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Effectiveness of Acceptance and Commitment Therapy in Reducing Panic, Blame-Anger, and Withdrawal Symptoms in COVID-19 Bereaved Individuals

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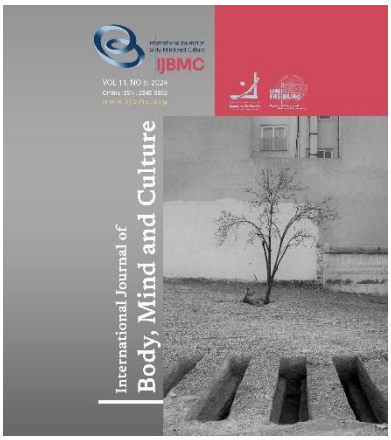

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ABSTRACT

Objective: This study aimed to evaluate the effectiveness of ACT in reducing panic behavior, blame-anger, and withdrawal symptoms among individuals grieving the loss of loved ones to COVID-19.

Methods and Materials: A quasi-experimental pretest-posttest design was employed. A total of 30 bereaved individuals (aged 20–50) from Khorramabad, Iran, were recruited via convenience sampling and randomly assigned to an experimental group (n = 15) receiving eight sessions of ACT or a control group (n = 15) receiving no intervention. The Hogan Grief Reaction Checklist was used to assess symptoms related to grief. Data were analyzed using ANCOVA.

Findings: ACT significantly reduced panic behavior ($p < .05$, $\eta^2 = 0.608$), blame-anger ($p < .05$, $\eta^2 = 0.714$), and withdrawal symptoms ($p < .05$, $\eta^2 = 0.586$) in the intervention group compared to controls. Effect sizes indicated strong clinical relevance.

Conclusion: Findings suggest that ACT is an effective intervention for managing grief-related emotional distress among COVID-19 bereaved individuals. Given the persistence of grief symptoms, future research should explore the long-term efficacy of ACT and compare its effectiveness with other therapeutic approaches.

Keywords: Acceptance and Commitment Therapy, Grief, Anger, COVID-19.

Introduction

Loss and grief are natural and necessary experiences in life. These experiences can either be expected or sudden. Death and the experience of loss are common occurrences in hospital and medical settings (Kanzaria et al., 2016). In late December 2019, a new virus, later named the coronavirus, was detected in China, which subsequently spread worldwide, infecting many individuals and causing a significant number of deaths globally (Weinstock et al., 2021). The World Health Organization (WHO) declared the spread of this virus a public health emergency of international concern (Paules et al., 2020), and due to the high mortality rate, many families have experienced the loss of family members (Ramaci et al., 2020). The damage caused by the coronavirus is not only related to the loss of individual lives but also affects the surviving family members.

These individuals face restrictions that prevent them from holding mourning rituals and expressing their emotions of sorrow and grief (Goveas & Shear, 2020). Survivors are required to remain in home quarantine for a while, and the inability to interact with others or perform traditional mourning rituals may further exacerbate psychological harm (Singer et al., 2020).

Grief is a shared human experience, and sadness is a natural response to the death of a loved one. The vast majority of individuals who lose someone typically adapt within a period of six to twelve months and eventually find a new sense of normalcy in their lives. However, for some, this process may take longer (Gesi et al., 2020). People experiencing grief may exhibit symptoms such as separation distress, shock, confusion, numbness, emptiness, and depression (Shulla & Toomey, 2018). Grief-induced panic behaviors can manifest in various forms, including intense yearning, feelings of guilt, anger, bitterness, and avoidance behaviors (Eisma & Lenferink, 2023). Grief-induced panic behavior is a complex phenomenon that encompasses a range of emotional, behavioral, and affective reactions triggered by the loss of a person, object, or situation (Silva et al., 2023). Individuals who experience intense grief may display a combination of approach and avoidance behaviors, with yearning and rumination positively correlated with avoidance behaviors and prolonged grief symptoms (Eisma & Lenferink, 2023).

Another common experience among grieving individuals is withdrawal. Grief can lead to social isolation and hinder the healthy grieving process, potentially resulting in complicated grief (Mayer et al., 2023). Withdrawal due to grief is a typical reaction observed in individuals who experience profound loss. The grief from the unexpected death of a loved one can lead to withdrawal from social interactions and support systems. Additionally, prolonged grief disorder, characterized by severe and persistent grief, can intensify feelings of isolation and withdrawal (Lenferink et al., 2024). This withdrawal may stem from the negative emotions and hidden sadness that caregivers experience, depriving them of potential support and coping mechanisms (Crepaldi et al., 2020).

Grief reactions often involve a spectrum of emotions, including yearning, sadness, guilt, anger, and self-blame (Zhou et al., 2023). Self-blame and anger are common emotional reactions intertwined with grief. Individuals who experience intense grief often experience increased self-blame (Lenferink et al., 2024). Furthermore, grief may be intensified by factors such as discordance in funeral arrangements, which may lead to anger during the grieving process (Tao et al., 2022). Initial grief coping reactions, such as self-blame and anger, can disrupt the grieving process (Prigerson et al., 2022).

Meanwhile, the psychological need of the bereaved person for support during the mourning period increases. One psychological intervention that can be effective in this regard is Acceptance and Commitment Therapy (ACT). The core principle of ACT is that most psychological problems stem from experiential avoidance—an individual's tendency to avoid unwanted private experiences, such as thoughts, feelings, or emotions, and attempt to control or suppress them. ACT targets experiential avoidance to promote psychological flexibility, encompassing six core processes: defusion, acceptance, present-moment contact, self-as-context, values, and committed action (Bakhtiari et al., 2020). Given the statistics on COVID-19 infections and deaths, imposed restrictions, the lack of a definitive treatment for the virus, and the psychological impact on survivors, the implementation of psychological interventions to enhance mental well-being and reduce harm in the community is crucial. With this background, and recognizing the research gap in this area, the current study aims to investigate the effectiveness of Acceptance and Commitment Therapy (ACT) in reducing panic behaviors, self-blame, anger, and withdrawal caused by grief in the survivors of COVID-19 victims in Khorramabad city.

Methods and Materials

Study Design and Participants

This study employed a quasi-experimental pretest-posttest design with a control group to examine the effectiveness of Acceptance and Commitment Therapy (ACT) in reducing panic behavior, blame-anger, and withdrawal symptoms in individuals grieving the loss of loved ones due to COVID-19. Given the challenges associated with fully randomized controlled trials in grief-related research, a quasi-experimental approach was selected to ensure practical feasibility while maintaining internal validity. Participants were assessed

at two time points: baseline (pretest) and post-intervention (posttest).

The statistical population consisted of bereaved individuals aged 20 to 50 years who had lost a first-degree relative to COVID-19 within the previous 6 to 12 months and were residing in Khorramabad, Iran. A power analysis was conducted using G*Power 3.1, assuming an effect size of 0.6, an alpha level of 0.05, and 80% statistical power, which recommended a sample size of at least 34 participants. However, due to resource limitations, a total of 30 individuals were recruited using convenience sampling from local hospitals, grief counseling centers, and social media platforms.

Participants were randomly assigned to one of two groups using block randomization (1:1 ratio): Experimental Group (n = 15): Received eight sessions of ACT. Control Group (n = 15): Did not receive any intervention but were placed on a waitlist to receive ACT after study completion.

The inclusion criteria for the study included willingness and consent to participate, being within the age range of 20 to 50 years, experiencing grief due to COVID-19, attending all therapy sessions, and having no psychiatric or chronic medical conditions or substance addiction. The exclusion criteria included withdrawal of consent, addiction to any substances, having chronic medical diseases, receiving any pharmaceutical or psychological treatment for grief or psychological distress related to the death of loved ones during the intervention period, and missing more than one session of therapy.

Instruments

Hogan Grief Reaction Checklist (HGRC): The Hogan Grief Reaction Checklist (Hogan et al., 2001) is a well-established instrument for measuring grief, developed based on empirical studies with mourners. It has a significant advantage over theoretical tools as it is grounded in the real-life experiences of bereaved individuals. The checklist comprises 61 items that evaluate common reactions to grief. Respondents are asked to rate the intensity of their feelings over the past two weeks on a 5-point Likert scale (1 = does not describe me at all, 5 = perfectly describes me). The scores range from 61 to 305. The scale consists of six subscales: hopelessness, panic behaviors, self-blame and anger, withdrawal, disorientation, and personal growth. Examples of items for each subscale include: Hopelessness subscale: "My hopes are shattered." Panic behaviors subscale: "At times, my heart beats faster than usual without any reason." Personal growth subscale: "I have a better perspective on life." Self-blame and anger subscale: "I feel vengeful and angry." Withdrawal subscale: "I feel disconnected from others." Disorientation subscale: "I easily forget things, such as names or phone numbers." In the original study by Hogan et al. (2001), Cronbach's alpha for the subscales was reported as follows: hopelessness, 0.89; panic behaviors, 0.90; personal growth, 0.82; self-blame and anger, 0.79; withdrawal, 0.87; and disorientation, 0.84 (Hogan et al., 2001). In international research, the reliability of the scale was assessed using Cronbach's alpha, with values ranging from 0.76 to 0.87 (Breen et al., 2021). In domestic studies, the reliability of the HGRC was also evaluated using internal consistency, with Cronbach's alpha for the entire scale at 0.90 and subscale reliability ranging from 0.79 to 0.87 (Moeini et al., 2020). In the current study, the reliability of the full scale was 0.84, with subscale reliability ranging from 0.65 to 0.74.

Intervention

The experimental group received eight 90-minute sessions of Acceptance and Commitment Therapy (ACT), conducted twice a week over a period of four weeks. Therapy was delivered in person at a local grief support center by a licensed clinical psychologist (Ph.D.) with specialized training in ACT. The intervention followed the standard ACT model and focused on six core processes:

Session 1: Introduction, basic principles of therapy, establishing session rules, patient expectations, review of therapy, and therapeutic goals.

Session 2: Introducing treatment options, creative hopelessness, the relationship between health and function, examining the internal and external world, and using metaphors.

Session 3: Values and goals, understanding control as a problem, not a solution, and identifying life values.

Session 4: Values and actions, introducing clean and unclean values, willingness, acceptance, and behavioral commitment with the use of metaphors.

Session 5: Desires, thoughts, and emotions, introducing the concept of roles and context, observing oneself, mindfulness, and self-observation.

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Session 6: Starting to act, cognitive fusion and defusion, and exercises for defusion using metaphors.

Session 7: Commitment to action and values despite obstacles, mindfulness walking, showing negative consequences of focusing on results, and discovering values and committed actions.

Session 8: Maintaining therapeutic achievements, understanding the nature of willingness and commitment, life story development, determining a pattern consistent with values, and increasing behavioral commitment.

Data Analysis

To ensure the appropriateness of the selected statistical methods, preliminary assumption testing was performed, including the Shapiro-Wilk test for normality, Levene's test for homogeneity of variance, and Box's M test for homogeneity of covariance matrices. Given that these assumptions were met, Analysis of Covariance (ANCOVA) was employed to assess between-group differences while controlling for baseline scores. Additionally, effect sizes (η^2, Cohen's d) were calculated to determine the clinical significance of observed differences. To address potential biases resulting from participant dropout, intention-to-treat (ITT) analysis was employed, utilizing multiple imputation techniques to handle missing data. All statistical analyses were conducted using SPSS version 27.

Findings and Results

The mean age of participants in the experimental group was 23.42 years (SD = 11.67), and in the control group, it was 16.40 years (SD = 9.85). In terms of gender distribution, the experimental group consisted of 8 men and 12 women, while the control group included six men and 14 women. Regarding education, 15 participants in the experimental group held a high school diploma or lower, and 5 had a university degree. In contrast, the control group consisted of 13 participants with a high school diploma or lower, and 7 had a university degree.

Table 1

Descriptive statistics for grief and its dimensions by group and measurement stage

Dependent Variable	Group	N	Pre-test Mean ± SD	Post-test Mean ± SD
Panic Behavior	Experimental	15	20.28 ± 7.36	20.46 ± 3.73
	Control	15	32.32 ± 5.14	32.70 ± 4.62
Self-blame & Anger	Experimental	15	21.86 ± 5.98	18.40 ± 4.37
	Control	15	24.66 ± 6.14	25.60 ± 8.60
Withdrawal	Experimental	15	23.93 ± 4.23	18.60 ± 5.55
	Control	15	25.46 ± 3.68	27.00 ± 6.00

Table 1 presents descriptive statistics for grief and its subscales across both groups at different measurement stages (pre-test and post-test). To assess the normality of the distribution of scores, the Shapiro-Wilk and Kolmogorov-Smirnov tests were conducted. Results indicated that the p-values for these tests were greater than 0.05, suggesting that the distributions of scores for all variables were normal ($p > 0.05$). Therefore, normal distribution of the data allows for the use of analysis of covariance (ANCOVA). Additionally, the F-value in Levene's test was not significant, indicating homogeneity of variances. The Box's M test result ($F= 4.829$, $p = 0.059$) confirmed that the assumption of homogeneity of covariance matrices was adequately met.

Table 2

Results of univariate analysis of covariance (ANCOVA)

Dependent Variables	Sum of Squares	df	F-Statistic	p-Value	Effect Size (η^2)	Statistical Power
Panic Behavior	814.06	1	15.55	0.005	0.608	1.000
Self-blame & Anger	173.76	1	26.74	0.011	0.714	0.999
Withdrawal	338.11	1	32.93	0.007	0.586	0.885

The ANCOVA results presented in Table 2 show that Acceptance and Commitment Therapy (ACT), after controlling for pre-test scores, had a statistically significant effect on reducing panic behavior, self-blame

& anger, and withdrawal ($p < 0.05$). The effect sizes (η^2) for all dependent variables were large, with values of 0.608 for panic behavior, 0.714 for self-blame & anger, and 0.586 for withdrawal. The statistical power was also very high for all outcomes, indicating that the study had sufficient power to detect meaningful differences.

Discussion and Conclusion

The present study aimed to evaluate the effectiveness of Acceptance and Commitment Therapy (ACT) in reducing panic behavior, self-blame & anger, and withdrawal in the survivors of COVID-19 victims in Khorramabad. The results indicated that ACT was successful in significantly decreasing panic behavior in the intervention group by the post-test stage, confirming the second hypothesis of the study. These findings align with the prior studies (Alipour Dehghani, 2020; Crepaldi et al., 2020; Davis et al., 2020)

From the perspective of ACT, human suffering is rooted in psychological inflexibility, which arises from cognitive fusion and experiential avoidance. The tendency to engage with or fight against unpleasant thoughts and feelings through avoidance is one of the reasons for psychological distress, particularly in panic behavior. ACT posits that psychological pain and distress stem from failing to meet behavioral needs and aligning with core values. Therefore, the primary goal of ACT is not to directly reduce symptoms, but to foster psychological flexibility. This allows individuals to change their relationship with their thoughts and emotions, learning to accept them without perceiving them as pathological, even when they are uncomfortable or unpleasant (Davis et al., 2020).

Furthermore, the results indicated that ACT led to a significant reduction in self-blame and anger among the intervention group by the post-test stage, confirming the third hypothesis of the study. This finding is consistent with previous research (Ahemaitijiang et al., 2020; Christopher et al., 2020; Wasson et al., 2020), which has shown that ACT and its associated techniques are effective in reducing self-blame and anger. The explanation for this outcome lies in the role of experiential avoidance, which, when persistent, exacerbates feelings of self-blame and anger in bereaved individuals. Cognitive defusion in ACT involves stepping back and observing thoughts as just thoughts, not objective truths. This process can reduce self-blame and anger associated with the loss of a loved one. Moreover, ACT helps individuals accept and commit to actions aligned with their values, which can promote resilience and a more compassionate view of their emotions, including the overwhelming feelings of guilt and anger that often accompany grief.

The results also demonstrated that ACT significantly reduced withdrawal behaviors in the intervention group by the post-test stage, thus confirming the fourth hypothesis of the study. This finding aligns with prior results (Moeini et al., 2020; Rosner et al., 2018; Weinstock et al., 2021), which reported that ACT and its techniques effectively reduce avoidance and withdrawal behaviors. The therapeutic relationship in ACT plays a crucial role in this process. When the therapeutic relationship aligns with the principles of ACT, it fosters acceptance, motivation, and continued engagement with therapy. This environment allows clients to explore both effective and ineffective behaviors, ultimately helping them develop the necessary skills to identify and engage in value-driven actions. By promoting committed action towards values, ACT helps clients overcome the trap of withdrawal and avoidance, encouraging them to face difficult emotions and life challenges more effectively.

The most significant limitation of the study was the lack of a follow-up period. Additionally, the sample size was relatively small, consisting only of COVID-19 survivors with grief symptoms, which may not adequately represent the broader population. Therefore, the generalization of the results should be done with caution. Another limitation was the use of a non-random convenience sampling method and self-reporting tools. Future studies should consider using random sampling or structured interviews to improve the reliability and validity of the results.

Another limitation was the absence of a comparison group using different therapeutic methods, which would have allowed for a more robust evaluation of ACT's effectiveness compared to other interventions. Future research could compare ACT with other third-wave therapies, such as self-compassion therapy, metacognitive therapy, and emotion-focused therapies, to assess their relative effectiveness. Furthermore, to increase the statistical power and robustness of findings, it is recommended that future studies include follow-up periods (3 to 6 months post-treatment) to assess the

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long-term impact of ACT on grief and psychological well-being.

In conclusion, the findings of this study suggest that ACT is an effective intervention for reducing panic behavior, self-blame & anger, and withdrawal in survivors of COVID-19. By fostering psychological flexibility and helping individuals align their actions with their core values, ACT can significantly improve the coping strategies of individuals experiencing grief and loss. However, future research should address the limitations of the current study and explore the long-term efficacy of ACT in different populations, as well as in comparison to other therapeutic approaches.

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Declaration of Interest

The authors of this article declared no conflict of interest.

Ethical Considerations

The study protocol adhered to the principles outlined in the Declaration of Helsinki, which provides guidelines for ethical research involving human participants. Ethical considerations in this study included the fact that participation was entirely optional. Ethical approval for the study was obtained from the Institutional Review Board (IRB) of Islamic Azad University, Kermanshah, ensuring compliance with research ethics guidelines.

Transparency of Data

By the principles of transparency and open research, we declare that all data and materials used in this study are available upon request.

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Authors' Contributions

All authors equally contribute to this study.

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