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RESEARCH PAPER

From Lived Experience to Clinical Insight: A Qualitative Study of Mental Health Experts' and Bereaved Individuals' Perspectives on Factors Leading to Prolonged Grief Disorder

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ABSTRACT

The Purpose of the research was to examine the causative factors linked to prolonged gr disorder (PGD) in bereaved adults who have lost a parent or both. The death of parents is ve painful and has long-term negative effects including pain, sadness, grief, limitlessness a social isolation on individuals' life. Bereaved people faced emotional and social issues due that loss and after a certain time period, if mental health issues raised persistently, it m cause prolonged grief disorder. Qualitative research method was used in this research. S Psychologists and Psychiatrists, and six bereaved people were interviewed semi-structur and the data were analysed thematically. The five main themes that were identified duri the analysis were psychological symptoms, grief progression, family dynamics, protecti factors, and socio-cultural and religious beliefs. Clinical evaluation and better treatme outcomes of bereaved people can be achieved by incorporation of family support, cultura sensitive and focused psychological interventions.

Keywords: Parental Loss, Prolonged Grief Disorder (PGD), Family Dynamics, Socio Cultural Factors, Mental Health Experts

Introduction

Parental loss is a serious life event that can severely disrupt the affective state of a person, his or her relations with others, and self-care routines. Despite the fact that bereavement is a universal phenomenon, its expression is very diverse in terms of culture, development, as well as, situational context. This paper explores the far reaching consequences of parental loss on various aspects of human existence and explores how dependency on parental systems can complicate the grieving process. The work sheds light on the common ground and the professional attitude to the grieving phenomenon by applying an international lens.

A parental loss is a highly overwhelming process that may cause deep grief, emotional numbness, social isolation, and inner emptiness. Although most people learn to cope with this life-changing experience over time, a significant number of people still persist and can develop PGD a worsened emotional upheaval that interferes with everyday performance (Bonanno & Malgaroli, 2020; Nielsen et al., 2019).

Prolonged Grief Disorder (PGD) is a mental health condition that is increasingly being recognized as a unique phenomenon with persistent yearning, emotional distress, and functional impairment that is beyond the culturally accepted mourning expectations (Prigerson et al., 2009; Killikelly et al., 2017). PGD is a chronic disturbance that hinders the psychological adaptation and normal life compared to normative grief, which normally decreases with time (American Psychiatric Association, 2022; WHO, 2019).

Literature Review

Modern theories assume that PGD is a result of personal experiences influenced by personal vulnerabilities and attachment patterns and relational processes, thus highlighting its heterogeneous character (Stroebe et al., 2017; Shear, 2015). The cultural determinants also regulate the manifestations of grief and its duration, making unusual grief in a certain culture possibly normal in another one (Rosenblatt, 2008; Stelzer et al., 2020). The empirical data points to the risk factors including insecure attachment, the lack of social support, traumatic loss situations, and pre-existing mental health conditions that increase the maintenance of the PGD symptoms (Bonanno et al., 2007; Lundorff et al., 2017). PGD can therefore be thought of as a multifaceted disorder which is brought about by the combination of personal, cultural, and contextual factors.

Kubler-Ross (1969) suggested a series of five affective stages, namely denial, anger, bargaining, depression, and acceptance, and he argued that people can experience them in a non-linear manner (Maciejewski et al., 2007). PGD is characterized by severe and prolonged grief symptoms that exceed the culturally-determined time limits of mourning, and is characterized by inability to come to terms with loss, constant craving, lack of emotions, and obsession with the dead (Prigerson et al., 2009). PGD can make people stuck at specific levels (e.g. extended denial or anger) and disrupt the transition to acceptance and adaptation (Shear, 2012).

The cultural norms have a significant impact on the expression of grief and support systems. The prevalence of PGD shows great difference in cross-cultural studies and support of family and community has a protective effect in collectivist cultures, but with the pressure to conform to communal grief, and individual expression is permitted in individualistic cultures (Hilberdink et al., 2023). PGD risk is alleviated by protective factors, including resilience, group rituals, spirituality, and supportive settings (Stroebe et al., 2017). However, a lot of current PGD studies involve quantitative symptomatology and do not provide insight into how people are able to make meaning out of loss or how cultural contexts influence grieving (Murphy et al., 2022). Qualitative designs can provide a sensitive understanding of the grief experience; grieving individuals often underline the abruptness of the death, the nature of relationships before the loss, and the existence of the social and cultural support systems as the key factors contributing to the severity and duration of the grief (Eisma et al., 2020). The grieving path can be extended further in a setting where social recognition, rituals, or emotional validation are absent (Gauthier and Gagliese, 2021). Other risk factors identified by mental health professionals are insecure attachment, maladaptive cognitions, and underlying mental health problems (Prigerson et al., 2009; Shear, 2015).

Even though PGD has become a recognized psychiatric syndrome in recent times, the mechanisms behind its formation are not well-understood. So far, the studies have mainly focused on symptomatic and diagnostic measures, overlooking the complex individual, social and cultural contingencies that perpetuate enduring grief. An in-depth comprehension requires the combination of both clinical knowledge and lived experience. This paper, therefore, attempts to fill this gap by looking at the views of bereaved people and mental health practitioners. Grieved participants will recount their emotional issues, coping, and situational factors, and the clinicians will provide information based on therapeutic practice and theories. The synthesis of these two perspectives is aimed at the study generating a comprehensive representation of PGD, which will inform sophisticated assessment instruments, customized interventions, and effective preventive measures. This integrative perspective emphasizes the need to match practice with real experience of mourning and thereby offer more compassionate, effective and culturally sensitive practice to individuals who are at risk of Prolonged Grief.. Moreover, the aggregated professional knowledge can empower the practitioners to detect high-risk individuals promptly, and some pre-emptive measures can be taken to mitigate the maladaptive grief patterns before they become institutionalized. Diagnostic and therapeutic approaches can be further

optimized through considering the impact of various cultural mourning patterns and contextual factors (Ruiu et al., 2024), which will not affect the clinical effectiveness.

Material and Methods

In this research qualitative research design was used with incorporation of in-depth interviews for data collection. Past studies which were most related with the core issues of the study were consulted and many of the statements were drawn from these studies. Moreover, for constructions of interview questions the guidelines of worthy supervisor was considered for the guidelines of semi-structured interview from experts who are practicing with clinical population. For this purpose, open-ended questions were formulated for the interview.

Inclusion Criteria for Psychologist and Psychiatrist

- Psychologist with Post graduate degree in Clinical Psychology from HEC recognized university were included.
- Psychologists who have at least 6 to 8 years of experience in public or private sector included.
- Psychiatrists holding specialty fellowship diploma (FCPC) awarded by the College of Physicians and Surgeons Pakistan (CPSP) were included.
- Having Minimum 5- 10 years of experience in public or private sector.

Inclusion criteria of Participants

- Age rage of the targeted respondents between 19 – 35 years.
- Participants who can comprehend Urdu.
- Participants who have lost single or both parents from 1-3 years
- Participants are taken from government and private institutes
- Unmarried individuals are included.

Procedure

Psychologists and Psychiatrists were approached individually either at their workplaces or at homes, educational institutions and by researcher's links. All research participants were guided and informed about the study objective. The time frame of interview was based on 40 to 50 minutes as per need of the study. Every respondent had open permission for share their opinion about the issue as per open ended questions.

After the formal permission of the participants all the interviews of the study were reordered and it was assured that these recording would be used only for the study purposes.

All the recorded or written material was examined and analyzed as per need of study and the responses of the participants were noted on separate sheet with care to avoid any unnecessary issues. In addition, all the responses about PGD reviewed with care and tried to count all the responses and keep in record without any negligence. The basic purpose of the interviews was to identify the ideas, concepts and study related modules which are underlying of grief.

Statistical Analysis

After conducting of interviews, data was transcribed, translated and analyzed using a thematic analysis method (Braun & Clarke, 2006). For that purpose, NVivo software 10 was used.

Results and Discussion

Figure 1: The Word Cloud illustrating key factors associated with prolonged grief disorder

This word cloud illustrates the most salient terms identified through qualitative analysis of interviews with mental health professionals and bereaved individuals. The dominance of each word is determined by its frequency in the data, thus highlighting the major role of psychological symptoms, personality-related variables, family and social support, and environmental factors in the etiology and persistence of prolonged grief disorder.

Figure 2: The hierarchal chart: Hierarchical representation of themes related to prolonged grief disorder

This figure presents the comparative analysis of coded nodes based on the qualitative data and arranged according to the frequency of references that are assigned to each thematic category. The proportionate sizes of the segments portray the prevalence of the codes, thus highlighting the key thematic areas such as grief trajectory, psychological symptomatology, family factors, environmental and peer contexts, protective factors, and socio-cultural and religious constructs that are involved in prolonged grief disorder.

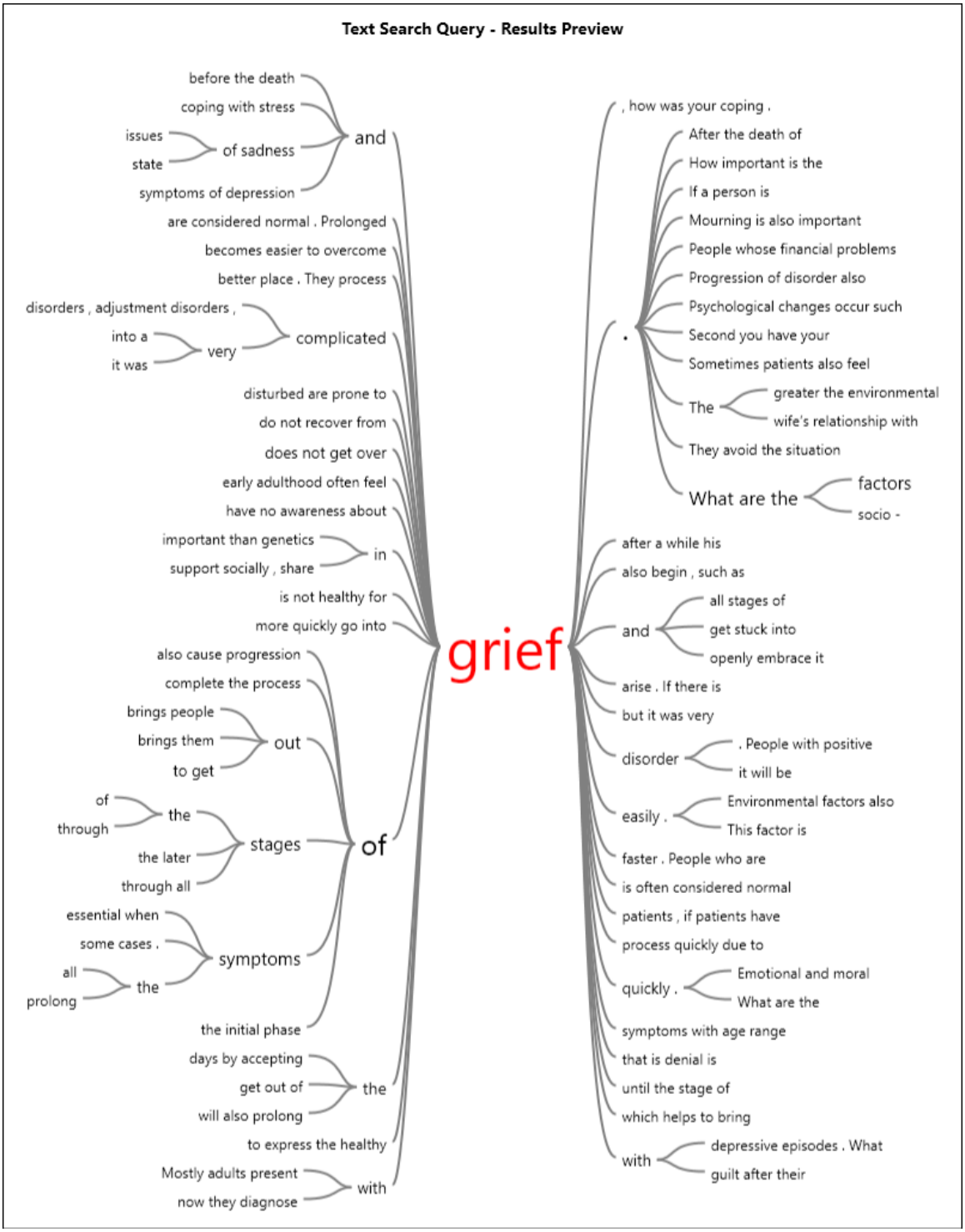

Figure 3: Text Search Query (TSQ) map illustrating concepts related to grief

The figure represents the outcome of a text-search query that was used in the course of a qualitative analysis and defines the contextual manifestations of the word grief in the narratives of participants. The branching schema represents the interdependence of grief

and coping processes, grief stages, psychological symptoms, environmental factors, socio-cultural environments, and the trajectory patterns leading to complicated or protracted grief. In general, the visualization summarizes the diverse and complex ways of interpreting grief, both adaptive and maladaptive ways of responding to loss.

Discussion

NVivo (version 10) was used to conduct thematic analysis, which became the major means of corpus analysis (see Figures 1-3). The entire process of thematic analysis, which included the data recording, transcription, coding and theme generation was performed manually in the NVivo environment. First, the qualitative data was collected by means of interviews that were later transcribed. NVivo was used to code the transcripts that had been completed. The coded data was identified by the researcher and the relationships between these key themes were analyzed. The coding process has particularly focused on the causes of the emergence and advancement of the grief after the loss of parents.

The argument given in this paper is directly based on the results depicted in Figure 2. Figures 1 -3 present the synthesis of qualitative data of in-depth interviews with mental-health professionals and bereaved people, and Figure 2, demonstrates the systematic coding and thematic analysis of their stories. All of the discussed interpretations, comparisons and explanations are implemented with reference to the frequency, clustering and interrelationships of the used coded nodes represented in Figure 2 that incorporate psychological symptoms, progression of grief, the effects of family and the environment, protective factors, and the socio-cultural and religious beliefs. Therefore, the argument is not based on premises and secondary interpretations but, instead, anchored on the primary experiences and professional enlightenment of the participants as recorded in the qualitative interview and displayed in the node-comparison map.

A set of five main research questions has been used to guide the investigation. The initial question involved the nature of psychological manifestations by bereaved people after the death of their parents. Categorized symptom domains that were reported by expert clinicians and bereaved participants are as follows: (a) Loneliness: Individuals with persistent grief disorder (PGD): They cited that they experienced loneliness following the death of their parents. They often talked of a desire to have the love, support and warmth that was once given. This feeling of loneliness and alienation only grew with time, which could have hindered the process of grieving and increased the mourning. (b) Denial: The immediate loss of parents tended to induce shock reaction where some were stuck in the denial stage of the grief and they would not accept the fact that they had lost a loved one. (c) Guilt: A general feeling of guilt was also commonly experienced. The participants stated that they felt self-blame over perceived lack of opportunity to offer more care or spend more time with their parents. Certainly, the survivor guilt occurred in certain instances where people were left to wonder why they survived yet their parent had not. Such guilt, without being addressed, can deepen sadness, affect emotional healing, and lead to extended grief. (d) Hopelessness: Grieved subjects often characterized a pessimistic view of self and of future, and they viewed life as meaningless with the death of a parent. This overwhelming feeling of desperation, which is based on the absence of parental support, can kill the motivation and perspective thus hindering the path to recovery and even causing depression or PGD. (e) Weeping Episodes: The participants in PGD were characterized by frequent and most times uncontrolled crying. These types of episodes served as a kind of emotional outburst, a source of temporary distress relief. Crying in most instances continued even after the normal mourning phase due to constant reminders of the dead and the inability to accept the loss and hence affecting normal functioning. (f) Depression: PGD subjects developed deep sadness, low mood, and suicidal ideation in some of them. There was functional impairment as one is seen to withdraw themselves in their day to day activities and they like to stay in their state of sadness. (g) Emptiness: A major symptom which was mentioned was emptiness after parental loss. Grieving respondents described

this as a blank inside where sense of security and belongingness had once been that they were never complete and could not easily adapt to life without parents. (h) Aggression: A portion of the participants who had PGD exhibited aggression or anger towards other people or themselves. This aggression seemed to be the result of helplessness in connection with the loss of the dead and was the stages of grieving that were not resolved. (i) Sadness: Sadness was the most noticeable and recognizable emotion, which included experiences of loss, yearning and emptiness. The symptoms were observed in tears and withdrawal, and general heaviness which in long term may lead to depression or PGD. (j) Auditory Hallucinations: The auditory hallucinations were commonly heard by grieved people who heard their dead parents talking. This can be experienced both in periods of strong desire or weakness and can give temporary relief though combined with long-term distress in the case of intrusion, thus indicative of PGD. (k) Physical Symptoms: The grief was physical and was expressed through fatigue, headaches, chest tightness, muscular tension, gastrointestinal and insomnia and lack of appetite. These somatic symptoms were an indication of the state of the body activation of the stress response and, in the long run, it threatened the general health. (l) Reminiscing: A large number of the bereaved participants indulged in reminiscence of their parents including thinking of their fondest memories and family customs. Although reminiscing may play a therapeutic role of maintaining emotional attachment, excessive use can trap people in the past, preventing the ability to adapt to the present and continuing with grief. (m) Loss of Interest: Sadness, yearning, emptiness and hopelessness were stimulated leading to the reduction of engagement in activities previously enjoyed. This development of disinterest was a normal reaction to a major bereavement and when still observed long-term, was an indicator of prolonged grief or depression. (n) Flashbacks: The participants reported intrusive flashbacks involving the deceased or death conditions especially at times when the participants were at their worst. These flashbacks increased emotional and psychological stress and, unless treated, interfered with everyday life and prolonged emotional pain.

Second question was about factors that were involved in the development of grief symptoms. The identified predominant themes are provided below: Personality Personality has a final say in how people deal with the death of a loved one (see Figure 1 and Figure 2). These characteristics include; resilience, emotional sensitivity, dependence and optimism, which adjust the extent and length of grief. Individuals with flexible and adaptable personalities are more likely to develop healthier coping mechanisms, and highly dependent and introverted people are likely to experience increased loneliness and problems with adapting to loss. In addition, personality defines the type of grief expression; whilst some people openly express their feelings, others close them thus making them vulnerable to prolonged grief responses.

(b) Emotional Support: Emotional support is an essential component after the loss of parents who are usually the main caregivers and stabilizing factor in different situations. The removal of these support systems, be it the emotional support or financial one or both, is a deep psychological shock especially when the mother dies. Emotional support becomes evident in a form of comfort, empathy and the ability to understand, and maybe offered by close family, friends, or community networks. The various forms of support can be active listening, acknowledging the feelings, remembering the deceased, and even just being present when a person is going through a hard time. This kind of support helps create a feeling of belonging, reduces the feeling of isolation and allows bereaved people to express themselves more easily, thus, serving as a buffer of protection that eases the risk of the development of prolonged or complex grief.

(c) Financial Problem: Financial problems tend to add to the weight of bereavement particularly when the deceased was the main breadwinner or played a central fiscal role. Grieving people can end up being left with the responsibility of paying bills, paying off government debts or financing the funeral. The resulting financial burden increases stress

levels, insecurity, and even makes the process of mourning difficult, usually distracting with the aspect of survival other than the emotional healing process. Constant financial distress could create anxiety and pessimism, and, thus, increase the risk of complicated grief as people have to deal with both the loss and daily difficulties.

(d) Helplessness: Helplessness is a ubiquitous response to loss of a loved one especially parents. The understanding that nothing can bring the bond back makes the person feel powerless and overwhelms the person affecting his everyday processes. This can lead to withdrawal, overdependence on other people or may have no purpose. Although transient helplessness is a normal aspect of grieving, chronic or severe forms of displaying helplessness prevent adjustment and may raise the likelihood of depression or prolonged grief disorder.

(e) Dependency on Deceased: Dependency on the deceased is the strong emotional or economic interdependence prevailing before death and frequently being compounded in the parent child relationship. There is a sudden lack of direction, care, or support which will create confusion and hopelessness and intensify the grieving process. This dependency, which is yet unresolved, can hinder development of independence and hence extend grief and make acceptance of the absence to be complicated.

(f) Non-supportive Environment: Lack of empathic, supportive and practical help will increase the challenge of dealing with the loss of a parent. Lack of empathy, help or understanding by family, friends or community encourages isolation and the bereaved person will be overwhelmed by the criticism or pressure to move on thus nullifying their feelings. This aggressiveness interferes with normal grief, enhances loneliness, and can lead to maladaptive coping, depression or cross-generational grief.

(g) Coping: Coping refers to the strategies and processes that are used to cope with the emotional, cognitive and physical needs that follow the loss of a loved one. Parents who have lost their children tend to rely on an amalgamation of processes, among them the search of social support, the display of feelings, the performance of meaningful dances, faith, and inner resources. These strategies of adaptation reduce distress and encourage adaptation. On the other hand, maladaptive strategies include avoidance, withdrawal, or denial and these extend the sufferings and delay recovery. Personality, cultural setting, and the character of the preceding relationship are factors that determine how one copes and hence affect the course of grief.

(h) Hiding Emotions: This is the most frequent reaction to bereavement and will likely be motivated by either culture, family pressures, or the fear of being judged. Constant repression of sorrow, rage, or fragility may damage the normal processing of grief and, in the future, they can manifest as stress, irritability, or somatic symptoms, which increase the risk of prolonged grief. Sharing feelings, whether through conversation, cries, remembering the past is a powerful tool in getting pain out and facilitating the healing process.

(i) Lifestyle: Lifestyle is an important factor that influences the occurrence of psychological disorders among the bereaved people. Psychological distress can be accelerated by participation in health promoting activities, e.g. regular exercise, socializing and scheduled routines and prolonged by unhealthy lifestyles.

(j) Quality of Relationship: A good relationship that pre-exists with the deceased significantly affects the level of grief. An intimate, warm and supportive relationship is likely to bring deep pain, identity disturbances, and conflicted or strained relationship presents even more complexities that include guilt, remorse and unresolved anger. These ambivalent feelings hinder recovery and increase the chances of the development of a long-term grief disorder.

(k) Severe Sadness: Severe sadness, especially when the sadness is prolonged and severe is one of the hallmarks of prolonged grief disorder (PGD). This distress can take the form of uncontrolled crying, avoiding social interactions and lack of ability to find pleasure or meaning. This condition disrupts the ability to take part in the healing process, compromising mental health by making one susceptible to depression and anxiety. The transition between normal grief and PGD is important to prevent and this can be achieved by early detection and specific psychological counseling.

(l) Burden of Responsibility: Death of the parents has the potential to thrust a lot of responsibility on those who are left behind especially where they have to shoulder responsibilities to take care of other siblings, take care of the house and provide financial support. A change of role increases stress and can promote a sense of incompetence or guilt. The concomitant burden may also cause the individual to be distracted by the need to survive and thus slows down or makes the grieving process difficult.

(m) Negative Thinking: Negative thoughts often occur in bereavement and they include hopelessness, self-accusation, and catastrophizing (e.g. life will never get better). It is normal to be pessimistic every now and then, but when negative thinking is continued over time, it increases emotional suffering and hinders adaptability. The result of such cognition can lead to depression or PGD through hindering positive coping and continuing hopelessness.

(n) Awareness/Lack of Awareness: The lack of awareness on psychological disorders, especially PGD, decreases the chances of proper intervention. Failure to understand chronic sadness as a form of weakness or seeking attention encourages the development of fault and loneliness. It is this misconception that postpones the detection of signs of depression, hopelessness, and functional impairment, and as a result, puts an individual at risk of developing untreated depression, anxiety, or a worsened PGD.

(o) Psychiatric History: A personal or family psychiatric history interferes with vulnerability to protracted grief and makes it difficult to cope. Past diagnoses of depression, anxiety disorders, PTSD, substance use disorders, drain resilience, hinder emotional regulation and intensify withdrawal and hopelessness post bereavement. Traumas that have not been overcome can reappear in the process of mourning and worsen the situation. Thus, the study of psychiatric history is necessary to refer to high-risk people and prevent PGD or its complications through the application of preventive or therapeutic measures.

Background Experiences: The childhood experiences play a substantive role in how people react to bereavement. The type of attachment bonds with parents and caregivers are crucial factors that define the type of attachment, emotion responses, and compensatory behaviors. As an example, a nurturing and nurturing upbringing can be associated with increased resilience that will allow the person to face the grief in more beneficial manners. On the other hand, childhood experiences of neglect, strife or unstable relationships can act as problematic when the bereaved have to go through the grieving process as the tension may not have been resolved and it can reoccur when the parent leaves the life of the bereaved. Individuals with traumatic childhoods often have heightened psychological distress when their parents die and as a result of this they develop more protracted grief symptomatological.

(q) Unresolved Matters: The Unresolved issues are the unresolved issues, feelings or relationship dynamics that were not fully resolved and burdened the bereaved persons after the death of a loved one. During the period that follows the death of their parents, bereaved people tend to feel guilty, believing that they should have been thankful and offer an apology, or complete their duties. Such incomplete feelings may trigger emotional acuity since grieving people are obsessed with the idea of what could have been. This kind of rumination will only increase guilt, sorrow and anger thus blocking the natural healing

process. Without solving any of the issues, they have the propensity to extend the mourning experience and instill continuous craving, lack of acceptance of death, a feeling of guilt, and obstructions to normal life, and trouble with the adjustments of living in the world without the person he lost.

Question three was an issue on the role of the family, the environment and the social milieu in which the grieving process takes place. The themes that were found to be major were:

(a) Environment: The physical and social environment brings a tremendous impact on the process of grief stages. Symptoms of grief can become acute and prolonged by an already depressed or unfriendly environment, in combination with isolation of a bereaved one.

(b) Avoidance: Clinical scholarship recommends that grief disorder can be heightened by the use of avoidance as an element of defense to emotional trauma e.g. the loss of a parent. Avoidance is the conscious attempt to avoid thoughts, feelings, environment, or stimulus that cause reminders of the deceased. As an example, a grieved parent may avoid going to a room where the parent used to be, not talk about mutual memory or into self-immolation coping, thus contributing to the emotional distress. Even though avoidance would provide temporary emotional safety, it would hamper the normal grieving process, which would eventually lead to numbness, unresolved grief, and difficulties adapting to a life without the dead. Despite the fact that avoidance is still a relevant characteristic of persistent grief disorder (PGD), it is likely to keep people trapped in months of grief instead of recovery.

(c) Social Support: Social support also acts as a buffering mechanism to bereaved individuals with the result of grieving parental death being alleviated. Effective management of intensive emotions, the creation of strong coping strategies, and avoiding the adverse consequences of PGD are linked to a strong social support.

(d) family support: the family support is the most important element in the grieving process. Mutual emotional validation, collective reminiscence and practical support are the main aspects of family support. Lack of this kind of family support may increase isolation and enhance the severity of grieving responses.

(e) Emotional Awareness: One vital area that is imperative in coping with bereavement is responsiveness to emotions. Grief contextualization is made possible by identifying and interpreting emotions like sadness, anger, guilt, and loneliness. Inability to identify these affective conditions makes the bereavement process cloudy and may even have devious twists. Through time spent to understand the emotional landscape of the bereaved, families can foster an atmosphere that will help them to heal. The natural course of grief plus delayed intervention measures prepares families to legitimize experiences, reduce alienation, and provide an open discussion, therefore, avoiding the build-up of unexpressed feelings and the development of deeper psychological problems.

(f) Expression of Emotions: Specialists agree that the genuine expression of feelings is a component of the experience of grief stages. Grieving individuals who withhold their emotions upon the loss of a parent are prone to be stuck in the first stage of sorrow that can predispose him to PGD. Faking emotional health and intentionally hiding emotions can be harmful to the long-term symptom of grief.

(g) Genetics: Genetic predisposition: Genetic predisposition is a major factor in the development of psychological disorders. Regarding the case of PGD, the predisposition to persistent mental discomfort could have genetic roots, so the hypothesis that genetic factors could be mentioned when risk has to be assessed might prove true.

(h) Irritation: It can result in irritation or frustration in other members when one of the family members is grieved. The sorrowful mood, isolated behavior or the lack of ability to engage in daily activities by a bereaved person may produce a sense of fatigue or helplessness in the viewer. This annoyance is not a part of the natural display of indifference, but is instead an emotional reaction toward the weight of the burden of coping when trying to help someone. The reaction of family members is very different- some of them are open-minded to show their emotions and others are quiet- this brings tension, misunderstanding and annoyance to the family. It is important to note that irritation is often the result of stress, and not meant as a purposeful rejection. Families can reduce stress by promoting free communication, making joint responsibilities, and experiencing empathy to each other and building a more positive atmosphere in especially difficult times.

Forth question covered the protective issues which could help bereaved people to go through the stage of grieving. The key themes that were identified with the help of the thematic analysis are:

(a) Healthy Routine: It may be effective to recover the emotional disturbance and grieving process substantially by individuals who keep a healthy routine: exercise, self-care, balanced nutrition, and sufficient sleep. Being able to predict due to a regular routine that keeps the day routines the same, reduces stress, helps in managing emotions, and neutralizes the disorder associated with grief.

(b) Supportive Environment: The environment is supportive; this is a critical component of grief treatment and healing. It will allow the grieved to express feelings about death, provide realistic support toward expert help and develop an environment that will help them cope with the loss of a parent. By having family members who understand them, friends who are compassionate and a friendly community around them the bereaved people will feel less isolated and they will be in a better position to deal with emotional pain. This kind of environment is a refuge where one can grieve, talk about the good moments of life, and feel confirmed thus alleviating the pressure of mourning. Furthermore, it has been shown that emotional and social support is the foundation of the decrease in PGD risk due to the development of the healthy coping strategies, resilience, and future hopes. A hostile environment on the other hand can enhance loneliness, guilt or helplessness to hinder the healing process.

(c) Resilience: Experts indicate that when patients possessing grief are resilient, they can overcome the challenge of grief, manage their emotions and get back to normal life with the processes of grief. Resilient people accept that they are grieving and share feelings and eventually get a sense of meaning out of loss and still stay attached to relationships, duties and aspirations. Resilience encompassing factors that are protective include quality support, effective coping styles, problem-solving techniques, spiritual/religious beliefs and well-organized habits. Other internal attributes that bring resilience include optimism, adaptability, and regulation of emotions. As much as resilience does not eliminate grief, it allows victims to endure pain without being overwhelmed altogether, thereby reducing the chances of getting PGD or other mental illnesses.

(d) Emotional Strength: Emotional strength is a combination of positive personality traits, coping, and family support and friends. It refers to the ability to handle, control and express emotions in a fair balance particularly when dealing with such a precarious situation like the death of a parent. It is a strength that enables the bereaved individuals to face sadness, longing or anger without turning into a complete helpless person. Instead of putting grief into silence, one can feel pain and be functional seeking support and getting used to loss gradually using the power of emotions. It usually presents itself in the form of endurance, forbearance and the capacity to derive significance in pain. People can develop this power through self-reflection, creating positive relationships with others, religious or cultural practices and focusing on individual development. Emotional robust people are a

reservoir against depression or grief that takes long to heed to, making them adjust healthily and have a positive view.

(e) Positive Thinking: The concept of positive thinking is a very important element in dealing with the grief symptoms after the death of a parent. Those people who have positive expectations of a better future and who do not give up hope are in a better place to mitigate the symptoms of grief and respond to negative emotions. As a more general influencing factor, personality greatly affects the results of grief treatment. It is a psychological assumption that people with positive personalities, positive views and resiliency have a higher restorative ability of normalizing emotions.

(g) Psychological Help: Psychological support is one of the major components of grief treatment. PGD sufferers can learn to manage grief stages effectively with the help of a professional. The bereaved persons cannot do without psychological care. One might feel miserable, guilty, or despairing when he/she has lost a parent. In such life-threatening times, the presence of trained personnel such as psychologists, counselors and therapists provide guidance and emotional outlets in a structured way. Professional assistance lowers the chances of prolonged grief disorder, depression, and anxiety, and teaches one to live through loss.

Fifth question explored how socio-cultural and religious views impact on grieving of people who lose their parents. (a) Social support: Social support is an important buffer during the post-loss adaptation of bereaved persons. It works to alleviate the overwhelming emotional load that goes along with grieving, providing psychological relief, encouragement and practical support. Since supportive relationships provide bereaved individuals with a channel through which they can express their affective conditions, diminish the feeling of isolation, and gain acceptance of their pain, this support does not only help them to combat the effects of psychological stress but also promotes healthier coping strategies. The social support is practiced by empathy, compassion and active listening which will lead to understanding of the inner affect and emotional response of the bereaved person to loss of a parent. In addition, the proximity of others who are involved in common activities or routines also fights loneliness and provides a stable ecosystem that is favorable to the emotional and psychological healing that is needed during the time of grief. (b) Religious beliefs: According to the experts, religiosity and spirituality can have complicated effect on prolonged grief disorder, which differs in individuals. The negative religious coping strategies can be increased by the grieving symptoms but other studies show that religiosity and spirituality can moderate negative states and lead to triumph over grief and emotional self-control. Religiosity refers to the level of commitment to religious beliefs, values, and practices, and it mainly determines the way in which individuals cope with the gruesome process after bereavement. In the loss of their parents, most people who are bereaved find comfort in religion to find comfort, meaning, and hope. Religions help people to conceptualize death as a continuation of the spiritual process and not a final endpoint. Participation in ceremonies like prayers, communal meetings or memorials services is an emotional buffer, and it develops a feeling of togetherness. Religions often provide interpretative frameworks that assist grieving individuals to derive meaning out of their loss which gives them an idea of life, death and whether they will continue to live afterwards. Concerns can be addressed by a belief in a higher force or the persistence of the soul to bring acceptance to the loss. Such rituals as funerals and memorials help not only to honor the deceased but also organize the grieving process to provide social and spiritual support. Good faith may lead to resilience and purpose-oriented attitude; others may struggle with the spiritual crisis, such as faith doubt, being lonely, or being angry at the god-created, thus exacerbating affective distress and complicating the grieving process. (c) Catharsis: Catharsis has been defined as the expression of strong affective conditions to alleviate psychological tension. Within grieving, cathartic processes are usually evidenced in the form of crying, discourse, written expression, or in creative activities like art, poetry or prayer. In

bereaved individuals of parents, these outlets of expressiveness help release the expended pain, and thus lower the burden of emotion, avoiding the self-adaptative effects of situating emotion in the repressed form. Catharsis is affected mostly by cultural values and rituals. When bereaved persons are attended by other people, their feelings and sympathies relieve the feelings of loneliness. Catharsis is not just a release of emotion; it is a significant process that leads to healing, and allows one to face grief and not to avoid it. Sharing grief with that of supportive friends or in secluded places is a great relief and it helps in the process of accepting grief. Catharsis is not equally effective in all individuals and cultures, openness may comfort some bereaved persons, others may be exposed or may simply prefer to use a more restrained form of coping. (d) Belief in death: Belief in death is the conceptualisation of death by people. Parental death forces people to experience mortality and to understand the boundaries of human life and, thus, it affects their grieving. Grief Reconciling death as an inherent aspect of life can enable bereaved people to adjust meaningfully to death. To some, this belief bolsters appreciation of life, fosters strength and acceptance although to others it may increase levels of anxiety, fear, or hopelessness. These beliefs are heavily influenced by cultural and religious backgrounds. Most cultures consider death as a change and not an end thus providing comfort and lessening hopelessness. Individuals who view death as final might have more emptiness and existential distress. Finally, the way, in which a person understands and processes the concept of death, has a essential impact on grief process. (e) Death through disease: In case parents die after many years of sickness, the bereavement experience takes a different dimension. As families observe the deterioration of a loved one, they tend to undergo anticipatory grief and develop a sense of the imminent loss. This expectation could alleviate death shock, since the truth of the death has been already psychologically faced. However, the constant processes of caring and the observation of suffering of the parents may wear out the relatives who are left, making them more susceptible to complex grief. Such bereavements bring a mixture of joy at the end of pain, guilt at that joy and great grief at the end. Grieving persons can also have intrusion thoughts about illness, hospital and times of decline which can increase the intensity of grief, provoke flashbacks or create avoidance tendencies. (f) Death anniversaries: Death anniversaries are enormously touching and may increase the sense of loss and the desire to see a deceased parent again. These historic dates are powerful reminders of the absence as they overwhelm the thought streams with flashbacks of relationships and the circumstances that resulted in death. To most, anniversaries become very sad, tearful or sometimes physical reactions such as exhaustion, nervousness months and even years after the event. On the other hand, to others, these dates turn into a reminiscence and recovery day. The religious or cultural rituals associated with the bereaved person, including prayer, grave visits, storytelling or community traditions, can help the bereaved person to pay homage to their loved one and maintain a continuity of contact. Whereas others may be relieved in such commemoration, there are those who are overwhelmed emotionally and retreat inwardly. Eventually, the anniversaries of the bereaved individual will depend on the coping mechanisms, the social support, and the current location of the bereaved individual on the bereavement trajectory.

Conclusion

The loss of parents in the period of young adulthood during the development phase may significantly disrupt emotional health, interpersonal relationships and normal operation. Some might experience long term challenges especially when there is a deep history of parental dependency or where there is a lack of social support networks. Even though the phenomenon of grief is universal, its phenomenology and the resulting effect differ significantly across cultures, which makes it the necessity to ensure that professionals provide culturally sensitive support. The identification of prolonged grief disorder as a bona fide psychiatric disorder helps to intervene early and properly. Early intervention by the professional, therapeutic counseling and offering conducive living conditions enable the affected young adults to adapt, bring balance in their lives and find new meaning after the loss of their parents.

Recommendations

When a parent dies, young adults are exposed to complex impacts which include emotional, social and academic impacts. The degree of parental dependency, cultural milieu, and individual emotional vulnerability are some of the variables that mental-health practitioners should factor in order to effectively offer interventions. Culturally congruent support, early engagement in psychotherapies, and malleability in distribution of daily chores all have a role of reducing the chances of long term grief. Adaptation to a specific intervention to match the cultural background of both the group and the individual needs leads to a better result and healthier coping. It can have significant positive outcomes in the recovery process since a favorable environment where young adults are recognized, embraced, and understood can provide significant support to their recovery journey. The more acutely sensitive interventions based on cultural backgrounds and personal needs will increase the effectiveness, allowing grieving young adults to cope with their loss with greater emotional stability and resilience.

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