Addressing Grief and Bereavement: A Scoping Review of Psychosocial Interventions During and Post COVID-19

Introduction

The COVID-19 pandemic has been recognized as an international public health crisis. So far, over 650 million confirmed cases and approximately 6.6 million deaths have occurred globally directly due to COVID-19 (World Health Organization [WHO], 2022). The pandemic also led to a significant indirect death toll due to financial repercussions, impact on healthcare systems, increased violence and physical and psychological stress (Ray & Subramanian, 2020).

Deaths caused by COVID-19 and its associated complications led to grief that was inhibited, disenfranchised, complicated, prolonged or traumatic (Eisma et al., 2020; Ramadas & Vijayakumar, 2020; Yu et al., 2022). There were various reasons for this. Due to the quarantine rules, social distancing and safety protocols during the pandemic, the dying and mourning process was impacted. For example, usual funeral rites could not be carried out. This contributed to a worsening of grief reactions as it limited opportunities for people to bid goodbye to their loved ones (Gonçalves Júnior et al., 2020), access social support (Eisma et al., 2020) and express their grief freely (Ramadas & Vijayakumar, 2020).

Further, deaths due to COVID-19 were often sudden and unexpected, even amongst healthy and young individuals (Kaul, 2020), which led to more severe and more traumatic grief reactions among bereaved individuals (Kokou-Kpolou et al., 2020). Healthcare professionals, too, were impacted by death during COVID-19, as they were at a greater risk for witnessing loss (Inchausti et al., 2020).

Hence, many healthcare institutions, organizations and researchers trialled psychosocial interventions to address grief and bereavement during COVID-19, focused on reducing the adverse consequences of bereavement and promoting positive adaptation after the loss (Yu et al., 2022). However, the pandemic created unique demands for the provision of such mental health services, namely, adaptation to the shifting nature of the pandemic, navigation of the move towards briefer, remotely delivered sessions, the usage of appropriate methods to identify levels of need and the consideration of the needs of vulnerable populations (Duan & Zhu, 2020; Inchausti et al., 2020, Moreno et al., 2020; Rosen et al., 2020). Further, increased collaboration between mental health professionals and other professionals was required, sometimes through task-shifting of the delivery of psychological interventions either through digital means or through different professional groups (Békés & van Doorn, 2020).

Research identified mental health care needs specific to loss and grief during COVID-19 which would need to be addressed through psychosocial interventions. Examples included making challenging end-of-life decisions (e.g. when patients requiring mechanical support are unable to be extubated), assisting families in using social support networks despite social distancing protocols, addressing anticipatory grief and acknowledging the different nature of loss during COVID-19 (LeRoy et al., 2021; Stroebe & Schut, 2021). The need for an evidence-based, trauma-informed, resilience-focused and culturally-sensitive response to bereavement was highlighted (Kokou-Kpolou et al., 2020; Stroebe & Schut, 2021), as was the need for a systems response to mass bereavement, including collective meaning-making practices (Harrop et al., 2020). Specific sub-groups identified as needing mental health support included older adults, healthcare workers and children (Albuquerque & Santos, 2021;

Stroebe & Schut, 2021). With respect to the nature of interventions, remotely-delivered, proactive interventions aimed at crisis counselling were preferred (Harrop et al., 2020). Key components of grief interventions identified included structured psychoeducation, drawing on existing peer and social support (including group-based support) and formal risk assessment and referral (Laranjeira et al., 2022; Stroebe & Schut, 2021). Innovative approaches such as theatre-based interventions were also proposed (Rushton et al., 2020). Theoretical frameworks suggested to address grief included the Dual-process Model (DPM; Stroebe & Schut, 2021) and Cognitive Behavioural Therapy (CBT; Harrop et al., 2020). DPM posits that people who are grieving oscillate between confrontation and avoidance of the tasks of grieving and such oscillation is both normative and healthy (Stroebe & Schut, 2021). Hence, DPM aims to assist and facilitate oscillation between loss and restoration-oriented tasks of grieving. CBT focuses on helping individuals identify and differentiate between thoughts, feelings and behaviours related to grieving and use this increased awareness to modify thoughts and behaviours (Harrop et al., 2020). However, empirical evidence for the efficacy of these models during COVID-19 was lacking in the current literature.

To highlight two particular reviews previously conducted, Stroebe and Schut (2021) reviewed the literature on existing knowledge about adaptation to grief and bereavement in the pandemic, and Laranjeira et al. (2022) conducted a scoping review of interventions for family bereavement during COVID-19. One limitation identified by both reviews was the lack of studies providing empirical data or including detailed description of interventions, with most articles describing expert commentaries, reviews of studies conducted in previous pandemics and quick surveys (Stroebe & Schut, 2021). Stroebe and Schut's (2021) review included studies published up to June 2020, approximately three months into the pandemic, hence there is a need to conduct an updated review. Laranjeira et al. (2022) did not include a detailed narrative synthesis of the nature and components of grief and bereavement interventions, which would be important to elucidate to aid in deriving implications for research and practice.

Hence, there is a strong rationale to comprehensively identify and review the nature and components of psychosocial interventions used to address grief and bereavement during the past two years of the COVID-19 pandemic, with specific focus on delivered interventions or interventions described in sufficient detail. Such a review would have implications for future research and practice on interventions used to address grief and bereavement in emergency contexts as well as implications for policy around mental health care in emergencies. Due to the nascent nature of literature in this area (Munn et al., 2018), a scoping review methodology was considered appropriate.

Hence, we aimed to conduct a scoping review to review and analyze the current knowledge on interventions to address grief and bereavement during and post COVID-19 pandemic reported in the academic literature. It had two main objectives:

- To identify interventions employed to address grief and bereavement during and post COVID-19 pandemic in the academic literature, and
- To elucidate and critically review the nature and components of these interventions and further derive implications for future research.

Methods

Inclusion and Exclusion Criteria

Target Population. Interventions targeted at all age groups were included. Interventions could be targeted towards bereaved relatives or friends or healthcare workers. The loss need not have occurred as a consequence of acquiring COVID-19; only that it occurred during the period of the COVID-19 pandemic.

Type of Interventions. Interventions targeted at helping people with grief and bereavement were included. Interventions needed to be aimed, primarily, or at least substantially, at addressing grief and bereavement, if they formed part of another larger intervention. Grief and bereavement were defined as the loss of a loved one and did not include grief related to losses such as the loss of a home, job, educational opportunities, and so on. Individual, group and family-based interventions using any theoretical framework were included.

Type of Settings. Interventions delivered face-to-face in hospital, clinic, community or home settings or digitally were included.

Type of Studies. Quasi-experimental, observational or uncontrolled pre-post studies were included. RCT protocols and qualitative studies were also included. Studies were included irrespective of whether they measured outcomes. Theoretical articles, policy documents and papers that described recommendations for interventions without delivering them were excluded. Studies published in peer-reviewed journals in English between March 2020 and October 2022 were included.

Selection of Sources of Evidence

The following databases were searched: ProQuest, PubMed, SCOPUS, Web of Science and APA PsychNet. Searches were conducted between October 17, 2022 and November 23, 2022. The search strategies were decided based on discussion between two reviewers and preliminary trials (Table 6.1).

Table 6.1 *Example of search strategies*

Search strategies for SCOPUS
(TITLE-ABS-KEY (covid-19 OR covid OR pandemic OR sars-cov-2 OR coronavirus) AND TITLE-ABS-KEY (grief OR griev* OR mourn* OR bereavement OR bereave*) AND TITLE-ABS-KEY (therap* OR "psychosocial intervention" OR counselling OR counseling OR "psychosocial support" OR psychotherap* OR psychoeducation OR teletherapy OR intervention OR cognitive-behavioural AND therapy OR "psychological intervention" OR "social support" OR "digital health" OR e-health))

Titles and abstracts of all studies were screened for Scopus and Pubmed (RC) as well as for APA PsychNET, Web of Science and ProQuest (MM). Duplicates were deleted and relevant full-texts were accessed. Two full-texts could not be accessed for the review. Both reviewers (MM and RC) independently read each full-text and determined the eligibility of the study. A spreadsheet was used to record decisions and disagreements between reviewers were resolved through discussion and input from a third reviewer (CD).

Data Extraction

A template consisting of the following categories was designed in Microsoft Excel: study title, author(s), month and year of publication, location, methodology, aims, sample characteristics, intervention details, components of intervention and any quantitative/qualitative outcomes. Data was extracted by both reviewers independently and then reviewed together to resolve discrepancies.

Data Synthesis

Thematic analysis was used to identify relevant themes about the interventions. First, two reviewers (RC and MM) independently read through the data extraction spreadsheet line-by-line and identified preliminary themes from the data. All three reviewers then examined and discussed the preliminary themes, leading to a final list of themes.

Ethical Considerations

Since the review involved using already-published data that is in the public domain, ethical approval was not required.

Results and Discussion

Overview of Study Characteristics

The final list of eligible studies included 16 studies describing 15 interventions. The flow of studies in the review is displayed in Figure 6.1

<Insert Figure 6.1 here>

Locations of studies included China, Hong Kong, Italy, Spain, France, Portugal, Netherlands, Mexico and the USA, indicating a fairly global distribution. All selected studies were published in peer-reviewed journals, however, the study by Mallet et al. (2021) was published as a letter to the editor. Three studies were uncontrolled pre-post studies, five were RCT protocols and three were case studies. The other five studies described interventions carried out in a routine clinical setting; these will be referred to as ‘real-world’ studies hereon (US Food and Drug Administration, 2018). Sample sizes ranged between 1 (for case studies) to 1500 (Mellins et al., 2020). In the majority of studies (n=14), the primary aim of the intervention was addressing grief and bereavement while two studies included grief and bereavement as a significant component of larger interventions (Mellins et al., 2020; Tao et al., 2022). Table 6.2 summarizes these details of the interventions included.

The themes have been discussed in two categories: the nature of interventions and the components of interventions. The nature of interventions pertains to how interventions were delivered and the components of interventions pertain to what was delivered within the interventions. Both of these are described in Table 6.2 and 6.3 which display the interventions included in the review.

Nature of Interventions

Tables 6.2 and 6.3 provide data on the nature of all included interventions.

Aim of Interventions. Interventions could be categorized into Level 1 (preventive and supportive interventions) or Level 2 responses (treatment for mental health disorders) as per Rosen et al., (2020). Most delivered interventions (n=8) were supportive interventions for bereaved individuals and contained no formal assessment of symptoms of complicated, prolonged or traumatic grief. These interventions can be categorized as Level 1 interventions. On the other hand, most RCT protocols (n=4) formulated interventions including assessment of symptoms of depression, anxiety, stress, trauma or grief with explicit aims of preventing or reducing pathological grief. These interventions can be categorized as Level 2 interventions.

Target Population of Interventions. Interventions were mostly targeted towards bereaved relatives (n=11). However, Tao et al. (2022) focused on individuals who experienced psychological difficulties during the pandemic; a subset of whom was also bereaved. Other studies focused on interventions for healthcare workers (Bateman et al, 2020; Mellins et al., 2020), who had seen an unprecedented increase in witnessing death of patients. Thus, interventions were primarily directed towards those most likely to be exposed to loss during the pandemic.

Delivery of Interventions. While mental health professionals delivered a majority of the interventions (psychiatrists, clinical psychologists, counsellors; n = 7), three interventions were delivered in concert by psychologists and healthcare social workers, one by nurses (Mallet et al., 2021) and one by trained doulas (Reblin et al., 2022). Other studies (n=3) used self-guided web-based applications to deliver interventions. Two of these were completely unguided interventions, whereas one study proposed to compare an unguided version of the intervention with a therapist-guided (through email contact only) version of the same treatment (Reitsma et al., 2021). Overall, there was a trend towards a) using diverse professionals to deliver interventions, rather than only highly qualified mental healthcare professionals b) using self-guided interventions, both of which may be attempts to increase the scalability and accessibility of the interventions.

Modality of Interventions. A majority of interventions (n=11) were delivered completely through digital means. Modalities included telephone (n=4), videoconferencing (n= 3) and web-based applications (n=3). Two studies did not specify the exact delivery modalities (Tang et al., 2022; Yu et al., 2022).

Two interventions were blended. This included a case report wherein the sessions had started before the pandemic and were shifted to telephone due to lockdown (Santos et al., 2021) and an end-of-life intervention at a hospital where relatives were given opportunities to connect through video calls to the patients in ICU (Beneria et al., 2021).

Face-to-face interventions were reported in two studies: a single-session body-based intervention from China (Tao et al., 2022) and a case report about nature-based therapy (Spurio, 2021). Hence, remote methods served as the primary modality to deliver interventions under specific COVID-19 protocols whereas the nature of the therapy or setting specifications (end-of-life hospital setting, in the above instance) necessitated the use of face-to-face modalities.

Duration and Frequency of Interventions. A majority of interventions were brief (<6 sessions; n = 5), with two interventions including only one session for all participants (Borghi et al., 2021; Reblin et al., 2022). Mallet et al. (2021) did 1-4 sessions for all participants, based on perceived need. Self-guided interventions included 8-12 modules

accessed by mobile Apps. The total number of sessions was not specified for some studies (n = 4). Overall, a trend towards briefer interventions was seen.

Format of Interventions. Most interventions (n = 12) were delivered in individual formats. Studies by Mellins et al. (2020) and Yu et al. (2020) had provisions for individual and group interventions, with Mellins et al. (2020) and Bateman et al. (2020) running groups for healthcare workers. One-on-one interventions were used to support at-risk individuals (e.g. those recently bereaved) as well as provide more intensive services while group interventions were used to draw on community resources to cope with a calamity (COVID-19) that was affecting people at a community - not only individual level.

Components of Interventions

Table 6.3 outlines the components of all included interventions.

Theoretical Frameworks on Grief and Bereavement.

Dual Process Model (DPM). Four interventions used the DPM, which posits that grieving involves two kinds of stressors: loss and restoration-oriented stressors. Adaptive coping involves an oscillation between confrontation and avoidance of these two different tasks of grieving (Schut, 1999). Tang et al. (2022) used Complicated Grief Therapy, based on DPM, developed at Columbia (Shear et al., 2005) and Solomon and Hensley (2020) incorporated DPM principles into their EMDR-based therapy. DPM interventions had a mix of techniques aimed at both loss (e.g. confronting avoidance of emotions) and restoration (e.g. focusing on positive life aspects), oscillating between one loss session and one restoration-oriented session, aiming to parallel the model's process of grief oscillation (Debrot et al., 2022; Yu et al., 2022).

Therapeutic Approaches and Interventions.

Counselling Micro Skills. In several studies (n = 5), interventions emphasised using micro skills such as validation, summarising, reflection of feeling and content during the sessions. For example, Reblin et al. (2022) trained doulas to invite stories of loss, identify their key themes and reflect them to participants. Other studies did not explicitly refer to micro skills, but presumably used them as part of their larger intervention. Self-guided interventions, by their very nature, did not have opportunities for their use. Overall, counselling micro skills were considered a vital component of primarily supportive interventions.

Cognitive-Behavioural Therapy (CBT). Interventions using CBT (n = 3) focused on differentiating emotions, thoughts and behaviours as well as linking these three aspects to each other. Two interventions integrated CBT with other approaches. A common theme in CBT interventions was reducing avoidance, both to negative emotions as well as to desired behaviours, through exposure exercises and behavioural activation.

Positive Psychology. Two studies included elements from positive psychology (Dominguez-Rodriguez et al., 2021; Mellins et al., 2020). Mellins et al. (2020) described peer-support groups that focused on identifying ways to cultivate resilience by discussing coping strategies, valuing one's contribution and encouraging participants to reflect on what went well and express gratitude. Resilience was also reconceptualised as not 'snapping back'

to how one was before, but rather integrating difficult experiences into one's identity and growing from the process.

Mindfulness. Two studies reported using mindfulness (Dominguez-Rodriguez et al., 2021; Mellins et al., 2020). Dominguez-Rodriguez et al. (2021) presented a mindfulness exercise at the beginning and end of every session to situate the participant in the present moment along with containing mindfulness-based experiential exercises, such as identifying needs, difficulties, preoccupations and emotions in three modules. Mellins et al. (2020) shared weblinks to mindfulness-based meditation and exercises on their CopeColumbia website.

Body-based Techniques. Many studies (n = 4) used body-based techniques such as relaxation (Borghi et al., 2021), yoga and dance therapy (Yu et al., 2022), body scan (Solomon & Hensley, 2020). A culturally-derived body-based technique called 'moving to emptiness' technique was used by Tao et al. (2022). It involved asking participants to identify and locate a target symptom in a body part ('symbolic object'), visualizing a symbolic container having their internal resources and moving the symbolic object into the container. The relationship between grief and its bodily manifestation was acknowledged and addressed in these studies.

Eye-Movement Desensitization and Retraining (EMDR). Solomon and Hensley (2020) demonstrated the use of EMDR in the context of grief, trauma and the pandemic in their case report. Eight phases of EMDR were described: 1) History taking and building therapeutic rapport 2) Preparation, (psychoeducation, stabilization and coping strategies) 3) Assessment 4) Desensitization 5) Installation 6) Body Scan 7) Closure and 8) Reevaluation of the therapeutic process.

Core Content Of Interventions.

Addressing Basic Needs and Sharing Information. Several studies (n = 6) helped participants with practical and logistical difficulties and shared information regarding the same (e.g. helping family members to organise the funeral, contacts for religious representatives). Hence, addressing physical and social needs was seen as important in supportive interventions.

Screening and Assessment for Referral. Many studies (n = 5) included screening and assessment components (assessing risk factors, protective factors and psychosocial resources) and accordingly, referred individuals needing more specialist support. This showed that the briefer, supportive interventions acted as quick screenings, rather than intensive interventions.

Psychoeducation. Psychoeducation about the expected process, stages and emotions related to grief were a part of many interventions (n = 6). Debrot et al. (2022) specifically described their intervention as a psychoeducational model, including components on cognitions, emotions, behaviours and identity. Hence, psychoeducation was aimed at normalizing the experience of grief and reducing the uncertainty of participants' grieving experiences.

Facing Toward (Rather Than Turning Away From) The Emotional Pain of Grief. Studies used a number of techniques to help participants access their emotional pain, such as identifying and naming felt emotions (Dominguez-Rodriguez et al., 2021) and telling the

story of the loss (Reblin et al., 2022). Some studies used expressive writing to facilitate emotional processing, for example, journaling (Reblin et al., 2022) and structured writing prompts (Reitsma et al., 2021). Thus, processing, rather than avoiding, painful emotions related to grief became an important target of interventions.

Making Memories of the Deceased and Readapting to Life Without Them. Some studies reported unique ways of commemorating loved ones such as a memory ceremony, heart-healing reading, letter-writing, cultivating a linking object to the deceased and creating memory books (Santos et al., 2021; Yu et al., 2022). Another study included a module on alternative parting rituals for those who were unable to say goodbye in a traditional manner (Dominguez-Rodriguez et al., 2021). These studies highlighted how creative methods to honour the memories of the deceased became important, especially when the usual grieving process was interrupted. Further, some studies (n = 3) included components on helping bereaved persons reposition the role of the deceased person in their lives, adapt to a new life without them and restore a sense of future possibilities.

Self-care. Interventions targeted at bereaved relatives as well as healthcare workers (n=3) encouraged participants to gradually return to activities of daily living and promoted self-care in various domains: physical, emotional, cognitive and spiritual. In Mellins et al. (2020), self-care was framed as essential, not selfish, using the metaphor of oxygen masks on an aeroplane. Thus, it is seen that interventions kept the costs of caring in mind and tried to destigmatise self-care.

Drawing on Community Resources and Social Connections. Studies by Bateman et al. (2020) and Mellins et al. (2020) targeted healthcare workers and drew on community as the basis of the intervention (for example, Death Cafes aim to help staff reflect on distressing events related to patient care while focusing on development of a sense of community for themselves). Some studies (n = 3) also encouraged participants to connect with their social support networks. In fact, in Reitsma et al.'s (2021) intervention, participants were encouraged to invite someone close to them to be a part of the program. Thus, social support and community were seen as important resources, especially in the context of social distancing protocols.

Finding Meaning. Two studies encouraged participants to consciously make meaning and identify values (Mellins et al., 2020; Tang et al., 2021). For example, Mellins et al. (2020) encouraged healthcare professionals to identify their professional values, reasons for joining the medical profession and to reconnect to the same to find meaning in one's work during the pandemic.

Outcomes of Interventions.

Quantitative Outcomes. Majority of the studies (n = 9) studies measured or proposed to measure the outcomes of the interventions through quantitative means. RCT protocols usually proposed to study the outcomes through structured questionnaires whereas other studies involved rating scales to assess the outcomes. This may be because RCT protocols targeted symptoms of disorders such as PTSD, Complicated Grief Disorder while other interventions focused more on general well-being and preventive aspects.

Qualitative Outcomes. Some studies (n = 6) measured the qualitative outcomes of their intervention. Some of the outcomes were related to the symptoms of the participants (Tao et al., 2022) while others used qualitative measures to understand how the participants

felt post the intervention (n = 4). One of the interventions (Bateman et al., 2020) did not mention which qualitative outcomes would be measured.

Table 6.2 *Details of the study included in the review*

S. No.	Title	Author /Year	Location	Methodology	Aims	Sample characteristics
1.	A Phone-Based Early Psychological Intervention for Supporting Bereaved Families in the Time of COVID-19	Borghi et al., 2021	Milan, Italy	Real-world	The aim was to describe a phone-based primary preventive psychological intervention delivered to bereaved families by the Clinical Psychology unit of an Italian hospital	Bereaved family members (n=246)
	Phone follow up to families of COVID-19 patients who died at the hospital: families' grief reactions and clinical psychologists' roles	Menichetti et al., 2021			The aim of the study was to explore the families' experiences and needs and identify the role of the psychologists in this endeavour	

2.	End of Life Intervention Program During COVID-19 in Vall d'Hebron University Hospital	Beneria et al., 2021	Barcelona, Spain	Real-world	The aim was to describe an End of Life intervention program implemented during COVID-19 in the Vall d'Hebron University Hospital (HUVH)	Relatives of end-of-life patients (n=359)
3.	"Sustaining the unsustainable: Rapid implementation of a Support Intervention for Bereavement during the COVID-19 pandemic"	Mallet et al., 2021	Paris, France	Real-world	The aim was to provide informal peer-support to frontline staff using a rapid implementation of a Support Intervention for Bereavement (SIB) in a large academic hospital	Bereaved relatives (n=15)
4.	Psychosocial Intervention on the Dual-Process Model for a Group of COVID-19 Bereaved Individuals in Wuhan: A Pilot Study	Yu et al., 2022	Wuhan, China	Uncontrolled pre-post study	The objective of the paper was to review and analyze how the "Be Together Program" – a public welfare program for grief intervention worked and to discuss its results	Bereaved family members (n=45)

5.	The StoryListening Project: Feasibility and Acceptability of a Remotely Delivered Intervention to Alleviate Grief during the COVID-19 Pandemic	Reblin et al., 2022	Vermont, USA	Uncontrolled pre-post study	The aim was to determine the feasibility and acceptability of a brief, remotely delivered StoryListening storytelling intervention for individuals experiencing grief during the COVID pandemic	Bereaved family members or clinicians (n=62; 48 relatives, 16 clinicians)
6.	Death Cafés for prevention of burnout in intensive care unit employees: study protocol for a randomized controlled trial (STOPTHEBURN)	Bateman et al., 2020	New Orleans, USA	RCT Protocol	The aim of the study was to assess whether participation in regular debriefing can prevent burnout in intensive care unit (ICU) clinicians	Healthcare workers (n=200 ICU staff; 100 physician and 100 non-physician)

7.	A Self-Applied Multi-Component Psychological Online Intervention Based on UX, for the Prevention of Complicated Grief Disorder in the Mexican Population During the COVID-19 Outbreak: Protocol of a Randomized Clinical Trial	Dominguez-Rodriguez et al., 2021	Mexico	RCT Protocol	The aim of the study was to design and implement a self-applied intervention composed of 12 modules focusing on decreasing the risk of developing Complicated Grief Disorder, and increasing the life quality; with the secondary objective of reducing anxiety, depression, and increasing sleep quality	Bereaved relatives with symptoms of depression, anxiety or Acute Stress Disorder; within 6 months of death (n=49)

8.	Grief Reactions and Grief Counseling among Bereaved Chinese Individuals during COVID-19 Pandemic: Study Protocol for a Randomized Controlled Trial Combined with a Longitudinal Study	Tang et al 2021	Hong Kong, China	RCT Protocol	The objectives were to investigate demographic and related factors associated with prolonged grief symptoms among Chinese individuals bereaved due to COVID-19 (including grief reaction, trauma response, depression, anxiety, and suicide risk), develop training and evaluation programs for Chinese professional grief counsellors to develop and examine their competence and provide grief counseling for the bereaved during the pandemic and assess the effect of the intervention	Bereaved adults Phase 1: n=300 Phase 2: n=500 Phase 3: n=160

9.	Online treatment of persistent complex bereavement disorder, posttraumatic stress disorder, and depression symptoms in people who lost loved ones during the COVID-19 pandemic: study protocol for a randomized controlled trial and a controlled trial	Reitsma et al., 2021	Netherlands	RCT Protocol	The aim was to evaluate the short-term and long-term effectiveness of grief-specific online CBT in reducing PCBD, PTSD, and depression symptom-levels for adults who lost a loved one during the COVID-19 pandemic	Bereaved relatives (died at least 3 months earlier; have symptoms of PCBD, PTSD or depression) Phase 1: n=62 Phase 2: n=102
10.	Supporting People Who Have Lost a Close Person by Bereavement or Separation:Protocol of a Randomized Controlled Trial Comparing Two French-Language Internet-Based Interventions	Debrot et al., 2022	Switzerland but French speaking people throughout the world will be recruited	RCT Protocol	The aim of the intervention was to use the web-based application to increase the well-being and decrease the distress of the participants. It was also compared to the previous application and improved on the same	Bereaved adults or those experiencing separation (n=234)

11.	EMDR Therapy Treatment of Grief and Mourning in Times of COVID-19	Solomon & Hensley, 2020	USA	Case Study	The aim was to present a framework for treatment of grief and mourning with eye movement desensitization and reprocessing (EMDR) therapy	Individual client who had lost his father (n=1)
12.	Case Report: Parental Loss and Childhood Grief During COVID-19 Pandemic	Santos et al., 2021	Portugal	Case Study	The aim was to describe the intervention for loss of a parent during the COVID-19 pandemic	Individual client who had lost her father (n=1)
13.	Mourning from COVID-19 and Post-Traumatic Stress Disorder: New therapeutic tools in the treatment of pathological bereavement	Spurio, 2021	Rome, Italy	Case Study	The aim was to describe the intervention for loss of spouse during the COVID-19 pandemic	35 year old woman, bereaved by death of husband (n=1)

14.	Supporting the well-being of health care providers during the COVID-19 pandemic: The CopeColumbia response	Mellins et al., 2020	New York City, USA	Real-world	The aim was to describe CopeColumbia, a peer support program developed by faculty in a large urban medical center's Department of Psychiatry to support emotional well-being and enhance the professional resilience of Healthcare Workers	Healthcare workers Groups: n=186 (participants ranging from 1–30) Workshops - 43 Individual calls - 141. Total: 1500
15.	The Effectiveness of the Moving to Emptiness Technique on Clients Who Need Help During the COVID-19 Pandemic: A Real-World Study	Tao et al., 2022	Mainland China	Uncontrolled pre-post study	The aim of the study was to introduce and understand the effectiveness of a new technique called moving to emptiness technique (MET), which combined Western structural progress and core factors of Chinese culture	General adult population who might have trauma symptoms because of the pandemic (n=107)

Table 6.3 *Interventions described in the identified studies*

S. No.	Author / Year	Intervention details	Components of Intervention	Outcomes
1.	Borghi et al., 2021 Menichetti et al., 2021	**Delivery professionals:** Clinical psychologists **Modality:** Telephone **No. of sessions:** 1 **Type of intervention:** Supportive	The intervention consisted of active listening and emotional validation, assessment of psychosocial needs and resources, information-sharing, psycho-education about stages of grief, brief therapeutic actions like relaxation pills and assessment of early risk and protective factors and referrals for further psychological support	**Quantitative outcomes:** Not measured **Qualitative outcomes:** Notes of the psychologists reflected the gratitude of the relatives
2.	Beneria, A et al 2021	**Delivery professionals:** Healthcare social workers and clinical psychologists **Modality:** Face-to-face and telephone **No. of sessions:** Unclear **Type of intervention:** Supportive	The intervention consisted of social assessment by social workers and psychological assessment by clinical psychologists. It comprised of bad news communication, allowing face to face farewell to the patient, psychological support for bereavement, assessment of risk and protective factors and provision of information and referral	**Quantitative outcomes:** Not measured **Qualitative outcomes:** Intervention allowed the bereaved to say goodbyes. The emotional impact on practitioners were identified and addressed

3.	Mallet et al., 2021	**Delivery professionals:** Nurse **Modality:** Telephone **No. of sessions:** 1-4 calls **Type of intervention:** Supportive	Hospital staff referred patients for intervention. Nurses called patients on hotlines. The first line intervention used consisted of empathic statements; written psychoeducation; referrals; medical information; and providing contact details of religious representatives. The second line intervention focused on facilitating acceptance of loss and restoring a sense of possibility of future happiness	**Quantitative outcomes:** Not measured **Qualitative outcomes:** Not measured
4.	Yu et al., 2022	**Delivery professionals:** Social workers supervised by professional mental health specialists **Modality:** WeChat **No. of sessions:** Variable (participants can choose) **Type of intervention:** DPM based grief intervention	The intervention included Chinese cultural elements: memory ceremony; components on health anxiety, mindfulness, yoga, dancing therapy, heart-healing reading, letter-writing on a festival day and loss-oriented and restoration-oriented psychoeducation	**Quantitative outcomes:** These were measured using the Inventory of Complicated Grief (ICG-19) (Prigerson et al., 1995) **Qualitative outcomes:** Not measured

5.	Reblin et al., 2022	**Delivery professionals:** Doulas **Modality:** Video conferencing **No. of sessions:** 1 **Type of intervention:** Supportive	The intervention focused on inviting stories of loss and listening to experiences of the bereaved, identifying key themes and reflection, expressing gratitude for sharing, journaling and identifying and referring participants who needed greater intervention	**Quantitative outcomes:** Rates of enrolment, retention and completion of assessments were used to understand the feasibility of the intervention. **Qualitative outcomes:** Thematic analysis of interviews post-interventio n

6.	Bateman et al., 2020	**Delivery professionals:** Psychotherapists **Modality:** Video conferencing **No. of sessions:** 4 **Type of intervention:** Supportive (debriefing)	Group-based sessions (“Death Cafes”) focusing on informal discussions related to themes of death, loss, grief, and illness. The participants will be encouraged to reflect together about stressful events and be offered a space for community and collaboration for the employees which is not in the workspace	**Quantitative outcomes:** Primary outcome will be clinician burnout (measured by the Maslach Burnout Inventory; MBI). Secondary outcomes included depression (as measured by Patient Health Questionnaire-8 ; PHQ-8) and anxiety (measured by the Generalized Anxiety Disorder 7-item scale; GAD-7). These will be administered prior to the intervention, and then at 1 month, 3 months, and 6 months post enrolment **Qualitative outcomes:** No clarity on how these will be measured but it will be done

7.	Dominguez-Ridriguez et al., 2021	**Delivery professionals:** Unguided digital course **Modality:** A web-based platform on desktop or mobile **No. of sessions:** 12 "modules" **Type of intervention:** CBT, Mindfulness, and Positive Psychology	Different modules would include psychoeducation about grief phases, managing the pain of loss, understanding the experience of loss during COVID-19 e.g. deprived of rights; saying goodbye through parting strategies, adapting to loss through self-care, restoring daily activities and integrating with supportive networks and repositioning deceased person in lives and preventing relapse	**Quantitative outcomes:** Grief symptoms would be assessed **Qualitative outcomes:** Not measured
8.	Tang et al., 2021	**Delivery professionals:** Psychologist, social worker, or occupational psychological counsellor **Modality:** Online **No. of sessions:** 8-10 sessions **Type of intervention:** Prolonged Grief Disorder Therapy (Columbia University), adapted to the context of Chinese psychotherapy; Based on DPM	Sessions focused on understanding and accepting grief reactions, managing painful emotions, learning to care of the self, increasing contact with others, coping with difficult days and adapting to a new life	**Quantitative outcomes:** Primary outcomes to be assessed by the Prolonged Grief Questionnaire (PG-13), the 20-item PTSD Checklist for DSM-5 (PCL-5), the Depression Anxiety and Stress Scale (DASS-21), and the Posttraumatic Growth Inventory (PTGI) **Qualitative outcomes:** Not measured

9.	Reitsma et al., 2021	**Delivery professionals:** Part 1: Unguided digital course Part 2: guided by therapists through email contact **Modality:** Online, through secure website **No. of sessions:** 8 sessions **Type of intervention:** CBT	Sessions focused on psychoeducation about emotional reactions to bereavement, exposure to loss through structured writing, cognitive restructuring assignments and behavioural experiments and behavioural activation assignments	**Quantitative outcomes:** Measured using Traumatic Grief Inventory – Clinician Administered; PTSD Checklist for DSM-5; Patient Health Questionnaire (PHQ-9); COVID-19 Stressful Events self-report questionnaire **Qualitative outcomes:** Not measured

10.	Debrot et al., 2022	**Delivery professionals:** Unguided digital course **Modality:** Online **No. of sessions:** 10 sessions: one introductory, one closing and the rest 8 are based on 4 modules **Type of intervention:** Psychoeducational model grounded in DPM	Current intervention included sessions on introduction (focusing on psychoeducation), cognition focused loss and restoration oriented sessions, emotion-focused loss and restoration oriented sessions, behaviour-focused loss and restoration oriented sessions, identity-focused loss and restoration oriented sessions and conclusion (focusing on assessing the experience of intervention and preventing relapse)	**Quantitative outcomes:** Primary outcomes to be measured are grief symptoms, depressive symptoms, and eudemonic well-being while secondary outcomes included anxiety symptoms, coping strategies, aspects related to self-identity reorganization, and program satisfaction **Qualitative outcomes:** Not measured

11.	Solomon & Hensley, 2020	**Delivery professionals:** EMDR trained therapist **Modality:** Video conferencing **No. of sessions:** 8 phases of EMDR completed; but no. of sessions were unspecified **Type of intervention:** EMDR, Attachment theory, DPM	History, Preparation, Assessment, Desensitization, Installation, and Body Scan, Closure and Reevaluation	**Quantitative outcomes:** Not measured **Qualitative outcomes:** More engagement with family was seen. He was able to adapt to the new schedule and focus on work also increased
12.	Santos et al., 2021	**Delivery professionals:** Authors were the therapists for the child **Modality:** Fortnightly telephone calls; monthly face-to-face appointments **No. of sessions:** Unspecified **Type of intervention:** Art-based and talk-based therapy	Dealing with loss of a parent and sharing adaptive ways to think about him by choosing a linking object as memento, recalling positive experiences with him and creating a memory book including family stories, photographs, drawings etc.	**Quantitative outcomes:** Not measured **Qualitative outcomes:** Not measured

13.	Spurio, 2021	**Delivery professionals:** Psychotherapist **Modality:** Face-to-face **No. of sessions:** Unspecified **Type of intervention:** Psychotherapy + nature-based intervention	Narrative questions, forest bathing and walks in the forest with the therapist	**Quantitative outcomes:** Not measured **Qualitative outcomes:** Not measured
14.	Mellins et al., 2020	**Delivery professionals:** Psychiatrists and psychologists **Modality:** Video conferencing **No. of sessions:** 186 groups and 43 workshops **Type of intervention:** Positive psychology, CBT, ACT	Peer-Support Groups for identifying unique stressors and their influence on healthcare workers' well-being and resilience; One-to-One Peer Support Sessions for personalized discussion and to facilitate referrals; Town Halls (virtual talks) on relevant topics like stress management, anxiety, trauma, loss and grief, self-care; 24/7 access to resources through CopeColumbia website	**Quantitative outcomes:** Measured using rating scales for perceived helpfulness of the group (consistently high) and emotional distress (decreased over time) and willingness to recommend the group (high). **Qualitative outcomes:** Not measured

15.	Tao et al., 2022	**Delivery professionals:** Therapists **Modality**: Face-to-face **No. of sessions:** 2 or 3 sessions for most participants; highest sessions: 9 **Type of intervention:** Moving to Emptiness Technique	3 step intervention : The Trio Relaxation Exercise; Visualizing and Locating Target Symptom; and Visualizing Symbolic container.	**Quantitative outcomes:** Measured using influence rating (1-10) which decreased significantly post the intervention **Qualitative outcomes:** Word cloud analysis was done for target symptom and location

Unique Adaptations to the Pandemic

Interventions were adapted to the specific context of COVID-19 in the following ways:

Meeting Specific Needs. Interventions attempted to address the specific nature of grieving during the pandemic. For example, some case studies showed the challenges of working with unexpected losses: a child who lost her father (Santos et al., 2021) and a wife who had lost her husband (Spurio, 2021). Dominguez-Rodriguez et al. (2021) included a module on rights-deprived grief, which highlighted alternative ways of bidding goodbye when usual processes of mourning were not possible.

Creative Approaches. Some studies incorporated elements from different approaches such as arts-based intervention (Santos et al., 2021) and nature-based interventions to address grief (Spurio, 2021). Further, self-guided interventions as well as a component of Yu et al.'s (2022) intervention called the 'supermarket mode' (which gave participants a choice of attending any module) provided increased agency and flexibility to participants.

Acknowledging the Cultural Context. All studies based in China (n = 3) acknowledged and especially incorporated cultural context in their intervention. This included including culturally-relevant activities such as a memory ceremony on the zhongyuan festival (Yu et al., 2022), adapting an existing model to the researchers' cultural context (Tang et al., 2021) and using a technique based on the Chinese cultural concept of 'emptiness' (Tao et al., 2022).

Addressing the Needs Of Vulnerable Populations. Specific sub-groups such as older adults, healthcare workers and children have been identified as being at-risk by a previous literature review (Stroebe & Schut, 2021). Out of the studies selected in the current review, only one study reporting on a child's therapy (Santos et al., 2021) was found. Yu et al. (2022) included components on how adults could cope with losing their children due to

COVID-19. Two studies focused on healthcare workers' needs (Bateman et al., 2020; Mellins et al., 2020).

Critical Review and Future Directions

The pandemic necessitated quick responses to its specific needs. Many interventions aimed to address the unprecedented grief during the pandemic, through the immediate deployment of clinical resources. On the other hand, RCT protocols elaborated more detailed interventions to further evidence-based research on grief. Below, we discuss gaps in the literature, methodological limitations of the studies and limitations in intervention content.

Gaps in the Literature. Although there was a fairly global distribution of studies, the absence of published studies from South-East Asia, South America, Africa and Australia was notable. While there were some interventions focused on special populations such as healthcare workers and children, overall, most interventions did not specifically target vulnerable populations, which were disproportionately affected due to the pandemic (Stroebe & Schut, 2021). Family-focused interventions were also missing. This is an important lacuna as bereavement generally affects entire families (Lebow, 2020).

Methodological Limitations of Studies. Most studies that reported delivered interventions did not measure outcomes and the few studies that did measure outcomes did not have control groups, precluding conclusions about the effectiveness of interventions. All studies did not report detailed information on interventions. In fact, the number of sessions in the interventions, theoretical frameworks of the interventions as well as the components of the interventions were unclear in several studies.

Limitations in Intervention Content. Some missing themes in the content of interventions were addressing anger towards socio-political systems, the impact of media and components on spirituality and faith in grief and bereavement. Although trauma was mentioned in some studies, no study elaborated on how trauma-informed approaches were incorporated in their intervention. No intervention incorporated intersectionality or systems lens with qualitative studies giving voice to the lived experience of people being notably missing. Overall, there was a gap between the theoretical and policy recommendations in the research literature (Harrop et al., 2020) and reported interventions. Further, studies did not explore the possibility that those delivering these interventions may have experienced bereavement, thus, their training and supervision needs were not addressed.

Implications for Future Research and Practice

Overall, it was seen that experiences of grief and bereavement during this pandemic were distinctive and necessitated flexible and dynamic psychosocial interventions. While these interventions had a positive impact on the participants, certain limitations were also present. Hence, we would recommend that future research can focus on a) describing lived experiences, b) interventions for children, older adults, vulnerable populations and families, c) methodological robustness with detailed documentation, d) incorporating themes such as anger, impact of media and spirituality and faith, e) trauma-informed, systemic and intersectionality-based approaches, and f) addressing specific training and supervision needs for those delivering interventions. Future reviews could include broader definitions of grief including grief for intangible losses. One limitation of our review was that we restricted ourselves to academic literature; future reviews could also include interventions conducted by non-governmental organizations (NGOs), governments, commercial and public healthcare

sectors. Future research must also take a resilience-focused perspective to examining people's responses to grief and bereavement.

Conclusion

Our aim was to conduct a scoping review of the grief and bereavement interventions reported in the research literature during and after COVID-19. We found 16 studies (real-world, pre-post and RCT protocol studies), reporting on 15 interventions.

The interventions were preventive or early interventions, targeted towards bereaved family members and healthcare workers, delivered by diverse healthcare professionals and through self-guided modes, mostly through remote means, with a brief number of sessions, in individual as well as group formats.

Further, interventions used DPM as a primary theoretical approach as well as adapted approaches such as CBT to grief. Core components included screening and assessment for referral, addressing basic needs and sharing information, psychoeducation, facing toward (rather than turning away from) the emotional pain of grief, making memories of the deceased and readapting to life without them, encouraging community and social connection, promoting self-care and finding meaning.

Although interventions attempted to adapt to the unique context of the pandemic by addressing specific needs, using innovative approaches, acknowledging the cultural context and addressing the needs of special populations, certain limitations were also present. Interventions lacked well-defined theoretical underpinnings and did not take a trauma-informed, systemic or intersectionality lens. Future research, including intervention design and evaluation, may take these factors into consideration.

Funding: Nil

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