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Review article

A co-designed systematic review and meta-analysis of the efficacy of grief interventions for anxiety and depression in young people

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ABSTRACT

Background: Grief in young people is common and associated with symptoms of anxiety and depression, yet grief interventions for this age group are under-researched.
Method: We conducted a systematic review and meta-analysis to examine the efficacy of grief interventions in young people. The process was co-designed with young people and adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines. PsycINFO, Medline, and Web of Science databases were searched in July 2021 (updated December 2022).
Results: We extracted results from 28 studies of grief interventions with young people (14–24 years) that measured anxiety and/or depression (N = 2803 participants, 60 % girls/women). Cognitive behavior therapy (CBT) for grief demonstrated a large effect for anxiety and medium effect for depression. A meta-regression indicated that CBT for grief that included a higher degree of CBT strategies, was not trauma focused, had >10 sessions, offered on an individual basis, and did not involve parents, was associated with larger effect sizes for anxiety. Supportive therapy had a moderate effect for anxiety and a small-moderate effect for depression. Writing interventions were not effective for anxiety or depression.
Limitations: Studies are limited in number and there were few randomized controlled studies.
Conclusions: Findings indicate that CBT for grief is an effective intervention for reducing symptoms of anxiety and depression in young people experiencing grief. CBT for grief should be offered as the first line treatment for grieving young people experiencing anxiety and depression.
Protocol registration: PROSPERO (registration number CRD42021264856).

Grief is a normal and multifaceted response to loss that affects and is affected by multiple life domains (Wittkowski & Scheuchenpflug, 2021). We propose grief as an "active ingredient," central to reduction of anxiety and depression in grieving young people. Grief in young people is common; a longitudinal study of a representative sample in Scotland showed 62 % of all children are bereaved of a close family member by age 10 (Paul and Vaswani, 2020). This figure is higher for young people in low-and middle-income countries (Kentor and Kaplow, 2020) and will grow substantially due to COVID-19, with over 1.1 million children experiencing the death of a parent in the first 14 months of the pandemic (Hillis et al., 2021). The death of a family member during childhood is associated with short- and long-term symptoms of depression, post-traumatic stress disorder (PTSD), and prolonged grief disorder (Morris et al., 2016; Pham et al., 2018; Weinstock et al., 2021).

Young people are more likely than older adults to experience sudden, unexpected deaths, increasing the risk of depressive symptoms (Simbi et al., 2020). One-quarter of young people (<20 years) who died by suicide in the United Kingdom had experienced bereavement in childhood (National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, 2017). The impacts can be long-term, with studies showing that adults bereaved at a young age report substantial emotional and physical consequences (Chater et al., 2022) and higher rates of anxiety and depression (Parsons, 2011).

Despite these findings, grief interventions for young people (aged 14–24 years) are under-researched. More is known about grief interventions designed for older adults (Johannsen et al., 2019;

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Komischke-Konnerup et al., 2021) and children (Bergman et al., 2017; Rosner et al., 2010). The UK Commission on Bereavement (2022) showed half of the young people who responded (compared to 40 % of adults), reported they did not receive the support or have access to services they would have liked. Parents of young people bereaved during COVID-19 report that young people's access to services and service quality could be improved (Harrop et al., 2022). If grief is experienced as problematic but overlooked in standard treatments for anxiety and depression, the young person may not improve (Kentor and Kaplow, 2020).

Young people's views on grief interventions are missing in research. Involving young people in research about grief interventions will assist identifying what works and why, to inform evidence-based approaches for young people with anxiety and depression who are experiencing grief that is problematic for them. We focus on grief interventions for young people (14–24 years) grieving the death of a significant other and/or a significant non-death loss. The aim was to include young people as co-researchers in an insight analysis to identify evidence for grief interventions in reducing anxiety and depression in grieving young people. The research questions were: *Based on current evidence, in which ways, in which contexts, and for whom do grief interventions appear to work, and why? In which ways, in which contexts, and for whom does it appear not to work, and why?* (Wellcome Trust, 2021).

1. Methods

Consistent with reviews highlighting the importance of young people in guiding reviews of interventions that inform treatment (e.g., Egan et al., 2022), we aimed for ongoing collaboration with young people with lived experience of grief and anxiety and/or depression. Our lived experience lead (MC) helped develop the youth-led design. We established a lived experience Youth Advisory Committee (YAC), comprising 10 young people (18–24 years) in Australia and Malaysia ($M_{age} = 21.60$, $SD = 2.01$), to guide all aspects of the study, which was approved by the Curtin University Human Research Ethics Committee (HRE2021–0506).

1.1. Search strategy and selection criteria

PsycINFO, Medline, and Web of Science databases were searched in July 2021 and updated in December 2022, using the search terms and inclusion/exclusion criteria refined by the YAC (Tables 1 and 2). Grey literature was searched (WorldCat, Grey Literature Report) and key authors contacted for unpublished work. Reference lists of included studies were screened to identify studies not captured in the database searches.

Table 1
Search terms.

Grief	Psychopathology
Prolonged grief	Anxiety
Complicated grief	Anxiety disorders
Bereavement	Depression
	Trauma[a]
	Mood disorders
	Mental health
	Emotion regulation
	Health* anxiety[a]
	Resilience
	Recovery
	Coping
	Adjustment
	Psychological distress
	Post-traumatic growth[a]
	Wellbeing

[a] Terms suggested by the Youth Advisory Committee.

Table 2
Inclusion and exclusion criteria.

Inclusion	Exclusion
Tested grief intervention/prevention	Did not test a grief related intervention/ prevention
Sample was young people (14–24)	the sample was not an adolescent/young adult sample (i.e., mean age or mean age −/+ SD did not fall between 14 and 24 years)[a]
Measured anxiety/Post Traumatic Stress Disorder (PTSD) and/or depression at post-test	Did not measure anxiety/PTSD or depression at post test
	Qualitative studies
	Full-text unavailable in English

[a] If no mean age was reported, the study was included if there was a substantial overlap with our target group (e.g., combined child and adolescent samples were included).

1.2. Measures

Across the 28 studies, 14 grief measures were used, excluding various forms of the same questionnaire (e.g., short forms). Seven studies did not include a grief measure. See the supplementary materials for individual measures used in each study.

1.3. Procedure

The systematic review was registered with PROSPERO (CRD42021264856) and the PRISMA statement (Page et al., 2021) was followed. The original search resulted in 12,339 records, of which 27 were included in the systematic review and meta-analysis (see Fig. 1). Post-2000 titles/abstracts were screened by DG. Pre-2000 titles/abstracts were screened by DG and a YAC member (AB), yielding moderate agreement (Cohen's $k = 0.41$; Landis and Koch, 1977). All full text studies eligible for inclusion were screened by DG. CR screened a random 20 % of these articles, and there was almost perfect agreement (96.70 %, Cohen's $k = 0.82$; Landis and Koch, 1977) with DG. A psychology graduate screened the 881 additional articles found in the updated search and discussed with DG. One additional intervention study was found.

We engaged the YAC via fortnightly online meetings plus regular email and text contact. Members received AUD$50 for each meeting and other contributions (e.g., article screening, workshop facilitation). To gather insights from a broader group of young people with lived experience of grief and anxiety/depression, we hosted two 90-min online workshops. The YAC advised on recruitment materials, workshop questions (Table 3), and data interpretation. Recruitment occurred via social media. Young people aged 17 years and older provided written informed consent. Young people aged 14–16 years provided written assent and a parent/guardian provided written informed consent. Young people who participated in the workshops received AUD$50 for their time. One workshop was for young people aged 14–17 ($n = 2$, both 16) and the other for those aged 18–24 ($n = 8$, age range 20–22, $M_{age} = 20.75$, $SD = 0.80$). Finally, we worked with the YAC to develop an infographic and a video (see https://youtu.be/GxupXWl9ciA) to disseminate findings in ways relevant to young people.

1.4. Quality assessment

Dependent on study design, quality was assessed using The National Institutes of Health (2014) pre-post intervention measure or the controlled intervention measure (supplementary material Table 1). Both measures rate power, drop-out rates, psychometrics of outcome measures, protocol delivery, use of analyses, and group assignment/characteristics. An overall score is calculated by dividing the number of yes responses by the number of applicable items and categorized as poor (≤50 %), fair (50.01–74.99 %), and good (≥75 %).

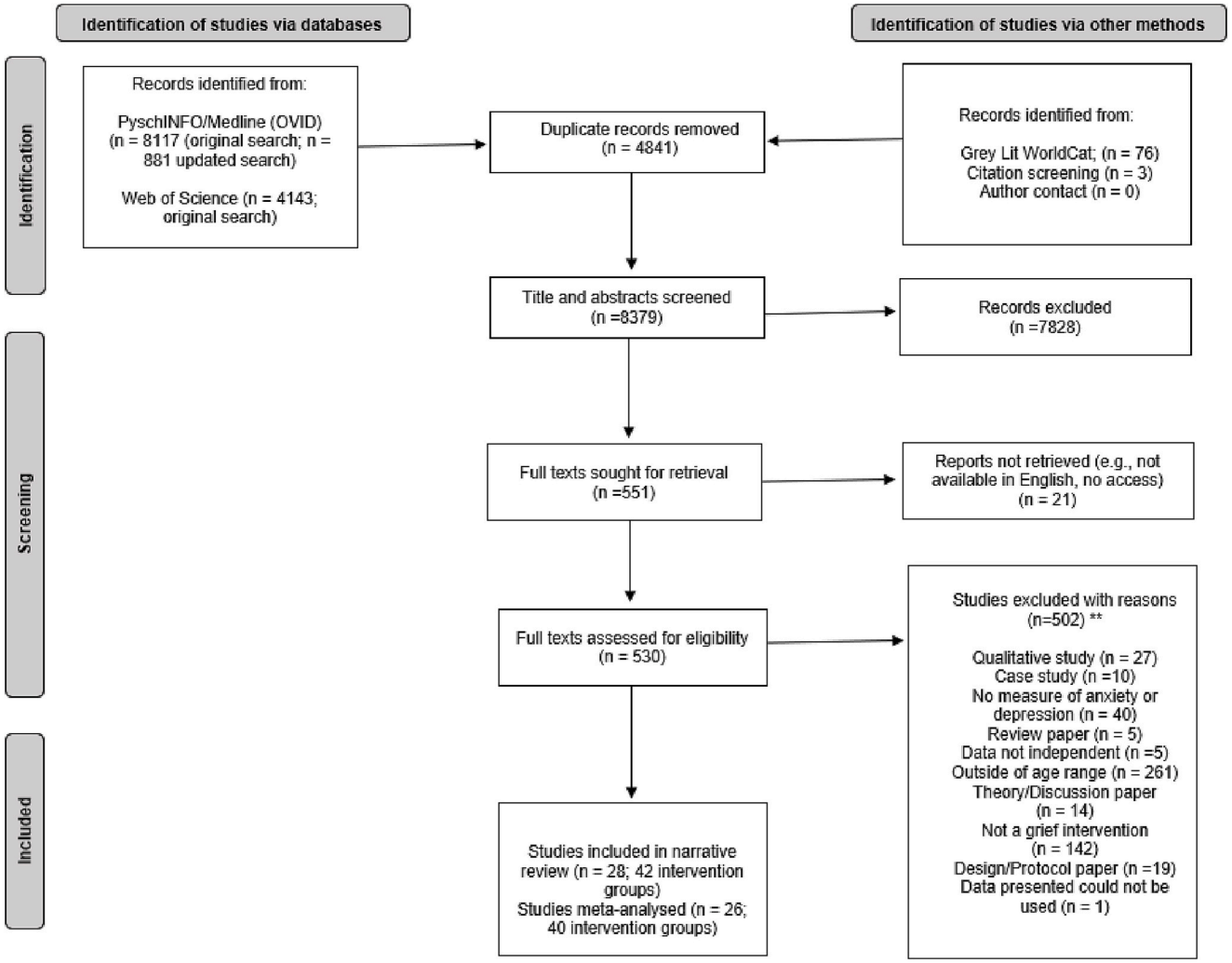

Fig. 1. PRISMA Diagram
Note. ** studies could be screened out for more than one reason.

Table 3
Workshop questions.

Questions
Thinking about the research findings we emailed you, do these fit with what you think is important for young people? Why/why not?
What might these findings mean for grief interventions in young people? How might this reduce anxiety and/or depression?
In thinking about these findings, are there any important things that are missing?
What kinds of things do you think would be most appealing for you/young people in a grief intervention?
Do you think a grief intervention would also help with depression or anxiety? Why? How?
Do you think grief is linked with anxiety and depression, and if so, how?
Thinking about the coping mechanism or strategies young people might use, which ones could be included in a grief intervention?
What doesn't work/what do you think young people wouldn't appreciate?
What are some challenges young people face in getting professional support for their grief?
What do you think works in a grief intervention and why?
What do you think might not work in a grief intervention and why? Is there anything you think might be harmful/not helpful?

1.5. Data analysis

Study data were analyzed in a systematic review and where possible a meta-analysis. To synthesize data across study designs (single-group pre-post, RCT, post-only), we pooled within-groups effect sizes for grief symptoms, anxiety/PTSD, and depression. Three studies used post-test-only designs with a control comparison (Loy, 1999; Poijula et al., 2001; Lichtenthal, 2007) and thus these effect sizes were imputed.[1] If there was more than one measure of the outcome and/or subscales, the average effect size was calculated. We did not have sufficient between-group or follow-up effect sizes to pool across studies. However, these were synthesized in the narrative review. Where possible, within-group effect sizes (Cohen's *d*) were extracted from the papers; if unavailable, they were calculated using the available statistics (e.g., pre/post means and SDs).[2] Effect sizes were coded so that a negative effect means a decrease in symptoms of grief, depression, or anxiety.

Interventions were grouped as cognitive behavior therapy (CBT), supportive therapy, or writing interventions. Effect sizes were pooled within intervention type. CBT for grief includes cognitive strategies such as learning to challenge unhelpful thoughts relating to the loss (e.g., self-blame) and behavioral strategies (e.g., relaxation, breathing exercises).

[1] Standard errors for these effect sizes were calculated using the N of the intervention group only, to be consistent with the within-groups effect sizes from the other studies.

[2] As few studies reported pre and post-test correlations between outcomes, $r = 0.5$ was substituted in for the calculation of the standard error for each effect size.

CBT for grief is similar in structure to regular CBT differing only in its focus on addressing grief-specific issues (e.g., avoiding social contact due to beliefs that it is unacceptable to experience pleasure when grieving) that maintain emotional distress. Supportive therapy for grief centers on providing support and encouragement to the young person and an opportunity to speak freely about loss-related thoughts and feelings. Writing interventions generally involve writing about the loss every day for a minimum of 15 min to facilitate emotional processing of the loss.

Due to significant differences between studies (e.g., number of sessions), we chose Hedges Random Effects Model to pool effect sizes across studies (Hedges and Olkin, 1985). Cochrane Q and I^2 statistics were computed to assess heterogeneity. If Cochran's Q was significant ($p <$ .10), this suggests a significant amount of heterogeneity in effect sizes across studies, and a meta-regression should be run if power permits (Page et al., 2021). I^2 is an estimate of the percentage of variance in effect sizes due to heterogeneity. I^2 values are categorized as low (0–40 %), medium (41–60 %), and high (61–100 %; Moher et al., 2009).

We evaluated publication bias through Egger's test of funnel plot asymmetry (Egger et al., 1997). If Egger's test is significant $p < .05$ publication bias is a potential issue (Egger et al., 1997). For outcomes where the Egger's test was significant, we ran a trim and fill analysis to adjust for publication bias (Duval and Tweedie, 2004). We only ran trim and fill analyses when Egger's test was significant because the trim and fill method can be inaccurate for heterogeneous pooled effects with no publication bias (Borenstein et al., 2021).

We conducted a moderator analysis within the CBT subgroup to account for the variance in the treatment protocols used, with some studies including many sessions/activities that could not be classified as CBT (e.g., supportive activities) and others with majority CBT-based material. SE and CR (both clinical psychologists) grouped CBT interventions as <50 % CBT or > 50 % CBT, based on information provided in the studies. Where heterogeneity levels were high, a meta-regression was conducted with CBT amount, individual/group, trauma focused/non-trauma focused, dose (short, medium, long) and parent involvement (yes/no) as moderators. We classified dose based on available information (e.g., number of sessions and session duration). Median dose was estimated at 12 h; thus, studies were categorized as short (⟨10h), medium (10- < 16 h), or long (16+ hours). All analyses were conducted in JASP (JASP Team, 2020).

Data from the workshops were analyzed via conventional content analysis (Hsieh and Shannon, 2005) by LB, SE, and CR.

2. Results

2.1. Study characteristics

There were 28 studies with 42 grief intervention groups that met our inclusion criteria (Fig. 1) comprising CBT ($n = 20$), supportive therapy ($n = 8$), and writing interventions ($n = 12$). There were 2803 participants across studies (60 % girls/women). Table 4 shows characteristics across intervention groups. See supplementary material Table 2 for individual study/intervention group characteristics.

2.2. Quality assessment

Study quality ranged from 23.08 %–92.86 % ($M = 62.48$ %, $SD =$ 16.06 %), indicating the average study quality was fair. Across the seven studies (25 %) assessed for quality by DG and CR, the same rating was achieved for 81.11 % of the criteria (Cohen's $k = 0.61$), indicating moderate-substantial agreement (Cha et al., 2018). Regarding individual studies, there was major disagreement between DG and CR on Cha et al. (2018); thus, SE rated the study to resolve the discrepancy. Detailed quality assessment of each individual study is available in the supplementary materials.

Table 4
Overview of characteristics across studies.

	K[a]	N
Country		
USA	25	985
Bosnia	4	182
Rwanda	3	56
Netherlands	3	144
Korea	2	956
Denmark	1	63
Finland	1	55
Nigeria	1	90
South Africa	1	193
Palestine	1	79
Age		
Children/adolescents (~6–18)	27	2419
Young adults (~19–30)	15	321
Therapy Type		
Cognitive Behavior Therapy	20	1056
Supportive therapy	8	1353
Writing intervention	12	311
Other (i.e., Hake, 1989; Harrsen et al., 2022)	2	83
Total number of participants	2803 (60 % girls/women)	

[a] Number of intervention groups.

2.3. Effects of grief interventions

2.3.1. Cognitive-behavior therapy

We found a large pooled within-groups effect size for grief (pooled $d = -0.80$ [−1.06, −0.54], $p < .001$), and anxiety (pooled $d = -0.81$ [−1.01, −0.61], $p < .001$), and a medium effect for depression (pooled $d = -0.53$ [−0.71, −0.35], $p < .001$; Table 5). However, there was substantial heterogeneity among effect sizes ($I^2 = 80.81$ %–90.86 %). There was also potential publication bias for all three outcomes (Egger's test $p < .05$). Trim and fill analyses found more conservative effect size estimates all three outcomes with effects on grief (pooled $d = -0.65$ [−0.91, −0.38]) and anxiety (pooled $d = -0.56$ [−0.80, −0.31]) reducing from large to medium, and effects on depression (pooled $d = -0.41$ [−0.60, −0.22]) reducing from medium to small. Forest plots including the weight of each study and trim and fill analyses can be seen for each outcome in the supplementary materials.

Interventions that were >50 % CBT had a larger effect on grief (d = −0.96 vs d = −0.48) and anxiety (d = −1.08 vs −0.52) than interventions that were <50 % CBT (Table 5). However, there were no significant differences in effect size between interventions that were >50 % CBT and those that were <50 % for depression (d = −0.58 vs −0.42; Table 5). However, after accounting for CBT amount heterogeneity was still moderate-high across all outcomes. Thus, we ran a meta-regression with CBT amount, individual/group, trauma focused/non-trauma focused, dose, and parent involvement as moderators. For grief symptoms, whether the intervention was individual or group, the amount of CBT accounted for significant variance in effect sizes across studies. Specifically, studies with individual opposed to group sessions and above 50 % CBT, reported larger effects (Table 6). For anxiety symptoms, all moderators accounted for variance in effect sizes (Table 6). Specifically, interventions that were more CBT-based, not trauma-focused, long/medium in duration, offered on an individual basis, and did not involve parents/guardians were associated with larger effect sizes. For depression symptoms, none of the moderators accounted for unique variance in effect sizes. Heterogeneity was still moderate-high across all three outcomes after accounting for the moderators. Egger's test indicated likely publication bias across all three outcomes for interventions that were <50 % CBT but not for interventions that were >50 % CBT (Table 5). However, trim and fill analyses only impacted the effect size for anxiety symptoms reducing it from medium

Table 5
CBT for grief pooled effects.

	CBT-All studies	CBT >50 % of treatment content	CBT <50 % of treatment content	Moderation effect [CBT-Type]
Grief				
Pooled effect [95 % CI]	−0.80 [−1.06, −0.54]***	−0.96 [−1.12, −0.80]***	−0.48 [−1.15, 0.18]	*B* = −0.57 [−1.07, −0.06]*
K	15	10	5	
Heterogeneity [I^2%]	Q (14) = 179.76 [90.85 %] ***	Q (9) = 34.70 [54.97 %] ***	Q(4) = 57.21 [96.26 %] ***	Q (13) = 91.91 [88.62 %]***
Egger's test	−2.68**	−1.40	−2.62**	
Trim and fill pooled effect [95 % CI]	−0.65 [−0.91, −0.38]***	NA	−0.48 [−1.15, 0.18]	
Anxiety				
Pooled effect [95 % CI]	−0.81 [−1.01, −0.61] ****	−1.08 [−1.32, −0.83]***	−0.52 [−0.73, −0.31]***	*B* = −0.54 [−0.87, −0.22]**
K	18	9	9	
Heterogeneity [I^2%]	Q (17) = 114.54 [84.27 %] ***	Q (8) = 26.03 [73.58 %]**	Q (8) = 22.75 [75.91 %] ***	Q (16) = 48.78 [75.45 %]***
Egger's test	**−3.23****	**−0.96**	**−4.53*****	
Trim and fill pooled effect [95 % CI]	−0.56 [−0.80, −0.31]***	NA	−0.45 [−0.71, −0.19]***	
Depression				
Pooled effect [95 % CI]	−0.53 [−0.71, −0.35]***	−0.58 [−0.70, −0.46]***	−0.42 [−0.91, 0.08]	*B* = −0.26 [−0.65, 0.13]
K	15	10	5	
Heterogeneity [I^2%]	Q (14) = 84.75 [80.81 %] ***	Q (9) = 25.85 [40.58 %]**	Q (4) = 34.26 [90.62 %] ***	Q (13) = 60.11 [80.94 %]***
Egger's test	−2.26**	−1.99	−3.41***	
Trim and fill pooled effect [95 % CI]	−0.41 [−0.60, −0.22]***	NA	−0.42 [−0.91, 0.08]	

CBT = Cognitive Behavior Therapy, CI = Confidence Interval, Egger's test = measure of publication bias.
*** p < .001; **p < .01; *p < .05.

Table 6
Meta-regressions for CBT for grief.

	B [95 % CI]	SE
Grief		
Intercept	−1.73 [−2.68, −0.77] ***	0.48
High CBT[a]	−0.41 [−0.82, −0.01]*	0.21
Group[b]	1.14 [0.31, 1.96] **	0.42
Trauma-Focused[c]	0.29 [−0.17, 0.75]	0.23
Dose (Medium)[d]	0.09 [−0.58, 0.76]	0.34
Dose (Long)[d]	−0.11 [−0.95, 0.73]	0.43
Parent/Guardian involved	0.67 [−0.05, 1.38]	0.37
Heterogeneity = Q(8) = 30.06, p < .001, I^2 = 67.33 %		
Anxiety		
Intercept	−1.05 [−1.54, −0.56] ***	0.25
High CBT + [a]	−0.56 [−0.82, −0.30] ***	0.13
Group[b]	0.67 [0.24, 1.11] **	0.22
Trauma-Focused[c]	0.54 [0.12, 0.97] *	0.22
Dose (Medium)[d]	−0.54 [−0.98, −0.10] *	0.23
Dose (Long)[d]	−0.63 [−1.15, −0.10] *	0.27
Parent/Guardian involved[e]	0.61 [0.15, 1.06] **	0.23
Heterogeneity = Q(11) = 19.30, *p* = .056, I^2 = 50.50 %		
Depression		
Intercept	−0.02 [−1.18, 1.13]	0.59
High CBT + [a]	−0.31 [−0.70, 0.09]	0.20
Group[b]	0.00 [−1.09, 1.10]	0.56
Trauma-Focused[c]	0.40 [−0.04, 0.85]	0.23
Dose (Medium)[d]	−0.44 [−0.96, 0.08]	0.27
Dose (Long)[d]	−0.54 [−1.27, 0.18]	0.37
Parent/Guardian involved[e]	−0.36 [−1.38, 0.67]	0.52
Heterogeneity = Q(8) = 32.46, p < .001, I^2 = 68.78 %		

CBT = Cognitive Behavior Therapy, High CBT = >50 % of sessions contained specific CBT strategies.
[a] Compared to low CBT interventions.
[b] Compared to individual interventions.
[c] non-trauma-focused CBT.
[d] Short dose.
[e] Parent/guardian uninvolved.
*** p < .001.
** p < .01.
* p < .05.

(d = −0.52) to small (d = −0.45).

2.3.2. Supportive therapy

There were moderate pooled effect sizes for supportive therapies on grief (pooled *d* = −0.72 [−1.22, −0.22], *p* = .005), and anxiety (pooled *d* = −0.62 [−1.07, −0.18], *p* = .006), and a small-moderate pooled effect size for depression (pooled *d* = −0.44 [−0.83, −0.04], *p* = .030). Publication bias was unlikely to be an issue across all outcomes; Egger's test (z) = 0.51, *p* = .610 (grief); Egger's test (z) = −0.45, *p* = .656 (anxiety); Egger's test (z) = −0.59, *p* = .552 (depression). However, the variance in effect sizes across studies for all three outcomes was very large (I^2 = 95.55 %–96.64 %), suggesting that the efficacy of supportive therapies for grief varies greatly. With only 5–6 effect sizes per outcome, we were underpowered (López-López et al., 2013) to conduct a meta-regression. However, interventions that involved the young person with a parent/guardian typically reported larger reductions in grief, anxiety/PTSD, and depression (Cha et al., 2018; Boelen et al., 2021; Christ et al., 2005) than those that did not (Loy, 1999; Poijula et al., 2001; Duke, 2013). There were no trends to suggest whether individual (Boelen et al., 2021; Christ et al., 2005) or group (Cha et al., 2018; Loy, 1999; Poijula et al., 2001; Duke, 2013) interventions were more effective. The two studies of weekend supportive grief camps reported no decreases in grief (Loy, 1999) or depression (Loy, 1999; Duke, 2013) at post-test; neither study measured anxiety. Forest plots including the weight of each study can be seen for each outcome in the supplementary materials.

2.3.3. Writing interventions

There was a significant but small pooled effect size for grief symptoms (pooled *d* = −0.26 [−0.45, −0.07], *p* = .009) but no significant pooled effects on anxiety (pooled *d* = − 0.12 [−0.29, 0.05], *p* = .168) or depression (pooled *d* = −0.02 [−0.14, 0.09], *p* = .715). Publication bias was unlikely to be an issue across all outcomes; Egger's test (z) = −0.08 (grief) *p* = .938; Egger's test (z) = −0.53, *p* = .593 (anxiety); Egger's test (z) = −0.60, *p* = .548 (depression). Heterogeneity was high for grief (I^2 = 61.36 %) but low for depression and anxiety (I^2 = 0.00 %). The emotional disclosure writing group from the pilot study by Lichtenthal (2007) that reported a moderate-large positive effect size for grief is likely the source of the variance. Forest plots including the weight of each study for each outcome are in the supplementary materials.

2.3.4. Narrative synthesis

There were not enough studies with between-group comparisons or follow-up to include in the meta-analysis, and we synthesize these here. Only 3 of the 28 studies included an active treatment comparison (i.e., between-groups) in an RCT design (Boelen et al., 2021; Hill et al., 2019; Layne et al., 2008). Similarly, few studies (*n* = 8; 30 %) included a

follow-up, ranging from 6 weeks (Range et al., 2000) to 12 months (Boelen et al., 2021; Jacob et al., 2014). Three studies of CBT for grief demonstrated changes were maintained at 4- (Layne et al., 2008) and 12-month follow-up (Boelen et al., 2021; Jacob et al., 2014). Two studies of supportive therapy found changes in depression and anxiety were maintained at 2-month (Duke, 2013) and 5-month follow-up (Cha et al., 2018), but neither used a control comparison. For writing interventions (Lichtenthal, 2007; Range et al., 2000; Anderson, 2002; Unterhitzenberger and Rosner, 2014), two studies (Lichtenthal, 2007; Range et al., 2000) included follow-up analyses for anxiety/PTSD and depression, and although some grief writing conditions had significant small-to-moderate within-group effects at follow-up, there were no significant differences between grief-writing groups and control-writing groups at follow-up. Importantly, a comparison of CBT and supportive therapy showed slightly more effective outcomes based on between groups comparisons at post-treatment, with this difference favoring CBT increasing at up to 12-month follow-up (Boelen et al., 2021), suggesting CBT for grief effects may be more enduring than supportive therapy.

We were unable to test-baseline grief symptoms as a moderator in the meta-regression due to a wide variety of measures used. However, among CBT interventions, groups where the participants had clinically significant grief or PTSD symptoms typically reported larger reductions in grief, anxiety, and depression (Boelen et al., 2021; Hill et al., 2019; Layne et al., 2008; Jacob et al., 2014; Barron and Abdallah, 2017; Cohen et al., 2004; Cohen et al., 2006; Layne et al., 2001; Spuij et al., 2013), compared to non-clinical samples (Grassetti et al., 2014; Herring, 2014; Meagher, 2007; Thurman et al., 2017; Salloum et al., 2001; Zachariah et al., 2012). Sandler et al. (1992) was an outlier, with no clinical inclusion criteria but showing a large decrease in depression at post-test. Finally, Hake (1989) and Harrsen et al. (2022) met our inclusion criteria but were not included in the meta-analysis since neither were CBT, supportive therapy, or a writing intervention. Hake (1989) studied a group intervention based on Kübler-Ross's (1969) stages of grief model, with no impact on depression or anxiety symptoms for males in juvenile detention. Harrsen et al. (2022) reported on a group intervention that employed multiple therapeutic techniques. In comparison to the waitlist control group, the intervention group showed large decreases in symptoms of prolonged grief, moderate decreases in depression and PTSD, but small and non-significant decreases in general anxiety post intervention. Given the combination of therapeutic approaches, it is difficult to determine which aspects led to decreases in grief, depression, and PTSD.

2.3.5. *Young people's views on grief interventions*

The young people we consulted in workshops emphasized several considerations regarding grief interventions. They described barriers to recognizing the need for support and in accessing support from systems that are under-resourced. For example, "The mental health system is under-funded. A lot of therapists are overworked, It's all about the meds. [Consequently] there's a real fear to trying to get help" and "It literally took me months to get into seeing someone." They expressed it was common for young people to access support because of relationship issues and then in therapy recognizing a pattern of self-sabotaging relationships because of previous loss. One asserted, "I wasn't able to work on issues of bullying or a break-up until I focused on grief."

Young people wanted to have their thoughts and feelings validated. They expressed a desire to be listened to so that interventions could be tailored to their needs. For example, "It's important to ask the young person what they want. They need to decide, not what the therapist thinks is right." They emphasized the importance of psychoeducation about emotional states. For instance, one commented "It would have been really helpful if someone had said feelings go away, that it doesn't last forever." On the other hand, they did not like psychoeducation based on stages of grief or moving on from their losses, because these notions discounted their experiences. For example, "My therapist allowed me the space to talk without pushing their view of grief on me," "The stages of grief model is frustrating and unhelpful," and "Don't push me to move on [from the grief/loss]."

Young people wanted specific and practical strategies relevant to their experiences and symptoms. Homework was important to help ensure the skills learned in the therapy session could be transferred to their lives outside of therapy. For example, "I am so lucky, my psychologist gives me homework, gives me apps to track my mood," and "I had a lot of anger [yet] I wasn't given any strategies; it was not helpful that symptoms were not dealt with." They wanted to know more about grief so that bereavement was not their first introduction to it: "Before my dad passed, I didn't know anything about grief. I think there should be more education because my friends didn't know how to help me either." They did not appreciate advice about seeking support from untrained peers. One described:

> "[The] biggest problem with grief resources, including from a therapist and doctor—[it's] frustrating they all said to reach out to someone about the grief, but my friends were not at a place or maturity to understand, they didn't want to hear from me, they didn't want to hear about it."

3. Discussion

The purpose of this review was to investigate what works for whom, and under what circumstances in relation to the efficacy of grief interventions in reducing anxiety and depression in young people. We performed a systematic review and meta-analysis of the literature and consulted with young people, in a process co-produced with young people.

The treatment with the greatest efficacy was CBT for grief, in particular when the intervention was delivered in an individual format and had a higher degree of CBT content. This is not surprising since interventions including active components of CBT as more than half of the treatment would have delivered a higher dose of the critical components of treatment; that is, the specific factors of CBT over non-specific factors (e.g., therapeutic alliance; Asnaani et al., 2020). Third, CBT for grief as opposed to trauma-focused CBT (e.g., exposure therapy) was more effective in reducing anxiety and depression. It is likely that trauma-focused approaches would be more effective for young people when trauma symptoms are the primary issue (Manzoni et al., 2021) and CBT for grief would be more effective when trauma symptoms are not the primary issue (Boelen et al., 2021). Finally, interventions of a medium/long duration (i.e., over 10 sessions) were more efficacious than those of a short duration. This is an intuitive finding given that participants received a higher dose of treatment and aligns with research findings concerning anxiety disorders (e.g., Levy et al., 2020). In contrast, there was no clear indication of which variables account for larger reductions in depressive symptoms.

Supportive therapy had a moderate effect on grief and anxiety and a small-moderate effect on depression. However, the impact of CBT was more enduring than supportive therapy at follow-up of up to 12 months (e.g., Boelen et al., 2021), suggesting CBT for grief has superior efficacy over supportive therapy. Consequently, CBT for grief is more effective in reducing symptoms of anxiety and depression in young people and should be the first line treatment.

Involvement of parents/guardians showed an interesting contrast between CBT and supportive therapy. In CBT for grief, interventions not involving parents/guardians were associated with larger effects for anxiety whereas in supportive therapy, interventions involving parents/guardians demonstrated greater efficacy. However, there is variability in how parents are involved in treatments for young people diagnosed with anxiety and depressive disorders, and this variability limits conclusions about whether and how parents should be involved (Lawrence et al., 2021). There were no studies of CBT or supportive therapy examining mechanisms underpinning the efficacy of interventions.

Writing interventions had a small effect on grief symptoms but not on

anxiety or depression. Writing interventions were not effective and should not be recommended. Weekend supportive grief camps are experienced as helpful by children (McClatchey and Wimmer, 2012) and their parents/caregivers (Griffiths et al., 2022) but appeared ineffective at reducing depression and grief symptoms.

The young people we consulted told us they wanted to be heard, involved in decision-making, and for grief interventions to be accessible and tailored specifically to them. These results underscore the critical importance of grief interventions being co-designed with young people. Young people wanted specific strategies to manage their symptoms. They were unanimous that stages of grief notions are unhelpful, which aligns with notions of grief as a linear, stage-based phenomenon having long fallen out of favor due to a lack of evidence (Breen and O'Connor, 2007). Suggestions about seeking social support were considered unhelpful because peers may be unable or unwilling to support them in their grief. The desire for more information about grief to enable them to help others and be helped by others, points to the need to promote grief literacy across the lifespan (Breen et al., 2022).

3.1. Implications

CBT for grief (e.g., Boelen et al., 2021), of 10 sessions or more, in an individual format, with >50 % of the intervention including specific CBT strategies, should be offered to grieving young people with symptoms of anxiety and depression. This recommendation is consistent with the views of young people, who desired interventions that included specific strategies for their symptoms and homework, both of which are core components of CBT. Grief interventions for young people should not include stage-based ideas of grief nor recommendations to seek support from untrained peers.

CBT for grief is the most effective intervention for reducing symptoms of anxiety and depression in young people and should be the first line treatment and more readily accessible. As with adults, universal grief interventions are not recommended (Johannsen et al., 2019). However, the shadow pandemic of grief (Neimeyer and Pentaris, 2022) present in the wake of the COVID-19 pandemic means young people's need for treatments is high, yet access and availability of evidence-based remain low. Prior to the pandemic, grieving persons at any age were not typically offered evidence-based treatments (Lichtenthal, 2018). The availability of and access to evidence-based treatments must be improved to address the substantial unaddressed distress and functional impairment suffered by the most vulnerable grieving persons. Grief should be considered in the assessment of young people experiencing anxiety and depression, and not uncritically conflated trauma. Policymakers should be aware of grief as an important issue for young people, because grief is not routinely considered in the prevention and treatment of anxiety and depression and is easily overlooked.

3.2. Limitations and future research

A key strength of this meta-analysis is that it was co-designed with young people with lived experience of grief and anxiety/depression, and that we consulted with a larger group of young people with lived experience to gather their insights about grief interventions. However, although we found factors such as a higher degree of CBT content and higher dose were associated with larger effect sizes, results should be interpreted with caution given we only had 14–17 effect sizes per outcome. Although sufficient, a greater number of studies may find different effects or other covariates accounting for these differences. To gain insights from a wide range of intervention studies we included other designs in addition to RCTs (e.g., pre-post, uncontrolled). Given the variability in study designs, the heterogeneity of therapies, the average study quality, and potential publication bias likely reducing the "true" effect of CBT for grief, more high-quality RCTs are needed to guide clinical practice. Future reviews could consider only RCTs when calculating effect sizes and to provide stronger evidence of causal mechanisms between grief interventions and anxiety and/or depression. Given the wide range of measures used, we were unable to include baseline grief symptoms as a moderator in our meta-regression, and thus were unable to determine whether CBT for grief is more effective at reducing anxiety and depression for individuals with higher grief at baseline, compared to individuals who have experienced a loss but do not have clinically significant symptoms. Future research should aim to answer this question to help further inform for whom interventions work. Many studies in this review did not include clinical assessments to determine if the primary problem was trauma or grief symptoms. Future research could determine if trauma-focused approaches would be more effective for young people when trauma symptoms are the primary issue, and if CBT for grief would be more effective when trauma symptoms are not the primary issue. Finally, given that the gold standard to determine treatment efficacy is the comparison to another active treatment (Chambless and Hollon, 1998), and only three studies included an active treatment comparison, the findings should be considered prudently.

One notable area that is missing is internet interventions; despite being available for grieving adults (Wagner et al., 2020) and a way to promote access to evidence-based therapies for grieving adults (Boelen et al., 2021), all studies we identified were delivered face-to-face. Future research should examine the efficacy of grief interventions for young people delivered via the internet to increase scalability in preventing and treating anxiety and depression in young people. Further, we found no grief interventions for reducing depression and anxiety symptoms among young people grieving non-death losses (e.g., parents' divorce). Our YAC identified this as a major gap in the research.

Future research should investigate the variables associated with greater efficacy in young people experiencing grief and depression. This could include identifying mediators of change and components of CBT responsible for change. Research is required to test the hypothesis that individual therapy is more targeted towards the individual's specific cognitive and behavioral processes maintaining their anxiety than group treatment and hence whether individual therapy is more effective due to an individualized formulation and treatment. Research should also examine whether not involving parents/guardians in CBT is superior because of a focus on changing individual factors (e.g., specific thoughts that maintain anxiety) less open to influence by parents/guardians, and whether mechanisms of action in supportive therapy involve improvements in support and hence including those around the individual in treatment helps to maximize support. Given the lack of effects for writing interventions, studies examining mechanisms of action are not recommended. Most studies did not include comparison to other interventions or follow-up periods. Researchers should seek to include these components in testing interventions for grief in young people to improve evidence for the durability of effects and compared to standard treatments for anxiety and depression.

3.3. Conclusion

CBT for grief demonstrated superior efficacy in young people aged 14–24 years. Interventions that target grief, in particular CBT for grief, demonstrate efficacy in reducing anxiety and depression in grieving young people. It is important to consider including young people in co-creating grief interventions to reduce anxiety and depression. Further evidence is required to demonstrate the translation of the encouraging findings of CBT for grief to scalable approaches such as internet interventions to address the widespread prevalence and impact of grief on young people.

CRediT authorship contribution statement

LB led funding acquisition, coordinated all aspects of the project, led the facilitation of YAC meetings and workshops, and contributed to drafting the manuscript. DG performed the literature search, led the

analytic strategy, conducted the meta-analysis, assisted the facilitation of the workshops, and contributed to drafting the manuscript. MC provided input to the funding proposal and recruitment of young people for workshops. AB conducted screening of articles and assisted facilitating the workshops. CR screened articles, classified interventions, assisted facilitating the workshops, and contributed to drafting the manuscript. SE classified interventions, assisted facilitating the workshops, and wrote the first draft of the manuscript. All authors provided input into and agreed to the submission of the final article.

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Declaration of competing interest

We declare no competing interests.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.jad.2023.05.032.

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