Effectiveness and Acceptability of Interventions Offered for Those Bereaved by Parental Loss to Suicide in Childhood: A Mixed Methods Systematic Review

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Effectiveness and Acceptability of Interventions Offered for Those Bereaved by Parental Loss to Suicide in Childhood: A Mixed Methods Systematic Review

Frances Graham, Warren Bartik, Sarah Wayland, and Myfanwy Maple

ABSTRACT
Objectives: Identify interventions offered for children bereaved by parental suicide, investigate reported effectiveness and explore the acceptability of identified interventions.
Method: Six electronic databases were systematically searched for primary studies investigating intervention effectiveness and acceptability, (August 2011 to June 2023). Eligibility required inclusion of participants bereaved by parental suicide during childhood among sample populations. Methodological quality was evaluated applying JBI critical appraisal tools. Narrative synthesis was conducted using parallel-results convergent design.
Results: Of the 22 eligible reports, 19 articles reported on 12 manual-based supports provided during childhood; three papers described users’ experiences of various specified intervention types offered following childhood loss. Twenty-one studies reported on interventions offered for heterogeneous participant groups that included children bereaved by parental suicide. Time from loss to intervention generally included both recent (1 < 30mths) and more distant loss, with just one intervention described as solely for recently bereaved children. Eight interventions (n = 12 studies) demonstrated significant positive effects (p < 0.05), for maladaptive grief, mental health, quality of life. Only one study investigated suicide-related outcomes. Qualitative findings (n = 8 studies) facilitated development of four acceptability themes: Perceived utility, Relationships, Components and Delivery.
Conclusions: Heterogeneity in causes of loss/trauma and relationships with the deceased limit specific conclusions regarding effectiveness/acceptability of reviewed interventions for children bereaved by parental suicide. Few sub-group analyses of effects were reported, and qualitative evidence specifically from children bereaved by parental suicide was limited. Further research is recommended regarding mixed-user interventions, specifically for children bereaved by parental suicide.

HIGHLIGHTS
• Significant effects: improved grief responses, mental health, quality of life
• Acceptability themes: Perceived utility, Relationships, Components, Delivery
• Findings derive from research involving heterogeneous user groups

KEYWORDS
Bereaved in childhood; parental suicide; intervention; effectiveness; acceptability; mixed methods systematic review

Supplemental data for this article can be accessed online at https://doi.org/10.1080/13811118.2024.2351101.
INTRODUCTION

Globally, over 700,000 people are lost to suicide each year (World Health Organization, 2022a). People of reproductive age (15-49yrs), potentially those with responsibilities for children, comprise approximately 65% of recorded suicides (WHO, 2021, 2022b). Thus, children bereaved by parental suicide can be recognized as a sizeable population; however few studies have investigated numbers of such children. Berman (2011) reported six close family members, including children, as exposed to every suicide. Burrell et al. (2021) and Kuramoto et al. (2010) found, on average, two children impacted by each parental suicide.

Many grievers accommodate their loss over time (Bonanno, 2004; Castelli Dransart, 2017; Harris et al., 2021). For bereaved children, supportive early parental care, family stability, strong social networks, and higher socioeconomic status may promote resilience to distress following parental loss (Burrell et al., 2017; Guldin et al., 2015; Hua et al., 2020). However, subgroups of bereaved children, including those bereaved by parental suicide, may experience significant challenges (Burrell et al., 2018; Jakobsen & Christiansen, 2011; Kuramoto et al., 2009).

These challenges include psychological disorders, for example, maladaptive grief (MG), depression, posttraumatic stress (PTSD), behavioral and emotional problems (Berg et al., 2016; Hamdan et al., 2012; Pham et al., 2018). Those bereaved may exhibit elevated risks of self-harm/suicide (Hua et al., 2019; Rostila et al., 2016). Kuramoto et al. (2013) reported age at loss may influence levels/duration of suicide risk for children bereaved by parental suicide, with young children (≤ 5yrs) experiencing the highest risk levels and for the greatest duration, approximately 20yrs post-loss. For children (6-12yrs), suicide risk was found to peak after five years, whilst teenagers’ suicide risk was highest during the initial 1-2yrs following parental suicide. Moreover, family history of suicide and strong attachment to the deceased may increase suicide risk and psychological distress for children bereaved by parental suicide (Tidemalm et al., 2011; Cerel et al., 2014; Meyer-Lee et al., 2020). Social problems can also arise (Doka, 1989; Mortell, 2015), with others minimizing, denying or deriding such children’s experiences (Cain & Lafreniere, 2015; Degroot & Carmack, 2022; Oexle et al., 2020). Perceived suicide stigma may increase anxiety and shame (Doka, 1999), prompting the bereaved to conceal details of their loss to avoid public humiliation (Hanschmidt et al., 2016). Grievers’ quality of life can consequently diminish (Azorina et al., 2019; Burrell et al., 2020; Pitman et al., 2018). Therefore, interventions may be needed to assist children bereaved by parental suicide as they mature through childhood and into adulthood, to ameliorate functional and psychological problems that may arise following their loss (Cerel et al., 2014).

Interventions that consider individual experiences, can lead to better health and functioning for service-users (Sturmberg et al., 2012). Moreover, users’ compliance with healthcare recommendations may increase for supports perceived as acceptable (e.g., Sidani et al., 2009; Tarrier et al., 2006). Thus, intervention acceptability may improve likelihood of uptake, adherence and completion, potentially contributing to overall effectiveness for a greater number of users.
There is a lack of published research regarding effects of interventions offered for children bereaved by parental suicide (Maple et al., 2018), and studies of intervention acceptability are limited (Sekhon et al., 2017). Recent reviews of interventions for suicide-bereaved people, including children (Andriessen et al., 2019; Journot-Reverbel et al., 2017) reported only one study published before the present review’s proposed coverage commencement (refer Method section) that examined intervention involving children bereaved by parental suicide (Pfeffer et al., 2002). Other reviews of interventions for bereaved children (Bergman et al., 2017; Clute & Kobayashi, 2013) located just two earlier studies regarding interventions offered to participant groups that included children bereaved by parental suicide (Camp Magik: McClatchey et al., 2009; Family Bereavement Program (FBP): (Sandler et al., 1992). Later research regarding these two interventions is discussed in the Results section, below.

To date, no published systematic review has focused on both effectiveness and acceptability of interventions offered for children bereaved by parental suicide, either exclusively or as part of heterogenous groups of bereaved/trauma survivors. This review therefore proposes to investigate quantitative research to identify outcomes, for which researched intervention demonstrated statistically significant effects (p < 0.05) for participants comprising or including children bereaved by parental suicide. Contemporaneously, the review will examine qualitative and quantitative research, which includes children bereaved by parental suicide among participants, for attributes that may contribute to intervention acceptability, broadly interpreted as encompassing satisfaction, suitability, perceived utility and face validity of interventions (Kaltenthaler et al., 2008; Sekhon et al., 2017).

This study poses the question: Do children bereaved by parental loss to suicide have access to effective and acceptable intervention? Three objectives are emphasized:

1. identify interventions offered for children bereaved by parental suicide,
2. investigate effectiveness of identified interventions,
3. explore acceptability of identified interventions.

METHOD

The review was conducted in compliance with PRISMA 2020 (Page et al., 2021) using recommendations from JBI Manual for Evidence Synthesis (JBI, 2020) concerning data presentation and synthesis. Mixed methods review methodology was followed (Grant & Booth, 2009); namely, the bringing together of quantitative effectiveness review and qualitative review on attitudes to interventions and their implementation. The review protocol was shared through ResearchGate (Graham et al., 2021). It was not published in any systematic-review-specific registry.

Inclusion/Exclusion Criteria

Inclusion criteria:

1. primary empirical research published in peer-reviewed journals: 1 August 2011 – 30 June 2023,
2. studies whose participants included a proportion (>0%) of people (any age), bereaved by parental suicide in childhood (<19 years), and
3. studies which measured intervention effects and/or reported on acceptability for interventions offered following such bereavement.

Exclusion criteria: case studies, books, grey literature, reviews; research centered on informal support, e.g., from family, friends, peers, or medication as interventions; studies that explain current/proposed intervention without appraising effectiveness/acceptability, (Supplementary file 1).

**Search Strategy and Study Selection**

In May/June 2021, in consultation with IT specialists, FG tested draft search strategies, and performed scoping searches for selected databases: CINAHL-Complete, PubMed, ProQuest Central-Psychology, Sociology-Collection, PsycInfo, PsycArticles. Potential terms from titles, abstracts, key words of ten eligible studies identified from scoping searches, were examined and highlighted. FG then conferred with UNE School of Health librarian, WB, SW, and MM to refine/confirm robustness of final strategies. (Supplementary 2).

Between September 2021 and March 2022 database searches were conducted, limiting retrieval coverage to August 2011–December 2021 (Supplementary 3). This coverage period was selected so that review learnings might still be relevant to interventions under development or currently available for children bereaved by parental suicide. Using Covidence systematic review software (Veritas Health Innovation, 2021), FG and AC independently screened titles/abstracts of retrieved studies, then independently reviewed full-text articles. Search coverage was subsequently extended to 30 June 2023, and titles/abstracts of retrieved studies from the extended search independently screened by FG and WB in December 2023. Two additional articles were selected for independent full-text review by FG/WB, but excluded for not meeting inclusion criteria. FG performed manual searches examining reference lists of articles selected for full-text review to identify/screen studies citing selected research. Consensus on study selection was reached, following 90% initial inter-rater agreement during screening, through regular discussion between FG and AC/WB, with adjudication on any unresolved disagreement by MM.

Database searches identified 352 records. Removal of duplicates (n = 101) left 251 records for title/abstract review. Thereafter, a further 219 were excluded as not satisfying inclusion criteria, generating retrieval of 32 reports for full text screening. Following full-text screening, 22 records were selected for critical appraisal, comprising sixteen records from database searches and six from citation searching (Figure 1).

**Data extraction and critical appraisal**

Using JBI data extraction and critical appraisal tools (JBI, 2020) FG, in consultation with WB, SW and MM, developed data collection spreadsheets, completed data extraction, and appraised each study for possible bias in research design, analysis, reporting,
FIGURE 1. PRISMA flow diagram.
for example, recording relevant reasoning for risk of bias as low, medium, high. (Supplementary 4).

**Synthesis Methods**

**Effect Measures**

Due to diversity of outcome measures, standardized mean difference effect size (Cohen’s $d$) was selected as universal effect measure. Odds ratios (OR; $p<.05$), where reported, were converted to Cohen’s $d$ to facilitate comparability (Chinn, 2000). As this review concerned an under-examined population, appraisal of effect sizes by referring to earlier research was not considered possible (Vacha-Haase & Thompson, 2004). Accordingly, ranges of small (.2), medium (.5), large (.8), were used to interpret effect size (Cohen, 1988).

**Design**

Narrative synthesis was selected to accommodate the breadth of the research question and dissimilarity of data, help organize studies into more analogous groups to address review objectives, and generate an end-product relevant for researchers/intervention providers (Barnett-Page & Thomas, 2009; Lucas et al., 2007). Acknowledging the diversity of findings from this review, differing perspectives were adopted for analysis of quantitative findings – post-positivist, and qualitative evidence – constructivist. Thus, parallel-results convergent design was nominated as synthesis strategy. Quantitative and qualitative evidence were separately analyzed and reported in the review Results. Integration of evidence was then presented during interpretation of results in the Discussion. (Hong et al., 2017; Popay et al., 2006; Stern et al., 2021).

**Quantitative evidence**

**Effectiveness.** FG conducted preliminary synthesis of significant effects to help illuminate patterns regarding the nature of outcomes and effect sizes, iteratively examining extracted data, compiling detailed textual descriptions of intervention attributes, participant characteristics, study contexts. Tables/charts were developed to analyze how effectiveness may have been moderated by study variables, including methodological quality, design, participant particulars, intervention details. A collaborative process between FG, WB, SW and MM shared tabulated data of potential moderator variables, intervention descriptions, and analyses of relationships discerned for reported significant effects (Popay et al., 2006).

**Acceptability.** Quantitative evidence of acceptability was limited to completion rates; it was not possible for this review to make meaningful inferences regarding contributors to variations in intervention completion.

**Qualitative evidence**

**Acceptability.** Reflexive thematic analysis, embracing the value of the subjective dimension of qualitative analysis, was used for synthesis of qualitative findings (Braun &
Clarke, 2006; Braun & Clarke, 2021; Gough & Madill, 2012; Zimmer, 2006). Using NVivo 12 software (QSR International Pty Ltd, 2020), FG interpreted evidence reflexively to inductively code data and reduce findings into fewer key meaning-units to respond to the research question, iteratively reexamining assumptions and purposefully making decisions around the wording of participants’ perceptions (Braun & Clarke, 2019). Regularly conferring with WB, SA and MM, FG explored and refined relationships within meaning-units using vote-counting of numbers of studies/participants reporting observations as descriptive technique, to rationalize ideas, review evidence strengths/limitations, conceptualize themes (Braun & Clarke, 2021; Langley et al., 1995; Light & Smith, 1971; Popay et al., 2006). Independently, WB examined extracted qualitative information and coding choices to assess credibility of proposed themes. Lastly, FG and WB conferenced to deliberate upon and distill those themes to the ones presented in this review.

Certainty Assessment. See Supplementary 5.

RESULTS
Of the 22 included papers, 19 studies evaluated 12 manual-based interventions and three studies reported findings regarding a number of specified intervention types. Twenty-one studies (96%) involved heterogenous participant groups, which included a mix of participants bereaved by parental suicide in childhood and other participants with experience of bereavement/trauma from different causes and/or loss of non-parental loved ones. One study examined support provided exclusively for children bereaved by parental suicide (Daigle & Labelle, 2012); significant effects were not reported in this study, assessed low-quality.

Twelve studies (55%) reported significant effects (p < 0.05) from eight interventions, for grief responses, mental health, quality of life. Only one included study investigated suicide-related outcomes (Sandler et al., 2016). Qualitative findings from eight reports (36%) supported the development of four acceptability themes: Perceived utility, Relationships, Components, Delivery.

Included studies
Reviewed studies comprised three randomized controlled trials (RCTs), five pseudo-RCTs, four quasi-experimental, one descriptive observational, three mixed method (MMR) and six qualitative studies. (Table 1).

Critical appraisal revealed studies of medium-high (n = 1), medium (n = 13), and low (n = 8) quality (Supplementary 6).

Study participants
Participant heterogeneity across included studies encompassed diverse childhood bereavements, e.g., sudden medical events, including heart attacks; long-term medical conditions, such as cancer; violence, including accidents, homicide, suicide; and loss of loved ones with differing relationships to the bereaved, e.g., friends, parents, other
## TABLE 1. Summary of included studies and interventions (sorted by study design, and alphabetically by intervention).

<table>
<thead>
<tr>
<th>Author, date, location</th>
<th>Intervention, classification (delivery mode)</th>
<th>Components</th>
<th>Control</th>
<th>Sample(^1) Participant ages, (% bereaved by parental suicide &amp; their ages)</th>
<th>(^3)Outcome measures (timing of data collection)</th>
<th>(^4)Quantitative evidence of Effectiveness – Significant effects (p &lt; 0.05) are presented in bold (effect size)</th>
<th>Qualitative evidence of Acceptability – Emerging themes (Qualitative approach)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thurman et al., 2017, South Africa</td>
<td>Abangane, selective (group)</td>
<td>Psychoeducation, CBT, grief therapy, and indigenous stories, songs, games, discussions on cultural death rituals, activities to farewell the deceased</td>
<td>Waitlist</td>
<td>382 bereaved female adolescents; 13-17yrs at intervention &amp; study, M = 46yrs, SD = 3yrs, from loss to intervention, (&lt; 3%)</td>
<td>IGTs, IG-C, CB-G, CES–DC, BYM-P (pre- &amp; 3mths post-intervention)</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Boelen et al., 2021, Netherlands</td>
<td>CBT Grief-Help indicated (individual)</td>
<td>Psychoeducation, CBT with exposure therapy, trauma narrative construction and processing, Separate group counseling sessions provided for caregivers</td>
<td>Nondirective supportive counseling</td>
<td>134 bereaved children with elevated PGD symptoms; 8-18yrs, M = 13.1yrs, SD = 2.84: ages at intervention &amp; study, M = 37.4mths, SD = 36.2mths, from loss to intervention (&lt; 21%)</td>
<td>IPG-C, CFI, CPSS, CBCL (pre- to post-; 3, 6, 12mth follow-ups)</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Goldbeck et al., 2016, Germany</td>
<td>TF-CBT, indicated (group)</td>
<td>Psychoeducation, CBT including trauma narrative construction and processing, affective modulation, exposure therapy, relaxation, separate and joint sessions with child &amp; caregiver groups</td>
<td>Waitlist</td>
<td>159 children with experience of trauma, including traumatic loss, with elevated PTSS; 7-12yrs, M = 13.03, SD = 2.80yrs: ages at intervention, &gt; 3mths from trauma/loss to intervention &amp; trauma experienced when participant was &gt; 2yrs old, with reference made to participant bereaved 8yrs prior, (&lt; 2%)</td>
<td>CDI, SCARED, CBCL, CAPS–CA, OPTCI, &amp; UCLA-R (at 6yr follow-ups)</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

(b) Quantitative: Pseudo-RCTs

<table>
<thead>
<tr>
<th>Author, date, location</th>
<th>Intervention, classification (delivery mode)</th>
<th>Components</th>
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<th>Sample(^1) Participant ages, (% bereaved by parental suicide &amp; their ages)</th>
<th>(^3)Outcome measures (timing of data collection)</th>
<th>(^4)Quantitative evidence of Effectiveness – Significant effects (p &lt; 0.05) are presented in bold (effect size)</th>
<th>Qualitative evidence of Acceptability – Emerging themes (Qualitative approach)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Luecken et al., 2014, US</td>
<td>FBP, selective (group)</td>
<td>Family therapy: Psychoeducation, CBT, delivered in joint and separate group sessions for children and their caregivers</td>
<td>Self-study literature program</td>
<td>139 youth &amp; young adults parentally bereaved in childhood(^7); 8-16yrs at intervention, 3-28mths from loss to intervention, 14-23yrs: date of study (&lt; 10%)</td>
<td>CBCL (pre- to post-; 3mths, 14mth, 6 yr follow-ups)</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Schoenfelder et al., 2015, US</td>
<td>FBP</td>
<td>As above</td>
<td>As above</td>
<td>218 youth &amp; young adults parentally bereaved in childhood(^7); 8-16yrs at intervention, 3-40mths from loss to intervention, 14-23yrs: date of study (&lt; 13%)</td>
<td>Future expectations scale</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>Sandler et al., 2016, US</td>
<td>FBP</td>
<td>As above</td>
<td>As above</td>
<td>218 (at 6yrs) &amp; 209 (at 15yrs) youth &amp; young adults parentally bereaved in childhood(^7); 8-16yrs at intervention, 3-30months from loss to intervention, 14-23yrs 6mths post-test</td>
<td>Future expectations scale</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

(continued)
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<thead>
<tr>
<th>Author, date, location</th>
<th>Intervention, classification (delivery mode)</th>
<th>Components</th>
<th>Control</th>
<th>Sample</th>
<th>1Participant ages, (% bereaved by parental suicide &amp; their 2ages)</th>
<th>2Outcome measures (timing of data collection)</th>
<th>Quantitative evidence of Effectiveness – Significant effects (p &lt; 0.05) are presented in bold (effect size)</th>
<th>Qualitative evidence of Acceptability – Emerging themes (Qualitative approach)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sandler et al., 2018, US</td>
<td>FBP</td>
<td>As above</td>
<td>As above</td>
<td>194 youth and young adults parentally bereaved in childhood, as detailed above in Sandler 2016, at 15yrs</td>
<td>ASR YABCL CDI SAGC (at 15yr follow-up) Physiological measures Self-rated emotional responsiveness (at 15 yr follow-up)</td>
<td>Internalizing (small to medium) Externalizing (small to medium) Use of services for mental health problems (small to medium)</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Danvers et al., 2020, US</td>
<td>FBP</td>
<td>As above</td>
<td>As above</td>
<td>152 young adults parentally bereaved in childhood, as detailed above in Sandler 2016, at 15yrs</td>
<td></td>
<td></td>
<td></td>
<td>n/a</td>
</tr>
</tbody>
</table>

(c) Quantitative: Quasi-experimental studies –

<table>
<thead>
<tr>
<th>Author, date, location</th>
<th>Intervention, classification (delivery mode)</th>
<th>Components</th>
<th>Control</th>
<th>Sample</th>
<th>1Participant ages, (% bereaved by parental suicide &amp; their 2ages)</th>
<th>2Outcome measures (timing of data collection)</th>
<th>Quantitative evidence of Effectiveness – Significant effects (p &lt; 0.05) are presented in bold (effect size)</th>
<th>Qualitative evidence of Acceptability – Emerging themes (Qualitative approach)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spuij et al., 2015, Netherlands</td>
<td>CBT Grief-Help, indicated (individual)</td>
<td>Psychoeducation, CBT with exposure therapy, trauma focused grief therapy, sharing loss narrative with caregiver. Caregiver-child exercises provided to improve their communication skills to help children process their grief</td>
<td>No control</td>
<td>10 bereaved children with elevated PGD symptoms, 10-18yrs at intervention/study, 6-18mths post loss (≤ 60%)</td>
<td>IPCG-C CDI CPSS CBCL (pre- to post-)</td>
<td>PGD severity (large) Depression (small to medium) PTSS (large) Internalizing Externatizng</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Hill et al., 2019, US</td>
<td>MGT, indicated (individual)</td>
<td>Phase I: psychoeducation, Phase II: narrative construction, trauma-focused grief therapy, sharing loss narrative with caregiver. Caregiver-child exercises provided to improve their communication skills to help children process their grief</td>
<td>No control</td>
<td>65 bereaved children with elevated prolonged grief/psychological distress, 6-17yrs at intervention/study, 3-16yrs at loss, 1-8mths from loss to intervention (≤ 6%)</td>
<td>PCBD checklist UCLA-RI SMFQ (pre-, post-phase I, post-phase II)</td>
<td>MG reactions (Phase I: large &amp; Phase II: medium to large) PTSS (Phase I: large &amp; Phase II: medium to large) Depression (Phase I: large &amp; Phase II: medium to large)</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Davis &amp; Tungol, 2019, India</td>
<td>TAAT, indicated (group)</td>
<td>Psychoeducation, CBT, grief therapy, trauma processing, art therapy, mindfulness</td>
<td>No control</td>
<td>10 parentally bereaved female children with elevated prolonged grief/psychological distress, 12-17yrs at intervention/study, 8-60mths post loss (10%)</td>
<td>DASS-21 (pre- to post-)</td>
<td>Depression (large) Anxiety (large) Stress (large)</td>
<td>n/a</td>
<td></td>
</tr>
<tr>
<td>Herres et al., 2017, US</td>
<td>TGCT-A indicated (group)</td>
<td>Phase I: psychoeducation; Phase II: narrative construction and processing using trauma or grief therapeutic approaches, sharing narrative with group; Phase III: consolidation, promoting developmental progress.</td>
<td>No control</td>
<td>44 children with experience of loss-related or other trauma, with elevated PTSS or MG, M=13.4yrs, SD=7.8yrs, at intervention/study Date of loss or other trauma not reported (≤ 9%)</td>
<td>BPC, SDQ, SMFQ, 8 grief items aligned with DSM-5, UCLA-RI (pre-) Self-rated top problem severity (pre-, post-Phase I, post-Phase II, post-Phase III)</td>
<td>Internalizing &amp; externalizing - to examine covariance with MG &amp; PTSS, and moderating effects on top problems’ rates of change Top problems (classified into internalizing &amp; externalizing) (large)</td>
<td>n/a</td>
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</table>

(d) Quantitative: Descriptive observational research –

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<thead>
<tr>
<th>Author, date, location</th>
<th>Intervention, classification (delivery mode)</th>
<th>Components</th>
<th>Control</th>
<th>Sample</th>
<th>1Participant ages, (% bereaved by parental suicide &amp; their 2ages)</th>
<th>2Outcome measures (timing of data collection)</th>
<th>Quantitative evidence of Effectiveness – Significant effects (p &lt; 0.05) are presented in bold (effect size)</th>
<th>Qualitative evidence of Acceptability – Emerging themes (Qualitative approach)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daigle &amp; Labelle, 2012, Canada</td>
<td>PCBS, selective (group)</td>
<td>Psychoeducation, CBT including psychosocial activities, grief therapy, problem-solving, art and drama, and bibliotherapy components. Caregivers joined sessions for last 30mins to enhance family communication</td>
<td>No control</td>
<td>8 children bereaved by parental loss to suicide, 6-12yrs at intervention/study Intervention provided as soon after loss as participants were willing, (100%)</td>
<td>Grief Scale BYI EQ-I- YV (pre- to post-)</td>
<td>MG reactions Depression Anxiety Internalizing Externatizng General mental health problems Quality of life: school, personal &amp; social domains</td>
<td>n/a</td>
<td></td>
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</tbody>
</table>
### TABLE 1. Continued.

<table>
<thead>
<tr>
<th>Author, date, location</th>
<th>Intervention, classification (delivery mode)</th>
<th>Components</th>
<th>Control</th>
<th>Sample 2</th>
<th>Participant ages, (% bereaved by parental suicide &amp; their 2 ages)</th>
<th>Outcome measures (timing of data collection)</th>
<th>Quantitative evidence of Effectiveness – Significant effects (p &lt; 0.05) are presented in bold (effect size)</th>
<th>Qualitative evidence of Acceptability – Emerging themes (Qualitative approach)</th>
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<tbody>
<tr>
<td>(e) Mixed method research (MMR) –</td>
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<tr>
<td>Grassetti et al., 2015, US</td>
<td>TGCT-A, indicated (group)</td>
<td>Refer to components as set out for Herres et al., 2017, above</td>
<td>No control (Quantitative component - quasi-experimental study)</td>
<td>Refer to participant data as set out for Herres et al., 2017, above</td>
<td>8 grief items aligned with DSM-5 PCBD criteria SMFQ UCLA-RI (pre-, post-Phase I, post-Phase II, post-Phase III)</td>
<td>MG reactions (medium to large) Depression PTSS (medium to large)</td>
<td>n/a (MMR study design included qualitative data collection/ analysis of children's narratives which was not reported. Rather, it was used by the researchers to allocate participants to trauma or grief therapeutic approaches)</td>
<td></td>
</tr>
<tr>
<td>Veale, 2014, Ireland</td>
<td>Children’s Bereavement Group, selective (group)</td>
<td>Psychoeducation, grief therapy utilizing artwork, physical activities, worksheets, activities to remember the deceased, storytelling, mindfulness, play components</td>
<td>No control (Quantitative component - descriptive observational study)</td>
<td>5 suicide bereaved children, 8-12yrs at intervention &amp; study 1-4yrs from loss to intervention (60%: 8, 9 &amp; 10yrs: ages at intervention/ study, 4, 8 &amp; 9yrs: ages at loss)</td>
<td>Function Assessment CBCL Function Assessment &amp; Social network/ relationship strength method, Semi-structured interviews (pre to post, 6mth &amp; 4yr follow-ups)</td>
<td>MG reactions Internalizing Externalizing Quality of life: school, personal &amp; social domains Components Delivery Perceived utility: • Grief responses: acceptance, meaning making, universality • Psychological wellbeing: internalizing • Quality of life: social domain • Personal growth: altruism (Child-centric approach)</td>
<td></td>
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</tr>
<tr>
<td>Griffiths et al, 2022, Australia</td>
<td>LHCK, selective (grief camp)</td>
<td>Psychoeducation and grief therapy, artwork, play, commemoration activities, mindfulness, separate and joint sessions for children and caregivers</td>
<td>No control (Quantitative component - descriptive observational study)</td>
<td>12 children bereaved by caregiver loss, 5-12yrs at interventions’ study 1.5 - 66mths from loss to intervention (60%: 7yrs: at intervention/ study, 4yrs: age at loss)</td>
<td>IPG-C SDQ CSQ: closed &amp; open questions Post-test child &amp; parent open-ended questionnaires (pre- to post, &amp; 6mth follow-up)</td>
<td>PGD symptoms Internalizing Externalizing Quality of life: social domain (small to medium) Components Delivery Perceived utility: • Psychological wellbeing: internalizing • Quality of life: social domain • Personal growth: gratitude/ positivity (Child &amp; parent open ended questioning)</td>
<td></td>
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</tr>
<tr>
<td>McClatchey &amp; Wimmer, 2012, US</td>
<td>Camp MAGIK, indicated (grief camp)</td>
<td>Trauma and grief-based focus, psychoeducation, artwork, reflection, memorial service, camp and play components. Separate caregivers’ psychoeducation workshop to help support children’s grief</td>
<td>n/a</td>
<td>19 children bereaved by caregiver loss with elevated PTSS and CTG symptoms 8-17yrs at intervention/ study, 1-66mths from loss to intervention, (11%: 16 &amp; 17yrs: ages at intervention)</td>
<td>Semi-structured interviews with children and parents, (3 &amp; 9mths post-intervention)</td>
<td>n/a Components Relationships Perceived utility: • Grief responses: acceptance, universality • Psychological wellbeing: depression • Quality of life: school domain</td>
<td></td>
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</tbody>
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(continued)
<table>
<thead>
<tr>
<th>Author, date, location</th>
<th>Intervention, classification (delivery mode)</th>
<th>Components</th>
<th>Sample</th>
<th>Control</th>
<th>Outcome measures (timing of data collection)</th>
<th>Quantitative evidence of Effectiveness – Significant effects (p &lt; 0.05) are presented in <strong>bold</strong> (effect size)</th>
<th>Qualitative evidence of Acceptability – Emerging themes (Qualitative approach)</th>
</tr>
</thead>
<tbody>
<tr>
<td>McClatchey et al., 2021, US</td>
<td>Camp MAGIK</td>
<td>Refer to components as set out for McClatchey Wimmer, 2012, above</td>
<td>8 parentally bereaved adolescents/young adults, who had attended camp &amp; returned as volunteers, • 10-17yrs at intervention, • 16-18yrs when started as camp volunteers, • 8-17yrs at loss, • study interviews: within 2yrs of volunteering (22%: 11 &amp; 15yrs at intervention, 8 &amp; 15yrs at loss, &gt;18 &amp; &gt;16yr at interview)</td>
<td>n/a</td>
<td>Semi-structured interviews (within 2yrs of volunteer experience)</td>
<td>n/a</td>
<td>• Personal growth: improved self-concept (Phenomenology) Components</td>
</tr>
<tr>
<td>Brewer &amp; Sparkes, 2011, UK</td>
<td>Rocky Center, selective (residential weekends - grief camp)</td>
<td>Psychoeducation, grief counseling, groupwork sessions, play and social components, and activities in remembrance of deceased parents</td>
<td>13 parentally bereaved children/young adults, &lt;18yrs at intervention participation, 3-13yrs: ages at loss 9-25yrs: ages at interview (38%: 12-19yrs at interview, 3-13yrs at loss)</td>
<td>n/a</td>
<td>Overt researcher observation of Rocky Center participants spanning two years, in-depth interviews &amp; archive analysis (2-15yrs post loss)</td>
<td>n/a</td>
<td>Components</td>
</tr>
<tr>
<td>Koblenz, 2016, US</td>
<td>Therapist services Selective/ indicated interventions (individual)</td>
<td>Interventions components referred to by participants included individual therapy, grief therapy, bereavement-focused therapy, remembering the deceased, commemorative activities, group activities with other bereaved children</td>
<td>19 adults bereaved by childhood parental loss, 3-19yrs: ages at loss 19-39yrs: ages at interview (11%)</td>
<td>n/a</td>
<td>Unstructured open-ended group interviews</td>
<td>n/a</td>
<td>Components</td>
</tr>
<tr>
<td>Andriessen et al., 2019, Australia</td>
<td>Various specified types of interventions e.g. counseling, grief camps, psychiatry, psychologists, support groups selective/ indicated (individual, group, grief camps, &amp; none)</td>
<td>Individual grief therapy, mental health support, counseling</td>
<td>39 adolescents &amp; young adults bereaved in childhood by the loss of a loved one, 13-18yrs at loss, 13-27yrs at interview, 6mths–10yrs, M = 4.92yrs, SD = 3.08yrs, from loss to date of interview, (&lt;16%-14-23yrs at interview)</td>
<td>n/a</td>
<td>Open-ended individual telephone interviews</td>
<td>n/a</td>
<td>Delivery</td>
</tr>
<tr>
<td>Andriessen et al., 2022, Australia</td>
<td>Various specified types of interventions, e.g. psychologists, grief</td>
<td>Psychoeducation, psychosocial support, professional community-based counseling,</td>
<td>18 adolescents &amp; young adults bereaved in childhood by the loss of a loved one to suicide, 12-18yrs at loss, 14-23yrs at</td>
<td>n/a</td>
<td>Open-ended individual telephone, or group face-face interviews</td>
<td>n/a</td>
<td>Components</td>
</tr>
</tbody>
</table>
TABLE 1. Continued.

<table>
<thead>
<tr>
<th>Author, date, location</th>
<th>Intervention/ classification (delivery mode)</th>
<th>Components</th>
<th>Control</th>
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</thead>
<tbody>
<tr>
<td>camps, support groups selective/ indicated (individual, group, grief camps, &amp; none)</td>
<td>counseling provided at school; some interventions also incorporated family sessions</td>
<td>interview, 1-9 yrs, M = 3.72 yrs, SD = 2.09 yrs, from loss to date of intake, (61% 14-23 yrs at interview)</td>
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</tbody>
</table>

Quantitative evidence of Intervention, (Outcome measures (timing of data collection))

Effectiveness – Significant effects (p < 0.05) are presented in bold (effect size).

Qualitative evidence of Acceptability – Emerging themes (Qualitative approach)

Qualitative evidence of Relationships

Perceived utility:
- Grief responses: acceptance
- Psychological wellbeing: general mental health, internalizing (Inductive content analysis)

(1) Intervention/ abbreviations: Abangane - translated as "friends" in isiZulu; Camp MAGIK = Mainly About Grief In Kids camp intervention; CBT = cognitive behavioral therapy; CEBT = Cognitive Emotional Behavioral Therapy; CG = control condition group; FBP = Family Bereavement Program; IG = intervention group; LHCK = Lionheart Camp for Kids; MG = maladaptive grief; MGT = Multidimensional Grief Therapy; MMR = study applying mixed methodology; PCBS = Group Therapy Program for Children Bereaved by Suicide; PGO = prolonged grief disorder; PTSS = post-traumatic stress symptoms; Rocky Center = pseudonym applied by the researchers for this bereavement intervention; TAAT = Transactional Model of Acceptance Art Therapy; TF-CBT = Trauma-focused CBT; TGCT-A = Trauma and Grief Component Therapy for Adolescents.

(2) Participant ages = Age range/ mean (M) age at date of intervention, age at date of loss or time from loss to intervention participation, and/ or age at study participation, if reported.

(3) Outcome measures: ASR = Adult Self-Report (Achenbach & Rescorla, 2003); BPC = Brief Problem Checklist (Chorpita et al., 2010); BPM-P = Brief Problem Monitor-Parent Form - 19-item subset of the Child Behavior Checklist (Achenbach et al., 2011); BYI = Beck Youth Inventories of Emotional and Social Impairment (Beck et al., 2001); CAPS-CA = Clinician-Administered PTSD Scale for Children and Adolescents (Nader et al., 1996); CBCL = Child Behavior Checklist (Achenbach, 1991a; Achenbach and Rescorla, 2004); CBI-G = Grief subscale of Core Bereavement Items (Burnett et al., 1997); CDI = Children’s Depression Inventory (Kovacs, 1992; Kovacs, 2003); CES-DC = 20-item Center for Epidemiological Studies-Depression Scale for Children (Faulstich et al., 1986; Children’s Hope Scale (Nader et al., 1996); CGAS = Children’s Global Assessment Scale (Shaffer et al., 1983); CIDI = Composite International Diagnostic Interview (Robins et al., 1988); CPSS = Child PTSD Symptom Scale (Foa et al., 2001); CPTQ = Child Post-Traumatic Cognitions Inventory (De Haan et al., 2016); CSQ = 10-item caregiver questionnaire adapted from Client Satisfaction Questionnaire (Larsen et al., 1979); DASS-21 = Short Depression and Anxiety Stress Scales - 7 items per scale (Singh et al., 2013); Future Expectations Scale (Eccles, 1997); EQ-5Y = BarOn Emotional Quotient Inventory: Youth Version (Bar-On & Parker, 2000); Function assessment (Bolton & Tang, 2002); GPA measured as average of core subject class grades from school transcripts for the year preceding 6 year follow-up; Grief Scale constructed from grief descriptions by Worden (1991); ICG-RC = Inventory of Complicated Grief-Revised for Children (Priegerson et al., 1995; Melhem et al., 2013); IGTST = Intrusive Grief Thoughts Scale (Holland et al., 2013); ILK = Inventory of Quality of Life for Children (Mattejat & Remschmidt, 2006); IPG-C = Inventory of Prolonged Grief for Children (Priegerson et al., 1995; Priegerson et al., 2009); PCBD checklist = Persistent Complex Bereavement Disorder Checklist (Layne et al., 2014); Psychological measures - Cardiac interbeat interval, cardiac pre-ejection period, and respiratory sinus arrhythmia; Possible Jobs Scale (Tucker et al., 1997); SACA = Service Assessment for Children and Adolescents (Stiffman et al., 2000); SCARED = Screen for Child Anxiety-Related Emotional Disorders (Birmaher et al., 1999); SDQ = Strengths and Difficulties Questionnaire (Goodman, 1997; Goodman et al., 1998); Self-rated top problem severity - participants identified and rated their top three problems in baseline-screening interviews and then rated the problems' weekly severity at the start of each therapy session (Weisz et al., 2011); SMFQ = Short Mood and Feelings Questionnaire (Angold et al., 1995); Social network/ relationship strength method, adapted from Family Links Map developed by Hogan et al. (2002); UCLA-RI = UCLA PTSD Reaction Index (Elhai et al., 2013; Pynoos et al., 1998; Steinberg et al., 2004); YABCL = Young Adult Behavior Checklist (Achenbach & Rescorla, 2003); YSR = Youth Self Report (Achenbach, 1991b).

(4) FBP research: 244 children and their caregivers from 156 bereaved families participated in original RCT (Sandler et al., 2003).

relatives. Three quantitative studies and one MMR involved children with experience of non-loss trauma within participant cohorts, e.g., abuse, domestic violence. Percentages of participants bereaved by parental suicide during childhood are presented in Table 1, and discussed in the Quantitative and Qualitative findings sections, below.

**Identified interventions**

Of the 12 identified manual-based interventions, six were designed as selective interventions targeted to children from specific subgroups of the population with above average risk of developing psychological disorder, such as parentally- or suicide-bereaved children. Four group interventions and two bereavement camps were classified as selective. The remaining six identified interventions were designed as indicated interventions for high-risk individuals already demonstrating measurable signs of psychological disorder, for example elevated MG or PTSD symptoms (Institute of Medicine, 1994). These indicated interventions comprised three groups, two individual interventions and one bereavement camp.

Ten interventions reported time from loss to intervention. Only one support was offered solely for recently bereaved children (FBP: <30mths post loss) and nine were provided for participants, with experience of both recent (<30mths) and longer-term bereavement/trauma.

The supports investigated alongside other intervention types included grief therapists, psychologists, camps and support groups.

A broad range of intervention components were identified including psychoeducation, grief therapy, cognitive behavioral therapy (CBT). All indicated interventions used trauma-focused approaches incorporating loss narrative construction.

**Quantitative findings**

**Participant heterogeneity**

All eight interventions that demonstrated significant effects involved heterogeneous user groups, including children bereaved by parental suicide and other participants with experience of childhood trauma/loss from diverse causes, with variously-related deceased. Notwithstanding heterogeneity, significant effects were mostly reported for study participants as one combined group, i.e., intermixing findings for children bereaved by parental suicide and findings for other participants. Eleven studies reported percentages of children bereaved by parental suicide as between <2% to <21% (Table 1). Only one study, assessed low quality, reported a majority of suicide-bereaved participants (60%: Spuij et al., 2015). Thus, whilst sub-group findings specific to childhood parental suicide might provide useful information, they could have questionable statistical power.

**Significant effects**

Significant intervention effects were reported for grief responses, mental health, quality of life. These effects were visually analyzed by reference to study design, intervention type, participant ages (Figure 2). Key results are discussed below, (Table 1 provides details of interventions, related studies and participant).
FIGURE 2. Quantitative evidence: Significant intervention effects. Organized by: (a) study design; (b) intervention type; and (c) participant ages at intervention/ research participation.
(b) Organized by intervention type

<table>
<thead>
<tr>
<th>Author Intervention</th>
<th>Significant effects:</th>
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<tbody>
<tr>
<td></td>
<td>Grief response:</td>
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<td>Mental health:</td>
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<td></td>
<td>MG reactions</td>
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<td></td>
<td>Depression</td>
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<td></td>
<td>Anxiety</td>
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<td>Externalizing</td>
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<td>PTSS</td>
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<td>General concerns</td>
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<td></td>
<td>Suicide behaviors</td>
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<tr>
<td></td>
<td>Social domain</td>
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</table>

**Indicated interventions:**

**Individual**
- Boelen CBT-Grief Help
- Spuij CBT-Grief Help
- Hill MGT

**Group**
- Goldbeck T-CBT
- Davis: TAAT
- Grassetti TQCT-A
- Herres TGCT-A

**Selective interventions:**

**Group**
- Thurman Abangane
- Luecken FBT
- Sandler 2016 FBT
- Sandler 2018 FBT

**Grief Camp**
- Griffiths LHCK

**Effect sizes:**

- Large
- Medium to large
- Medium
- Small to medium
- Small

**Note:**
(1) See Table 1 for legend.
(2) Statistically significant effects:
   - Cohen’s d: small ≤ .2,
   - medium .5, large ≥ .8.

**FIGURE 2.** Continued.
(c) Organized by participant ages at intervention/ research participation

<table>
<thead>
<tr>
<th>Author</th>
<th>Intervention</th>
<th>Grief response</th>
<th>Mental health</th>
<th>Anxiety</th>
<th>Externalizing</th>
<th>Internalizing</th>
<th>PTSS</th>
<th>General concerns</th>
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<tr>
<td></td>
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<td>MG reactions</td>
<td>Depression</td>
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<tr>
<td>Children ≤ 12yrs at intervention</td>
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<tr>
<td>Griffiths</td>
<td>LHCK: 5-12yrs</td>
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</table>

| Children ≤ 12yrs & adolescents (12-18yrs) at intervention |
| Boelen      | CBT-GH: 8-18yrs |    |               |         |              |              |      |                 |                  |               |
| Spuij       | CBT-GH: 10-18yrs|    |               |         |              |              |      |                 |                  |               |
| Hill        | MGT: 6-17yrs   |    |               |         |              |              |      |                 |                  |               |
| Goldbeck    | TF-CBT: 7-17yrs |    |               |         |              |              |      |                 |                  |               |

| Adolescents (12-18yrs) at intervention |
| Tharman     | Abungane: 13-17yrs |       |               |         |              |              |      |                 |                  |               |
| Davis       | TAAT: 12-17yrs   |    |               |         |              |              |      |                 |                  |               |
| Grassetti   | TGCT-A: grade 7/8|    |               |         |              |              |      |                 |                  |               |
| Herres      | TGCT-A: grade 7/8|    |               |         |              |              |      |                 |                  |               |

| Adolescents (12-18yrs) & young adults (19-32yrs) at testing for follow-up research participation (8-16yrs at intervention) |
| Luecken     | FBT: 14-23yrs at 6yr follow-up testing |    |               |         |              |              |      |                 |                  |               |
| Sandoller 2016 | FBT: 14-23yrs at 6yr & 23-32yrs at 15yr follow-up testing |    |               |         |              |              |      |                 |                  |               |
| Sandoller 2018 | FBT: 23-32yrs at 15yr follow-up testing |    |               |         |              |              |      |                 |                  |               |

**Effect sizes:**
- Large
- Medium to large
- Medium
- Small to medium
- Small

**Note.**
1. See Table 1 for legend.
2. Statistically significant effects:
   - Cohen’s $d$: small ≤ .2,
   - medium .5, large ≥ .8.

**FIGURE 2.** Continued.
**Grief responses.** Two individual and two group interventions \((n = 5\) studies) reported significant MG reductions: CBT Grief-Help, \((n = 2\) studies), (i) small-medium effects post & -3mths, medium-large –6 & -12mths, (ii) large; MGT, large–Phase I, medium-large–Phase II; Abangane: small; TGCT-A: medium-large.

**Mental health.** Five indicated interventions demonstrated significant mental health effects \((n = 7\) studies). Both individual interventions ameliorated participants’ depression and posttraumatic stress (PTSD) – CBT Grief-Help, \((n = 2\) studies), (i) small-medium, both concerns, (ii) small-medium and large, respectively; MGT, large – Phase I, medium-large – Phase II, for both concerns. Three indicated group supports alleviated a broader range of psychological difficulties:

- Anxiety & depression – TAAT: large; Tf-CBT: small-medium
- Externalizing & internalizing – TAAT: large; Tf-CBT: small-medium & medium, respectively; TGCT-A: large
- PTSD – Tf-CBT: small-medium; TGCT-A: medium-large
- General psychological concerns – Tf-CBT: medium

Two selective group interventions demonstrated significant beneficial effects \((n = 4\) studies): Abangane, depression: small, externalizing: small-medium; and FBP, \((n = 3\) studies), (i) externalizing –6yrs: small-medium; (ii) suicide behaviors, -15yrs: large, –6 & -15yrs combined: medium-large; (iii) internalizing, externalizing, general psychological concerns, -15yrs: small-medium.

**Quality of Life.** One MMR (camp intervention) reported significant positive effects (small-medium) on quality of life for children (5-12yrs).

**Moderating Variables.** Only one intervention (CBT Grief-Help) was investigated for moderating effects. Boelen et al. (2021), RCT, reported greater MG improvements for parentally-bereaved participants vis-a-vis other relatives, and more pronounced short-term MG effects for older participants. Spuij et al. (2015), uncontrolled exploratory study, reported less sizeable ameliorating effects on externalizing for suicide-bereaved participants, and on depression for children with more distant loss; neither variable demonstrated moderating effects in the 2021 study.

In summary, most effectiveness evidence was demonstrated for grief responses and psychological concerns in studies that involved adolescent intervention participants (12-18yrs) either exclusively or together with younger children (<12yrs). More sizeable beneficial effects were reported in uncontrolled studies, with controlled studies evidencing a greater number of smaller effects. Indicated interventions demonstrated a greater number and increased size of effects (Figure 2).

**Qualitative findings**

**Participant heterogeneity**

The eight studies that evidenced acceptability reported findings developed from majority consensus of heterogeneous users, including participants bereaved by parental suicide in childhood, and generally did not refer to variations among users’ perceptions, notwithstanding heterogeneity. Six studies reported 8-25% participants as bereaved by parental
suicide in childhood; two studies reported higher percentages (Andriessen et al., 2022: 61%; Brewer & Sparkes, 2011: 38%). One study reported overall similarity in responses for suicide-bereaved children and other participants, (Andriessen et al., 2019); another involved only suicide-bereaved participants (Andriessen et al., 2022); neither alluded to differences arising from reported varying relationships.

All studies however emphasized that, as qualitative research, findings were unique to their particular participants, providing illuminative, not definitive, answers to research questions. Hence, evidence presented supportive of qualitative findings in this review includes quotations from participants bereaved by parental suicide in childhood, where reported; other participants’ perceptions have also been quoted as illustrative of developed themes.

**Acceptability**

Four acceptability themes were developed:

**Perceived utility.** This theme, derived from eight studies, incorporated four subthemes – grief responses, mental health, quality of life, personal growth (Figure 3 provides supporting evidence).

Firstly, “Grief responses”, was evidenced for two camps (n = 3 studies), one group intervention (n = 1 study), and several specified intervention types (n = 3 studies), and encompassed positive, adaptive response changes: acceptance, meaning-making, universality.

Secondly, participants perceived improvements for four “Mental health” concerns (n = 6 studies) – anxiety, depression, general mental health, internalizing. Most mental health evidence was provided retrospectively by teenage/adult participants (13-39yrs; n = 3 studies) for individual interventions offered following childhood bereavement.

Thirdly, two camps (n = 3 studies) and one group intervention (n = 1 study) evidenced benefits to “Quality of life”: school, personal, social domains.

Finally, three “Personal growth” attributes emerged: altruism; positivity/gratitude; improved self-concept, across three camps (n = 4 studies), one group (n = 1 study), and several specified supports (n = 1 study). Two camp studies reported most personal growth evidence (9-25yrs, 16-18 + yrs).

**Relationships.** Six studies evidenced three underlying sub-themes.

Firstly, participants welcomed “Connection,” with facilitators and with interventions (n = 5 studies):

... importance of feeling ... connected through ... personal relationship, (Andriessen et al., 2022, p. 3; 14-23yrs: interview: 12-18yrs: suicide-bereavement).

[camp is] part of my personality... ’I am a student... waitress... I volunteer at camp ... it became part of me, (McClatchey et al., 2021, p. 236; female; 16yrs; both parents, murder/suicide).

Secondly, campers (n = 2 studies) appreciated “Peer-bonding”:

... bonding ... with ...other people ... brings ... people together, to feel wanted, to feel... their lives are not over, (McClatchey & Wimmer, 2012, p. 25; female; 16yrs; parental suicide).
<table>
<thead>
<tr>
<th>Effects</th>
<th>Elements/domains</th>
<th>Sample participant observations</th>
<th>Participant quote(s)</th>
<th>Study contexts*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grief/loss</td>
<td>Acceptance</td>
<td>“[I] remember coming back to school and how much easier it was to accept and understand the world... cause I can feel again... camp gave me the ability to feel” (McClatchey, 2012, p. 20)</td>
<td>Male: 14yrs; parent: heart attack</td>
<td>4</td>
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<td>“after the group, I felt I could talk to people - before the group, I bottled things up and never really talked about my Da” (Veale, 2014, p. 198)</td>
<td>Female: 10yrs; parent suicide</td>
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<td></td>
<td>Meaning-making</td>
<td>“I’ve realized that it was never my fault...She didn’t lay her problems on me... she knew it would be too much...understood me. I’m not angry at her anymore...I think that everything went wrong” (Andriessen, 2019, p. 3)</td>
<td>Female: 13-27yrs at study date; 13-18yrs at loss; aunt-godmother suicide</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Universality</td>
<td>“It was good to know that there were other people... I realized I’m not the only one who’s been through it” (Brewer, 2011, p. 218)</td>
<td>Reported as “typical” participant observation; 9-25yrs, study date; 3-13yrs, loss; parentally bereaved</td>
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<td>“I got to meet people who knew how I was feeling - and other people who had lost parents and understood the pain and the emptiness... It helped me feel like I’m not alone.” (McClatchey, 2012, p. 23)</td>
<td>Female; 17yrs; parent suicide</td>
<td>3</td>
</tr>
<tr>
<td>Mental health</td>
<td>Anxiety</td>
<td>“some adolescents... reported substantial benefit with their... anxiety” (Andriessen, 2019, p. 3)</td>
<td>13-27yrs, study date; 13-18yrs: loss of loved one</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Depression</td>
<td>“in grade scho., I was so depressed. So my parents put me in therapy in 9th grade... I stayed throughout high school, and it changed my life.” (Koblenz, 2016, p. 221)</td>
<td>19-39yrs, study; 3-19yrs, parentally bereaved</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>General</td>
<td>“They taught [sic] you not to be sad, when you talk about stuff” (McClatchey, 2012, p. 19)</td>
<td>Male; 10yrs; parent: cancer</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Internalizing</td>
<td>“…literally saved my life. If I didn’t go... I probably wouldn’t be here” (Andriessen, 2021, p. 4)</td>
<td>Female; 14-23yrs, study date; 12-18yrs, suicide bereaved</td>
<td>2</td>
</tr>
<tr>
<td></td>
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<td>“You don’t realizing it before, but everything just feels... easier afterwards” (Andriessen, 2021, p. 4)</td>
<td>Female; 14-23yrs, study date; 12-18yrs, suicide bereaved</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“I fall asleep quicker at night. I’m happier... My feelings and heart” (Griffiths, 2019, p. 8)</td>
<td>5-12yrs at intervention; loss of caregiver</td>
<td></td>
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</tbody>
</table>

**FIGURE 3.** Perceived utility: Qualitative evidence. *Number of research studies that provided evidence for each theme.*
| Quality of life | School | “... during school I joined a musical... I remember singing in front of Camp... I think that was the first step... after... I was like I can’t let anything hold me back. Now I take more steps and I auditioned for this and I did that,” (McClatchey, 2012, p. 25) | Female; 16yrs; parenthood suicide | 1 |
| | Self | “So if you have the opportunity [of volunteering at camp] ... go through it again... then you feel empowered afterwards” (McClatchey, 2021, p. 238) | Female; 16yrs; parent: medical negligence | 2 |
| | Social | “I liked making new friends” (Veale, 2014, p. 200) | Male; 8yrs; parent suicide | 4 |
| | | “I am still in touch with everyone I went to camp with almost three years ago ... me and this one kid, we’ve been best friends for like three years because of camp” (McClatchey, 2021, p. 236) | Female; 16yrs; loss of cousin: in childbirth |  |
| Personal growth | Altruism | “I want to help other people who have suffered in the same way as me as much as I can... they don’t have to feel bad...” (Brewer, 2011, p. 215) | Male; 12yrs; parent suicide | 3 |
| | | “four years post-intervention. Two participants told of how they have taken leadership roles in their schools on suicide, suicide bereavement and prevention.” (Veale, 2014, p. 201) | 12-16yrs, 6-yr follow up interview; 4-11yrs, parent/uncle suicide |  |
| | Positivity/ | “once you’ve experienced the lows the happiness is, you sort of appreciate it a lot more” (Brewer, 2011, p.213) | Male; 17yrs; parent suicide | 3 |
| | gratitude | “When you are happy you take advantage of that happiness, ... you make the most of it and I think that’s the most important thing you make the most out of life ... enjoy it while you’ve still got it.” (Brewer, 2011, p. 213) | Male; 19yrs, study date; 8yrs, parent suicide |  |
| | Self-concept | “I was thankful. Camp helped me out a lot ... they gave so much to me,” (McClatchey, 2021, p. 235) | Female; 16yrs; 8th parents: murder/ suicide |  |
| | | “I think now I kind of look at it as maybe I’m a better person for it because I’ve had something like that.” (Brewer, 2011, p. 211) | Female; 17yrs; parent: cancer |  |
| | | “I am more confident than I used to be... I don’t feel like I have to let anything hold me back anymore.” (McClatchey, 2012, p. 25) | Female; 16yrs; parent suicide |  |

* Number of research studies that provided evidence for each theme

FIGURE 3. Continued.
... all shared that bond... able to understand... all had something similar happen, (McClatchey et al., 2021, p. 235; female; 18yrs: interview; 16yrs: loss; parent: medical negligence).

Thirdly, having “Trust” in providers was important (n = 3 studies):

what helps... most was having someone... I... feel comfortable talking to... no judgement... understands where I’m coming from... (Andriessen et al., 2019, p. 4; female; 13-27yrs: interview: 13-18yrs: suicide-bereaved)

I felt... she was listening to me... felt respected and heard, (Andriessen et al., 2022, p. 4; female; 14-23yrs: interview; 12-18yrs: suicide-bereaved)

In conclusion, most evidence in support of the Relationships theme concerned “Connection” and “Trust”, and stemmed from retrospective recollections of various interventions, by adolescent/adult participants (n = 2 studies; 13-27yrs: interview; 12-18yrs: loss).

Components. Five intervention components contributed to acceptability (n = 7 studies).

“Commemorative activities” helped (n = 3 studies). For example, older parentally-bereaved participants (19-39yrs: interview; 3-19yrs: loss) appreciated ceremony, and positive memories, “Rituals were comforting,” ... “I love looking at pictures of him ...” (Koblenz, 2016, pp. 211, 214). Camp participants (8-17yrs) valued communicating with the deceased, e.g., “... they let all their feelings in a balloon ... let it go ... ‘That helped,’” (McClatchey & Wimmer, 2012, p. 22; male; 8yrs; parent heart attack).

“Creative/play-based activities” were also important (n = 4 studies). Talent show performances, for example, had “profound impact” (McClatchey & Wimmer, 2012, p. 25; female; 16yrs; parent suicide). Younger children (≤12yrs) liked hands-on activities, including “making things” ... “Shaking the glass... with colors mixing,” (Griffiths et al., 2022, p. 8; campers; 5-12yrs; caregiver loss); “play with toys... drawing,” (Veale, 2014, p. 200; male; 8yrs; parent suicide).

Thirdly, participants valued creating “Loss narratives” (4 studies), e.g.,

When... written... you get... better glimpses of what happened... better realization ... helps you cope... (McClatchey & Wimmer, 2012, p. 22; teenage boy; parent suicide).

As... young people tell their stories... the more they... restructure events favorably the more... enhanced their sense of personal well-being, (Brewer & Sparkes, 2011, p. 211; 19-39yrs: interview; 3-19yrs: parental loss).

It helped you... get over it because you talk about it more. (Veale, 2014, p. 198; male; 9yrs; parent suicide).

“Counselling” also rated highly (n = 3 studies). For example, individual counseling was “so much relief,” (Andriessen et al., 2022, pp. 3-4; female, 14-23yrs; 12-18yrs: suicide-bereaved). Group counseling was “really helpful” (McClatchey & Wimmer, 2012, p. 19; female; 17yrs; parent suicide).

Finally, “Learning activities” were useful (n = 2 studies), e.g.,

She taught me a lot of strategies to deal with things, (Andriessen et al., 2022, p. 4; female, 14-23yrs; 12-18yrs: suicide-bereaved).

... when I left camp ... I realized ... subliminally I was using things ... I learned at camp, (McClatchey et al., 2021, p. 235; female; 17yrs; parent: cancer).
Delivery. Two contributors to acceptability emerged \( (n = 4 \text{ studies}) \),

Firstly, “Agency,” was highly rated \( (n = 2 \text{ studies}) \), e.g., “He’d just talk to me and I’d completely guide the conversation… made me feel better,” (Andriessen et al., 2022, p. 5; female, 14-23yrs; 12-18yrs: suicide-bereaved). Another participant observed, “We wouldn’t just have to sit down and listen, could play… having a laugh,” (Veale, 2014, p. 200; male: 8yrs; parent suicide).

Secondly, users appreciated “Skills and commitment” \( (n = 4 \text{ studies}) \). Suicide expertise was important, “He was a child’s counsellor… tailored to suicides … knew what I was going through,” (Andriessen et al., 2022, p. 6; female, 14-23yrs; 12-18yrs – suicide-bereaved). Dedicated professionals were acknowledged, “If you lose someone… that’s the place to go… really got into people’s lives… They are there for you,” (McClatchey & Wimmer, 2012, p. 25; female; 16yrs; parent suicide). Caregivers also found intervention “beneficial to… my children… excellent… from committed caring people,” (Griffiths et al., 2022, p. 7: children, 5-12yrs; caregiver loss).

In conclusion, a clear set of acceptability themes were formed, which may be useful for intervention developers/facilitators to consider for loss/trauma survivors including children bereaved by parental suicide. Notably, the themes encompass perspectives of younger children (<12yrs), adolescents (12-18yrs) and adult study participants (19-39yrs; 3-19yrs: loss).

DISCUSSION

This study presents the first mixed method systematic review of the effectiveness and acceptability of interventions offered for children bereaved by parental suicide.

Identified interventions

Some parallels emerged with recent reviews concerning suicide-bereaved children (Journot-Reverbel et al., 2017); suicide-bereaved people (Andriessen et al., 2019); parentally-bereaved children (Bergman et al., 2017). These earlier reviews covered research from 1975-2018, and reported on only three interventions offered to participants that included children bereaved by parental suicide from research published prior to this review’s coverage period (2011-2023). In contrast, the current review provided new information regarding twelve manual-based interventions and various specified intervention types.

Effectiveness

Significant effects from this review correspond with earlier research. Bergman et al. (2017) reported significant effects ameliorating MG and PTSD for one indicated intervention offered to participants including children bereaved by parental suicide. The present study revealed additional effects for anxiety, depression, externalizing, internalizing, and general psychological difficulties across five indicated interventions. Secondly, for selective interventions offered for participants including children bereaved by parental suicide, Andriessen et al. (2019), reported significant effects for anxiety, depression; Bergman et al. (2017) described small effects for grief, anxiety, depression, externalizing, internalizing, social
difficulties. The present study evidenced more sizeable effects for these outcomes, and revealed new selective intervention effects on suicide behaviors and quality of life. Notably, inclusion of more wide-ranging study designs, heterogenous participant groups, and recency of research explains new information uncovered by the present review.

**Acceptability**

This review’s acceptability themes are consistent with previous research findings. Perceived utility aligns with emphasis from Dyregrov (2011) that professional support for suicide-bereaved people, including children, must be developed and offered for users’ specific needs, e.g., grief concerns, psychosocial distress. Highlighted as new learning is the value bereaved participants placed on acquiring adaptive grief responses and personal growth.

The Relationships theme has some correspondence with earlier youth-friendly intervention research regarding the importance of connection and trust, (Ambresin et al., 2013; Hawke et al., 2019). Reflecting Clute and Kobayashi (2013), this theme also included campers’ appreciation of peer-bonding with other bereaved children.

The Components theme aligns with appreciation for creative/play-based and learning activities from Clute and Kobayashi (2013). New findings emphasize the benefits of commemorative activities, loss narratives and counseling.

Finally, participants’ appreciation of skilled providers, corresponds with conclusions in Ambresin et al. (2013) and Hawke et al. (2019). New information regarding Delivery concerns the value of user agency embedded in intervention delivery.

**Strengths and Limitations**

Strengths of this review included rigorous study selection, with all title/abstract screenings and full-text reviews conducted independently by two researchers. The inclusion of qualitative acceptability data was also a strength, enhancing understandings of a greater range of interventions offered for children bereaved by parental suicide.

Attention is drawn to several limitations. Firstly, the restricted number of eligible studies and methodological concerns, including small sample sizes, moderated review findings. Also, diversity of outcome measures used may limit comparability of effects (Wilson et al., 2021). Furthermore, most included research reported findings for heterogeneous participant groups with experience of childhood loss/trauma from diverse causes including suicide, encompassing various relationships including parents, without explicit subgroup analyses. Caution is therefore recommended in applying findings of intervention effectiveness for children bereaved by parental suicide.

**Research Implications**

High-quality research is recommended to investigate effect variations for participant subgroups, particularly children bereaved by parental suicide, from interventions offered to heterogenous groups of bereaved/trauma survivors. Research aimed at increasing understanding of acceptability of mixed group interventions for children bereaved by parental suicide is also recommended.
**Conclusions**

This review provides a contemporary inventory of evidence-based interventions offered for mixed groups of children exposed to loss/trauma from diverse causes and relationships. Heterogeneity however limits specific conclusions regarding effectiveness for children bereaved by parental suicide. Further, applicability of acceptability findings for children bereaved by parental suicide was implicit rather than explicit in most qualitative studies. Nonetheless, this review presents evidence illuminative of intervention attributes that may improve acceptability for children impacted by loss/trauma, including bereavement by parental suicide.

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**DATA AVAILABILITY STATEMENT**

The authors confirm that the data supporting the findings of this study are available within the article and/or its supplementary files.
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