranceisco, 2015). Group homogenity is also associated with increased group cohesion and better outcomes (Yalom & Leszcz, 2005). When individuals experience the same type of bereavement there may be similar themes or symptoms in their grief reactions (Houck, 2008) which specific therapeutic support groups are well placed to address.

Despite the clinical rationale for cancer-specific therapeutic bereavement groups, and some evidence that participants find them beneficial (Souter & Moore, 1990), there is little published research regarding their effectiveness. The most extensive evidence for cancer-specific therapeutic bereavement groups has come from Yalom and colleagues (Lieberman & Yalom, 1992; Yalom & Lieberman, 1991; Yalom & Vinogradov, 1988). They found that taking part in an eight-session therapeutic group was associated with increased self-esteem and reduced role strain. Themes identified from the groups included opportunities for change, new relationships, time and rituals.

Aims of the Present Study

Bereavement research has been criticised for lacking methodological rigour. The two main issues identified are poor study design and the lack of validated psychological outcome measures. Although the use of control groups in bereavement research is recommended (Schut & Stroebe, 2011), before randomised controlled trials (RCTs) are conducted, preliminary research should understand and define the problem, develop appropriate interventions and suitable evaluation. This iterative process can provide a firm grounding for any subsequent rigorous trials to be carried out and should be the first process of intervention research (Campbell et al., 2007).

This study evaluated a new therapeutic bereavement support group intervention that had recently been developed. The dual processing model of coping with bereavement (Stroebe & Schut, 1999) provided a framework for the design of the intervention and its manualisation. The intervention also incorporated aspects of self-help groups, Cognitive Behavioural Therapy (CBT) and Compassion Focused Therapy (CFT). Outcomes across a range of psychological measures were collected pre- and post- intervention and at three-month follow-up.

The study aimed to answer the following questions:

i. Does the intervention lead to changes in the following domains: grief responses, psychological symptoms, self-compassion and resilience?
ii. How do participants experience the intervention: what do they find helpful or unhelpful?

Method

Overview

This was a longitudinal cohort study using a pre-, post-intervention design. Participants took part in a six-session therapeutic bereavement support group over a period of eight weeks. Quantitative data were collected via online questionnaires at baseline, intervention completion and three-months after the final session. Some outcome measures were also collected prior to every session. The outcome measures assessed a range of domains: grief responses, psychological symptoms, self-compassion and resilience. In addition, a small waiting list group was used to estimate changes in outcomes over time with no intervention.

Setting

The research was conducted in collaboration with The Loss Foundation, a UK charity that provides support to people who have had a cancer-related bereavement. It provides free, open, professionally facilitated self-help groups and other supportive events (e.g. coffee mornings) for adults across London and in Oxford.

In addition to their current self-help groups, The Loss Foundation had recently developed therapeutic support groups, which differed from their self-help groups as they were closed, time-limited and professionally-led therapeutic groups that targeted cancer bereavement grief reactions. These groups were also free of charge and self-referred, but as they were set-up as part of a research study members had to take part in the research in order to be included.

Participant Recruitment and Procedure

Adults who had lost a loved one to cancer were recruited through The Loss Foundation. The eligibility criteria for participants were:

i) Aged 18 or over.

ii) Experience of bereavement by cancer.

iii) The time since bereavement must have been more than 6 months, so as not to interfere with a natural recovery process (Henk Schut & Stroebe, 2010).

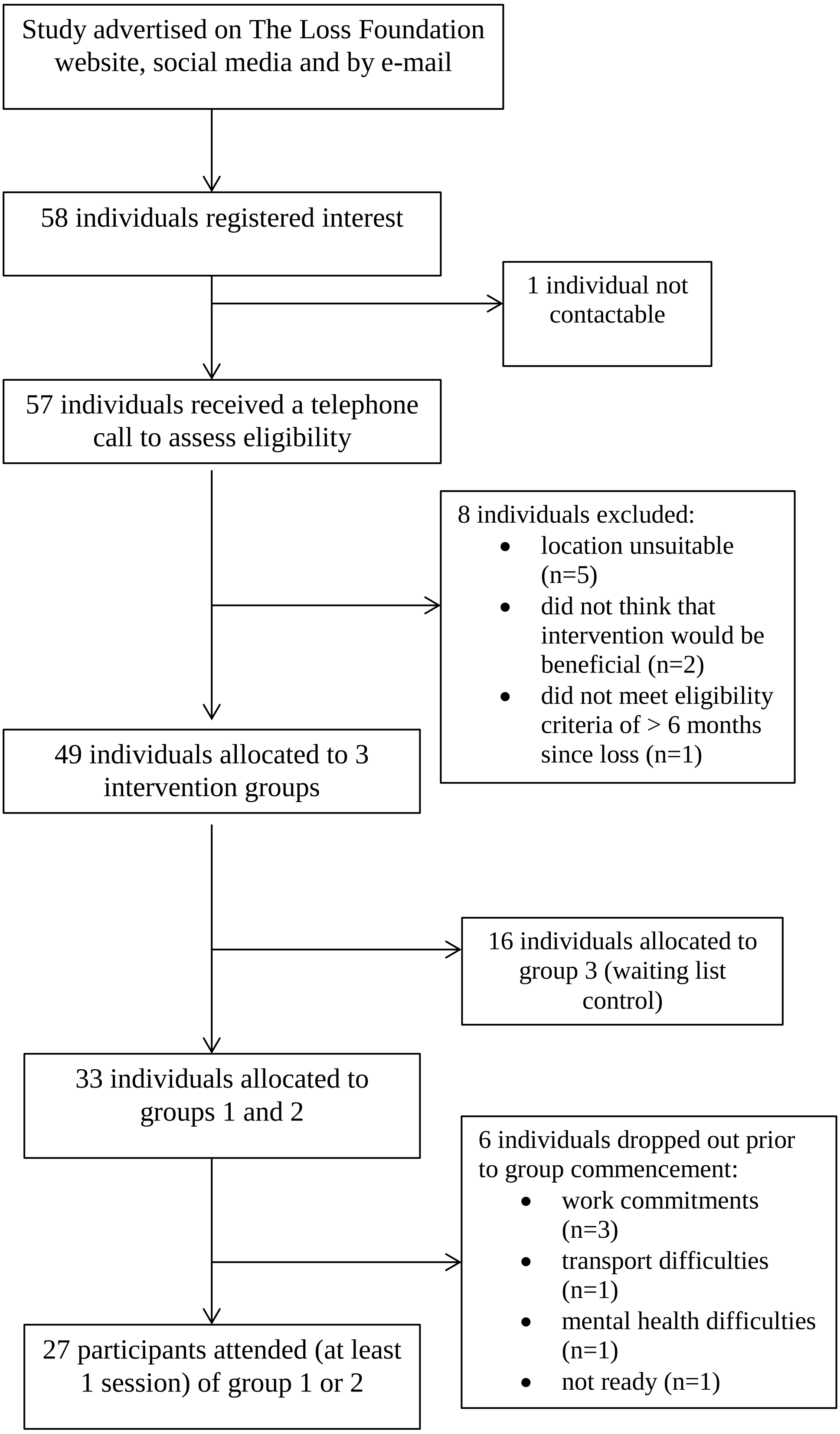
iv) Self-referral to The Loss Foundation or via a related organisation.

The exclusion criterion was significant substance or alcohol misuse, which would interfere with participants' ability to take part in the research.

The participant recruitment procedure is presented in Figure 1. Participants were recruited using The Loss Foundation mailing list, website and social media. Basic information about the study and how to register interest was displayed on their website and social media accounts. In addition, an e-mail with a link to register interest in the study was sent to all individuals on their mailing list (see Appendix A).

Individuals registered their interest using an online form. During registration they were provided with the study information sheet (see Appendix B) and asked to provide their contact details. A total of 58 individuals registered their interest: 57 received a screening phone-call; one was not contactable. The screening phone-call used a protocol (see Appendix C) to assess individuals' eligibility, explain the study and answer any questions.

Figure 1. *Participant Recruitment Procedure*



Following the screening phone-calls, 49 individuals met the eligibility criteria and were allocated to one of three therapeutic support groups. Allocation was partly random but also took into account participant time preferences or time since bereavement in order to meet eligibility criteria. Three groups were run to ensure clinically appropriate group sizes and maximize therapeutic benefits. The groups were identical in content but began at different points in the year (e.g. January and March); the present study only includes pre-post data from the first two groups. Groups one and two were allocated 33 participants (17 in the first group and 16 in the second); but prior to the start of the intervention six participants dropped out of the study. Therefore, the total number of participants was 27. In addition 11 participants from group 3 were used as a waiting list comparison group.

Sample Size Calculation

The primary focus of the study was to measure the psychological changes that occurred as a result of the group bereavement intervention. These changes were measured using quantitative outcomes. Using G*Power it was calculated that in order to detect a large effect size of d=0.80 with an alpha of 0.05, a sample size of 15 would be required. To detect a medium effect size of d=0.50 with an alpha of 0.05, a sample size of 35 would be required.

With an alpha of 0.05, the achieved sample of 27 gave a power of 97% to detect a large effect size of d=0.80, and a power of 68% to detect a medium effect size of d=0.50.

Ethical Approval

The study received ethical approval from the University College London Research Ethics Committee in December 2015 (see Appendix D). All participants were provided with written information about the study and gave informed consent prior to participating (see Appendices B and E). Participants were given the opportunity to ask questions about the research as part of the informed consent process.

Participant Characteristics

Table 1 shows the demographic characteristics of participants, most were female (n=22) and well-educated having continued education beyond A-levels (n=21). The majority identified as White British (n=24) and a minority identified as British Asian (n=3). Their ages ranged from 26 to 71 years, with a mean of 48.9 (SD=15.2). Following their bereavement a third of participants reported having received psychological treatment, a third continued to receive psychological treatment, and a third did not receive any treatment.

Table 2 presents information about the participants' loss and the characteristics of their relationships with the deceased. The majority had experienced the bereavement of a spouse or partner (n=11), followed by the loss of a parent (n=7) or a sibling (n=6).

The average length of the relationship with the deceased was 32.5 years (SD=16) but this ranged from 7 to 69 years. The median length of time since the bereavement was 18 months (SD=24.8), with a range of 6 to103 months. Most participants saw their loved one daily in the three months preceding their death (n=19) and were present at the death (n=20).

Therapeutic Support Group Intervention

The six-session therapeutic bereavement support groups were already in use in the service and had been developed by The Loss Foundation. They were based on CBT and CFT models of distress (Beck, 2011; Gilbert, 2009) and covered three main components of bereavement support: psychoeducation, development of

Table 1. *Demographic Characteristics of Participants*

Variable	**Mean (SD) or frequency (%)**
Age (years)	48.9 (15.2), range 26-71
Gender	
Female	22 (81.5%)
Male	5 (18.5%)
Ethnicity	
White British	24 (89%)
Asian British Indian	2 (7%)
Asian British Chinese	1 (4%)
Marital status	
Single	8 (30%)
Widowed	10 (37%)
Married/Civil Partnership	4 (15%)
Long-term relationship	3 (11%)
Divorced	2 (7%)
Highest level qualification	
No qualifications	1 (4%)
GCSE’s	1 (4%)
A-levels	3 (11%)
Professional qualification (for example, teaching)	6 (22%)
NVQ/BTech/HND	1 (4%)
Undergraduate degree	8 (29%)
Postgraduate degree	6 (22%)
Prefer not to say	1 (4%)
Employment	
Full-time	15 (55%)
Part-time	4 (15%)
Unemployed & looking for work	2 (7%)
Retired	5 (19%)
Freelance	1 (4%)
Faith	
No religion	8 (30%)
Christian	8 (29%)
Hindu	1 (4%)
Jewish	1 (4%)
Other (not specified)	9 (33%)
Psychological treatment since bereavement	
Yes, previously	9 (33.3%)
Yes, currently	9 (33.3%)
No	9 (33.3%)

Table 2. *Bereavement Characteristics*

Variable	**Mean (SD) or frequency (%)**
Length of relationship with deceased (years)	32.5 (16), range from 7-69
Time since death (months)	26.3 (24.8), range from 6-103
Relationship with deceased	
Spouse or partner	11 (41%)
Parent	7 (26%)
Sibling	6 (22%)
Adult child	1 (3.6%)
Friend	1 (3.6%)
Nephew	1 (3.6%)
Gender of deceased	
Male	15 (56%)
Female	12 (44%)
Co-habiting with deceased prior to death	
Yes	15 (56%)
No	12 (44%)
Contact with deceased prior to death	
Every day or several times per day	24 (89%)
2-6 times per week	3 (11%)
Frequency of seeing deceased in 3 months preceding death	
Daily	19 (70%)
Several times a week	3 (11%)
Weekly	1 (4%)
Monthly	2 (7.5%)
Not at all	2 (7.5%)
Present at the death	
Yes	20 (74%)
No	7 (26%)
Death of other loved ones in past 3 years	
0	16 (59%)
1	8 (30%)
2	2 (7%)
4	1 (4%)

self-compassion and grief cognitions (see Appendix F for an example of the intervention manual).

The first component was psychoeducation, which is based on research that learning about the grief process is beneficial (Goldstein, Alter, & Axelrod, 1996) and that CBT for insomnia after bereavement improves sleep (Carter, Mikan, & Simpson, 2009; Connor & Davidson, 2003).

The second component aimed to develop self-compassion through compassionate mind training. Losing a loved one to cancer may result in a heightened state of threat detection where anxiety, shame and self-criticism are experienced. Developing self-compassion can help move from a state of threat to developing self-soothing and social safeness systems (Gilbert, 2009).

The third component used CBT principles to work with grief cognitions and behaviours that may be unhelpful. CBT for bereavement is effective in alleviating distress and evidence suggests that it be integrated in other approaches to ensure that the multidimensional nature of grief is considered (Currier, Holland, & Neimeyer, 2010).

Each session had specific aims and was structured as follows:

Session 1: psychoeducation about the grief experience (e.g. sleep difficulties and anxiety)

Session 2: self-care and daily routine

Session 3: self-compassion

Session 4: unhelpful cognitions

Session 5: developing resilience to unhelpful thoughts or memories through exposure

Session 6: reflections and endings

Sessions were two hours long and the intervention covered a period of eight weeks (sessions 1-3 were weekly and sessions 4-6 fortnightly). The intervention was delivered by qualified clinical psychologists who worked and volunteered for The Loss Foundation and who had experience of facilitating their self-help support groups. The author was present at the group sessions and provided some assistance in their delivery. The intervention took place in a central London location on a weekday evening.

Design and Data Collection

This was a longitudinal cohort study using a pre-, post-intervention design. Participants completed quantitative outcome measures online through a system called Qualtrics (www.qualtrics.com). An e-mail with a secure link to the survey was sent to participants. All outcome measures were collected via online questionnaires at baseline, intervention completion and three-months after the final session. In addition, some outcome measures were collected prior to every session. The outcome measures assessed several domains: grief responses, psychological symptoms, self-compassion, resilience and the helpful aspects of the intervention. Table 3 shows all of the measures and the time points at which they were administered.

Outcome Measures

The selection of outcome measures was based, in part, on the findings from the literature review (Part I) that common outcomes used to evaluate bereavement interventions include measures of grief, trauma, mood and psychological symptoms. Outcome measures of self-compassion and resilience were also included in order to reflect the nature of the intervention, as the therapeutic support group was based on CFT and aimed to enhance self-compassion and resilience. It was beyond the scope

Table 3. *Outcome Measures and Point of Collection*

Outcome Measures	**Session 1 (Baseline)**	**Session 2**	**Session 3**	**Session 4**	**Session 5**	**Session 6**	**Intervention Completion (1 week)**	**Follow-up (3 month)**
The Grief Intensity Scale	✓	.	.	.	.	.	✓	✓
The PTSD Checklist for DSM-5	✓	.	.	.	.	.	✓	✓
The Patient Health Questionnaire-9	✓	✓	✓	✓	✓	✓	✓	✓
The Generalized Anxiety Disorder-7	✓	✓	✓	✓	✓	✓	✓	✓
The Self-Compassion Scale – Short Form	✓	✓	✓	✓	✓	✓	✓	✓
The Connor-Davidson Resilience Scale-Short Form	✓	✓	✓	✓	✓	✓	✓	✓
The Helpful Aspects of Therapy	.	✓	✓	✓	✓	✓	✓	.

of the present study to conduct qualitative interviews with participants about their experiences of the intervention. Therefore a brief self-report measure of what participants found helpful and unhelpful about the intervention was selected. In order to not over burden participants, additional outcomes such as utilisation of health care services were not included in the present study.

The Grief Intensity Scale (GIS; Prigerson & Maciejewski) is a 12-item self-report questionnaire that measures time from loss, grief intensity and functional impairment. The time from loss item uses a 5-point scale with response categories from “0=Less than 1 Month” to “4=More than 24 Months”. Items 2-4 measure frequency of symptoms; a sample item is “In the past month, how often have you felt stunned, shocked, or dazed by your loss?”. Each item is scored on a 5-point scale with response categories “0=Not at all” to “4=Several times a day”. Items 5-11 measure the intensity if symptoms; a sample item is “Do you feel bitter over your loss”. Each item is scored on a 5-point scale with response categories “0=Not at all” to “4=Overwhelmingly”. The functional impairment item asks if any areas of function have been reduced, with a categorical “yes” or “no” response.

For the present study the analysis excluded the time since loss and functional impairment items to create a 10-item measure of grief intensity with scores ranging from 0 to 40; higher scores reflect elevated intensity of grief. The scale resembles the same author’s Prolonged Grief-13 (PG-13; Prigerson et al., 2009) which has one additional intensity item and also includes a functional impairment item and frequency item. In order to compare the present measure with the PG-13 the scale was pro-rated by multiplying the total score by 1.10. Both the GIS and PG-13 have strong psychometric properties (Prigerson et al., 2009). Cronbach’s alpha for the intensity items in the present study was 0.84.

The PTSD Checklist for DSM-5 (PCL-5; Weathers et al., 2013) is a 20-item self-report questionnaire that assesses symptoms of PTSD. A sample item is “In the past month, how much were you bothered by repeated, disturbing, and unwanted memories of the stress experience?” Each item is scored on a 5-point scale with response categories of “0=Not at all” to “4=Extremely”; this provides a total severity score of 0-80. Blevins, Weathers, Davis, Witte & Domino (2015) reported that the measure has strong psychometric properties: the internal consistency was 0.94 and the test-retest reliability was 0.82 over a period of a week. Cronbach’s alpha in the present study was 0.86.

The Patient Health Questionnaire-9 (PHQ-9; Kroenke, Spitzer, & Williams, 2001) is a 9-item self-report questionnaire that measures the severity of depressive symptoms. A sample item is “Feeling tired or having little energy”. Each item is scored on a 4-point scale with response categories of “0=Not at all” to “3=Nearly every day”; this provides a 0 to 27 severity score. Kroenke et al. (2001) reported that the measure has strong psychometric properties: the internal consistency was 0.89 and test-retest reliability between patient self-report and mental health professional administering the measure telephonically 48 hours later was 0.84. The measure also has good convergent validity (r=0.73) with the mental health subscale of the Short-Form General Health Surv. The PHQ-9 has not been validated with bereaved populations. Cronbach’s alpha in the present study was 0.83.

The Generalized Anxiety Disorder-7 (GAD-7; Spitzer, Kroenke, Williams, & Löwe, 2006) is a 7-item self-report questionnaire that measures the severity of anxiety symptoms. A sample item is “Feeling nervous, anxious or on edge”. Each item is scored on a 4-point scale with response categories of “0=Not at all” to “3=Nearly every day”; this provides a 0 to 21 severity score. Spitzer et al. (2006)

reported that the measure has strong psychometric properties: the internal consistency was 0.92 and test-retest reliability was 0.83 over a period of a week. The measure has strong convergent validity with the Beck Anxiety Inventory (r=0.72) and the anxiety sub-scale of the Symptom Checklist-90 (r=0.74). The GAD-7 has not been validated with bereaved populations. Cronbach's alpha in the present study was 0.90.

The Self-Compassion Scale-Short Form (SCS-SF; Raes, Pommier, Neff, & Van Gucht, 2011) is a 12-item self-report questionnaire that measures self-compassion. A sample item is "I'm disapproving and judgmental about my own flaws and inadequacies". Each item is scored on a 5-point scale with response categories of "1=Almost Never" to "5=Almost Always"; this provides a total score of 12-60. Raes et al. (2011) reported that the measure has strong psychometric properties: the internal consistency was 0.85 and the test-retest reliability over a period of five months was 0.71. The total score of the SCS-SF correlates highly (r=0.98) with the longer 26-item Self-Compassion Scale. Construct validity of the SCS-SF has not been tested but the long version of the SCS was negatively correlated (r=-0.65) with the self-criticism subscale of the Depressive Experiences Questionnaire. The SCS-SF has not been validated with bereaved populations. Cronbach's alpha in the present study was 0.81.

The Connor-Davidson Resilience Scale-Short Form (CD-RISC 10; Connor & Davidson, 2003) is a 10-item self-report questionnaire that measures resilience. A sample item is "I am able to adapt when changes occur". Each item is scored on a 5-point scale with response categories of "0=Not True at All" to "4=True Nearly All of the Time"; this provides a total score from 0-40. However, due to an administrative error in the present study, one of the intermediate scale points was accidentally omitted, and so the response scale had 4 rather than 5 scale points, yielding a maximum score of 30. In order to compare the scores with normative samples, they would therefore need to be pro-rated by a factor of 1.33. Campbell-Sills & Stein (2007) reported that the measure has good psychometric properties: the internal consistency was 0.85 and the total score on the CD-RISC 10 correlates highly (r=0.92) with the longer 25-item version CD-RISC. Construct validity of the CD-RISC 10 has not been exmained but the CD-RISC was positively correlated with the Kobasa hardiness measure (r=0.83) and negatively correlated with the Perceived Stress Scale (r=-0.76). The CD-RISC-10 has not been validated with bereaved populations. The Cronbach's alpha in the present study was 0.91.

The Helpful Aspects of Therapy (HAT; Llewelyn, 1988) is a post-session self-report questionnaire that asks about perceptions of key change processes in therapy. It is partly qualitative and captures perceptions of helpful and unhelpful aspects of the previous session. An example item is "Of the events which occurred in the last group session, which one do you feel was the most helpful or important for you personally? Please describe what the event was." Each event is then scored as to how helpful or unhelpful it was on a 5-point scale with response categories of "0=Not at all" to "4=Extremely". Two questions ask participants to identify, describe and then rate first a helpful and second an unhelpful event. In addition, there are two optional questions for participants to identify, describe and then rate other helpful and unhelpful events.

Results

Data Screening

The data were screened to check whether normality assumptions were met. Five variables showed a deviation from normality, therefore the data were analysed using two-tailed Wilcoxon signed rank tests.

There were no missing data at baseline with 100% data completion (n=27), but at intervention completion (session 6) there was 85% data completion (n=23) and at 3-month follow-up 93% data completion (n=25).

Attendance of therapeutic sessions was high; 74% (n=20) of participants attended all six therapeutic sessions, 19% (n=5) attended three or four sessions and 7% (n=2) attended two or less sessions.

Baseline Population Characteristics

Baseline scores indicate that the sample had moderate levels of depression, anxiety and PTSD symptoms before the start of the intervention (Table 4). Self-compassion and resilience scores were lower than published scores in general population samples (Antúnez, Navarro, & Adan, 2015; Raes et al., 2011). Symptoms of grief intensity were lower than published scores of bereaved parents (Lichtenthal et al., 2015).

Pre- and Post-Intervention Comparisons

Baseline and intervention completion

Table 4 displays the pre- and post-intervention comparisons. Symptoms of anxiety and depression were reduced: Wilcoxon signed-ranks tests showed a reduction in participants' scores on the PHQ-9 (z = 3.07, *p*=.002, *d*=.60) and GAD-7 (z=3.13, *p*=.002, *d*=.46) at baseline and intervention completion. There was a

Table 4. *Outcome Measures at Baseline and Intervention Completion*

Measure	**Baseline (n=27)**		**Completion (n=23)**		**Wilcoxon Signed Ranks**		**Cohen's *d***
	M	**(SD)**	**M**	**(SD)**	***z***	***p***	
GIS	22.56	(7.45)	11.30	(3.62)	(4.17)	<.001	1.87
PCL-5	35.70	(12.91)	28.52	(13.44)	(2.45)	.014	0.54
PHQ-9	10.85	(5.61)	7.65	(5.01)	(3.07)	.002	0.60
GAD-7	9.59	(5.40)	7.17	(5.20)	(3.13)	.002	0.46
SCS-SF	31.63	(7.86)	36.69	(7.29)	(2.68)	.007	0.67
CD –RISC 10	13.07	(6.05)	13.83	(6.43)	(6.43)	.359	0.12

Note: PHQ-9 = The Patient Health Questionnaire-9; GAD-7 = The Generalized Anxiety Disorder-7; SCS-SF = The Self-Compassion Scale-Short Form; CD-RISC 10 = The Connor-Davidson Resilience Scale-Short Form; GIS = The Grief Intensity Scale; PCL-5 = The PTSD Checklist for DSM-5

decrease of 3.2 points on the PHQ-9, with a moderate effect size. There was also a decrease of 2.42 points on the GAD-7, with a small to moderate effect size.

There was an increase in self-compassion: scores on the SCS-SF increased between pre- and post-intervention (z=2.68, *p*=.007, *d*=.67). There was an increase of 5.06 points on the SCS-SF, with a moderate to large effect size. There were no changes in resilience, no differences were found between pre- and post-intervention scores on the CD –RISC 10 (z=6.43, *p*=.359, *d*=.12).

Symptoms of grief intensity and PTSD reduced: Wilcoxon signed-ranks tests showed a decrease in participants' scores on the GIS (z = 4.17, *p*=<.001, *d*=1.87) and PCL-5 (z=2.45, *p*=.014, *d*=.54) at baseline and intervention completion. There was a decrease of 11.26 points on the GIS, with a large effect size and a decrease of 7.18 points on the PCL-5, with a moderate effect size.

An intention-to-treat analysis was also conducted using participants' last observation carried forward; this showed substantially the same results.

Baseline and follow-up (3 months after intervention completion)

Table 5 displays the pre-intervention and three months post-intervention comparisons. At three-month follow-up symptoms of depression were reduced (z = 2.4, *p*=.017, *d*=.60): there was a decrease of 2.81 points on the PHQ-9 with a moderate effect size. Similarly, symptoms of grief intensity and PTSD were also reduced. Wilcoxon signed-ranks tests showed that there continued to be a reduction in participants' scores on the GIS (z = 3.7, *p*=<.001, *d*=.79) and PCL-5 (z=4.08, *p*=<.001, *d*=.90) at baseline and follow-up.

Table 5. *Outcome Measures at Baseline and Follow-Up (3 months after completion)*

Measure	**Baseline (n=27)**		**Follow-Up (n=25)**		**Wilcoxon Signed Ranks**		**Cohen's *d* at follow-up**	**Cohen's *d* at completion**
	M	**(SD)**	**M**	**(SD)**	***z***	***p***		
GIS	22.56	(7.45)	17.08	(6.18)	(3.70)	<.001	0.79	1.87
PCL-5	35.70	(12.91)	25.52	(9.46)	(4.08)	<.001	0.90	0.54
PHQ-9	10.85	(5.61)	8.04	(3.50)	(2.40)	.017	0.60	0.60
GAD-7	9.59	(5.40)	7.52	(4.72)	(1.76)	.079	0.41	0.46
SCS-SF	31.63	(7.86)	35.45	(7.33)	(1.68)	.094	0.50	0.67
CD –RISC 10	13.07	(6.05)	14.38	(6.20)	(1.45)	.147	0.21	0.12

Note: PHQ-9 = The Patient Health Questionnaire-9; GAD-7 = The Generalized Anxiety Disorder-7; SCS-SF = The Self-Compassion Scale-Short Form; CD-RISC 10 = The Connor-Davidson Resilience Scale-Short Form; GIS = The Grief Intensity Scale; PCL-5 = The PTSD Checklist for DSM-5

There was a decrease of approximately 5.48 points on the GIS, with a large effect size, and a decrease of approximately 10.18 points on the PCL-5, with a large effect size.

There was no reduction in anxiety symptoms, or improvement in self-compassion or resilience at follow-up. Wilcoxon signed-ranks tests showed no change between pre- and three months post-intervention scores on the GAD-7 (z=1.76, *p*=.079, *d*=.41), SCS-SF (z=1.68, *p*=.094, *d*=.50) and CD –RISC 10 (z=1.45, *p*=.147, *d*=.21).

An intention-to-treat analysis was conducted using participants' last observation carried forward; this showed substantially the same results except for outcomes of self-compassion. Wilcoxon signed-ranks tests showed a continued increase between pre- and three months post-intervention scores on the SCS-SF but a smaller effect size (z=2.02, *p*=.043, *d*=.37).

Reliable Change

Reliable change in outcomes between baseline and intervention completion and follow-up were calculated using Cronbach's coefficient alpha as the reliability estimate for each measure (Table 6) (Jacobson & Truax, 1991).

Between baseline and intervention completion the majority of participants experienced a reliable improvement in symptoms of grief (n=16), and approximately a quarter experienced reliable improvements in self-compassion (n=6), PTSD symptoms (n=5) and symptoms of depression (n=5). Two participants experienced a reliable deterioration on one outcome measure: one participant experienced a reliable deterioration in resilience (but also a reliable improvement in grief symptoms and no change in other outcome measures), the other participant reliably deteriorated in PTSD symptoms (and had no reliable change on any other outcome measures).

Table 6. *Reliable Change in Outcomes at Baseline and Intervention Completion, and Baseline and Follow-Up (3 months after completion)*

	Baseline – Intervention Completion			**Baseline – Follow- Up**		
Measure	**% Improvement (n)**	**% No change (n)**	**% Deterioration (n)**	**% Improvement (n)**	**% No change (n)**	**% Deterioration (n)**
GIS	70 (16)	30 (7)	0 (0)	36 (9)	64 (16)	0 (0)
PCL-5	22 (5)	74 (17)	4 (1)	28 (7)	72 (18)	0 (0)
PHQ-9	22 (5)	78 (18)	0 (0)	24 (6)	76 (19)	0 (0)
GAD-7	13 (3)	87 (20)	0 (0)	20 (5)	72 (18)	8 (2)
SCS-SF	26 (6)	74 (17)	0 (0)	13 (3)	88 (21)	0 (0)
CD –RISC 10	17 (4)	78 (18)	4 (1)	13 (3)	83 (20)	4 (1)

Note: PHQ-9 = The Patient Health Questionnaire-9; GAD-7 = The Generalized Anxiety Disorder-7; SCS-SF = The Self-Compassion Scale-Short Form; CD-RISC 10 = The Connor-Davidson Resilience Scale-Short Form; GIS = The Grief Intensity Scale; PCL-5 = The PTSD Checklist for DSM-5

At 3-month follow-up reliable improvement in symptoms of depression (n=6), anxiety (n=5) and PTSD (n=7) increased compared to outcomes at intervention completion. However, reliable improvement decreased for resilience (n=3), self-compassion (n=3) and grief (n=9). Although over a third of participants still experienced an improvement in symptoms of grief intensity. A small proportion of participants experienced a reliable deterioration in symptoms of anxiety (n=2) and resilience (n=1). One participant who experienced a deterioration in anxiety symptoms showed no reliable change on other outcome measures except for a reliable improvement in depression symptoms. A participant who experienced a reliable deterioration in anxiety symptoms reliably improved on outcome measures of grief and PTSD symptoms but experienced no reliable change in depression symptoms, resilience or self-compassion. The participant who experienced a reliable deterioration in resilience showed no reliable change in grief symptoms or self-compassion but did experience a reliable improvement in symptoms of PTSD, anxiety and depression.

Waiting List Control Group

Outcomes from 11 participants on the waiting list for the third bereavement support group were used to estimate changes in outcomes over time in the absence of the intervention. Group three was the last therapeutic group to be delivered. Therefore, participants who were allocated to this group waited for three months before the start of their group, thus creating a non-randomised waiting list control condition (as the assignment to this group was not completely randomised).

When participants were allocated to the third group and entered the waiting list, outcome measures were collected for all variables (except for the HAT). The same outcome measures were collected at initial assessment and at the end of the waiting list period.

Attrition and participant characteristics

Although 16 participants were allocated to group three, four participants were unable to participate; therefore 12 participants completed the measures at initial assessment. Of these 12, one participant dropped out before the end of the waiting list period, leaving 11 participants completing measures at both initial assessment and the end of the waiting list.

Participants in the comparison group had similar characteristics to participants in the intervention group. Most were female (n=10) and well-educated, having continued education beyond A-levels (n=10). Nearly all participants identified as White British (n=11) with one identifying as Armenian. Their ages ranged from 26 to 54 years, with a mean of 42.6 (SD=10).

The majority of participants had experienced the bereavement of a spouse or partner (n=7), followed by the loss of a parent (n=4) or a sibling (n=1). The average length of the relationship with the deceased was 26 years (SD=12) but this ranged from 8 to 45 years. The mean length of time since the bereavement was 16 months (SD=9.9), with a range of 4 to 42 months; this was a shorter period compared to participants in the intervention group. Most participants saw their loved one daily in the three months preceding their death (n=9) and most participants were present at the death (n=8).

Regarding psychological functioning, compared to the comparison group participants in the waiting list control group were broadly similar. They also had moderate levels of depression and PTSD symptoms and high levels of grief intensity, but lower levels of anxiety symptoms. Their self-compassion and resilience scores were also lower than published scores in general population samples (Antúnez et al., 2015; Raes et al., 2011).

Initial assessment and end of waiting list comparisons

Wilcoxon signed-ranks tests showed that there were no differences between initial assessment and end of waiting list scores (Table 7). That is, there was no change on any of the outcome variables in the three months between initial assessment and the end of the waiting list. This suggests that changes in outcomes did not occur spontaneously over three months and that the changes identified in the intervention group could be attributed to the intervention.

However, a Mann-Whitney U test was used to compare initial assessment scores between participants in the comparison and intervention groups (Table 8). These results show that participants in the comparison group had lower levels of depression, anxiety, grief and PTSD symptoms compared to participants in the intervention group. Therefore, the waiting list group may not be a suitable comparison group as they were experiencing lower levels of psychological difficulties compared to participants in the intervention group.

Helpful Aspects of Therapy

A content analysis was conducted to examine the written qualitative responses from the HAT questionnaire (Pistrang & Barker, 2012). An inductive approach, using a low level of inference was used to categorise the aspects of the intervention sessions that were stated as being helpful. Once the categories were established, their occurrence for each session, across participants, was counted (Table 9).

Table 7. *Comparison Group Outcome Measures at Initial Assessment and End of Waiting List*

Measure	**Initial Assessment (n=12)**		**End of Waiting List (n=11)**		**Wilcoxon Signed Ranks**	
	M	**(SD)**	**M**	**(SD)**	***z***	***p***
GIS	19.00	(6.68)	19.45	(6.28)	.060	.952
PCL-5	22.83	(8.29)	21.00	(10.29)	.357	.721
PHQ-9	7.17	(5.72)	7.45	(5.59)	.854	.393
GAD-7	5.00	(4.51)	5.81	(3.97)	.850	.395
SCS-SF	33.75	(9.23)	31.00	(6.36)	.479	.632
CD –RISC 10	16.90	(5.16)	14.72	(5.01)	1.03	.301

Note: PHQ-9 = The Patient Health Questionnaire-9; GAD-7 = The Generalized Anxiety Disorder-7; SCS-SF = The Self-Compassion Scale-Short Form; CD-RISC 10 = The Connor-Davidson Resilience Scale-Short Form; GIS = The Grief Intensity Scale; PCL-5 = The PTSD Checklist for DSM-5

Table 8. *Outcome Measures at Initial Assessment for Waiting List Group and Intervention Group*

Measure	**Waiting List Group (n=11)**		**Intervention Group (n=27)**		**Mann Whitney U**	
	M	**(SD)**	**M**	**(SD)**	***z***	***p***
GIS	19.00	(6.68)	25.93	(7.44)	2.563	.010
PCL-5	22.83	(8.29)	35.70	(12.91)	3.182	.001
PHQ-9	7.17	(5.72)	10.85	(5.61)	2.09	.036
GAD-7	5.00	(4.51)	9.59	(5.40)	2.87	.003
SCS-SF	33.75	(9.23)	31.63	(7.86)	.548	.599
CD –RISC 10	16.90	(5.16)	13.07	(6.05)	1.77	.080

Note: PHQ-9 = The Patient Health Questionnaire-9; GAD-7 = The Generalized Anxiety Disorder-7; SCS-SF = The Self-Compassion Scale-Short Form; CD-RISC 10 = The Connor-Davidson Resilience Scale-Short Form; GIS = The Grief Intensity Scale; PCL-5 = The PTSD Checklist for DSM-5

Table 9. *Content Analysis from the HAT Questionnaire*

Session	**Content**	**Count**
Session 1		
	Explanation of different models of grief	27
	Group therapeutic factors	24
	Psychoeducation of anxiety and physical aspects of grief	12
	Normalising of grief experience by facilitators	6
	Mindfulness exercise	2
Session 2		
	Information on flashbacks and triggers	24
	Value of self-care	13
	Group therapeutic factors	6
	Mindfulness exercise	3
	Normalising of experiences by facilitators	3
Session 3		
	Psychoeducation about self-compassion	12
	"The Perfect Nurturer" self-compassion exercise	9
	Mindfulness exercise	5
	Group therapeutic factors	2
	Email reminders about self-compassion	2
	Keeping a diary about triggers of flashbacks	1
	Video distributed about vulnerability	1
Session 4		
	Psychoeducation about emotions and cognitions	20
	Group therapeutic factors	4
	Mindfulness exercise	4
	Email reminders about self-compassion	1
Session 5		
	Exercise on loved one's qualities	17
	Information on conducting behavioural experiments	7
	Group therapeutic factors	7
	Mindfulness exercise	3
	Facilitator disclosure about own experiences	3
	Email reminders about self-compassion	1
	Practical strategies to cope with difficult thoughts or memories	1
	Completing outcome measures and noticing change	1
Session 6		
	Group therapeutic factors	12
	Values exercise	9
	Photo sharing	8
	Overview of intervention content in previous sessions	6
	Eating cake and informal discussions	3
	Mindfulness exercise	2

Participants identified various aspects of sessions as being beneficial, often identifying more than one feature of the session. The structured content of the sessions and associated exercises were consistently identified as being the most helpful aspects of the sessions. For example, for session 3, which focused on self-compassion, information about self-compassion was mentioned most frequently as being helpful, followed by the self-compassion exercise called ‘The Perfect Nurturer’ which aims to develop self-compassion.

Group therapeutic factors refer to the therapeutic experience of being in a group, for example universality, imparting information, altruism, and instillation of hope (Yalom & Leszcz, 2005). These were consistently identified as helpful aspects of the sessions, although their value appeared to change across sessions.

They appeared to be most important at the beginning and end of the intervention; they were the second most identified factor in session 1 and the most identified factor in session 6 (perhaps because there was no specific session content in the final session). Similarly, the mindfulness exercise, which was conducted at the end of every session, was mentioned by at least one participant for every session.

Discussion

The present study used a longitudinal pre-, post-intervention design to examine the impact of a six-session therapeutic group intervention on cancer-bereaved adults’ grief intensity, psychological symptoms, self-compassion and resilience. It also aimed to capture what participants found most helpful or unhelpful about the groups.

The findings show that over the course of the intervention symptoms of grief intensity, PTSD, anxiety and depression were reduced. There was a particularly large change in grief intensity, with most participants experiencing a reliable improvement. Participants' self-compassion also increased immediately after the intervention but no increase in resilience was identified.

At three months follow-up the improvement in participants' symptoms remained for grief, PTSD and depression with moderate and large effect sizes. However, the reduction in symptoms of anxiety, and increase in self-compassion was not maintained at follow-up (although the results from the intention-to-treat analysis suggest that self-compassion did improve).

A small waiting-list control group showed no change in any of the outcome measures in the three months between initial assessment and the end of the waiting list. This lends some weight to the interpretation that it was the intervention that led to the change.

The results from this study are promising as they demonstrate that, in the short-term, the intervention was beneficial for participants, which was reflected in improvements across all but one outcome measure. Due to a lack of similar studies into therapeutic support groups for cancer related loss, these results are best compared with studies where the cause of bereavement was not specified. The findings of the present study are consistent with other studies that have assessed the effects of structured bereavement group interventions and have found that they reduce grief and symptoms of psychological distress (e.g. Goodkin et al.,1999) and stress (Kang & Yoo, 2007) at intervention completion.

Longer-term, the psychological improvements remained, but only for symptoms of depression, PTSD and grief. This finding has been replicated elsewhere. Rheingold et al. (2015) assessed a 10-session manualised group intervention for adults who had lost a loved one to death by violence. Their study found reductions in symptoms of depression, PTSD and complicated grief at follow-up. Although their intervention was based on theories of separation and trauma distress, there was some overlap in the intervention components. Both used relaxation techniques and commemorative imagery of the lost loved one, which may account for the similar findings.

As there is limited research into bereavement interventions for cancer related loss, the findings of this study can also be considered within the broader evidence base for psychotherapeutic bereavement interventions. The most substantial meta-analysis to date (Currier et al., 2008) analysed the outcomes of 61 studies and found that psychotherapeutic bereavement interventions had small positive effects when measured immediately at post-treatment, but these benefits were not maintained at follow-up.

However, interventions that targeted people who displayed maladaptive coping with their loss had the largest positive effect sizes that compared favorably with psychotherapies for other difficulties. The authors concluded that bereavement interventions that are selective (i.e. actively sought by individuals) have minimal effects, and interventions that are universal (i.e. offered to anyone who has suffered a bereavement) have no additional benefits beyond the passage of time.

Although the findings from the present study reflect a similar pattern, i.e. that greater benefits are seen immediately after the intervention than at follow-up, the intervention was selective in nature and yet moderate effect sizes (and large effect sizes for grief symptoms) were observed. This discrepancy in findings is best explained by exploring the baseline characteristics of the study participants.

Although the inclusion criteria for the present study did not require participants to be experiencing maladaptive responses to their bereavement, baseline measures showed that participants had moderate levels of anxiety and depression and high levels of grief and PTSD symptoms. Therefore, it appears that applying a selective approach to recruitment does not mean that people who are experiencing maladaptive responses will be excluded.

The findings from the present study suggest the opposite; those who sought support from the voluntary sector may have been doing so because they recognised they were having difficulty adjusting to their bereavement. Despite a selective recruitment approach being used, the participants in this study are more reflective of participants in studies where inclusion criteria require a heightened risk of developing maladaptive grief responses or where adjustment difficulties are already present. The high baseline levels of psychological symptoms and distress also reflect the findings that cancer related bereavement has unique challenges and is associated with negative bereavement outcomes (Jonasson et al., 2009; Lichtenthal et al., 2010; MacKinnon et al., 2012).

A very large effect size for grief intensity symptoms was found at intervention completion (d=1.87) and large effect size at follow-up (d=0.79). Although these effect sizes are much greater than those reported by Currier et al. (2008; d=0.51) they are similar to the effect sizes observed in studies assessing interventions for prolonged grief. For example, in a study comparing CBT and supportive counseling an effect size between pre- and post- treatment of d=1.80 was found for the CBT condition (Boelen, de Keijser, van den Hout, & van den Bout, 2007). Similarly, in an RCT of CBT for prolonged grief the effect size for grief symptoms at treatment completion between participants in the experimental conditions and those in the waiting list condition was d=1.61 (Rosner, Pfoh, Kotoucova, & Hagl, 2014).

Effective Intervention Components

This study provides promising evidence that the intervention was successful, and it also gives an indication of what the effective components of the intervention may have been.

The findings from the HAT questionnaire provide some insight into participants' experiences of the group and what specific aspects of it were beneficial. What they identified as being helpful changed over the course of the intervention. In the first and last sessions participants identified the therapeutic group factors as being most helpful. But in the middle sessions the structured content of the intervention and its related exercises were most consistently identified as being most helpful.

These findings suggest that it was not simply the experience of being in a group with others who had experienced a similar loss, but the specific content delivered by the facilitators that may account for the improvement in symptoms.

Although the present study used a therapeutic support group treatment model, it did include aspects of self-help groups. For example, the first and last sessions of the present intervention deliberately had less structured content than the other sessions, as they were important 'beginning' and 'ending' sessions. Therefore, group factors may have been more relevant and salient to participants.

In-depth qualitative analysis was not conducted, but group factors that have been found to be important in self-help groups for cancer bereavement include shared experiences of grief, normalisation and validation of experiences and comfort in being with similar others (Hopmeyer & Werk, 1994). Despite group factors remaining important and helpful to participants throughout the intervention, they were less so in the sessions where there was more emphasis on structured therapeutic content.

The dual processing model of coping with bereavement provided a framework for the development of the intervention (Stroebe & Schut, 1999), which then used psychoeducation and techniques and exercises from CBT and CFT. Without conducting a dismantling study it is difficult to identify exactly what components of the intervention led to participants' change. However, an understanding of what aspects of CBT have been found to be effective in treating complicated grief may provide some insight. For example, identifying and changing negative beliefs and interpretations (session 4) can disrupt maintenance cycles, increase behavioural activation and the development of more adaptive beliefs. Exposure to unhelpful thoughts and memories (session 5) has also been identified as effective in facilitating the integration of the loss with existing knowledge (Boelen, 2006).

A possible mediator of the effectiveness of the intervention is the development of self-compassion. Most bereavement research is focused on reducing psychological distress and therefore uses measures of symptoms such as depression and anxiety. To the author's knowledge, little research has explored the effect of bereavement interventions on the development of psychological strengths and flexibility such as self-compassion and resilience, and this study found moderate effect sizes for self-compassion at intervention completion (d=.67) and at follow-up (d=.50).

Self-compassion has been found to enhance coping and resilience when experiencing life stressors such as divorce (Sbarra, Smith, & Mehl, 2012), childhood trauma (Vettese, Dyer, Li, & Wekerle, 2011) and HIV diagnosis (Kemppainen et al., 2013). The development of self-compassion should increase the emotional resources and adaptive coping of those who have lost a loved one to cancer and who may have experienced the additional challenges of being a caregiver.

It also complements the dual processing model of coping with bereavement; where individuals oscillate between confronting and accepting the pain and setting it aside. It may also be that when people are more self-compassionate they experience a decrease in uncompassionate responding (Germer & Neff, 2015).

The nature of this intervention being in a group is inherently self-compassionate as it reflects the common humanity of suffering, decreases isolation and negative self-judgment. Self-compassion was also a consistent thread throughout the intervention: every session included a mindfulness exercise, between sessions participants received compassionate email reminders, and the importance of self-care was consistently reiterated.

Study Limitations

Despite its promising results, the limitations of this study should be acknowledged; the most substantial limitation being the quasi-experimental design. Causal inferences clearly would have been stronger had a randomised trial been implemented. However, this was not feasible within the logistics of The Loss Foundation.

Findings from the small waiting list control group were interpreted as suggesting that changes across outcome measures do not occur in the absence of an intervention over a three-month period. Therefore, changes in the intervention group could be tentatively attributed to the effect of the intervention and not just the passage of time. Although the small waiting list control group was valuable, it was not fully randomised, the sample size was small, and the participants differed on baseline outcome measures compared to the intervention group participants.

Therefore this group may not have been appropriate to draw comparisons against as participants were less anxious and depressed and had lower levels of grief intensity and PTSD symptoms.

The follow-up period was three months after intervention completion; in order to fully assess the effectiveness of the intervention additional points of long-term follow-up could have been conducted. The sample size of this study was also small and participants were typically white, middle-class women. It is therefore difficult to generalise the findings of this study to other populations or to explore differences within the study sample, for example gender or age differences.

Grief is not only characterised by psychological distress but it can also have negative physical and social effects; particularly when grief is maladaptive it is associated with poor physical health, work adjustment and disability. The outcome measures used in this study were limited by only measuring psychological outcomes and did not include outcome measures of physical health or capture the social impact of grief (e.g. work attendance).

A final potential limitation is the researcher's initial positive expectations about the intervention. Previous psychotherapy research has demonstrated an association between researcher allegiance to the intervention and outcome (Elliott, Greenberg, Watson, Timulak & Freire, 2013; Luborsky et al.,1999). In the present study, the researcher assisted in the delivery of the intervention; ideally it would have been preferable for her to remain separate. However there were limited opportunities for her to influence the results, as self-reported outcome measures were used throughout.

Research and Clinical Implications

MRC guidance suggests that before RCTs are conducted, preliminary research should develop appropriate interventions and suitable evaluation to provide a firm grounding for any subsequent rigorous trials to be carried out (Campbell et al., 2007). Uncontrolled trials should be the first process of intervention research. This study constitutes such a first step and provides preliminary evidence that the group intervention was associated with improvements in psychological functioning across a range of bereavement outcomes. It was also shown to have no adverse or harmful effects, as the reliable deterioration of symptoms for participants was minimal.

The most appropriate next phase of research would be to conduct an RCT, which would allow assessment of the effectiveness of the intervention. An RCT could also assess who benefits most from the intervention. Although the present study was not targeted at people experiencing maladaptive responses to grief, participants displayed higher than average levels of psychological symptoms and grief intensity. Further research should assess the effectiveness of the intervention for participants experiencing different grief responses (e.g. adaptive and maladaptive).

An ethical challenge for bereavement research is the allocation of participants to a control group; therefore a waiting list control is most typically used. Utilising a fully randomised waiting list control with an equivalent sample size would help control for the effect of the passage of time on outcome measures as well as additional sources of bias. Further research should also consider conducting qualitative interviews that explore participants’ expectations and experiences of the intervention, which could help provide insight into its effective components.

Although there is still progress to be made in terms of further research, the current results have important clinical implications. This intervention was developed by The Loss Foundation in response to requests from their service users to provide a structured therapeutic group intervention. Uptake of the intervention was high and attrition was low, which suggests that there was a demand for a new type of intervention. Service users voiced their needs, and the quantitative outcomes and qualitative findings from the HAT indicate that these were met. This suggests that interventions such as this should be delivered to meet an unmet need of people who have been bereaved by cancer.

The Loss Foundation is a growing charity that is currently based in London and Oxford; but because the intervention was manualised it is possible that it could be replicated elsewhere by sharing the materials and training others to deliver the intervention. The intervention does not have to be limited to delivery by charities but could be provided by the NHS, for example in primary care services such as Improving Access to Psychological Therapies (IAPT). Provision of this intervention in IAPT may be particularly appropriate given its effectiveness in reducing symptoms of anxiety and depression.

Similarly, although the intervention was for those who had experienced a cancer related bereavement the intervention could be provided to other bereavement groups where members had experienced the same type of loss; as group homogeneity is associated with increased group cohesion and better outcomes (Yalom & Leszcz, 2005)

Although the economic cost of the intervention was not calculated, it was unlikely to be costly as it was delivered by volunteers, required minimal materials and was delivered in a group format. An additional avenue for further research would be to assess the cost effectiveness of the intervention.

Conclusion

Overall, the findings of this study provide preliminary evidence that a six-session therapeutic group is an effective cancer bereavement intervention. In addition to improvements across a range of psychological outcome measures, participants also reported that multiple aspects of the intervention were helpful.

Although further, more rigorous research should be conducted before the intervention is potentially scaled up, the initial results indicate that the intervention shows promise for helping people to cope with the life changing, painful experience of losing a loved one to cancer.

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Part III: Critical Appraisal

This critical appraisal contains reflections on several aspects of conducting the research reported in Part II of this thesis: (1) the strengths and limitations of conducting bereavement research in the voluntary sector; (2) measurement issues; (3) ethical considerations of bereavement research; (4) researcher reflexivity; and (5) the emotional impact of conducting bereavement research.

Conducting Bereavement Research in a Charity Setting

Conducting research within the setting of a small charity (The Loss Foundation) had both strengths and limitations. The benefits of working with a charity, rather than a large organisation such as the NHS, were clear early on in the research process.

Firstly, the research had been driven from the 'bottom-up' with the charity responding to service-users' expressed needs. The development of the therapeutic groups resulted from feedback from service users of The Loss Foundation's open support groups, who requested more structured therapeutic support. Unlike most NHS services, the charity did not have to negotiate the bureaucracy of setting up a new service and was able to quickly respond by developing therapeutic groups and setting up research to evaluate them.

Secondly, working within the charity setting meant that I was able to communicate with participants in a more relaxed and informal manner. For example, the recruitment e-mail (Appendix A) was written in a friendly, informal tone, which more accurately reflected my voice as a clinician; this would not have been possible in the more formalised setting of the NHS.

Thirdly, the findings of the study would provide valuable information to the charity, which would in turn benefit its service users. Due to its moderate sample size and methodological limitations, I was aware that the results of the study would only make a small contribution to the wider bereavement evidence base. However, I expected that the findings were going to be important to The Loss Foundation in helping inform their service design and provision as well as demonstrating value to potential funders. This is a strength of conducting practice-based research; the evidence that it generates can immediately be used to guide the service (Bower & Gilbody, 2010).

The main challenges of conducting research with a small charity were scale and resource constraints limiting the study methodology. The Loss Foundation survives on a small budget, it employs a part-time administrator, and has no fixed premises. This meant there was little additional support for participant recruitment, and the delivery of the groups had to be planned and budgeted carefully as they required volunteer psychologists to deliver the groups in hired rooms. Had the charity been bigger, with a larger staff and its own premises, more participants could have been recruited and more therapeutic groups could have been run.

As discussed in the empirical paper (Part II), the next steps for The Loss Foundation could be to conduct a Randomised Control Trial (RCT) as part of a phase III trial (Campbell et al., 2007). An endeavor such as this would require significant investment and additional resources. But if The Loss Foundation managed to overcome the challenges of obtaining research funding, they might consider partnering with an independent research organisation.

Larger scale research using more rigorous methodologies has been achieved by other bereavement charities, and their experiences could provide valuable learning. For example, Cruse Bereavement Care Scotland (a Scottish bereavement charity) conducted a collaborative efficacy study in partnership with researchers at Utrecht University in The Netherlands (Newsom, Wilson, Birrell, Stroebe, & Schut, 2011). Despite facing practical and ethical issues, they reported that the process was successful and has led to rigorous scientific bereavement research conducted in the field.

Measurement Considerations

In order to provide the best support for individuals who have been bereaved, it is important that interventions are tested thoroughly. One challenge to this is determining what interventions can be expected to achieve. Schut and Stroebe (2011) suggest that the aim of bereavement interventions should be ‘modest’, and that their function should be to ‘protect the bereaved from unnecessary consequences of loss’ (p.6). They also advise that bereavement research should go beyond reporting participant satisfaction and should include scientifically sound outcome measures.

It is unclear what Schut and Stroebe (2011) meant when they refer to bereavement interventions having ‘modest’ aims and how these might translate into outcome measures. Their suggestion that interventions should be protective implies that preventing participants from developing adverse reactions to their grief (such as complicated grief) or deterioration in their wellbeing may be appropriate goals. Although they advise using validated outcome measures, it is also unclear what level of change on such measures would be considered as ‘good enough’, and what the implications of potentially finding no changes on these outcomes would mean for the effectiveness of the intervention.

Most of the outcome measures in this empirical study were traditional symptom-based measured that assessed levels of psychological difficulties, such as anxiety and depression. The use of these psychological distress measures reflected those used in other studies of bereavement interventions (e.g. Currier, Neimeyer, & Berman, 2008), which aimed to achieve a reduction in symptomology as captured by changes on validated measures. However, the use of these measures is unlikely to have reflected the full array of benefits that participants experienced or changes that are only identifiable in the longer-term.

Limitations of symptom-based measures are not unique to bereavement research and parallels can be drawn from the cancer support group literature. For example, in a qualitative study of peer support for gynaecological cancers, recipients described benefits such as feeling understood, developing hope and making sense of their cancer experience (Pistrang, Jay, Gessler & Barker, 2012). As the authors point out, traditional symptom-based measures are unlikely to capture such benefits; they recommend that, although difficult to assess, constructs such as feeling supported and developing hope should be measured in order to fully assess the effects of peer support interventions. Arguably, the same could be said for bereavement interventions.

In designing the empirical study, I did attempt to go beyond measures of psychological symptoms by also including measures of self-compassion and resilience. Self-compassion is kindness and understanding to oneself when faced with suffering, and resilience is the ability to positively adapt within the context of adversity. Self-compassion and resilience theories move away from ‘deficit’ models of psychopathology and focus on strengths rather than weaknesses (Germer & Neff, 2015; Windle, 2011). Assessing these strength-based outcomes could be particularly relevant when researching uncomplicated grief, as it is a natural response to a significant life stressor and measuring symptoms such as depression could be pathologising.

Other indicators of benefits that could not be captured on symptom-based outcome measures came from a donation to the charity and informal participant feedback. At the end of the intervention, one of the participants made a £6,000 donation to The Loss Foundation as an expression of gratitude. Actions such as this are not captured on measures of symptoms, but are indicative of the value attributed to the intervention and possible change that the participant experienced as a result of attending the therapeutic group. As participants’ data was anonymised, it was not possible to identify if this participant experienced any change on symptoms measures but it would have been interesting to see if he or she had experienced any improvements based on the outcome measures used.

Similarly, spontaneous feedback from participants during the group sessions provided insight into the benefits that were gained. For example, one participant reported that on being asked how she was by a friend, for the first time she was able to answer honestly and share with her that she was struggling with her grief. She described this new experience of being honest as a huge relief. Another participant told the group how, following the session on difficult memories, she was able to access a happy memory of her mother for the first time since her death, which was of great comfort to her.

In order to fully capture the benefits experienced by participants’ researchers will need to be more creative about what outcomes they choose to measure. Based on recommendations by other authors (Gottlieb & Wachala, 2007; Pistrang et al., 2012), a theoretically sound approach to future evaluation would be to understand what is important and valued by participants, and then assess if this mediates change in clinical outcomes.

Ethical Considerations

Bereavement research has unique ethical issues that need to be considered when balancing the risks and benefits of conducting research (Cook, 1995). Although

I thought about ethical issues from the start some issues became apparent only later in the research process.

One issue was whether the participants - who had suffered a painful loss and were struggling with their grief - might find it distressing to complete the outcome measures. The initial measures asked, in detail, about their relationship with the loved one they had lost and the circumstances of the bereavement, e.g. if they had been present at the death. Because these questionnaires had the potential to elicit distress or intense grief, I considered how best to support participants through this process. This was particularly important as the measures were administered online, and participants might have been completing them in environments with little support.

After discussion with my supervisors, I decided that it would be important to prepare participants for the nature of the questionnaires and warn them that they might feel distressed whilst completing them. This message was presented at the start of the questionnaire, and at intervals throughout the questionnaires a message about self-care was also displayed.

I also set up a ‘checking-in’ e-mail that was sent to all participants after completing the first and last questionnaires (Appendix G), in order to see how they were feeling and normalise that they may have found the questionnaires difficult. Interestingly, many participants replied to this e-mail thanking me for checking with them and reporting that they had found completing the questionnaires upsetting, but that they were alright and did not require additional support. At the group sessions (at which I was present), I also asked participants how they were finding completing the measures. They all acknowledged that the questionnaires evoked emotional responses, but they were not distressed by this and were able to manage this reaction.

The ethical guidance on bereavement research typically refers to the potentially negative effects of conducting qualitative interviews, but gives little consideration to quantitative research using standardised psychological outcome measures (Cook, 1995; Parkes, 1995). This seems an important omission and researchers might consider using available features of questionnaire software such as setting up ‘checking-in’ e-mails or displaying messages advising on self-care or additional sources of support if distressed. Future researchers could also follow-up participants and ask them about their experiences of completing the measures and how they managed their distress, particularly if they are completed online and not in a research or clinical setting.

A second ethical issue was a tension between ethical values and obtaining a complete data set. Non-response is common in bereavement research (Schut, Stroebe, van den Bout, & Terheggen, 2008) and some participants did not complete the outcome measures. This meant I had to follow participants up and remind them to complete the measures.

Generally, a single follow-up e-mail was enough to prompt participants to complete the measures. However this was not true for all participants and I began to feel uncomfortable sending further e-mails. According to the ethical guidelines of the American Psychological Association (2010), the researcher should not put emotional or psychological pressure on participants in any way, especially if he or she is in a position of authority or influence over them. Numerous e-mails might have placed undue pressure on vulnerable participants. Repeated reminders were compromising my value of protecting the welfare of participants; I adhered to the principle that the wellbeing of my participants outweighed the value of a complete dataset.

A third ethical issue is the design of future research. Although I suggested above that the next steps for the research would be to conduct an RCT, I have concerns regarding the ethics of this approach in bereavement research (e.g. the allocation of vulnerable participants to a control group) and wonder if alternative types of research would better suit the field. While RCTs provide valuable evidence, they are not the only source of evidence, and although considered the gold standard in pharmacological research, they are not necessarily the gold standard in psychological therapies research (Westen, Novotny, & Thompson-Brenner, 2004). Conducting practice-based research is a valuable source of evidence in psychological therapies (Bower & Gilbody, 2010), and it may be most appropriate for bereavement research as it avoids the ethical issue of randomisation. Alternatively, conducting an exploratory trial may be a useful research avenue as it would provide further knowledge of how and why the intervention worked.

Researcher Reflexivity

While conducting the empirical study, I became aware of my own thoughts, feelings and assumptions about the research, and found Peshkin's (1988) writing on subjectivity helpful in considering this. Peshkin defines subjectivity as 'an amalgam of the persuasions that stem from the circumstances of one's class, statuses, and values interacting with the particulars of one's object of investigation' which will vary over time and in intensity (Peshkin,1988, p.17). He proposes that subjectivity is present throughout the research process, in both quantitative and qualitative research, and should be systematically reflected on by researchers. The value of researchers being curious and conscious of their own subjectivity is that they have an awareness of how it may be 'shaping their enquiry and its outcomes' (Peshkin,1988, p.17).

Although at the start of the research process I did not have Peshkin's writing to help me consider my subjectivity and was not consciously self-reflexive, I was aware as the research progressed that I had different subjective positions, which were filtering and changing my relationship with the research. Peshkin (1988) describes uncovering and naming one's different subjective positions and calls them subjective "I's", I have used this approach and identified three "I's" that exemplify some of my subjectivity. Had I begun the research process with a focus on understanding and uncovering my subjectivity, I wonder if additional "I's" would have emerged:

i. I was drawn to this research project both because the founder of The Loss Foundation was a former colleague, and I believed the charity provided invaluable support to people who had lost a loved one to cancer. I felt aligned to the charity from the outset of the study. I hoped the outcomes would present the charity in a positive light and demonstrate the excellent work that I believe that they do. I have identified this as my "ambassador I".
ii. I also took on the role of a clinician at the therapeutic groups: my "clinician I". I attended all of the therapeutic group sessions and, although I did not lead the therapeutic content, I led the mindfulness exercises, contributed to the session content, and spent time in the breaks talking to participants. Being present at the groups beyond the capacity of a researcher added to my bias of wanting the intervention to be successful, particularly as I heard in sessions how valuable participants were finding it and what a difference it was making to their lives.
iii. As the lead researcher of the empirical study, I attempted to approach the study pragmatically in order to conduct sound research that would be of scientific value. This role as a researcher was consistent throughout the process and reflects my "researcher I".

Identifying my three “I’s”, I recognised that at times they were in conflict with one another, but in other ways the interplay between them was beneficial to the research. For example, by attending the group sessions and being involved in the delivery of the intervention, I gained insight into how the intervention was structured and delivered, which would not have been possible from merely reading the treatment manual. I also heard from participants what they were gaining from the intervention and how it was beneficial. The insight gained from my position as a “clinician I” helped inform my “researcher I”; for example, about the limitations of the outcome measures and their inability to capture some of the experiences that participants spontaneously described at the groups.

Although Peshkin (1988) argues that quantitative researchers should observe themselves in order to identify the subjective personal qualities that emerge from their contact with their research, this process seems to be largely confined to qualitative research. In retrospect, I would have valued a more thorough examination of my different subjective positions throughout the process. In order to meaningfully engage with subjectivity, different techniques and methods can be used by researchers; for example, guidance by Gough and Madill (2012) includes a list of tasks for researchers to consider and their associated strategies. These include providing participants with space to elaborate on their responses by including open-ended questions in questionnaires, opportunities for verbal contributions and follow-up interviews with participants.

Identifying and exploring one’s own subjectivity seems particularly relevant in bereavement research regardless of whether it is qualitative or quantitative. Most researchers will have experienced the loss of a loved one and it is this universal nature of bereavement that makes ‘objective’ research impossible. Conscious recognition of subjectivity and noticing one’s own beliefs and assumptions, can only result in research that is of better quality (Gough & Madill, 2012).

Emotional Impact of Bereavement Research

At the start of the research process, I did not consider or anticipate the emotional impact of conducting bereavement research. It was not atypical for participants to be openly distressed in the group sessions and to cry, particularly when talking about their loved ones and their losses. Making the screening phone calls (where participants would often become emotional on the phone) and examining participants’ responses to questionnaires also elicited a strong emotional response in me (e.g. sadness). Open displays of emotions are common in bereavement research, particularly qualitative interviews, but are not usually reported in published papers because they are not the focus of the studies (Cook, 1995).

I found myself identifying with a number of participants who were of a similar age to me, and considering how I might feel if I had experienced the same loss. I have lost family members to cancer and could relate to many of the participants’ experiences, the reminder of my own losses elicited my own feelings of grief for loved ones that I have lost. Similarly, in his research with children about their understanding of death and dying, Koocher (1974) described learning that ‘the researcher cannot isolate himself from the feelings of loss and anxiety in others and himself’ (p.20). In her loss and grief research with school communities, Rowling (2009) described conducting qualitative interviews and being surprised at her strong emotional reactions to participants’ disclosures and distress. Although these two examples reflect some of my experience, they are in the context of qualitative research, where the personal impact of conducting research appears to be more widely recognised and discussed.

The effects of bereavement research on researchers appear to have been overlooked in the research literature. As an example of this oversight, in the 31 chapters of M. Stroebe, Hansson, Stroebe and Schut’s (2001) key handbook on bereavement research, there is no chapter or guidance on the impact of researchers working with bereaved individuals. One possible explanation for this might be that the nature of the topic, death, is an unspoken barrier to considering how working in this field might make researchers feel about death and dying in their own lives (Yalom & Lieberman, 1991). Researchers would benefit from having this aspect of the research discussed and written about, not only to normalise their experiences, but also to help them plan for the emotional impact of the work.

Despite the emotional impact of the research, paying attention to my emotional responses helped me identify my different subjective positions. For example, noticing feelings of pride when participants reported that the intervention was making a difference to their lives drew my attention to my “ambassador I” and alerted me to be aware of my bias in wanting the intervention to be effective. As objectivity is an impossible ideal, it is important for researchers in the field to be aware of their emotional responses, and be able to respond and manage any emotions that arise; for example, by using supervision and reflecting on their emotions as a source of potential bias in research.

Conclusion

M. Stroebe, Stroebe and Hansson (1988) propose that effective support and interventions for bereaved individuals should develop from a sound base of theoretically oriented and empirically derived knowledge. While this is laudable, my experience of conducting bereavement research in the voluntary sector has taught me that the development of this knowledge base remains challenging, and that bereavement research may not fit traditional expectations of research. Researchers need to navigate ethical challenges, their own subjectivity using reflexivity, and the emotional impact of conducting bereavement research. Despite these challenges it is important to help people who have experienced the painful loss of a loved one, particularly given that the death of someone loved is inescapable for most people across their lifetime.

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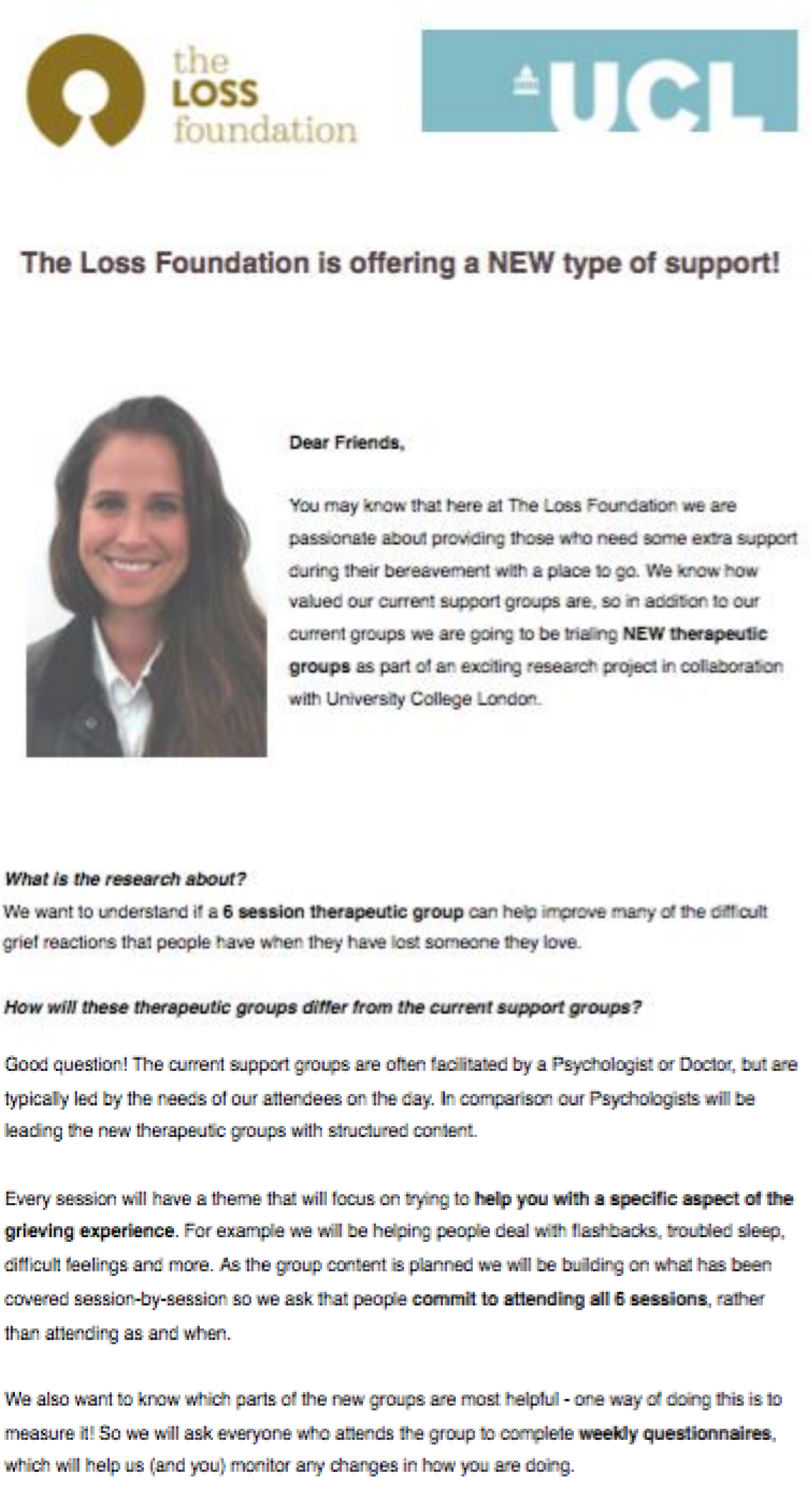
Appendix A: Participant Recruitment E-mail



The Loss Foundation is offering a NEW type of support!

Dear Friends,

You may know that here at The Loss Foundation we are passionate about providing those who need some extra support during their bereavement with a place to go. We know how valued our current support groups are, so in addition to our current groups we are going to be trialing **NEW therapeutic groups** as part of an exciting research project in collaboration with University College London.

What is the research about?

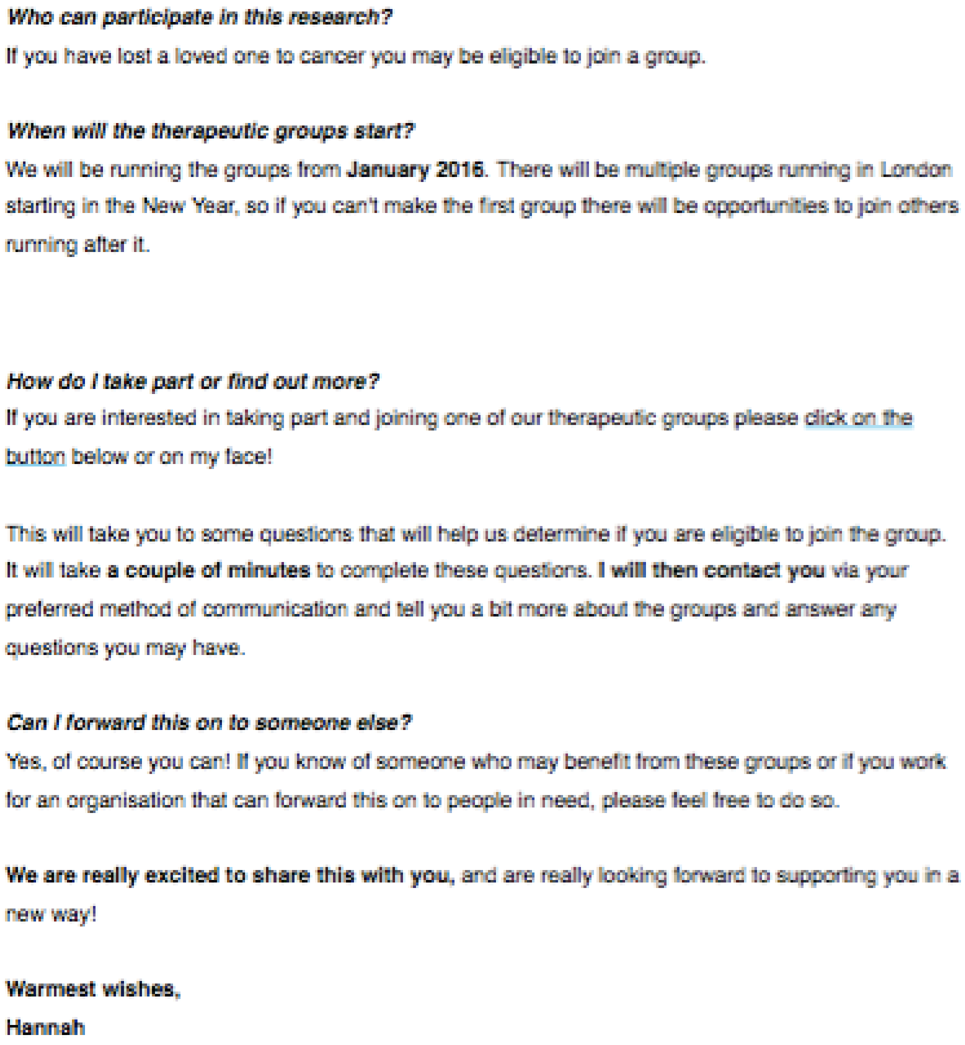
We want to understand if a **6 session therapeutic group** can help improve many of the difficult grief reactions that people have when they have lost someone they love.

How will these therapeutic groups differ from the current support groups?

Good question! The current support groups are often facilitated by a Psychologist or Doctor, but are typically led by the needs of our attendees on the day. In comparison our Psychologists will be leading the new therapeutic groups with structured content.

Every session will have a theme that will focus on trying to **help you with a specific aspect of the grieving experience**. For example we will be helping people deal with flashbacks, troubled sleep, difficult feelings and more. As the group content is planned we will be building on what has been covered session-by-session so we ask that people **commit to attending all 6 sessions**, rather than attending as and when.

We also want to know which parts of the new groups are most helpful - one way of doing this is to measure it! So we will ask everyone who attends the group to complete **weekly questionnaires**, which will help us (and you) monitor any changes in how you are doing.



Who can participate in this research?

If you have lost a loved one to cancer you may be eligible to join a group.

When will the therapeutic groups start?

We will be running the groups from **January 2016**. There will be multiple groups running in London starting in the New Year, so if you can't make the first group there will be opportunities to join others running after it.

How do I take part or find out more?

If you are interested in taking part and joining one of our therapeutic groups please click on the button below or on my face!

This will take you to some questions that will help us determine if you are eligible to join the group. It will take **a couple of minutes** to complete these questions. **I will then contact you** via your preferred method of communication and tell you a bit more about the groups and answer any questions you may have.

Can I forward this on to someone else?

Yes, of course you can! If you know of someone who may benefit from these groups or if you work for an organisation that can forward this on to people in need, please feel free to do so.

We are really excited to share this with you, and are really looking forward to supporting you in a new way!

Warmest wishes,
Hannah

Appendix B: Participant Information Sheet

RESEARCH DEPARTMENT OF CLINICAL, EDUCATIONAL AND HEALTH PSYCHOLOGY

Outcomes of Cancer Bereavement Therapeutic Support Groups

Information Sheet for Participants

We would like to invite you to take part in this research project. You should only take part if you would like to, and before you decide whether you want to take part it is important for you to read the following information and discuss it with others if you wish. Please ask us if there is anything that is not clear, or if you would like more information.

What is the project about?

The Loss Foundation is running new, six-session support groups for people who have lost someone they love to cancer. We want to find out whether or not the groups are beneficial, and in what ways. We are also interested in people's experiences of the support group, such as what parts of it they find most and least helpful.

Who is being invited to take part?

We are inviting everyone who has registered an interest in the support groups to take part in the research.

Do I have to take part?

It is up to you to decide whether to take part. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Even if you do decide to take part you are still free to withdraw at any time without giving a reason. Withdrawing from the study has no consequences for your participation in the group or for any other support you may receive from The Loss Foundation.

What will I be asked to do?

If you decide to take part we will ask you to complete some questionnaires before the group begins and after it ends (these will take about 25 minutes), as well as before each meeting (these will take about 10 minutes each time). The questionnaires will be about how you are feeling and how the group may be helping or not. They can be completed either online or on paper.

If the group is oversubscribed, The Loss Foundation will ask if you would like to be on a waiting list for the next one. If so, we will ask you to complete the questionnaires when you sign up for the study and again before the start of your group.

After the last group meeting, you may be invited to meet with a researcher to discuss your experience of being in the group. The interview will be audio-recorded so that we have an accurate record of what was said. The meeting will last about an hour, and will either take place at UCL or somewhere that you choose.

What will happen to the information that is collected?

Your responses on the questionnaires will be anonymous and will be analysed together with other people's responses. Recordings of interviews will be transcribed (written up); we will then delete the recordings. The transcriptions will be made anonymous; names and any identifying information will be removed so that you cannot be identified.

All written information will be stored securely and will be destroyed five years after the study has ended. All data will be collected and stored in accordance with the Data Protection Act 1998. If for any reason you decide to withdraw from the study, all information you provided can be deleted at your request.

Everything that you tell us will be kept confidential; only the research team will have access to what has been said. The only time confidentiality would be broken is if we became concerned that you or another person were at risk of serious harm. If we did need to tell someone else we would discuss this with you first where possible and it would be managed as sensitively as possible.

Once the project is over, the results will be written up as part of a postgraduate thesis and may be submitted for publication in an academic journal. Reports will not reveal the identity of anyone who took part. An anonymised summary of the findings will be sent to those who took part and to The Loss Foundation.

Are there any risks of taking part?
It is possible that you could feel upset when completing the questionnaires or taking part in an interview, although they cover topics that you are likely to have talked about in the group. If you were to become upset, you can discuss this with the researcher or with the facilitator of the group, and you will have the option of stopping.

What are the possible benefits of taking part?
We hope that the information we obtain from this study will advance knowledge about the principles of cancer bereavement support groups, and improve practice to help people who join support groups in the future.

Further information and contact details:
If you have any questions about this study, please contact the researchers:

Hannah Jerome, Clinical Psychology Trainee <Hannah.Lewis@ucl.ac.uk>
Chris Barker, Professor of Clinical Psychology <c.barker@ucl.ac.uk>
Nancy Pistrang, Professor of Clinical Psychology <n.pistrang@ucl.ac.uk>

Research Department of Clinical, Educational and Health Psychology
University College London
Gower St
London WC1E 6BT

Telephone: 020 7679 5962

Thank you for considering taking part in this study.

This study has been approved by the Research Department of Clinical, Educational and Health Psychology Ethics Chair
Project ID No: CEHP/2015/530
You will be given a copy of this information sheet to keep.

Appendix C: Telephone Screening Protocol

Telephone Screening for Group Suitability

- Thanks for registering interest
- Purpose of call it to give more information, check eligibility for group (we want to make sure that it will be helpful for you) and answer any questions that you have.
- Check information from registration form is accurate:
    - Name
    - Contact details
    - Date of bereavement
- Information about the new groups: *The current support groups are often facilitated by a Psychologist or Doctor, but are typically led by the needs of our attendees on the day. In comparison our Psychologists will be leading the new therapeutic groups with structured content. Every session will have a theme that will focus on trying to help you with a specific aspect of the grieving experience. This is based on what people have told us over the years about the things that they struggle with the most. We will also make sure the content incorporates the things our attendees are struggling with in particular, so that we can try to make sure that those attending get what they need out of the groups. As the group content is planned we will be building on what has been covered session-by-session so we ask that people commit to attending all 6 sessions, rather than attending as and when. This will take place over a 9-week period with the first 3 groups happening weekly and the last 3 fortnightly to allow you to digest and make sense of the material covered in session.*
- Information about completing questionnaires: *We will be incorporating everything we have learnt over the last 5 years about grief at TLF as well as what research has shown to be helpful to provide the best support model over the 6 sessions. To learn how helpful our support is we need attendees to fill out questionnaires. This allows us to see what you're struggling with, expectations, and if things change for you over time. This means that we can learn what is most helpful and provide it for more people .It is VERY IMPORTANT that people attending complete the questionnaires. We make this very easy for you in that it can be done online at home (we will send you an e-mail with a link the day before the group) or you can do it at the group.*
- Check if they have any questions: *E.g. I have some quick questions to run through with you but before I do so, do you have any questions on anything I've said so far?*

Some things I need to double check:

1. Are you over 18?
2. Do you have any disabilities/impairments that we would need to take into account, e.g any physical restrictions or visual impairments?
3. Are you able to commit to making all 6 sessions?
4. Are you able to commit to completing weekly questionnaires?
5. Are you able to get to the group, it will be in central London on a weekday evening?
6. Some of what we discuss will have emotional content and may be upsetting at times, and this is very natural in a group of this nature. We want to make sure we tell people about this and that they feel able to come along even though it may feel difficult at time. Is that something that you feel ok about it?

7. The sessions will involve tasks to complete during the week. This is a crucial part of the therapy as many of what we will be discussing involves building certain practices into your daily routine. The group session is an opportunity for you to tell us what worked and didn’t work for you in the week. We ask that all of our attendees commit to trying the activities we suggest with an open and curious mind. Do you feel this is a commitment you would be willing to make?
8. Do you use alcohol or drugs in a way that may interfere with your ability to attend the groups?

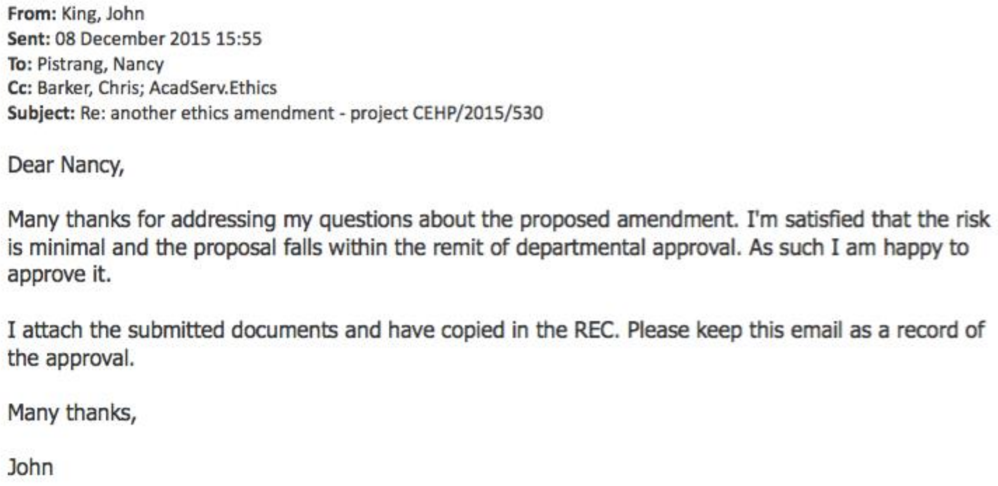
Outcomes:

If bereavement is > 6 months by January or February and they meet the eligibility criteria then we can say that it sounds like they will be eligible for a group. What we will do now is take this back to the team who are planning the groups and we will then let them know as soon as possible the details about their group.

OR

If bereavement is < 6 months by January or February then we need to explain that the research shows that in the first 6 months after a bereavement it isn’t always helpful to have professional support (like this group). To get the most benefit from this group we need to wait until 6 months after your loss, this is when it is most helpful. We have groups starting later in 2016 which you would then be eligible for, would you like to wait until then? In the meantime you can come to our socials and our peer support groups.

Appendix D: E-mail Confirmation of Ethical Approval



From: King, John
Sent: 08 December 2015 15:55
To: Pistrang, Nancy
Cc: Barker, Chris; AcadServ.Ethics
Subject: Re: another ethics amendment - project CEHP/2015/530

Dear Nancy,

Many thanks for addressing my questions about the proposed amendment. I'm satisfied that the risk is minimal and the proposal falls within the remit of departmental approval. As such I am happy to approve it.

I attach the submitted documents and have copied in the REC. Please keep this email as a record of the approval.

Many thanks,

John

Appendix E: Participant Consent Form

**RESEARCH DEPARTMENT OF CLINICAL,
EDUCATIONAL AND HEALTH
PSYCHOLOGY**

UCL

Outcomes of Cancer Bereavement Therapeutic Support Groups

Informed Consent Form for Participants

Please complete this form after you have read the Information Sheet and listened to an explanation about the research.

Title of Project: **Outcomes of Cancer Bereavement Therapeutic Support Groups**

This study has been approved by the Research Department of Clinical, Educational and Health Psychology Ethics Chair

Project ID No: CEHP/2015/530

You will be given a copy of this Consent Form to keep.

Participant's Statement

I ....
agree that:

- I have read the Information Sheet and the project has been explained to me orally;
- I have had the opportunity to ask questions and discuss the study; and
- I have received satisfactory answers to all my questions or have been advised of an individual to contact for answers to pertinent questions about the research and my rights as a participant and whom to contact in the event of a research-related injury.
- If I take part in an interview with the researcher, it will be audio recorded and I consent to use of this material as part of the project.

I understand that I am free to withdraw from the study without penalty if I so wish. I understand that I consent to the processing of my personal information for the purposes of this study only. I understand that any such information will be treated as confidential and handled in accordance with the provisions of the Data Protection Act 1998

I agree to take part in this study.

Signed: Date:

Investigator's Statement

I …………………………………………………………………..
confirm that I have carefully explained the purpose of the study to the participant and outlined any reasonably foreseeable risks or benefits (where applicable).

Signed: Date:

Appendix F: Example of the Intervention Manual

WEEK	TIME		ACTIVITY	FACILITATOR
3	20 mins	6:30-6:50	**3.0 Recap of last week** Last week recap Homework feedback Introduce content for session	Erin
	5 mins	6:50 – 6:55	**3.1 Introduction to self compassion** - Why is this important in grief?	Erin
	10 mins	6:55 – 7:05	**3.2 Group exercise** **What does compassion mean to you?**	Erin
	10 mins	7:05 – 7:15	**3.3 The flows of compassion**	Kirsten
	10 mins	7:15 – 7:25	**3.4 Three elements of self-compassion** Self kindness, common humanity and mindfulness	Kirsten
	10 mins	7:25 – 7:55	**3.5 The model of self compassion**	Kirsten
	30 mins	7:55 – 8:15	**3.6 Group exercise** **Perfect nurturer exercise**	Erin
	10	8:1	**3.7 Closing**	Erin

	mins	5 – 8:25	Set homework Questions Signposting	
	10 mins	8:25 – 8:30	**3.8 Mindfulness exercise** Compassion exercise – Self-compassion script	Hannah

Week 3: Self-compassion

WEEK 3 CONTENT

3.0 Recap of last week

- Last week recap – we talked through flashbacks, sleep and the benefits of routine.
- Homework feedback – volunteers to share some of the things they learned, comments they may have, questions they may have. Especially those who haven't spoken before.
- Introduce content for today's session – self-compassion. For those who have been on the retreat they may have heard the content but can never have too much compassion!
- Reminder of group rules – pointing to them rather than having to go through them all, but remind them that the facilitators may have to intervene here and there for time reasons.

3.1 Introduction to self-compassion

- Warn that this session can bring up difficult emotions. Do not be worried if you feel emotional, and it is safe to be emotional here.
- Compassion is a practice (a muscle that we need to train and use regularly to feel the benefits). Regular rehearsal of self-compassion makes it come more automatically to you.
- Grief and compassion. This is about being kind to yourself and challenging the 'inner critic/slave driver' that speaks up in your mind/thoughts. "How should I be?" Challenging the 'shoulds' in grief.

- We will spend this session going over the three components of self-compassion, the psychological model and will finish with a compassionate exercise. But first of all, what does compassion mean to you?

3.2 Group exercise

Flipchart exercise: What does compassion mean to you?

Write down what they say about compassion on the flipchart.

Go over the following points with them:

1. Compassion incorporates noticing that others are suffering.
2. Feeling moved by others' suffering so that our heart responds.
   - Feeling warmth, caring, desire to help.
   - Offer understanding and kindness when others fail rather than judgement.
     - Compassion is not the same as empathy or altruism, though they are similar. While empathy refers more generally to our ability to take the perspective of and feel the emotions of another person, compassion is when those feelings and thoughts include the desire to help.
3. Compassion rather than pity means you realise that suffering, failure and imperfection is part of a shared human experience.

3.3 The Flows of Compassion

- Self → Other – this is typically the one people struggle with the least. So recently I went and picked a friend up who was struggling with work and feeling quite isolated, she came to stay with me and we cooked dinner together and talked about how she was feeling.
- Self ← Other – *Put it to the group – Is this easier harder or the same as the first?* Some people find it harder to receive kindness. An example of this might be someone helping you out with some

errands because they know you are really overloaded at the moment.

  - Self → Self – *What about this one?* Often a double standard about showing ourselves compassion. Either we see being kind to ourselves as a sort of weakness because we should not be suffering or we don't think we deserve the compassion and yet if asked how we would treat others the answer is often a no brainer.

Acknowledge how much easier it is to direct compassion to others, but it can be hard to do it for ourselves.

3.4 Three elements of self-compassion

- **Self kindness**

  - Be warm and understanding when we suffer or feel inadequate rather than criticsing or ignoring our pain.

- Recognise that experiencing life difficulties is inevitable so be gentle with yourself rather than getting angry when life is not as advertised.
- When reality is denied or fought against, suffering increases. This includes stress, frustration, self-criticism.
- When reality is accepted with sympathy and kindness, emotional stability increases.
- You stop to tell yourself this is really difficult, and ask, 'How can I comfort myself?'
- Instead of criticism or judgement for finding things hard you are kind and understanding when confronted with these things.
- You may try to change to be more healthy/happy. Only done because you care about yourself. NOT because you are inadequate.
- You honour and accept your humanness – life is pain, loss is unavoidable in life. Open your heart to the reality and you can more readily feel compassion for yourself and fellow huma beings.

- **Common humanity**

  - When things are difficult it is often easy to feel alone.

- We are who we are! Many factors have come together to make us who we are today; the way we were parented, genetics, culture, environmental factors. There are many facets of our life we didn’t choose and have little control over.
- By recognising this life difficulties and our reaction to them do not have to be taken so personally but can be acknowledged with non judgement, compassion and understanding.

- **Mindfulness**
  - Balanced approach to negative emotions so feelings are neither suppressed or exaggerated.
  - An equal stance puts into perspective a larger picture (others suffering).
  - Observe negative emotions with openness and clarity.

3.5 The model of self-compassion

We know that the way we behave and feel are in part conditioned reactions from our brain that have evolved over millions of years as well as being a consequence of our own early childhood experiences. The model of compassion suggests we have three main types of emotion regulation systems;

1. The threat system
2. The drive system
3. The soothing system

The first two systems belong to the early or reptilian brain while the latter was developed in our brain later (mammalian brain).

We naturally seek kindness and support from others to calm away threats and to feel safe. The self-soothing system was designed as a threat regulator to help us relax and manage difficult feelings.

Neurobiology has evidenced that when we feel good with others, specific endorphin and oxytocin systems (soothing system) are activated which can also be activated when we care for others or we attend to ourselves with kindness.

The absence of threat does not necessarily trigger the self-soothing system.

We need all three systems. But the aim is to restore balance because the threat-system may be in overdrive which can cause excessive anxiety, anger or low mood. The aim is to understand how the 3 emotional systems affect us and to develop ways to activate the self soothing system to regulate the other two systems. This helps us build up psychological acceptance, resilience and flexibility.

Evolution has left us with a flawed system. We are stuck with a brain that we did not designed, which contributes to reacting in ways we don't want.
It is not your fault… but you are responsible!

3.6 Group exercise - Perfect nurturer exercise

- Sensitive
- Sympathise – to be moved by one's own distress
- Have a warm and genuine care for oneself
- Non-judgemental
- Empathic – understand the nature of distress
- Distress tolerance.

3.7 Closing

- Give out: Hand-out 3.1 (What is compassion and self-compassion), Hand-out 3.2 (Model of self-compassion, Building a compassionate image sheet, Compassionate letter writing.
- Homework exercise:
- Practice mindfulness exercise
- Complete the Perfect Nurturer sheet
- Try to practice self-compassion where possible
- Over the next two weeks need to make a note of: 3 things you've taken away from the tasks, anything you think you want to try to do differently or think differently about, and any questions you have for the facilitators.
- As well as carrying what we have been covering over the last few weeks – holding it in mind.

- There will be two weeks until we next meet. We have introduced more time between our last sessions to allow more time for practicing the things we've covered and consolidating new techniques.
- Any questions?
- Signposting to other supportive services

3.8 Mindfulness exercise

Cultivating compassion in grief

Appendix G: Participant ‘Checking-In’ E-mail

Dear (participant’s first name),

Thank you for completing the questionnaires. Given the nature of the material being thought about and considered I wanted to email you to check in that you were feeling ok. It can often be very emotional turning towards grief and it is important to me that you feel safe throughout the process. If any difficult emotions have come up I wanted to remind you that this is completely normal and understandable and should subside with time.

We look forward to seeing you at the group.

With warm wishes,
Hannah