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Interventions for Young Bereaved Children: A Systematic Review and Implications for School Mental Health Providers

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Abstract

Background: Many young children experience the death of a family member and they may be at risk for developing psychological and behavioral problems, but not much is known about how to help young children cope with such a stressful and painful experience. Objective: The purposes of this study are to identify the interventions for bereaved young children and examine the effectiveness of the interventions. Method: A systematic review of the literature was performed to investigate the effects of interventions for preschool-age children (3-5 years) who experience the death of a family member. Results: Seventeen studies that met the inclusion criteria for the purpose of this review were identified. All of the studies involved a small sample, and majority of the studies mixed preschool children with other older children in the sample. Play-based therapies were the most common interventions for grieving young children. Involving parents in the interventions, regardless of their therapeutic orientation, was a critical ingredient. Conclusions: Limited empirical evidence of positive intervention outcomes for preschool-age bereaved children was available. Surviving parents were seen as an important agent to help young children grieve and cope with the experience of loss. Implications for school mental health practice and research are provided.

Keywords: bereavement, grief, loss, young children, intervention, death

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Approximately 5-15% of children experience the death of a parent, sibling, grandparent, or other significant loved one before the age of 18 (Owens, 2008; Stern, Malkin, & Densen, 2010; U.S. Bureau of the Census, 2001). However, bereaved children are often treated as the invisible, unacknowledged grievers (Griffith, 2003; Rosen, 1984-1985). Loss of a parent or other family member in childhood is a painful, and sometimes traumatic experience that can be associated with grief symptoms and heightened risks for social, emotional, and behavioral problems that can persist through childhood, adolescence, and adulthood (Davies, 1991; Silverman, Baker, Cait, & Boerner, 2003). Young children who bereave at ages 3-5 may be particularly at risk for developing psychological and behavioral problems (Black, 1978; Rutter, 1966). This review focuses on the interventions for preschool-age children who experience the death of a family member.

Bereavement is a normal process, and grieving the loss of a loved one is a universal experience. However, children grieve differently than adults. Children's ability to process grief is significantly associated with various factors, including age and the level of understanding of death (Heath & Cole, 2011). Younger children may not fully understand what death is and view death as a temporary state that is reversible (Johnson, 2014; Nagy, 1948). In spite of their incomplete understanding of death, children know when they have been separated from a loved one (Glazer & Clark, 1999). Children may view this separation as abandonment. In addition, due to a young child's egocentrism, children under 5 may believe that the death of a loved one could have been caused by their thoughts (Nagy, 1948; Vargas-Irwin, 1999). These

misconceptions may impinge on young children's adaptive grieving process and cause a variety of psychological and behavioral symptoms.

Children may manifest their grief through somatic (e.g., stomach aches, loss of appetite, etc.), cognitive (e.g., concern about their or other family members' health, worry about separation from caregiver, etc.), emotional (e.g., sadness, fear, etc.), and behavioral (e.g., withdrawal, restlessness, etc.) reactions (Birenbaum, 2000; Dowdney, 2000; Sood, Razdan, Weller, & Weller, 2006). For preschool children, typical grief responses include confusion, nightmares, temper tantrums, clinging, and regressive behaviors such as bed-wetting, thumb sucking, and inconsolable crying.

Rooted in attachment theory, young children are quite dependent on their daily routine, including a caregiver's emotional and physical availability (Smith, 1991). Since a preschool aged child needs emotional nurturing, a young child who has experienced the loss of a loved one requires consistent encouragement (D'Antonio, 2011). When losing a loved one, the child loses a stable support system, including the emotional availability of their remaining caregivers. This change of support and routine can cause a young child to feel less secure, as well as more fearful (Smith, 1991). Fear, as well as the deregulation in a child's routine, can cause lasting changes to a child's ability to maintain homeostasis, therefore affecting their stress-response systems in the long term (Perez & Sundheim, 2015). The lack of caregiver availability can heighten a child's cortisol levels and the arousal of the sympathetic nervous system, especially in preschool aged children. Grieving at a very young age may have long-term and latent effects as Black (1978) found that children who had bereaved during early childhood had a higher likelihood of a psychiatric disorder as an adult.

Although most children are able to process grief and move on gradually without lasting symptoms, some children experience significant difficulties navigating the grief process (Cohen & Mannariono, 2011). Without successfully "working through" a process of grieving, children may develop significant psychological distress or pathological symptoms (Curtis & Newman, 2001). These symptoms, at times, may not simply go away on their own, and support or intervention may be required to facilitate children's adaptive grief process (Black & Urbanowicz, 1987).

A good number of interventions and treatments have been developed by practitioners and researchers to help bereaved children; however, most of the interventions have not been empirically supported. A recent meta-analysis conducted by Rosner, Kruse, and Hagl (2010) revealed that existing interventions for bereaved children tended to have a small to moderate effect. They identified music therapy and trauma-focused school-based brief intervention as two promising treatment models for working with bereaved children. However, only one study in Rosner et al.'s analysis included young bereaved children (3-5 years). Although children of all ages react to the loss of a significant family member, 3-5 year olds may react differently than older children due to their developmental capacities (Birenbaum, 2000; Bugge, Darbyshire, Rokholt, Haugstvedt, & Helseth, 2014). It is important to consider the bereaved child's age and developmental maturity when attempting to understand bereavement in young children and its clinical application (Melvin, & Lukeman, 2000). However, no published review concerning intervention effects on bereaved preschoolers has been available in the literature. The purpose of this systematic review was to examine the effects of interventions for helping preschool-age children cope with the death of a loved one. We use *preschool* and *young* child in this article to

reflect the compulsory commencement schooling age in the United States where children start elementary or primarily school at age 6.

Method

The search strategy surveyed four electronic databases, the Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsychINFO, ERIC, and PubMed. Similar to Ronser et al.'s (2010) method in their meta-analysis of interventions for bereaved children, this study used search terms *grief, grieving*, *bereavement*, *bereaved*, and *mourning*, combined with *death*, and *child*. We conducted our database search in Spring 2017 and covered all years available by the respective database. Quantitative, qualitative, and mixed method publications, including peer-reviewed journal articles and theses/dissertations, were included in order to obtain a comprehensive collection of studies. Additionally, the ancestry method was used to find more studies by scanning the reference lists in primary articles and reviews to inspect for relevant studies that had not yet been identified.

Inclusion criteria to select studies for this review were: (a) the population of interest included preschool-age children (3-5 years old) grieving the death of a parent or other close family member; (b) intervention, treatment, therapy, or support was involved; (c) intervention outcome was provided; (d) written in English. Studies with 3-5 year olds as only part of the sample were included. Studies without identifiable quantitative or qualitative outcomes were excluded from this review.

Initially, 658 publications were collected. Based on the title and abstract information, 146 articles were further reviewed for inclusion criteria by the authors. When in doubt, the entire article was read, and inclusion or exclusion was based on the content of the article. The first

attempt to review the 146 articles by the authors resulted in an unsatisfactory inter-rater agreement. Consequently, inclusion and exclusion criteria were further defined and clarified between the authors. All of the 146 articles were then reviewed by both of the authors individually for the second time, and 94% inter-rater agreement was attained. Any disagreement was further discussed to reach mutual consensus. Eventually, 17 studies met the inclusion criteria for the content of this review. The majority of articles excluded from this review were primarily conceptual papers, or studies that did not involve an intervention or whose sample did not include 3-5 year old children.

Because of the lack of a sufficient number of quantitative studies with compatible outcome measures, a meta-analysis was considered inappropriate and a structured narrative approach has been adopted. Figure 1 presents the flow of information obtained through different phases of systematic review (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009). Table 1 provides an overview of the 17 studies included in this review.

Compliance with Ethical Standards

Conflict of interest. All authors declare that they have no conflict of interest.

Ethical approval. This article does not contain any studies with human participants or animals performed by any of the authors.

Results

All of the identified studies involved a small sample size. In the participant samples, 3-5 year old bereaved children were often mixed with other older children, except for the five case studies and one quantitative study (Glazer & Clark, 1999) with an unknown number of preschoolers in the sample. About half of the studies, including four quantitative and five mixed

methods, reported some form of quantitative data, and eight studies were qualitative in design. Only two studies (Black & Urbanowicz, 1987; Wilson, 1995) used a control group, and the majority of the studies used pretest-posttest comparison or post-test/post-intervention only design. The interventions included: play therapy (6), expressive arts therapy (2), cognitive-behavioral therapy (2), family therapy (2), combination of play therapy and expressive arts therapy (1), and other unspecified therapeutic orientations (4). The two family therapy studies involved play therapy or play-based intervention with children within the family therapy model (Black & Urbanowicz, 1987; Muir, Speirs, & Tod, 1988). The interventions with unspecified orientations generally included psychoeducation and play-based activities. The majority (13) of the interventions involved parent or family components (e.g., companion parent group, joint child-parent session, etc.).

Family Therapy

The results of Black and Urbanowicz's (1987) quantitative study using a control comparison group yielded no significant effect of family-based intervention, although there was some indication suggesting that young children in the treatment group tended to adapt better than those in the control group, with some behavioral and school problems (e.g., restlessness, sleep problems, learning problems, etc.) appearing less common in the treated group ($p < .01$). Muir et al.'s (1988) study provided some qualitative evidence, based on parent report, to support the effect of a blended treatment of psychoanalysis and family therapy on helping children adapt, and on facilitating parent-child relationship. However, their study only involved one case and the qualitative evidence appeared weak.

Play Therapy

Mixed results regarding the effect of play therapy were found. Three qualitative studies, with each involving only one case, reported significant improvement in children's psychological and behavioral symptoms (Donovan, Balas, & Shapiro, 1995 [sleep problems, oppositional behavior, separation anxiety, distractibility, etc.]; Zeanah & Burk, 1984 [PTSD symptoms, sleep disturbance, anxiety, bedwetting, etc.]; Zelenko & Benham, 2002 [sleep problems, toileting, separation anxiety, aggression, etc.]). No direct evidence with respect to change in children's functioning was reported in Glazer's (1998) study, and inconsistent outcomes were found across two young children in Johnson's (2014) study. Although no evidence regarding the effect of intervention in improving children's functioning was reported, Glazer and Clark's (1999) study, which involved filial play therapy as part of the intervention scheme, provided some evidence in empowering surviving parents to help their children cope and facilitating stronger child-parent relationship.

Expressive Arts Therapy

Some significant quantitative evidence, with small effect sizes in changes in children's problem behavior and symptoms based on parent reports (e.g., anxiety, depression, social adjustment), was found in Webb-Ferebee's (2003) study involving an expressive arts group for children who grieved over the death of a sibling. However, there were no significant treatment effects based on teacher reports. Qualitative results from both Webb-Ferebee's (2003) and Chilcote's (2007) studies provided some indication of the effect of expressive art therapy in facilitating grief process and improving children's psychological functioning, including reducing behavioral problems and symptoms (e.g., externalizing problems: hyperactivity, aggression, self-control, etc.; internalizing problems: nervousness, fearfulness, sadness, withdrawal, etc.; school

problems: concentration, motivation, completing school work) and bringing hope for the future.

Cognitive-behavioral Therapy (CBT)

Two studies applying CBT with young bereaved children yielded inconclusive results. There was no information regarding the intervention effect on reducing psychological distress available in Stubenbort, Donnelly, and Cohen's (2001) study, where CBT group therapy was provided for bereaved children following an air disaster. However, the group activities appeared to help children communicate their feelings related to the loss, and normalize their grief experiences. There was some quantitative evidence indicating the effect of a manualized traumatic grief cognitive-behavioral therapy (TG-CBT) in improvement in a 5-year-boy's psychological and behavioral symptoms (e.g., anxiety, depression, school problems) in Brown, Pearlman, and Goodman's (2004) study.

Combined Program

Using a control-group, pretest-posttest design, Wilson's (1995) quantitative study evaluated a curriculum-based program that combined play therapy, expressive arts therapy, and group counseling techniques to support bereaved children (4-12 years). There were no significant intervention effects evident. Nonetheless, children in both control and intervention group showed fewer symptoms (e.g., immature regression, aggression, social withdrawal, irritability, school and learning problems, etc.) at follow-up.

Other Interventions

Siddaway, Wood, Schulz, and Trickey (2015) provided quantitative evidence to support the effect of a group program for children aged 3-12. The program consisted of three play-based workshops for children and a parallel parent group, aiming to provide social support, normalize

grief experiences, and facilitate adaptive expression of feelings, and foster coping skills. The results revealed significant improvement in children's behaviors, emotions, and relationships, with a medium effect size (d = .55) based on parent report and a small effect based on teacher report (d = .29).

Vargas-Irwin (1999) provided 10 theme-focused, activity-based weekly sessions for children and their surviving parents in parallel bereavement support groups. Similar to the group program in Siddaway et al.'s (2015) study, this program also focused on provision of social support, understanding and expression of grief and loss, normalization of grief process, and facilitation of communication and child-parent relationship. Quantitative results indicated that, in regards to the program's goals, helping children understand the concepts of death and facilitating expression of loss and grief were obtained. However, children's understanding of death and expression of grief were not directly measured. Qualitative data provided some evidence to support the effect of the program in helping children develop coping skills and improve their psychological and behavioral symptoms (e.g., depression).

Two residential camp programs (Braiden, McCann, Barry, & Lindsay, 2009; Miller, 2010) that provided psychoeducation and group activities for bereaved children and their families yielded some quantitative and qualitative support for the effects of those programs. The one-day grief camp in Miller's study and the two-day residential bereavement program in Braiden et al.'s study similarly aimed to help children and parents understand and normalize their grief reactions, foster positive communication within the family, and develop adaptive coping skills. They also helped parents develop skills for supporting their children at different stages of grief process. Pretest-posttest analyses in Miller's study revealed that the grief camp

improved children's adaptive responses. Qualitative data from both studies revealed that the camp programs helped bereaved children communicate their grief experiences, normalize their grief reactions, and feel supported in the grief process.

3-5 Year Olds Exclusively

Of these 17 studies, six included 3-5 year olds exclusively (Brown et al., 2004; Donovan et al., 1995; Glazer & Clark, 1999; Muir et al., 1988; Zeanah & Burk, 1984; Zelenko & Benham 2002). A common factor of five out of these six articles was play therapy for the preschool aged child (Donovan et al., 1995; Glazer & Clark, 1999; Muir et al., 1988; Zeanah & Burk, 1984; Zelenko & Benham 2002). Four of these articles (Donovan et al., 1995; Muir et al., 1988; Zeanah & Burk, 1984; Zelenko & Benham 2002) reported significant qualitative results, such as decreased behavioral and cognitive symptoms, due to play based therapies. Brown et al.'s (2004) research yielded some quantitative evidence in which their Traumatic Grief Cognitive Behavioral Therapy (TG-CBT) decreased a 5-year-old child's psychological and behavioral symptoms. A common denominator of all six articles was a family, or parent-child, component (Brown et al., 2004; Donovan et al., 1995; Glazer & Clark, 1999; Muir et al., 1988; Zeanah & Burk, 1984; Zelenko & Benham 2002). Glazer and Clark (1999) found that a family centered program, as well as filial therapy, yielded some evidence of a stronger parent-child relationship. It is important to note that five of these six studies (Brown et al., 2004; Donovan et al., 1995; Muir et al., 1988; Zeanah & Burk, 1984; Zelenko & Benham 2002) had only single child participant, whereas Glazer and Clark's (1999) research had an unknown number of participants.

Discussion

This review found that research on the effects of bereavement interventions for

preschool-age children is significantly limited. We located 17 studies that included interventions for young bereaved children (3-5 years); however, except for a few case studies, preschool-age children were often mixed with older children in the interventions. Only six out the 17 identified studies included 3-5 year olds exclusively. Moreover, all of the identified studies involved a small sample size, and only two studies with a control group design were found. Therefore, a meta-analysis was not feasible. Our review is the first attempt to systematically evaluate the effects of interventions for preschool-age children who experience the death of a family member.

Play therapy, expressive arts therapy, family therapy, and cognitive-behavioral therapy were often utilized to help young children cope with the loss of a family member, with play therapy or play-based activities being the most commonly adopted intervention option. For studies including 3-5 year olds exclusively, play based therapies were clearly the primary therapeutic options. This is not surprising as play is considered the natural medium of communication for young children and through which they gain understanding of their world (Landreth, 2012). Play has been showed to be related to preschoolers' psychological adjustment and social-emotional well-being (Ginsburg, 2007), and play therapy has been commonly used to treat children dealing with parental separation and other ongoing family crises (Dyson, 2015).

The majority of the interventions, regardless of their therapeutic orientation, included psychoeducation and parent/family components (e.g., companion parent group, filial therapy, parent-child joint session, etc.). They often focused on helping children and their parents normalize grief experiences, express grief and loss, develop coping skills, and facilitate adaptive communication and parent-child relationship.

Mixed and inconsistent results regarding the effects of these interventions for young

bereaved children were found across and within studies. Some studies reported evidence to support the effectiveness of interventions in children's behavioral symptoms and functioning (e.g., Braiden et al., 2009; Brown et al., 2004; Donovan et al., 1995; Miller, 2010; Muir et al., 1988; Siddaway et al., 2015; Vargas-Irwin, 1999; Webb-Ferebee, 2003; Zeanah & Burk, 1984; Zelenko & Benham, 2002); some other studies found no effects of interventions (e.g., Stubenbort et al., 2001; Wilson, 1995), or provided no direct evidence with respect to improvement in young children's behavior or symptoms (e.g., Chilcote, 2007; Glazer, 1998; Glazer & Clark, 1999). Qualitative studies generally provided narrative outcomes to support the effects of various interventions (e.g., play therapy, expressive arts therapy, family therapy, CBT, grief camp, etc.); however, quantitative data yielded inconsistent results.

Using a control group, pretest-posttest design, Wilson (1995) found no significant quantitative evidence to support the effect of a bereavement program that combined play therapy, art therapy, and counseling techniques, although children had less symptoms at follow-up. The effect of expressive arts group therapy was partially supported by Webb-Ferebee's (2003) quantitative evidences with small effect sizes. However, the effect of the intervention was only evident in parent reports, but not in teacher reports. Although quantitative evidence was reported by Brown et al. (2004) to support the effect of CBT based on changes on pretest and posttest scores on behavioral measures, the results were solely derived from one case study. The possible treatment effect of family therapy in children's behavioral and school functioning was reported in Black and Urbanowicz's (1987) quantitative study with a control group design, though the results were statistically significant at the .10 level. These results indicate that empirical evidence of positive intervention outcomes for preschool-age bereaved children was limited, and

compromised by methodological weakness in the design of the studies (e.g., small sample sizes, lack of a control group, non-random assignment, weak assessment instruments, etc.) (Curtis & Newman, 2001).

Nonetheless, the majority of studies reported beneficial effects of interventions with respect to helping young children understand the concepts of death, normalize their grief responses, and express grief and loss. Moreover, including parents and families in interventions was seen as a critical ingredient in supporting young bereaved children across studies and interventions. According to family systems theory, when a family experiences the loss of kin, all members of the household, including the surviving parents and children, and multiple family subsystems and the entire family life course are affected (McCubbin & Figley, 1983). Communication in the family may be disrupted, family routines may be interrupted, and family role relationships may become unsettled. These challenges may affect the progression of young children's work on psychological tasks during the grief process (Baker, Sedney, & Gross, 1992).

Research has identified post-death family environment as an important predictor of bereaved children's behavior and symptoms. Particularly, the surviving parents' psychological functioning and coping abilities have a powerful impact on children's adaptation and outcomes (Bugge et al., 2014; Wolchik, Tein, Sandler, & Ayers, 2006). Bowlby's (1973) attachment theory suggested that the quality of caregiving from a new caregiver upon separation or absence is significantly related to a child's adjustment to the loss. Developmentally, young children are sensitive to strong emotions and emotional withdrawal from others, and they need special attention to recover and manage their grief when experiencing the loss of a loved one. This requires the surviving parents to attend to their child's grief, as well as their own. In order to

meet their children's needs, parents need to understand what their child is communicating through their words or behavior. Parents must also discover what kind of information and support are important for young bereaved children in their grief process (Bugge et al., 2014). In addition, surviving parents/caregivers need to learn to work through their own grief adaptively and see grieving as a family process involving all family members. Because of the importance of family context, some type of family assessment and interventions that involve work with the surviving parents should always be considered when working with young bereaved children (Baker et al., 1992).

Implications

Schools have a unique position to help grieving children as they can potentially be a safe haven where children can maintain a sense of normalcy and continuity in the event of family crisis (Holland, 2008).

School mental health providers, such as school psychologists, counselors, and social workers, may help parents and teachers understand childhood grief process and psychological tasks that need to be accomplished over time at different stages of grief (Baker et al., 1992; Bowlby, 1980) through consultation or psychoeducational services. The resources compiled by Heath and Cole (2011) and Cohen and Mannarino (2011) can serve as a useful guide to assist school mental health providers in sharing critical information related to children's grief and practical intervention strategies with teachers and parents. Surviving parents' or caregivers' reactions to the child's grief, the availability of emotional support, and subsequent life circumstances following the death of a family member can significantly affect the child's adaptation and psychological outcomes (Silverman & Worden, 1992). To provide adequate

support for bereaved preschoolers, parents/caregivers need to understand the process of loss in young children, be aware of the child's grief reactions, help reorganize and stabilize the child's life, and facilitate adaptive coping (Zelenko & Benham, 2002). In addition, the subsequent psychological adaptation of surviving parents/caregivers needs to be monitored and supported as research has identified it as an important mediating factor that has a significant influence on children's outcomes (Dowdney, 2000). School mental health providers may provide basic mental health consultation to surviving parents to help them process their own grief and develop adaptive coping skills, as well guiding the bereaved family to relevant agencies, such as a support group in community-based mental health centers, hospitals, and hospices, for support (Masterman & Reams, 1988).

It is important to acknowledge that preschool children do not have a fully developed understanding of the death-related concepts due to their cognitive development (Nagy, 1948). Young children often make false assumptions about the causes of major events, and they may believe they are to blame and feel responsible and guilt for what happened (Norris-Shortle, Young, Williams, 1993). When working with preschool-age children, it is important to provide concrete information related to death in a direct and proactive manner and clarify misconceptions they have in order to help them dispel their fears and confusion (Schonfeld, 1989). Developmentally, young children are more likely to grieve through behaviors, bodily expressions and play, rather than through complex language (D'Antonio, 2011; Webb, 1993). Parents and educators should provide opportunities for preschool-age children to express their feelings through art, play, games or other developmentally appropriate activities in ways that are consistent with their cultural backgrounds (Baggerly & Abugideiri, 2010; Norris-Shortle et al.,

1993).

Limitations

This review has several limitations. The exclusive reliance on data that are published in peer-reviewed journals and dissertations in English language may not represent all of the evidence, resulting in a potentially biased presentation of existing conclusions. The applicability of the results of this review to young bereaved children from different cultural backgrounds is unknown. As aforementioned, the number of studies involving bereavement interventions for preschool-age children is small and young children were often mixed with older children in these studies. The effect of interventions for preschool-age children cannot be clearly determined because the studies generally did not provide separate results for young children from the entire sample. Among the few studies that included preschoolers exclusively, the sample often included one single case only, resulting in questions regarding the generalizability of the results. Because of the paucity of grief research on interventions for this specific age group, the results of this review analysis of literature must be interpreted cautiously. More empirical studies with adequate sample sizes, as well as the inclusion of appropriate comparison groups, are necessary to support the effect of various interventions for preschool-age children who experience the death of a family member. A major limitation refers to the variations in how intervention outcomes and children's psychological and behavioral functioning are measured among identified studies, resulting in difficulties with consolidating the findings across studies and generalizing the results to the target group. More sensitive instruments with increased reliability and validity are needed to adequately assess the effect of an intervention for young bereaved children.

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Figure 1

Flow Diagram of Search Outcomes

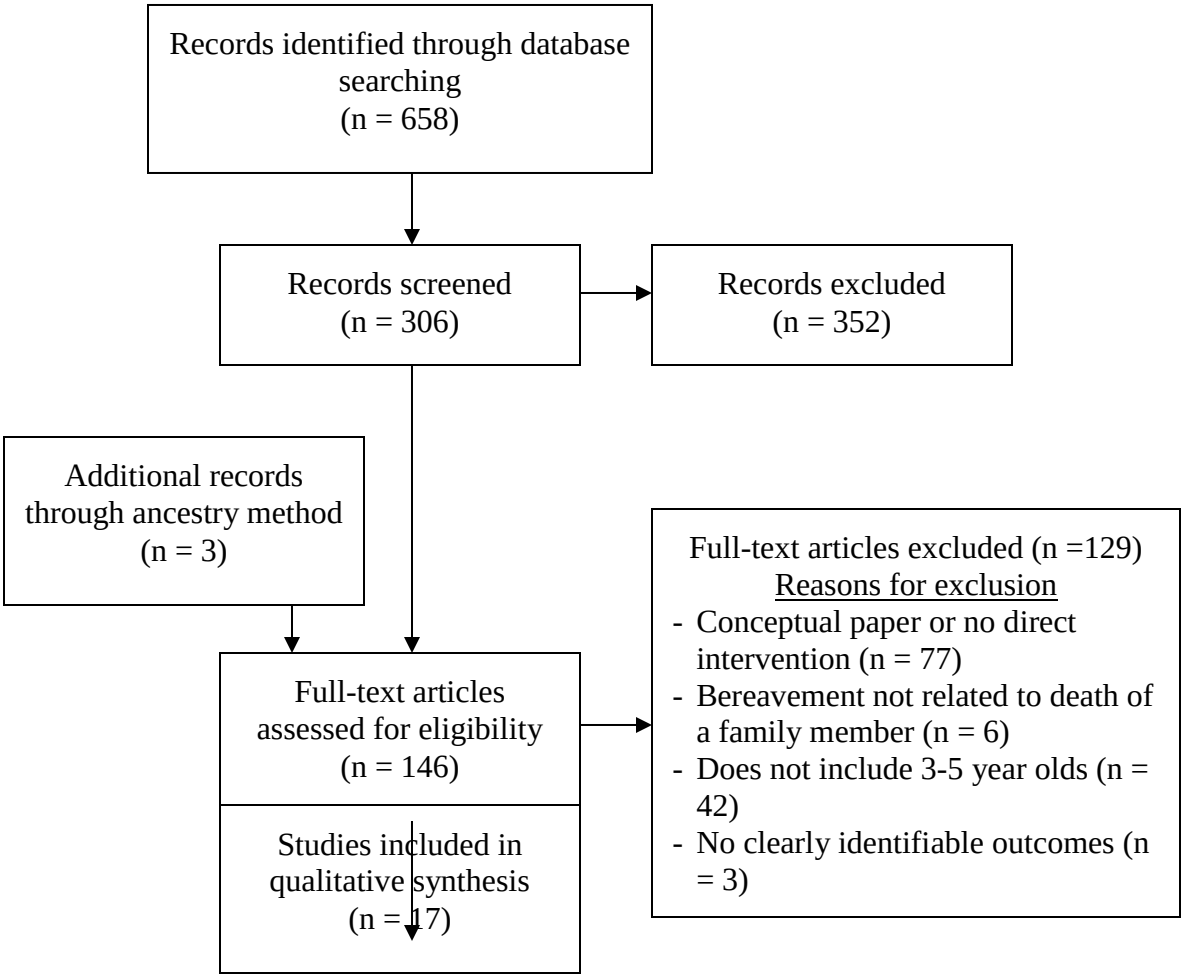

Table 1

Description of Studies Included

Study	Relationship to deceased	Type of intervention	Subject Description	Intervention/Therapeutic Orientation	Study Design	Outcomes
Black & Urbanowicz (1987)	Parent	Prevention	*N* = 45 families with 83 children (including 16 0-5 year olds, with 5 in treatment group and 11 in control group)	Family therapy Main components: - Encourage expression of loss and grief, using play materials for children - Improve communication between children and the surviving parent - Model appropriate behaviors and responses	Quantitative; control group, follow-up design <u>Child outcome measures:</u> Percentages of children exhibiting behavioral (e.g., sleep problems, restless, school problems, etc.), mood (e.g., depression), and health problems obtained through interviews in control and treatment groups.	Some indication of possible treatment effects in terms of young children's behavioral problems or school/learning problems, although not significant ($p <$ .1).
Braiden, McCann, Barry, & Lindsay	Family member	Prevention	*N*= 5 families, including 7 adults and 8 children (5-16 years)	Two-day residential program including separate sessions for parents and children;	Qualitative; pre-post intervention design	Some qualitative evidences in improvement in children's (e.g.,

(2009)				psychoeducation and unspecified counseling orientation Main components: - Form social support - Develop understanding of grief process - Normalize grief responses - Facilitate coping skills and positive outlooks at the individual and family level - Help parents develop skills for supporting their children at different stages of grief.		understood the cause of death better, wanted to communicate more, felt less alone and happier, developed coping strategies, etc.), parents' (e.g., developed coping skills, helped their children understand the death, developed skills to support and manage their children, etc.), and families' (e.g., enabled more open and honest communication, etc.) functioning.
**Brown, Pearlman, & Goodman	Parent	Psychotherapy	*N* =1 (5 years)	Manualized traumatic grief cognitive-behavioral therapy (TG-CBT);	Quantitative; pretest-posttest, 6-month follow-up	Some quantitative evidences in

(2004)				individual sessions for the child and the parent and two joint sessions Main components: <u>Trauma-focused module</u> - Psychoeducation - Stress-inoculation training (e.g., relaxation and cognitive restructuration) to facilitate coping strategies - Cognitive and affective processing - Joint child-parent session to help the parent reinforce the child's coping skills <u>Grief-focused module</u> - Encourage mourning - Memory making - Social skills building - Meaning making of loss - Joint child-parent session to facilitate communication	<u>Child outcome measures:</u> - Psychiatric trauma symptoms (Interview Schedule for Children: Predictive Scales, DPS) - Global functioning (Global Assessment of Functioning from DSM-V; GAF) - Emotional and behavioral functioning (Behavioral Assessment System for Children (BASC) - Student-teacher relationship (Student Teacher Relationship Scale, STRS)	decreased behavioral and psychological symptoms (e.g., anxiety, depression, school problems).
Chilcote (2007)	Loved one or traumatic	Prevention	*N* = 113 (5-13 years)	Art therapy groups	Qualitative	Some indication of effects in

	event (tsunami)			Main component: - Facilitate emotional expression - Process feelings		processing grief and expressing hope for the future.
**Donovan, Balas, & Shapiro (1995)	Parent	Psychotherapy	*N* = 1 (3 years)	Dynamic play therapy accompanied by parental counseling and consultation with school teacher	Qualitative	Significant qualitative evidence in improvement in behavioral problems at home (e.g., sleep problems, separation anxiety, worries, oppositional behavior, etc.) and in school (e.g., hyperactivity, distractibility, concentration problems, etc.)
Glazer (1998)	Someone special	Prevention	*N* = 9 (4-14 years)	Play therapy	Qualitative; pre-post content analysis	No direct evidence in change in children's functioning was reported. A greater

						integration in the drawings at discharge.
**Glazer & Clark (1999)	Family member	Prevention	*N* = n/a (preschoolers)	Integrated family-centered programs that involve grief groups, play therapy, and filial therapy Main components: -Increase the understanding of death - Facilitate identification and expression of feelings - Normalize grief responses - Reorganize and facilitate parent-child relationship - Empower parents to support their children	Mixed method <u>Child outcome measures:</u> Parent-child relationship (The Parenting Satisfaction Scale)	Some evidence in facilitating stronger child-parent relationship
*Johnson (2014)	Parent	Psychotherapy	*N* = 6 (3-10 years), including one 3-year-old boy and one 5-year-old girl.	Group play therapy	Mixed method; multiple case study pretest-posttest design <u>Child outcome measures:</u> -Grief symptoms in children (Child	Inconsistent results on psychological and behavioral outcomes across the two young children (3-5 years). Some quantitative

					Behavior Checklist; CBCL) - Distress (Wong-Baker Faces Scale) - Qualitative analysis of emotions and themes using MAXQDA Software	evidence in reducing hurt feelings for both cases.
*Miller (2010)	Family member	Prevention	*N* = 7 (5-11 years)	One day grief camp; group activities for children, parents, and families Main components: - Normalize grief reactions - Facilitate expression of emotions - Foster communication within the family - Educate parents about childhood grief.	Mixed method; pretest-posttest Child outcome measures: - Child coping responses such as communication and expression of grief (assessed by an non-standardized pre-post evaluation form)	Quantitative evidences in improved adaptive responses. Qualitative evidences in positive attitudes toward expression of emotions

**Muir, Speirs, & Tod (1988)	Parent	Psychotherapy	*N* = 1 (4 years)	Blend of child psychoanalysis and family therapy (individual play-based therapy for the child, individual therapy for the surviving parent, and a joint family)	Qualitative	Parent reported that the child appeared to cope well and return to a state of normalcy. Increased parent-child relationship.
Siddaway, Wood, Schulz, & Trickey (2015)	Family member	Prevention	*N* = 52 (38 at follow-up) (3-12 years)	CHUMS Child Bereavement Group, including three bereavement workshops for children and separate groups for parents Main components: - Social support and normalization - Foster coping skills - Improve family relationships	Quantitative; naturalistic one-group pretest-posttest design <u>Child outcome measures:</u> - Psychological problems (Strengths and Difficulties Questionnaire; SDQ)	Significant quantitative evidence, with a medium-size decrease in symptoms reported by parents and a small-size decrease in symptoms reported by teachers.
Stubenbort, Donnelly, & Cohen (2001)	Family member	Prevention	*N* = 12 (5-12 years)	Separate trauma-focused cognitive-behavioral therapy groups for children and their parents Main components: - Psychoeducation	Qualitative	Qualitative evidence supporting increased communication of feelings and normalization of

				- Normalize grief experiences - Increase coping skills - Build ongoing support		feelings
*Vargas-Irwin (1999)	Family member	Prevention	*N* = 22 families with 37 children (including 7 3-6 year olds)	Parallel bereavement support groups for children and parents (theme-focused, activity-based sessions) Main components: - Facilitate understanding and expression of grief and loss - Normalize grief reactions - Provide social support - Enhance communication in family and relationship between the child and the surviving parent - Develop coping skills	Mixed design; pretest-posttest <u>Child outcome measures:</u> -Meet therapeutic goals (Ratings of Child Participation and Involvement Questionnaire) -Death concept (Smilansky Death Concept Scale) -Behavioral problems and adaptive behaviors (Child Behavior Checklist; CBCL)	Some quantitative evidence in attaining program goals with respect to understanding the concept of death and expression of grief and loss. Some qualitative evidences in reduced symptomatology, increased social support, and increased use of coping skills.
*Webb-Ferebee (2003)	Sibling	Prevention	*N* = 8 families, including 6 fathers, 8 mothers, 2 grandparents, and 11	Expressive arts group therapy (weekend camp with 3 follow-up session over a 6-week period)	Mixed method: pretest/posttest quasi-experimental group design	Some significant quantitative evidences with small effect

			children (3-15 years)	Main components: - Foster emotional expression and healing - Facilitate coping and conflict resolution skills	<u>Child outcome measures:</u> - Problem behavior and symptoms (Behavioral Assessment System for Children; BASC) - Anxiety symptoms (Beck Anxiety Inventory; BAI) - Depression (Beck Depression Inventory; BDI)	sizes in changes in children's problem behavior and symptoms based on parent reports [total d = .20, depression d = .33, anxiety d = .25, and social adjustment d = .26; as reported in Rosner et al.'s (2010) meta-analysis study]. However, no significant effects on behaviors and symptoms based on teacher reports. Qualitative evidences in improvement in children's (e.g., emotional stability and self control, internalizing and

						externalizing problems, school problems), parents (e.g., depression and anxiety symptoms), and families' functioning (e.g., cohesion and expressiveness).
*Wilson (1995)	Family member	Prevention	*N* = 22 (4 -12 years), with 9 in the control group and 13 in the intervention group	Support group and curriculum based programs, using play therapy techniques, expressive arts therapies, and counseling group techniques.	Quantitative; pretest-posttest, follow-up, control group design <u>Child outcome measures:</u> -Anxiety symptoms (Revised Children Manifest Anxiety Scale; RCMAS) -Behavior issues and psychopathology (Louisville Behavior Checklist; LBC)	No evidence of intervention effects. Less symptoms for both control and intervention groups at posttest and follow-up.

**Zeanah & Burk (1984)	Parent	Psychotherapy	*N* = 1 (4 years)	Play therapy, accompanied by parent support and guidance	Qualitative	Significant improvement in behavioral symptoms (e.g., PTSD; sleep disturbance, fears, anxiety, bedwetting, etc.), and school functioning.
**Zelenko & Benham (2002)	Parent	Psychotherapy	*N* = 1 (3 years)	Trauma-informed play therapy, accompanied by work with caregivers Main component: - Format new attachment bond with surviving caregiver - Facilitate caregiver's understanding of grieving process in young children - Reorganize the child's life - Facilitate the acceptance of loss	Qualitative	Significant improvement in psychological and behavioral symptoms (e.g., loss of toilet training, sleep problems, nightmares, separation anxiety, aggression and fears)

Note: *Dissertation.
**3-5 year olds only