# Title: Care of Bereaved Persons: A Systematic Review

Running Title: Bereavement Care (2/7 words)

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## Abstract

**Background:** Bereavement after the death of someone close is universal and physicians may be uncertain if or what interventions may be beneficial.

**Purpose:** Synthesize effects of healthcare interventions on caring for bereaved patients.

**Data Sources:** We searched 8 databases from inception, supplemented with screening reviews, guidelines, federal register entries, and expert input in March 2025.

**Study Selection:** Dual independent reviewers selected randomized controlled trials comparing interventions for bereaved or soon-to-be bereaved children and adults to usual care or an alternative intervention (CRD42023466057).

**Data Extraction:** We abstracted (abstractor-checker model) general grief symptoms, grief-disorder symptoms, depression, and other outcomes. We assessed the risk of bias in individual studies, used random effects meta-analysis, and assessed strength of evidence (SoE).

**Data Synthesis:** 162 trials reported in 294 publications studied interventions such as psychotherapy; expert-facilitated support groups; pharmacotherapy; peer-support; self-help interventions; writing, music and art; enhanced provider contact, and integrative medicine for bereaved persons. We found benefit with individual psychotherapy (moderate SoE for improved grief, grief disorder, and depression symptoms); and low SoE that expert-facilitated support groups may improve grief and depression symptoms, and enhanced contact with healthcare providers may improve depression symptoms. Evidence for other interventions were based on single studies, found no benefit, and/or had insufficient SoE.

**Limitations:** Research has focused on grief in adults, populations were complex, and the review may have missed culturally specific interventions.

**Conclusions:** Individual psychotherapy probably improves general grief/grieving and depression symptoms. Expert facilitated support groups may also improve grief and depression symptoms. Enhanced provider contact may also improve depression symptoms. Evidence for other interventions is sparse.

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(270, 275 max)

## Introduction

The death of someone is a universal human experience, yet one of the most challenging experiences an individual may go through in their lifetime (1). Grief is unique to each bereaved individual and is a non-linear experience (2, 3). Most bereaved individuals experience loss and feelings of acute grief following the death without the need for formal intervention but a small subset of bereaved individuals develop more intense prolonged grief with high levels of distress and significant functional impact that lasts 6 to 12 months, and sometimes beyond, following the death (4-6). To facilitate timely identification and intervention, “prolonged grief disorder” (PGD) was introduced as a formal diagnosis for this type of grief in 2018 in the ICD-11 (7) and in 2022 in the DSM-5-TR (8), broadly defined as a condition characterized by intense, persistent, and disabling grief that lasts longer than what is typically expected after bereavement.

Bereavement impacts physical and mental health, such as through anxiety, depression, sleep disturbance, cardiovascular disease, and mortality (9-12). Although various interventions are offered to bereaved and grieving individuals, little is known about the effectiveness and potential harms of these interventions for both bereaved individuals who may be at risk for developing PGD, as well as for those who have been diagnosed with PGD, including the optimal time to implement these interventions (e.g., predeath, post loss, etc.), among who, and in what settings.

The purpose of this systematic review is to synthesize the available evidence on effects of interventions for bereaved individuals. The key question guiding the review was: What are the effectiveness, comparative effectiveness, and harms of interventions for people (i) at risk for grief disorders related to bereavement and (ii) diagnosed with prolonged grief disorder? The findings of the review informed an advisory panel convened by Substance Abuse and Mental Health Services Administration (SAMHSA).

## Methods

This manuscript is based on a larger review (13, 14) of bereavement care. A multi-disciplinary technical expert panel (TEP) reviewed and provided input on the review protocol, helped prioritize key outcomes, and advised on potential effect modifiers that should be explored. The review is registered (CRD42023466057) and methods followed the AHRQ Methods Guide for Effectiveness and Comparative Effectiveness Reviews and reporting followed standard guidelines (15) (16).

### Data Sources and Searches

We searched PubMed, EMBASE, CINAHL, PsycINFO, Social Work Abstracts, Dimensions, and US and international research registries (clinicaltrials.gov, ICTRP) from inception on March 31, 2025, using a peer reviewed strategy (Supplement Table 1). We also searched Cochrane Database of Systematic Reviews (CDSR) and PROSPERO for reviews and clinical practice guidelines from the ECRI repository, G-I-N, MagicApp, and ClinicalKey for reference-mining, contacted content experts, and AHRQ portal submissions of supplemental evidence from the public.

### Study Selection

This review focused on grief that follows human death, though we note that grief can occur in response to other losses. We included randomized controlled trials (RCTs) comparing interventions for bereaved or soon-to-be bereaved children or adults to a group receiving no intervention, usual care, or an alternative intervention (Appendix Table 1). We identified key outcomes of interest with the help of the TEP (Appendix Table 2); here we present the outcomes most commonly reported for the longest reported follow-up point. Rather than restricting to a set of known or currently clinically indicated interventions, we sought to identify all available approaches that have been evaluated in appropriate research studies.

All citations were screened by two independent reviewers (DZ, KOH, MY, SH) at the abstract and full text level. Screening was supported by a literature review software machine learning algorithm (17) that re-reviewed screening decisions for consistency and reviewer errors.

### Data Extraction and Quality Assessment

One reviewer abstracted and an experienced methodologist checked participant characteristics including the relationship to the deceased and the deaths’ characteristics, intervention setting and timing of the intervention in the grieving process. We established a taxonomy of interventions with input from the TEP. This taxonomy differentiated psychotherapy, expert-facilitated support groups, pharmacotherapy, peer support, spiritual counseling, self-help interventions, and other (writing, music, art; comprehensive support; integrative medicine) interventions (Appendix Table 3).

We assessed risk of bias in individual studies focused on performance bias, attrition bias, detection bias, reporting bias, and other sources of bias such as early termination of studies, inadequate reporting of intervention details, and lack of intention-to-treat analyses (18); criteria are described in Supplement Table 1. We assessed applicability to routine practice in typical U.S. settings based on factors such as: study eligibility criteria; demographics of enrolled versus target populations; intervention characteristic relative to care models currently in use; and the relevance and timing of outcome measures.

### Data Synthesis and Analysis

We performed random effects meta-analysis models appropriate for large and small number of studies (19) and reported point estimates together with 95 percent confidence intervals (CI) in R version 4.5.0 (20). A large number of assessment scales exist for the outcomes of interest and in order to be able to determine treatment effects, we converted to measure-independent standardized mean differences (SMD) and relative risks (RR) and converted absolute numbers to rates and proportions to facilitate comparisons across studies. We assessed heterogeneity using graphical displays and the I2 statistic and explored sources when I2 was above 70%. We evaluated indication of publication bias for all effect estimates using the Begg and the Egger test (21, 22), the trim-and- fill method to provide alternative estimates (23), and report results and funnel plots where publication bias was indicated. To present meta-analysis results in a clinically meaningful manner we converted the estimated standardized difference back to points for the most frequently used questionnaire. We calculated the pooled standard deviation across all studies that used the same scale and multiplied this by the pooled effect, giving a result in terms of the original scale across identified studies.

Subgroups of interest determined *a priori* included different timing for interventions (pre-death; acute phase; 6-12 months, >12 months post death) and patients diagnosed with PGD following ICD-11 or DSM-V-TR criteria. We explored potential effect modifiers including gender of the bereaved person, relationship to the deceased (e.g., death of a spouse); age of the deceased (e.g., death of a child); expected (e.g., following hospice care) vs unexpected death; violent (e.g., death due to homicide) vs non-violent death; adults vs pediatric samples; US vs non-US (capturing cultural differences); setting of death (e.g., hospital), and timing, by adding variables to the meta-analytic model. Sensitivity analyses excluded high risk of bias studies to determine the robustness of results. We applied the AHRQ Evidence-based Practice Center (EPC) strength of evidence (SoE) criteria to evaluate the body of evidence, informed by GRADE guidance, see Appendix Table 4 (24). We differentiated between high, moderate, low, and insufficient evidence to characterize uncertainty associated with the summary estimate.

### Role of the Funding Source

AHRQ commissioned the project, funded by the Patient Centered Outcomes Research Institute (PCORI). The scope and aims of the review were developed in consultation with representatives from AHRQ, PCORI, SAMHSA, and the American Psychological Association (APA). AHRQ and PCORI approved the protocol and review. All representatives provided feedback, but did not directly participate in the literature search, study selection, data analysis or interpretation.

## Results

### Description of studies

Searches retrieved 13,668 citations and we screened 5,701 publications as full text as documented in the literature flow diagram (Appendix Figure 1). We identified 162 RCTs reported in 294 publications that met eligibility criteria. Of these, a third was based in the US (55/162) and a third in European countries (57/162). Other frequent study locations included Australia and Canada. Studies evaluated a wide range of multi-faceted, complex interventions. The evidence tables (Supplement Table 3-10) document any cultural background information that shaped the interventions, but this was rarely reported in identified studies. Settings included outpatient, hospital, and hospice; and studies used a variety of recruitment strategies from media advertisements to offering the intervention to all relatives of a dying patient in a hospital. Study populations included children and adults, and participants varied in many aspects that were assessed as potential effect modifiers. Study populations included suicide survivors (45), hospital staff, bereaved mothers of children aged 3 to 30 years who had experienced deep hurt from another person related to the loss (46), teenage war bereaved Afghani refugees (47), and incarcerated bereaved male adolescents (48). Figure 1 provides an overview of the available evidence base showing participant characteristics, Appendix Figure 2 shows characteristics such as the age of the deceased in the included studies. Our pre-specified effect modifier analyses detected very few systematic effects, but analyses indicated that intervention effects may vary for men and women for selected outcomes (a 10% increase in %-female was associated with a 0.09 SMD difference in treatment effect; CI 0.02, 0.16; p 0.014; for the outcome depression); although analyses were limited by the small number of single-sex studies and are based on indirect comparison across studies (low SoE for differential effect, Supplement Table 12).

Risk of bias and applicability are displayed in Supplement Figure 1 and Supplement Figure 2. Two thirds of studies (95/162) were categorized as high risk of bias, often due to lack of blinding. A common applicability issue were patients in the research studies judged to be more complex than seen in typical practice. The online supplement shows detailed risk of bias (Supplement Table 2), applicability (Supplement Table 3), and grading of the strength of evidence (SoE; Supplement Table 12) results. Findings for key outcomes are summarized in Table 1. Results are discussed below by intervention category. Of note, no study evaluated spiritual counseling.

### Psychotherapy

69 studies evaluated psychotherapeutic approaches for individual bereaved adults or children (Supplement Table 4). Studies evaluating psychotherapeutic interventions were diverse, encompassed different approaches providing psychological therapy, cognitive and behavioral training, or counseling, and involved multiple and unique intervention components. Across studies, we found a positive effect of psychotherapy on grief disorder symptoms, i.e., indicators of a maladaptive grieving process (SMD -0.97; CI -1.30, -0.64; 21 RCTs, n=1501; moderate SoE; Figure 2). The pooled effect translates to an almost 11-point reduction on the most commonly used scale in the dataset, the Inventory of Complicated Grief (ICG, scale range 0-76). Effect estimates varied across studies and heterogeneity was high (I2 87%). Twelve CBT approaches found a reduction in grief disorder symptoms (SMD -0.81; CI -1.21, -0.41; 12 RCTs, n=947; I2 84%), but still with high heterogeneity. A sensitivity analysis excluding high risk of bias studies found a similar effect estimate (SMD -1.08; CI -1.57, -0.60). There was indication of publication bias (Egger, p 0.02, Begg p 0.04; funnel plot in Supplement Figure 1) but using the trim-and-fill method did not suggest a different summary estimate.

We also found positive effects of psychotherapeutic approaches on general grief and grieving symptoms (SMD -0.51; CI -0.82, ¬0.21; 17 RCTs, n=955; I2 60%; moderate SoE; Supplement Figure 1). The clinical impact translates to an 8-point reduction in scores on the Texas Revised Inventory for Grief (TRIG; scale range 27-135). A sensitivity analysis did not suggest that the result was primarily based on high risk of bias studies (alternative estimate SMD -0.68; CI -1.12, -0.23).

Psychotherapeutic interventions were also associated with reduced depression symptoms compared with no treatment (SMD ­0.67; CI -0.92, -0.42; 33 RCTs, n=1997; I2 82%; moderate SoE; Figure 2), which is equivalent to a 7-point reduction in the Beck Depression Inventory-II (BDI-II, scale range 0-63). Twelve CBT approaches found a reduction in depression symptoms (SMD -0.65; CI -1.09, -0.20; 11 RCTs, n= 867; I2 77%), but still with high heterogeneity, Excluding high risk of bias studies resulted in a similar SMD -0.78; CI -1.19, -0.37). The analysis detected some indication of publication bias (Egger p 0.08, Begg p 0.10, funnel plot in Supplement Figure 1), but using the trim-and-full method did not suggest a different summary estimate.

We found 4 RCTs that evaluated psychotherapeutic interventions for PGD (28-31) but studies reported on different outcomes and/or comparators or provided insufficient detail for effect estimates. Three included adults, one included children and adolescents. One study (32) reported improvements in grief disorder symptoms (SMD -0.65; CI -1.38, -0.08; 1 study, n=33; low SoE), one a positive effect on grief symptoms (SMD -6.65; CI -8.32, -4.98; 1 study, n=36; low SoE) (30). A comparative effectiveness study (31) found significantly greater improvements among children and adolescents receiving cognitive behavioral therapy compared to those receiving supportive counseling. This study also found better outcomes in depression and PTSD symptoms for those receiving cognitive behavioral therapy in the long term at 12 months. Meta-regressions indicated that participants with complicated grief may report better treatment effects than participants not characterized as experiencing complicated grief for the outcome depression symptoms, but analyses were limited due to the small number of studies (low SoE, Supplemental Table 12).

### Expert-facilitated Support Groups

37 RCTs evaluating expert-facilitated support groups using diverse therapeutic and educational approaches (Supplement Table 4). Interventions were group meetings that targeted children and adults, and the deceased were most often adults, such as parents or spouses. We found a positive effect on general grief /grieving symptoms (SMD -0.30; CI -0.59, -0.01; 9 RCTs, n=1412; low SoE; Figure 3), with some heterogeneity (I2 77%). This effect translates to a 3-point reduction on the Grief Reaction Index (GRI, scale score range 0-10). Excluding high risk of bias studies indicated a smaller effect (alternative estimate SMD -0.13; CI -0.40, 0.15).

Few support group studies reported on grief disorder symptoms, and we did not detect a systematic effect on this outcome (SMD -0.14; CI -0.59, 0.30; 4 RCTs; n=595; low SoE; Supplement Figure 2).

Although 13 studies reported on depression symptoms, we determined the evidence insufficient to make any clear conclusions due to data imprecision and inconsistency (see Supplement Table 12).

### Pharmacotherapy

Three studies evaluated pharmacotherapy (nortriptyline, citalopram, diazepam). No two studies reported on the same outcome (Supplement Table 5). One RCT (33) reported a combination of citalopram plus complicated grief therapy positively affected grief disorder symptoms (RR 0.65; CI 0.53, 0.79; 1 study, n=198; low SoE) and suicidal ideation (RR 0.21; CI 0.07, 0.60; 1 study, n=198; low SoE) in adults with complicated grief, but results varied by outcome regarding which component was critical for the success (33). Results for all other outcomes were determined to be insufficient SoE.

### Peer Support

Four RCTs evaluated peer support interventions for adult participants, including support groups that were not facilitated by healthcare personnel. No two studies reported on the same outcome measure and none found a systematic clinical improvement for any of the key outcomes. Evidence was insufficient due to lack of studies or lack of replication and study limitations such as unclear power to detect effects. Study and intervention characteristics and results of each individual study are documented in the Supplement Table 6.

### Self-help Interventions

Eleven self-help intervention studies included self-guided web-based modules, apps, and booklets for adults. Three RCTs reported on grief disorder symptoms, 2 on grief symptoms, and 2 on quality of life, but effect sizes varied and evidence was deemed insufficient to make any conclusion regarding the effect of self-help interventions. We did not identify a systematic effect from 6 trials on depression symptoms (SMD -0.09; CI -0.22, 0.05; 6 RCTs, n=1077; I2 0%; low SoE). Evidence was insufficient for other outcomes due to lack of studies (Evidence Table Supplemental Table 7; forest plots Supplement Figure 5).

### Other Interventions

#### Writing, Music, and Art

Eighteen RCTs examined writing, music, or art to address grief (Supplement Table 8). Interventions included different expressive writing, positive writing, and specific writing assignment with varying structure and interventions were mostly aimed at adults, but included also three studies in grieving youth. Music approaches included Orff-based music, sacral music, or imaginal dialogue music therapy. Art therapy included creative art groups and online art therapy. Across studies, we did not detect a systematic effect of the interventions on grief disorder symptoms (SMD -0.34; CI ‑1.03, 0.35; 6 RCTs, n=267; I2 77%; low SoE), general grief symptoms (SMD 0.03; CI -0.70, 0.77; 3 RCTs, n=146; I2 16%; low SoE), or depression symptoms (SMD -0.08; CI -0.75, 0.59; 5 RCTs; n= 232; I2 70%; low SoE). Effects on quality of life were conflicting between the two studies reporting on the outcome and no meaningful summary effect could be determined (all outcomes Supplement Figure 6). Evidence was insufficient to assess the effect of individual approaches due to small numbers of studies and/or conflicting results.

#### Comprehensive Support/Enhanced Provider Contact

Eighteen RCTs examined interventions on healthcare practice change interventions that enhanced contact with healthcare providers to provide more comprehensive support (e.g., check-ins with relatives of dying patients). Approaches were diverse, most included multiple components such as scheduled check in calls, and unique elements, but all targeted adults. Interventions involved different healthcare personnel, including midwives in interventions after miscarriage, follow up calls from nurses, and support for primary care physicians (Supplement Table 9). Studies reported on different outcomes (Supplement Table 9). Evidence was insufficient for effects on grief disorder symptoms or quality of life because of variation across the two studies such that no meaningful conclusion could be made. Likewise, evidence was insufficient for grief symptoms due to conflicting results and heterogeneity, different interventions that are difficult to combine, and a large number of high risk of bias studies. Eight studies found a reduction in depression symptoms after more comprehensive support was implemented compared to usual care (SMD -0.44; CI -0.83, -0.04; I2 83%; 8 RCTs, n=1410; low SoE). Clinically the effect is equivalent to a 2-point reduction on the subscale for depression in the Depression Anxiety Stress Scale (DASS; scale score range 0-42). There was some heterogeneity; excluding high risk of bias studies resulted in a wide confidence interval but similar effect estimate (SMD -0.51; CI -1.16, 0.12). Research was insufficient for evidence statements for subgroups of provider interventions such as those specifically targeting support after pregnancy termination (Table 1).

#### Integrative Medicine

In the 3 RCTs classified as integrative medicine for adults (Supplement Table 10), two reported on grief symptoms, but effects estimates varied and there was insufficient evidence to make conclusions (Supplement Table 10, Supplement Figure 8).

Across interventions there was insufficient evidence to address other priority outcomes including incidence of grief disorder, loneliness, suicide/attempted suicide/completed suicide, suicidal ideation, adverse health behaviors, and unintended consequences of the intervention.

## Discussion

Our systematic review identified a substantial number of RCTs (n=162) in the international literature (55/162 were U.S. studies) of varying quality that have evaluated interventions for bereaved people to date. Much of the evidence we found described the effects of interventions for bereaved individuals who are at risk for but not formally diagnosed with PGD (158 v 4 RCTs). This highlights both the availability of some evidence to guide current practice as well as the opportunity for further research to expand our understanding of how to effectively and appropriately intervene on this uniquely complex human process.

The large body of literature we found describing a range of interventions for bereaved persons *at risk for grief disorder*, underscores the various options for supporting bereaved and grieving individuals regardless of whether they are formally diagnosed with a clinical disorder. We specifically found moderate SoE for the positive effect of psychotherapy on some outcomes. However, we found insufficient or no evidence of the effectiveness of other common interventions such as peer support groups and spiritual counseling. Indeed, peer support groups have been shown to be effective at improving outcomes in other health contexts (34-36) and are a feasible approach to providing support in the community. Similarly, though we found no evidence on spiritual counseling interventions, it is known that many individuals, bereaved or otherwise, rely on spiritual supports (37) through local religious and community organizations to cope with illness, loss, and emotional wellbeing. This conspicuous gap in knowledge reinforces the need for more research on interventions provided in both healthcare and community settings. Community settings may be more accessible to bereaved individuals than clinician-provided interventions such as psychotherapy or expert-led groups, and they could be feasible to implement and scalable to different settings.

Though there has been ongoing tension in the field over what should be considered normal grief/grieving versus what should be clinically assessed as prolonged grief; i.e., extending for a year or more with significant functional impairment and high symptom intensity (38), there is agreement that bereaved individuals may need different levels of support over different phases of their grieving and could benefit from timely and appropriate attention. For some, this could mean intervening on more prolonged grief responses, when appropriate. We found few studies addressing the effectiveness of interventions for bereaved persons formally diagnosed with prolonged grief disorder, likely owing to the very recent inclusion in diagnostic manuals of a formal diagnosis and consequently, its limited use in research studies to date. However, this small body of evidence shows promise for psychotherapeutic intervention, adding to our understanding of its effectiveness for managing grief in general. With the inclusion of prolonged grief disorder in the ICD-11 and more recently in the DSM-5-TR, future research might usefully examine the effectiveness of different types of interventions among those with diagnosed grief disorder, to better understand where, when, and which formalized interventions could be useful.

Furthermore, current research examining the effectiveness of interventions on bereaved individuals centers on a small set of key outcomes, such as grief symptoms, depression symptoms, and grief disorder/symptoms of grief disorder. We found little about the effect of interventions on a wider range of patient-centered outcomes identified as meaningful by our expert panel, such as substance use, quality of life, loneliness, and suicide and suicidal ideation. Some may be challenging to measure and require more research focused on reliable and valid measurement, while others may be simply overlooked as targets of grief interventions and in research. However, such outcomes have been described among bereaved persons (39-44), have significant impact on day-to-day lives and ability to function, and warrant further attention. We identified additional gaps in evidence highlighting the need for more research among bereaved children and adolescents; and those bereaved by mass casualty events, gun violence, or drug overdose; given the small number of identified studies.

Our applicability assessment highlights several limitations to this systematic review. First, while we restricted to studies published in English to ensure transparency and applicability of the evidence to future US recommendations, this may have overlooked interventions available in other cultures that could inform culturally-sensitive bereavement care in the US. Second, although the need for culturally sensitive and appropriate bereavement care is widely accepted, we found little information in existing studies on cultural considerations that may shape diagnosis and treatment and many intervention included established components such as psychoeducation. This is critical for future research to address given that the variation in sociocultural practices and norms around grief and bereavement likely impacts the feasibility, appropriateness, and effectiveness of grief interventions. Third, geographic setting was a key applicability issue; many included studies evaluated interventions in non-US settings and while there is some generalizability of the grief and bereavement experience across populations, interventions are potentially implemented and delivered differently in US versus non-US health and community settings, given structural and cultural differences. Fourth, populations across our included studies were clinically diverse, and often complex and highly specified, and thus and may not apply to all situations. Finally, the applicability of included interventions was also limited with some studies testing intense interventions not typical of usual practice, a highly selected intervention team, or unclear training/expertise of the professionals involved in providing care.

Our understanding of how to support bereaved persons’ health and wellbeing has evolved considerably, with significant growth in research in the past three decades. While a range of effective interventions exist for practitioners to offer their grieving patients, more information is needed on how to effectively target these interventions to the specific circumstances of bereaved individuals. Importantly, more evidence is needed on how to effectively treat patients suffering from prolonged grief disorder.

## Declarations

**Role of the Funding Source**

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**Conflict of Interest**

None of the authors have any conflict to declare.

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**Figures**

Figure 1: Evidence Map Participants and Interventions

Legend: Participant characteristics differentiating adults and children targeted in the interventions. The figure also shows the proportion of female participants, and differentiates between grief and complicated grief characterizing the participants where applicable. The figure maps the available studies by intervention category.

Figure 2: Effect of Psychotherapeutic Interventions on Grief Disorder Symptoms, Grief Symptoms, and Depression Symptoms

Legend: Random effects meta-analysis of randomized controlled trials evaluating the effect of psychotherapeutic bereavement interventions on grief disorder symptoms compared to passive control groups (e.g., treatment as usual) in bereaved adults and children. The forest plots show the study identifier and the age group (children or adults) and individual effect estimates of all contributing studies. Also indicated is whether the study included primarily unselected grieving participants or participants with complicated grief and the percent of female participants (both variables identified as potential effect modifiers).

Studies reported on different measures of grief disorder symptoms, grief symptoms, and depression symptoms and the figure shows standardized mean differences reported at the latest follow up (ranged from 1-18 months from the start of the intervention).

Abbreviations: %f percent female participants, CG complicated grief

Figure 3: Effect of Expert-Facilitated Support Group Interventions on Grief Disorder Symptoms and Grief Symptoms

Legend: Random effects meta-analysis of randomized controlled trials evaluating the effect of expert-facilitated support group interventions for bereavement on grief disorder symptoms and grief symptoms compared to passive control (e.g., treatment as usual) in bereaved adults and children. Studies reported on different measures of grief disorder symptoms and grief symptoms and the figure shows standardized mean differences reported at the latest follow up (ranged from 0.5-72 months from the start of the intervention). The forest plot shows the study ID, age group (children or adults), and individual effect estimates of all contributing studies. Also indicated is whether the study included primarily unselected grieving participants or participants with complicated grief and the percent of female participants (both variables identified as potential effect modifiers).

Abbreviations: %f percent female participants, CG complicated grief