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Grief-Focused Cognitive Behavioral Therapies for Prolonged Grief Symptoms: A Systematic Review and Meta-Analysis

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Background: Studies suggest that cognitive behavioral therapies (CBTs) may be efficacious in reducing symptoms of prolonged grief disorder (PGD), but no comprehensive overview and pooled estimate of CBTs' effect on PGD in adulthood exist. We conducted a systematic review and meta-analysis of randomized controlled trials. ***Method:*** Studies were selected independently by two researchers based on a systematic literature search in Pubmed, APA PsycInfo, Web of Science, and Embase. Meta-analyses provided pooled effect sizes for the effects of CBTs on PGD symptoms and secondary outcomes. We explored potential moderators of effect, risk of bias of included studies, and evaluated the quality of the meta-analytical evidence through the Grading of Recommendations, Assessment, Development, and Evaluation system. ***Results:*** The meta-analysis included 22 studies of 2,602 bereaved adults (averaged study M_{age} = 49 years). CBTs had a statistically significant medium effect on PGD symptoms at postintervention ($K = 22$, $g = 0.65$, 95% CI [0.49, 0.81]), and a large effect at follow-up ($K = 7$, $g = 0.90$, 95% CI [0.37, 1.43]). Statistically significant small-to-medium effects were found at postintervention on posttraumatic stress symptoms ($K = 10$, $g = 0.74$, 95% CI [0.49, 0.98]), depression ($K = 19$, $g = 0.53$, 95% CI [0.36, 0.71]), and anxiety ($K = 9$, $g = 0.35$, 95% CI [0.22, 0.49]). The effects on PGD remained unchanged when adjusted for possible outliers. None of the moderator analyses reached statistical significance. ***Conclusion:*** This review suggests that CBTs are efficacious in reducing PGD symptoms in adulthood. Generalization of findings should be done with caution due to considerable inconsistency and indirectness of meta-analytic evidence.

What is the public health significance of this article?
This review suggests that grief-focused cognitive behavioral therapies are efficacious in reducing prolonged grief disorder symptoms in adulthood and to some extent also bereavement-related depression, anxiety, and posttraumatic stress symptoms.

Keywords: prolonged grief disorder, cognitive behavioral therapy, grief, meta-analysis

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Recently, two significant diagnostic manuals, the 11th revision of the *International Classification of Diseases* (*ICD-11*; World Health Organization, 2023) and the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed., text rev.; *DSM-5-TR*; American Psychiatric Association, 2022), introduced a new grief-specific diagnosis called prolonged grief disorder (PGD). The core symptoms of PGD in both manuals involve an intense longing for and preoccupation with the deceased. Associated symptoms

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The authors have no conflicts of interest to disclose.

All data and study materials can be provided by Katrine B. Komischke-Konnerup upon request. The data set used for this study has not been used in previous publications or currently in press works. The study was preregistered at PROSPERO (Registration No. CRD42022359625).

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revolve around emotional pain associated with the loss, such as profound sadness, anger, and disrupted identity. These symptoms must deviate from cultural and social norms, result in functional impairment, persist for more than 6 months postloss according to *ICD-11*, and be present at least 1 year postloss according to *DSM-5-TR*. PGD is associated with psychological disorders, such as depression, anxiety, and posttraumatic stress disorder (PTSD), and leads to severe negative outcomes, including increased suicidality and diminished quality of life and daily functioning (Boelen & Prigerson, 2007; Komischke-Konnerup et al., 2021; Latham & Prigerson, 2004). Thus, individuals experiencing PGD symptoms are in urgent need of effective treatment. A meta-analysis of various psychotherapies specifically targeting grief has only found a small pooled effect (see Johannsen et al., 2019, for review). However, this study did not compare the efficacy of different types of therapy, even though various research groups hypothesize that grief-focused therapies based on cognitive behavioral therapies (CBTs) hold particular promise for PGD treatment (Doering & Eisma, 2016; Simon et al., 2020). It is crucial to assess the empirical evidence and obtain a combined estimate of the efficacy of grief-focused CBTs for PGD symptoms to determine whether these therapies are particularly beneficial in treating PGD symptoms.

Grief-Focused CBTs: Theoretical Model and Key Components

Boelen et al. (2006) proposed a cognitive behavioral conceptualization of PGD, in which three interrelated core processes are seen as crucial in the development and maintenance of PGD, and thus must be targeted in psychotherapy to alleviate PGD symptoms. Those core processes include (a) insufficient integration of the loss into autobiographical memory, (b) maladaptive grief cognitions, and (c) problematic anxious and depressive avoidance strategies (Boelen et al., 2006). Three key CBT components are believed to target these core processes, that is, exposure, cognitive restructuring, and behavioral activation (Boelen et al., 2006). *Exposure* aims to reduce maladaptive anxious avoidance and facilitate the integration of the loss into the autobiographical memory. This is done by a gradual confrontation with avoided internal and external loss-related stimuli. *Cognitive restructuring* aims to change maladaptive cognitions into more helpful cognitions. This is done by identifying maladaptive cognitions, testing the validity and utility of maladaptive cognitions, and formulating alternative cognitions that are more helpful to the individual. *Behavioral activation* aims to reduce depressive avoidance by increasing the individual's engagement in valuable and enjoyable activities by systematically registering activities, identifying valuable activities and goals, and planning actions necessary to achieve these goals (Boelen et al., 2006; Eisma et al., 2015). When effectively targeting one core process of PGD with one key CBT component, it is proposed that this could also impact the remaining core processes (Boelen et al., 2006). Over the past years, several grief-focused CBT-based therapy manuals have been developed (Doering & Eisma, 2016). Grief-focused CBTs sometimes utilize different names, can include varying degrees of key CBT components, and may incorporate additional methods (e.g., motivational interviewing). However, they all focus on reducing bereavement-related distress and enhancing adaptive coping with bereavement.

Current State of Evidence

In a review of 11 studies, Currier et al. (2010) found small significant effects of CBTs across different complicated grief reactions (e.g., symptoms of PGD, depression, anxiety, and PTSD) when compared to non-CBT interventions ($d = 0.27$, 95% CI [0.09, 0.44]) and no treatment ($d = 0.38$, 95% CI [0.09, 0.67]). However, symptoms of PGD were only assessed in 21.7% of the included studies, limiting the conclusions that can be drawn for the efficacy of CBTs for PGD symptoms. Since 2010, a growing number of studies have evaluated CBTs for PGD symptoms (e.g., Rosner et al., 2014; M. K. Shear et al., 2016; Wagner, Grafiadeli, et al., 2022). More recently, a meta-analysis of solely internet-based CBTs found moderate-to-large effects on symptoms of PGD and PTSD (Wagner et al., 2020). Likewise, two recent reviews of grief-focused interventions suggested that CBTs were effective in reducing symptoms of PGD, PTSD, anxiety, and depression in bereaved adolescents and children (Breen et al., 2023; Saladino et al., 2024). While the evidence provided by these reviews is suggestive of CBT as an effective web-based treatment and for treating young, bereaved individuals with PGD symptoms, there is a need for an up-to-date comprehensive overview of CBTs and their overall efficacy for adults with PGD symptoms.

Objectives

The aim of the present review was to estimate the overall efficacy of grief-focused CBTs for PGD symptoms based on the currently available empirical evidence for bereaved adults. A secondary aim was to estimate the efficacy of grief-focused CBTs for symptoms of depression, PTSD, and anxiety. We hypothesized that CBTs would lead to clinically meaningful reductions in symptoms of PGD, depression, PTSD, and anxiety compared to control groups from pre- to postintervention and at follow-up. In addition, we aimed to explore potential moderators of the identified effects to learn more about associations between the magnitude of effects and characteristics of treatment and participants in the studies.

Method

The review was preregistered at PROSPERO (Registration No. CRD42022359625) and reported in accordance with guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-analyses and the Meta-Analysis Reporting Standards (Appelbaum et al., 2018; Page et al., 2021).

Search Strategy

The search was performed in four electronic databases: Pubmed, APA PsycInfo, Web of Science, and Embase. The search string was based on the PICO approach (Sackett et al., 1996) and included the following keywords: *Population* (grief OR griev* OR mourn* OR bereave*), *Intervention* (intervention OR therapeut* OR therapy OR treat* OR counsel* OR trial*) AND ("cognitive behavioral" OR "cognitive behavioural" OR exposure OR "cognitive restructuring" OR "cognitive reappraisal" OR "behavioral activation" OR "behavioural activation" OR "goal work" OR "cognitive behavioural therapy" OR "cognitive behavioral therapy" OR "complicated grief therapy" OR "complicated grief treatment"), and *Outcomes*

("prolonged grief" OR "complicated grief" OR "persistent complex bereavement disorder" OR depress* OR anxiety OR "posttraumatic stress" OR PTSD OR "post-traumatic stress"). The search string was adapted to different databases using, for example, MeSH terms in Pubmed (see details in Supplemental Materials). Backward and forward citation search was done to identify additional relevant studies. The search was conducted on September 26, 2022, and updated on April 24, 2023.

Selection Procedure and Data Extraction

The study selection and data extraction were done independently by two authors (KBKK and MMM). Interrater reliability between the two authors was evaluated for each step of the selection process with Cohen's κ (McHugh, 2012). Disagreements were discussed with a another author (MOC or PAB). Studies were included if they met the following criteria: (a) adult individuals (sample age ≥18), (b) bereavement due to loss of a close person to death (e.g., partner, child, friend, perinatal losses), (c) investigated grief-focused CBTs with at least one key CBT component (CBTs with other main foci than grief were not included, e.g., CBT for insomnia), (d) included a non-CBT control group, and (e) used a quantitative validated measure of PGD symptoms. Only peer-reviewed studies written in English were included. Qualitative studies, case studies, small pilot studies ($N < 10$), and gray literature (e.g., conference abstracts) were not included. A post hoc decision was made to only include randomized controlled trials (RCTs) to reduce potential bias.

The following data items were extracted. *Outcomes*: symptoms of PGD, PTSD, depression, and anxiety at preintervention, postintervention, and follow-up. *Study characteristics*: country, sample size, intervention dropout (percent dropout in the CBT arm), and comparison group (active, passive, competing control). *Population characteristics:* percent women in the sample and mean age. *Grief-related characteristics*: cause of death (natural, unnatural, mixed), relationship to deceased (partner, sibling, child, perinatal, mixed), mean time since the loss (months), if participants were included in the study based on (a) the presence of clinically relevant PGD symptoms and (b) time criterion ≥6 months postloss (yes/no). *Treatment characteristics:* key CBT components applied, formats (individual, group), delivery (digital, face-to-face), dose (number and duration of sessions), duration of treatment (weeks), treatment provider (psychologist, self-guided, student therapists), and additional non-CBT components applied.

Risk of Bias Assessment

Two authors (KBKK and MMM) independently evaluated possible bias in the included studies using the revised Cochrane Risk of Bias tool (Sterne et al., 2019). Bias in five domains was assessed: (a) randomization process, (b) deviations from intended interventions, (c) missing outcome data, (d) measurement of the outcome, and (e) selection of the reported result. All domains were rated as either "low risk of bias," "high risk of bias," or "some concerns." An overall assessment was conducted for each study indicating whether the overall risk of bias was either low, high, or with some concerns about potential bias (Sterne et al., 2019). Disagreements were solved by negotiation between KBKK and MMM.

Computing Effect Sizes

Hedges's g, a variation of Cohen's d, correcting for possible bias due to small sample sizes, was used as the standardized effect size (ES). ESs for the differences between the CBT and control group on PGD symptoms and secondary outcomes were computed based on pre- and postintervention means and *SD*s for both groups. The same procedure was followed for computing ESs for follow-up assessments. In case of missing data, the authors of the study in question were contacted to provide these data. If means and *SD*s were unavailable, ES was estimated based on other statistics, for example, p values.

Frequentist Meta-Analytical Strategy

Pooled ESs and 95% confidence intervals were calculated for the effects of CBTs on symptoms of PGD, PTSD, depression, and anxiety using the inverse variance method, taking the precision of each study into account. A random-effects model was used, with positive values indicating ESs in the hypothesized direction. Heterogeneity was examined using Q and I^2 statistics (Cooper et al., 2009). Because of the generally low statistical power of heterogeneity tests, a more liberal p value of <0.10 was used to determine significant heterogeneity (Poole & Greenland, 1999). The I^2 statistic is an estimate of the variance in a pooled ES that is accounted for by heterogeneity, that is, true differences between ESs rather than sampling error (Higgins et al., 2003). If the results indicated heterogeneous ESs ($I^2 > 0.0$), the 95% prediction interval was calculated. The prediction interval quantifies the distribution of the ESs, indicating that in 95% of cases, the true effect of a new and unique study (from the same family of studies) will fall within this range (InThout et al., 2016).

Possible sources of heterogeneity were explored by conducting subgroup and moderator analyses for several categorical and continuous (a) study characteristics, for example, type of control group; (b) intervention characteristics, for example, format (individual vs. group); and (c) participant characteristics, for example, mean sample age. When $K \geq 10$, categorical and continuous moderators were analyzed with metaregression.

The possibility of publication bias was evaluated with funnel plots and Egger's method (Egger et al., 1997; Peters et al., 2008). If the results were suggestive of publication bias, an adjusted ES using the Duval and Tweedie's (2000) trim-and-fill method was calculated. We further assessed the possible influence of small study effects due to possible publication bias with the Precision-Effect Test–Precision-Effect Estimate with Standard Error method (PET-PEESE; Stanley & Doucouliagos, 2014), which examines the relationship between the ESs of studies and their precision (inversely related to the standard error). The PET part of the test looks for evidence of bias by testing whether smaller, less precise studies show larger ESs. The PEESE part then attempts to correct for any detected bias by adjusting the effect size estimates. Outliers were defined as ESs with values smaller or larger than 2 *SD*s from the pooled ES, and their possible influence on the results was examined with a sensitivity analysis omitting the identified outliers. The calculations were conducted with Comprehensive Meta-Analysis, Version 3 (Borenstein et al., 2013), and various formulas in Microsoft Excel.

Supplementary Bayesian Analyses

To aid the interpretation of the results, a Bayesian model-averaged meta-analysis (Gronau et al., 2017) was conducted. Bayesian methods enable direct probability statements about the hypotheses themselves (Heck et al., 2023). Furthermore, Bayesian methods avoid other issues associated with null hypothesis significance testing, such as the overreliance on relatively arbitrary *p* value thresholds and the dichotomization of results into "significant" and "nonsignificant" (Wasserstein & Lazar, 2016). The procedure examined the results of four models: (a) fixed-effect null hypothesis (fH_0), (b) fixed-effect alternative hypothesis (fH_1), (c) random-effects null hypothesis (rH_0), and (d) random-effects alternative hypothesis (rH_1). Bayesian model-averaged analysis thus avoids selecting either a fixed- or random-effects model and addresses two questions considering the observed data: What is the plausibility that the overall effect is nonzero and the ESs are heterogeneous? An uninformed prior probability was chosen, that is, 25%, for each of the four models, and 2,000 iterations were used. With regard to parameter distributions, previously recommended defaults were chosen (Gronau et al., 2017). Thus, a zero-centered Cauchy prior with a scale of 0.707 for the ES was used. For the between-study variation, an empirically informed prior distribution on nonzero between-study deviation estimates based on standardized mean difference ESs from 705 meta-analyses published in *Psychological Bulletin* between 1990 and 2013 was used (van Erp et al., 2017). This distribution has been approximated by an inverse gamma (1, 0.15) prior to the standard deviation (τ; Gronau et al., 2017). The Bayesian analyses were conducted with the computer software JASP (JASP, 2023).

Quality of Meta-Analytical Evidence

The quality of meta-analytical evidence was evaluated according to the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) system (Guyatt et al., 2011). The assessment focused on (a) risk of bias, (b) inconsistency, (c) indirectness, (d) imprecision, (e) publication bias, (f) magnitude of effect, (g) dose–response gradient, and (h) the effect of plausible confounding factors and was conducted by KBKK and MMM.

Results

Study Selection

See Figure 1 for a flow diagram of the selection process. In total, 2,152 records were identified from the electronic databases of which 880 were duplicates. The initial abstract and title screening included 1,278 studies. The level of interrater reliability for this screening was moderate (95%, Cohen's $\kappa = 0.68$). The full-text screening consisted of 114 studies. Ninety-three studies were not considered eligible (see Figure 1, for reasons). The interrater reliability of this screening was strong (93%, Cohen's $\kappa = 0.80$). One additional eligible study was identified through citation search, resulting in a final inclusion of 22 studies.

Study Characteristics

The study characteristics are shown in Table 1. The review included 22 RCTs with a total of 2,952 participants of which 86% were women. The study sample mean age ranged from 32 to 68 years with an average of 49 years. Eleven studies investigated losses due to various causes of death (46%), and nine studies exclusively investigated loss due to either natural causes, for example, illness ($K = 5$; 23%), or unnatural causes, for example, suicide, or homicide ($K = 4$; 18%). Most studies examined mixed types of relationships to the deceased ($K = 17$; 77%). Mean time since loss ranged from 5.99 to 59.2 months with an average of 32.2 months. Most studies used a passive control condition ($K = 14$; 64%). Four studies used active control (e.g., supportive counseling), whereas four studies included competing control (e.g., interpersonal therapy or Eye Movement Desensitization and Reprocessing [EMDR]). Thirteen studies (59%) included participants according to the ≥6-month time criterion for PGD, and 14 studies included participants based on the presence of PGD symptoms as determined by cutoff values. To assess PGD symptoms, 17 studies used a version of the Inventory of Complicated Grief, three studies used the 13-item Prolonged Grief Inventory, and two studies used a version of the Traumatic Grief Inventory. Seven studies (32%) included follow-up assessments at between 1 and 12 months postintervention. The average intervention dropout rate was 24%.

CBT Characteristics

Different numbers and combinations of key CBT components were included in the CBTs. Most CBTs included exposure ($K = 18$; 82%). About half of the CBTs included cognitive restructuring ($K = 13$; 59%) and behavioral activation ($K = 12$; 55%). Eight CBTs (36%) included additional non-CBT components (e.g., EMDR). Most CBTs were delivered by a psychologist ($K = 13$; 59%) in an individual format ($K = 19$, 86%). Fifty-five percent of the CBTs were delivered face-to-face ($K = 12$), whereas 45% were delivered digitally ($K = 10$). The average treatment dose was 11.7 sessions lasting on average 69.6 min delivered over an average of 11.7 weeks. For detailed CBT characteristics, see Supplemental Table S1.

Overall Efficacy

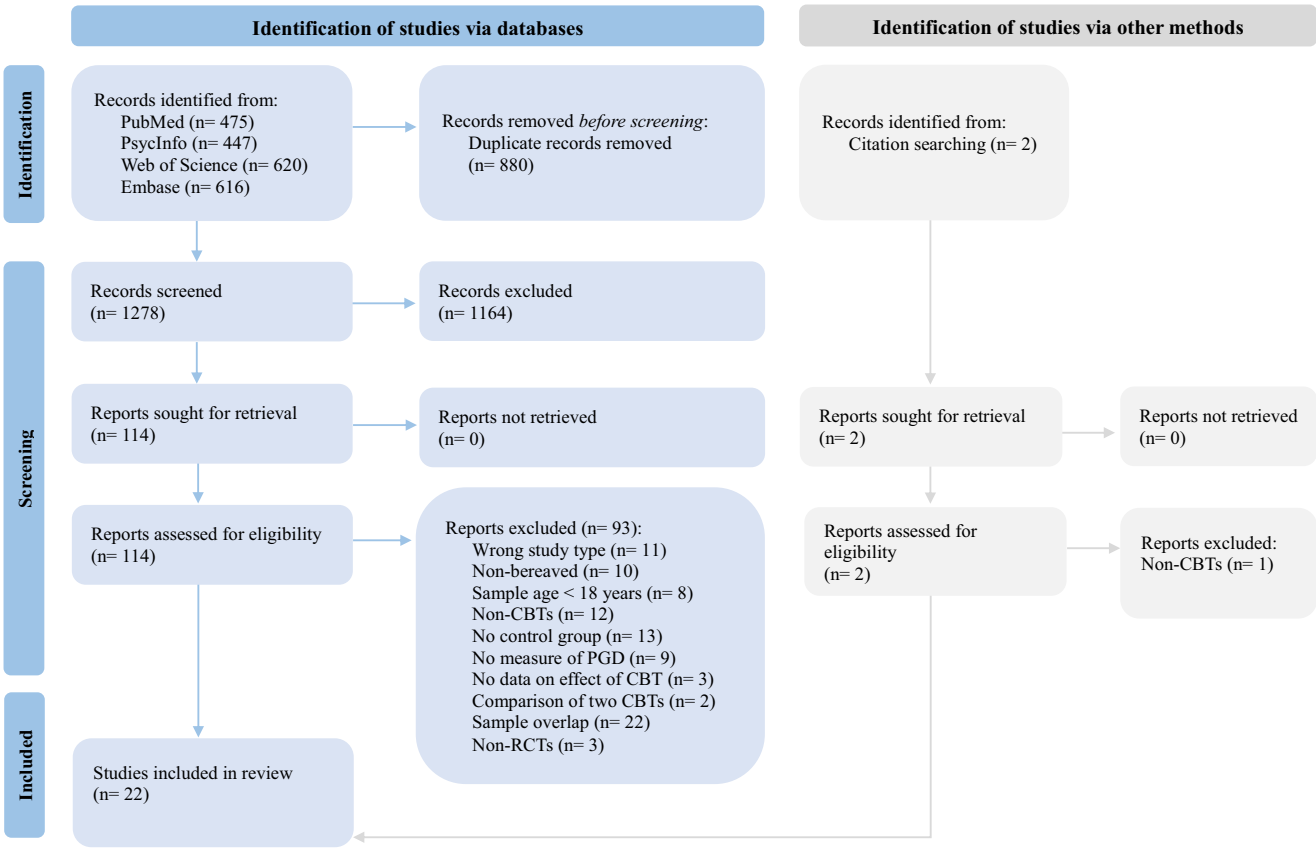
As seen in Table 2, the pooled effect of CBT on PGD symptoms corresponded to a medium ES at postintervention ($g = 0.65$) and a large ES at follow-up ($g = 0.90$). The pooled effect of CBTs on PGD symptoms remained statistically significant and corresponded to a medium ES or larger across all subgroups of studies (see Table 2). Concerning the secondary outcomes of PTSD and depression, statistically significant effects corresponding to medium ESs were found ($g = 0.74$ and $g = 0.53$) and small ES for anxiety at postintervention ($g = 0.35$). At follow-up, only the pooled ES for anxiety reached statistical significance ($g = 0.40$; see Table 2). See forest plots in Supplemental Figures S1 and S2.

Risk of Bias

The results of the risk of bias assessment for each study are reported in Figure 2. In most studies (82%), high risk or some concerns about bias in the measurement of PGD symptoms were present due to self-report measurement without blinding the outcome assessor. In terms of the selection of reported results, there were some concerns about the risk of bias in 82% of the studies mostly due to the lack of a preregistered analysis plan. One study had a high risk of bias in missing outcome data, but in 41% of the studies, there were some

Figure 1

PRISMA 2020 Flow Diagram of the Search and Selection Process



Note. PRISMA = Preferred Reporting Items for Systematic Reviews and Meta-Analyses; CBTs = cognitive behavioral therapies; PGD = prolonged grief disorder; RCT = randomized controlled trial. See the online article for the color version of this figure.

concerns mostly due to a lack of sensitivity analyses. However, most studies had a low risk of bias in the randomization process (91%) and deviations from intended interventions (91%).

Publication Bias

Based on inspections of funnel plots and Egger's test, there were indications of possible publication bias in favor of the larger effects of CBTs on PGD symptoms at postintervention. When imputing one "missing study" with the Trim-and-Fill procedure, the adjusted ES remained medium ($g = 0.63$). As the PET test indicated larger effects of smaller studies, we adjusted the effect size estimate with the PEESE method. As seen in Table 2, the adjusted ES was smaller ($g = 0.39$) but remained statistically significant. When examining possible outliers, two studies (Meysner et al., 2016; Papa et al., 2013) reported ESs below or beyond 2 *SD*s from the pooled ES. When these outliers were omitted in a sensitivity analysis, the pooled ES did not change ($g = 0.65$).

Heterogeneity and Moderator Analyses

As indicated by the high I^2 values shown in Table 2, a considerable proportion of the variance in ESs is expected to be explained by systematic between-study differences beyond random error, with nearly all heterogeneity tests reaching statistical significance. When exploring possible explanations for heterogeneity with metaregression, none of the moderators reached statistical significance at the 5% level (see Table 3). A trend toward greater efficacy of CBTs was observed when a clinically relevant level of PGD symptoms had been used as an inclusion criterion compared to studies without this inclusion criteria ($p = .055$).

Supplementary Bayesian Analyses

When examining the overall effect of CBTs on PGD symptoms at postintervention, the results of the supplementary Bayesian analysis very strongly favored the alternative hypothesis, that is, that the difference between CBTs and control conditions is different from zero. The probability of the alternative hypothesis approached 100% with a relative probability of the competing hypotheses corresponding to a Bayes factor (BF; Goodman, 1999) of 563,000. Likewise, the probability of heterogeneity approached 100% with a BF of 81,600 indicating very strong evidence (Rouder et al., 2009). The evidence for the efficacy of CBTs at follow-up was not as extreme as for postintervention but remained strong with a probability of 95% for the alternative hypothesis and a BF of 19.2, indicating that the

Table 1
Characteristics of the Included Studies

	Study characteristic					Bereavement characteristic			
Author (year)	Country	Control group	Sample size; dropout[a]	Mean age; women	Assessment time and outcome	Time since loss (month)	Cause of death	Relation to deceased	Inclusion of participants based on PGD criteria
Boelen et al. (2007)	The Netherlands	Supportive counseling	*N* = 54; 25.6%	44 years; 74.1%	Postintervention and 6 months follow-up: PGD (ICG)	44.58	Mixed	Mixed	Symptom cutoff met (yes)[b] ≥6-month time criterion met (no)[c]
Eisma et al. (2015)	The Netherlands	Wait-list	*N* = 47; 45.7%	46 years; 91.5%	Postintervention and 3 months follow-up: PGD (ICG-R); PTSD (PSS); depression (HADS); anxiety (HADS)	31	Mixed	Mixed	Symptom cutoff met (yes) ≥6-month time criterion met (yes)
Kaiser et al. (2022)	Germany	Wait-list	*N* = 87; 11%	47 years; 83%	Postintervention: PGD (ICG); PTSD (IES-R); depression (PHQ-9); anxiety (GAD-7)	28.73	Natural	Mixed	Symptom cutoff met (yes) ≥6-month time criterion met (no)
Kersting et al. (2011)	Germany	Wait-list	*N* = 83; 31.3%	34 years; 100%	Postintervention: PGD (ICG); PTSD (IES); depression (BSI); anxiety (BSI)	15.4	Natural	Perinatal	Symptom cutoff met (no) ≥6-month time criterion met (no)
Kersting et al. (2013)	Germany	Wait-list	*N* = 228; 13.9%	34 years; 92.1%	Postintervention: PGD (ICG); PTSD (IES-R); depression (BSI); anxiety (BSI)	9.93	Natural	Perinatal	PGD symptoms met (no) ≥6-month time criterion met (no)
Lacasta and Cruzado (2023)	Spain	Psychoeducational and emotional expression intervention	*N* = 249; 20.3%	59 years; 81%	Postintervention and 12 months follow-up: PGD (ICG); depression (BDI-II); anxiety (BAI)	7.13	Natural	Mixed	PGD symptoms met (yes) ≥6-month time criterion met (yes)
Lenferink et al. (2020)	The Netherlands	Wait-list	*N* = 39; 18.2%	53 years; 74.4%	Postintervention: PGD (TGI-SR); PTSD (PCL-5); depression (QIDS-SR)	22.59	Unnatural	Mixed	PGD symptoms met (yes) ≥6-month time criterion met (yes)
Litz et al. (2014)	The United States	Wait-list	*N* = 87; 25.6%	55 years; 67.9%	Postintervention: PGD (PG-13); PTSD (PCL-C); depression (BDI-II); anxiety (BAI)	8.38	Natural	Mixed	PGD symptoms met (yes) ≥6-month time criterion met (no)
Meysner et al. (2016)	Australia	EMDR	*N* = 19; 5.3%	46 years; 63.2%	Postintervention: PGD (ICG); PTSD (IES)	66	Mixed	Mixed	PGD symptoms met (no) ≥6-month time criterion met (yes)
Nam (2016)	South Korea	Supportive counseling	*N* = 89; 11.1%	67 years; 51.7%	Postintervention and 1-month follow-up: PGD (ICG); depression (GDS)	15.29	NR	NR	PGD symptoms met (yes) ≥6-month time criterion met (yes)
Papa et al. (2013)	The United States	Wait-list	*N* = 25; 15.4%	49 years; 88%	Postintervention: PGD (ICG-R); PTSD (PCL-S); depression (DASS)	30.6	NR	NR	PGD symptoms met (yes) ≥6-month time criterion met (yes)
Reitsma et al. (2023)	The Netherlands	Wait-list	*N* = 65; 40.6%	54 years; 84.6%	Postintervention: PGD (TGI-CA); PTSD (PCL-5); depression (PHQ-9)	5.99	Mixed	Mixed	PGD symptoms met (no) ≥6-month time criterion met (no)
Rosner et al. (2014)	Germany	Wait-list	*N* = 51; 20.8%	48 years; 86%	Postintervention: PGD (PG-13); depression (SCL-90-R); anxiety (SCL-90-R)	59.16	Mixed	Mixed	PGD symptoms met (yes) ≥6-month time criterion met (yes)
K. Shear et al. (2005)	The United States	Interpersonal therapy	*N* = 102; 27%	48 years; 87.4%	Postintervention: PGD (ICG); depression (BDI-II); anxiety (BAI)	37.52	Mixed	Mixed	PGD symptoms met (yes) ≥6-month time criterion met (yes)
M. K. Shear et al. (2014)	The United States	Interpersonal therapy	*N* = 151; 18.1%	66 years; 81.5%	Postintervention: PGD (ICG); depression (BDI)	38.4	Mixed	Mixed	PGD symptoms met (yes) ≥6-month time criterion met (yes)
M. K. Shear et al. (2016)[d]	The United States	Placebo	*N* = 195[e]; 20.8%	54 years; 75.9%	Postintervention and 6 months follow-up: PGD (ICG); depression (QIDS-SR)	57.69	Mixed	Mixed	PGD symptoms met (yes) ≥6-month time criterion met (yes)
Supiano and Luptak (2014)	The United States	Grief support group	*N* = 39; 40%	68 years; 82.4%	Postintervention and 1.5 months follow-up: PGD (PG-13); depression (BDI-II); anxiety (BAI)	27.89	Mixed	Mixed	PGD symptoms met (yes) ≥6-month time criterion met (yes)
Treml et al. (2021)	Germany	Wait-list	*N* = 58; 6.7%	44 years; 86.2%	Postintervention: PGD (ICG); depression (BDI-II)	NR	Unnatural	Mixed	PGD symptoms met (yes) ≥6-month time criterion met (yes)
van Denderen et al. (2018)	The Netherlands	Wait-list	*N* = 126; 50.8%	49 years; 74%	Postintervention: PGD (ICG); PTSD (IES)	50.64	Unnatural	Mixed	PGD symptoms met (no) ≥6-month time criterion met (yes)

(*table continues*)

Table 1 (*continued*)

Author (year)	Study characteristic					Bereavement characteristic			
	Country	Control group	Sample size; dropout[a]	Mean age; women	Assessment time and outcome	Time since loss (month)	Cause of death	Relation to deceased	Inclusion of participants based on PGD criteria
van der Houwen et al. (2010)	International	Wait-list	*N* = 932; 39.8%	43 years; 93.5%	Postintervention and 6 months follow-up: PGD (ICG-9); depression (CES-D)	40.44	Mixed	Mixed	PGD symptoms met (no) ≥6-month time criterion met (no)
Wagner, Grafiadeli, et al. (2022)	Germany	Wait-list	*N* = 140; 28.6%	41 years; 89.3%	Postintervention: PGD (ICG); depression (BDI-II)	29.03	Unnatural	Mixed	PGD symptoms met (no) ≥6-month time criterion met (no)
Wagner, Hofmann, and Maaß (2022)	Germany	Wait-list	*N* = 86; 19.2%	32 years; 96.5%	Postintervention: PGD (ICG); depression (BDI-II)	49.32	Mixed	Sibling	PGD symptoms met (no) ≥6-month time criterion met (no)

Note. PGD = prolonged grief disorder; ICG = Inventory of Complicated Grief; ICG-R = Inventory of Complicated Grief–Revised; PTSD = posttraumatic stress disorder; PSS = PTSD Symptom Scale; HADS = Hospital Anxiety and Depression Scale; IES-R = Impact of Event Scale–Revised; PHQ-9 = Patient Health Questionniare–9; GAD-7 = Generalized Anxiety Disorder–7; IES = Impact of Event Scale; BSI = Brief Symptom Inventory; BDI-II = Beck Depression Inventory–II; BAI = Beck Anxiety Inventory; TGI-SR = Traumatic Grief Inventory–Self-Report; PCL-5 = PTSD Checklist for *DSM-5*; *DSM-5* = *Diagnostic and Statistical Manual of Mental Disorders, fifth edition*; QIDS-SR = Quick Inventory of Depressive Symptomatology–Self-Report; PG-13 = 13-item Prolonged Grief Inventory; PCL-C = Civilian Version of the PTSD Checklist; EMDR = Eye Movement Desensitization and Reprocessing; GDS = Geriatric Depression Scale; NR = not reported; PCL-S = PTSD Checklist–Specific Indexed; DASS = Depression Anxiety Stress Scales; TGI-CA = Traumatic Grief Inventory–Clinician Administered; SCL-90-R = Symptom Checklist–90–Revised; ICG-9 = nine-item version of ICG; CES-D = Center for Epidemiological Studies–Depression Scale; *ICD-11* = 11th revision of the *International Classification of Diseases*.
[a] Dropout rate in the intervention group at postintervention. [b] Yes = the study had an explicit inclusion criterion of the presence of clinically relevant PGD symptoms before a participant was included in the study determined by, for example, cutoff values on a self-report measure of PGD symptoms, no = the study did not include participants based on the presence clinically relevant PGD symptoms or used broader inclusions criteria, for example, presence of symptoms of PGD, PTSD, or depression. [c] Yes = the study had an explicit inclusion criterion concerning time since loss consistent with *ICD-11* PGD diagnosis, in which participants were only included if the loss happened more than 6 months ago, no = no time inclusion criteria were applied or the study included participants earlier than 6 months postloss. [d] This is a four-armed trial including evaluation of drugs. Due to the focus of the present study (efficacy of cognitive behavioral therapies), we only focused on the comparison of (a) the therapeutic intervention with placebo versus (b) placebo alone as a control group. [e] Total number of participations randomized into the two arms in focus in this review.

alternative hypothesis is 19.2 times more likely than the null hypothesis. The evidence for heterogeneity was very strong with the probability approaching 100%.

Overall Quality of Meta-Analytical Evidence

Based on the GRADE approach (Guyatt et al., 2011), the overall quality of meta-analytical evidence was moderate, indicating moderate confidence in the effect estimate, but recognizing that it may be substantially different due to indications of inconsistency (large degree of heterogeneity and inability to identify statistically significant causes) and indirectness (eight out of 22 studies did not include participants based on the presence of clinically relevant PGD symptoms). There were some indications of small study effects due to possible publication bias, but when adjusting statistically for small study effects, the overall effect remained statistically significant. No serious limitations were judged for risk of bias and imprecision. See the detailed descriptions of the GRADE evidence profile in Supplemental Table S2.

Discussion

In the past decade, CBTs have been developed to treat bereaved individuals who struggle in coping with their loss and suffer from PGD symptoms. The present meta-analysis of 22 RCTs found that CBTs had an overall statistically significant medium effect on PGD symptoms, which often corresponds to a clinically meaningful effect (Norman et al., 2003). The effect remained statistically significant when adjusted for possible publication bias, and the confidence intervals ranged between just below medium and large effects (95% CI [0.49, 0.81]). Even when compared to active or competing control conditions (e.g., supportive counseling or competing therapies), CBTs had statistically significant medium pooled effects on PGD symptoms (g = 0.50–0.60). At follow-up, an overall large effect of CBTs was found ($K = 7$, $g = 0.90$). Supplementary Bayesian analyses found very strong evidence in favor of a nonzero effect of CBTs on PGD symptoms. In addition, at postintervention, medium pooled effects were found for secondary grief-related outcomes of PTSD and depression and a small pooled effect for anxiety. Taken together, the results suggest that CBTs are efficacious in reducing symptoms of PGD, PTSD, depression, and, to a lesser degree, anxiety.

Nevertheless, recent trials have indicated that approximately 47%–56% of individuals still experience clinically relevant symptoms of PGD after intervention (e.g., Lacasta & Cruzado, 2023; Reitsma et al., 2023). Furthermore, the results of the present meta-analysis indicated considerable heterogeneity, that is, that a large proportion of the variation in study outcomes is expected to be due to systematic between-study differences. Moreover, the prediction intervals in the present meta-analysis, that is, the intervals in which the effects of similar future studies are expected to fall were broad. Together, this indicates that future research needs to identify which intervention characteristics, for example, formats and components, work best for whom, for example, which age groups, types of loss, and so forth. None of the moderator analyses of potential associations between effect and specific characteristics of the studies (i.e., the interventions and participants) reached statistical significance. Nevertheless, based on the currently available research, potential associations between treatment effect and specific characteristics of the interventions and participants are discussed in the following sections to provide an

Table 2
Results of Meta-Analysis of Randomized Controlled Trials of Grief-Focused CBTs

Outcome (group)	Time point	*K*	*N*	Heterogeneity				Pooled effect size			
				Q	*p*	I^2	T^2	Hedges's *g*[a]	95% CI	*p*[b]	95% PI[c]
PGD											
All studies	Post	22	2,602	69.7	<.001	69.9	0.09	0.65	[0.49, 0.81]	**<.001**	[0.00, 1.30]
Adjusted for publication bias[d]	Post	(23)						0.63	[0.47, 0.79]		
Sensitivity analysis[e]	Post	(20)	2,562	61.1	<.001	68.9	0.08	0.65	[0.49, 0.81]	**<.001**	[0.03, 1.27]
PET-PEESE[f]	Post	22						0.39	[0.20, 0.58]	**<.001**	
All studies	FU	7	1,341	83.9	<.001	92.8	0.44	0.90	[0.37, 1.43]	**.001**	[−0.94, 2.74]
Study characteristics											
Passive control group	Post	14	1808	52.5	<.001	75.3	0.12	0.70	[0.49, 0.92]	**<.001**	[−0.09, 1.49]
Active control group	Post	4	372	3.5	.319	14.6	0.01	0.60	[0.36, 0.85]	**<.001**	[−0.10, 1.30]
Competing intervention	Post	4	422	11.8	.008	74.6	0.13	0.50	[0.11, 0.90]	**.013**	[−1.28, 2.28]
Excluding high risk of bias studies	Post	20	2,430	59.8	<.001	68.2	0.08	0.61	[0.44, 0.77]	**<.001**	[−0.01, 1.23]
Intervention characteristics											
CBT component: Exposure	Post	18	2,374	53.7	<.001	68.3	0.08	0.61	[0.43, 0.77]	**<.001**	[−0.01, 1.23]
CBT component: No exposure	Post	4	228	8.1	.043	63.1	0.14	0.88	[0.48, 1.29]	**<.001**	[−0.98, 2.76]
CBT component: Restructuring	Post	13	1,631	43.1	<.001	72.1	0.08	0.63	[0.41, 0.85]	**<.001**	[−0.04, 1.30]
CBT component: No restructuring	Post	9	971	23.4	.003	65.7	0.06	0.67	[0.42, 0.93]	**<.001**	[0.01, 1.33]
CBT component: Activation	Post	12	1,156	26.8	.005	59.0	0.07	0.65	[0.41, 0.89]	**<.001**	[0.00, 1.30]
CBT component: No activation	Post	10	1,446	39.8	<.001	77.3	0.13	0.65	[0.40, 0.90]	**<.001**	[−0.23, 1.53]
One CBT component	Post	5	264	8.1	.087	50.9	0.09	0.88	[0.50, 1.25]	**<.001**	[−0.79, 2.17]
Two CBT components	Post	14	2,153	49.5	<.001	73.7	0.09	0.60	[0.41, 0.79]	**<.001**	[−0.09, 1.29]
Three CBT components	Post	3	185	3.2	.201	37.6	0.04	0.54	[0.05, 1.04]	**.031**	[−3.57, 4.66]
Individual format	Post	19	2,250	56.8	<.001	68.3	0.09	0.67	[0.49, 0.85]	**<.001**	[0.01, 1.33]
Group format	Post	3	352	12.7	.002	84.2	0.22	0.53	[0.09, 0.96]	**.017**	[−6.05, 7.11]
Face-to-face delivery	Post	12	986	30.2	.001	63.5	0.10	0.68	[0.46, 0.90]	**<.001**	[−0.07, 1.43]
Digital delivery	Post	10	1,616	30.8	<.001	70.7	0.06	0.61	[0.39, 0.82]	**<.001**	[−0.01, 1.23]
Participant characteristics											
PGD (natural cause)	Post	5	652	8.0	.091	50.1	0.04	0.81	[0.53, 1.11]	**<.001**	[0.01, 1.61]
PGD (unnatural cause)	Post	4	318	15.1	.002	80.1	0.23	0.58	[0.23, 0.94]	**.001**	[−1.62, 2.79]
PGD (inclusion criterion)[g]	Post	14	1,144	24.8	=.024	47.6	0.05	0.78	[0.55, 0.96]	**<.001**	[0.25, 1.30]
PGD (not inclusion criterion)	Post	8	1,458	26.0	<.001	73.1	0.08	0.49	[0.25, 0.71]	**<.001**	[−0.25, 1.23]
PGD (≥6-month postloss criterion)	Post	13	1,026	31.3	.002	61.6	0.09	0.71	[0.50, 0.92]	**<.001**	[0.01, 1.41]
PGD (≥6-month postloss not criterion)	Post	9	1,576	26.0	.001	69.2	0.07	0.56	[0.34, 0.79]	**<.001**	[−0.12, 1.24]
Secondary outcomes											
PTSD	Post	10	735	20.4	.016	55.9	0.08	0.74	[0.49, 0.98]	**<.001**	[0.03, 1.45]
Anxiety	Post	9	865	7.7	.466	00.0	0.00	0.35	[0.22, 0.49]	**<.001**	[0.18, 0.52]
Anxiety	FU	3	245	1.2	.537	00.0	0.00	0.40	[0.14, 0.66]	**.002**	[−1.29, 2.09]
Depression	Post	19	2,438	64.5	<.001	72.1	0.09	0.53	[0.36, 0.71]	**<.001**	[−0.13, 1.19]
Depression	FU	5	1,091	55.7	<.001	92.8	0.45	0.59	[−0.04, 1.22]	.064	[−1.78, 2.96]

Note. CBT = cognitive behavioral therapies; *K* = number of studies; *N* = total number of participants; PGD = prolonged grief disorder; Post = postintervention; FU = follow-up; PTSD = posttraumatic stress disorder.
[a] Hedges's *g*: standardized mean difference adjusted for small sample bias (Hedges & Olkin, 1985). [b] *p* values (two-tailed): statistically significant ($p < .05$) in bold. [c] 95% prediction interval (PI), that is, the interval in which 95% of future observations from the same family of studies will fall. Only calculated when $I^2 > 0.0$ (InThout et al., 2016). [d] If Egger's test < 0.05, Hedges's *g* is adjusted for publication bias with the Duval and Tweedie's trim-and-fill method (Duval & Tweedie, 2000) with (*K*) = number studies + imputed "missing studies." [e] Sensitivity analysis excluding outliers defined as values smaller or greater than 2 *SD*s from the pooled effect size. [f] The Precision-Effect Test–Precision-Effect Estimate with Standard Errors (PET-PEESE; Stanley & Doucouliagos, 2014). [g] The study had an explicit inclusion criterion that clinically relevant PGD symptoms had to be present before a participant was included in the study determined by, for example, cutoff values on a self-report measure of PGD symptoms.

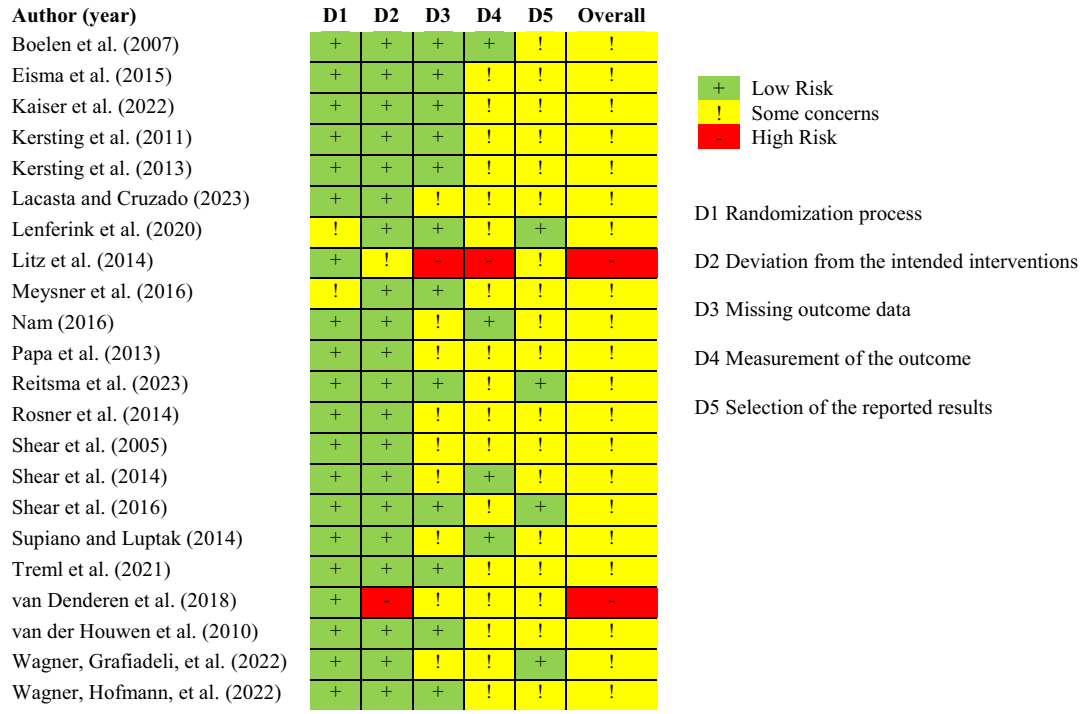
overview of what is currently known and to point to knowledge gaps that must be addressed in future research.

What CBT Components, Formats, and Delivery Types Work?

The present review revealed statistically significant medium effects across CBTs with different combinations of key CBT components. A large pooled effect was observed for studies of CBTs without exposure, whereas studies of CBTs with exposure were associated with a medium pooled effect. This was unexpected because studies directly comparing CBTs with and without exposure indicate that CBTs with exposure led to greater reductions in PGD symptoms (Boelen et al., 2007; Bryant et al., 2014). However, a recent RCT comparing a combined exposure and behavioral activation therapy with cognitive therapy found no significant differences in terms of reducing PGD symptoms in bereaved veterans (Acierno et al., 2021). It should be noted that only four of the 22 included studies did not include exposure, and the moderator analyses did not reach statistical significance. Furthermore, a larger number of key CBT components in the intervention did not appear to moderate the overall effect, and the largest pooled effect was found in the subgroup of studies of CBTs with only one key CBT component. This could suggest that the effective application of only one key CBT component may be sufficient to reduce PGD symptoms. This is in line with the

Figure 2

Risk of Bias of the Included Studies



Note. See the online article for the color version of this figure.

assumption that when one core process of PGD is targeted effectively, it may have a beneficial spillover effect on other core processes (cf. Boelen et al., 2006). However, it should be noted that most of these studies were underpowered, and some included additional non-CBT components (e.g., EMDR).

Both studies of group and individual CBT formats were found to reduce PGD symptoms. However, only three studies examined group-based CBTs (e.g., Lacasta & Cruzado, 2023), and no study had directly compared group and individual CBT formats. While group therapy may have advantages in the treatment of bereaved individuals in terms of targeting loneliness (Vedder et al., 2022) and is potentially more cost-effective, the evidence based for grief group therapy is still weak (see Maass et al., 2022, for review). The results of the present review could be taken to suggest that CBTs delivered in groups may be as efficacious as individual therapy, but RCTs directly comparing these formats are needed before firm conclusions can be drawn.

Both studies of digital and face-to-face delivery of CBTs yielded a medium pooled effect on PGD symptoms. While digital CBTs have advantages, for example, geographical independence (Wagner et al., 2020), all digital CBTs were compared to a passive control group, which may inflate ESs (Furukawa et al., 2014), whereas face-to-face CBTs were more often compared to active or competing controls (eight out of 12 studies). Head-to-head comparisons are needed to uncover whether digital CBTs are noninferior to face-to-face CBTs in reducing PGD symptoms. Furthermore, more knowledge is needed about whom digital CBTs are most suitable for (e.g., older vs. younger adults). In the present review, the mean age was generally lower in studies of digital CBTs than in studies of face-to-face CBTs (42 vs. 53 years).

Finally, differences in treatment duration in weeks and number of sessions in the studies did not appear to moderate the effect of CBTs. Future research must establish whether brief CBTs (e.g., Eisma et al., 2015) are as effective as CBTs of longer duration (e.g., Rosner et al., 2014).

For Whom Do Grief-Focused CBTs Work?

The mean sample age did not appear to moderate the overall efficacy of CBTs. It is worth noting that the majority of participants included in the studies were of middle age. Specifically, only three studies featured participants with a mean age surpassing 60 years, while an equal number of studies had a mean age below 40 years. This highlights the need for research to comprehensively assess the efficacy of CBTs across a broader spectrum of age groups, including both older and younger individuals. Moreover, the effect was not influenced by percent women in the sample, suggesting that CBTs may be efficacious for men and women. Nevertheless, our ability to interpret this result is challenged by that men were underrepresented in the included studies (only 13% of men).

Studies that included participants based on clinically relevant PGD symptoms and applied the ≥6-month time criterion yielded a larger pooled effect than studies using other inclusion criteria. Yet, only the moderating effect of inclusion of participants based on cutoffs for clinically relevant PGD symptoms approached statistical significance. However, studies that applied broader inclusion criteria, that is, symptoms of PGD, PTSD, or depression, also reported large effects on PGD symptoms (Reitsma et al., 2023; van Denderen et al., 2018), and even studies not applying the ≥6-month

Table 3
Results of Moderator Analyses for Effects of Grief-Focused CBTs on PGD Symptoms at Postintervention

Moderator	*K*	Slope[a]	95% CI	*p*[b]	R^2 [c]
Study characteristics					
Passive control condition (ref. active or competing)	22	0.13	[−0.20, 0.45]	.441	0.00
Study year (2001–2023)	22	0.01	[−0.02, 0.04]	.361	0.12
Participant characteristics					
PGD symptoms as inclusion criterion (ref. not a criterion)[d]	22	0.28	[−0.01, 0.56]	.055	0.28
Six months postloss inclusion criterion (ref. not a criterion)	22	0.16	[−0.14, 0.45]	.298	0.14
Mean sample age (years)	22	0.01	[−0.01, 0.02]	.225	0.17
Percent women in the sample	22	−0.01	[−0.02, 0.01]	.369	0.17
Time since loss (months)	21	−0.01	[−0.01, 0.00]	.222	0.12
Intervention characteristics					
Face-to-face delivery (ref. digital delivery)	22	0.08	[−0.23, 0.38]	.619	0.06
Individual format (ref. group format)	22	0.13	[−0.30, 0.56]	.547	0.00
Exposure included (ref. exposure not included)	23[e]	−0.28	[−0.69, 0.13]	.177	0.14
Restructuring included (ref. restructuring not included)	23[e]	−0.04	[−0.35, 0.26]	.775	0.00
Activation included (ref. activation not included)	23[e]	−0.01	[−0.31, 0.29]	.932	0.00
Intervention duration (weeks)	22	0.01	[−0.01, 0.03]	.327	0.05
Number of sessions	22	0.02	[−0.01, 0.06]	.134	0.16
Intervention dropout (%)	22	0.00	[−0.01, 0.01]	.970	0.00

Note. CBT = cognitive behavioral therapies; PGD = prolonged grief disorder; *K* = number of studies in the analysis; ref. = reference category.
[a] Metaregression (maximum likelihood method), conducted when $K \geq 10$. Positive slope: Moderator associated with larger effects of CBTs on PGD symptoms; negative slope: Moderator associated with smaller effects of CBTs on PGD symptoms. [b] Two-tailed *p* value. [c] R^2 analog: The proportion of the variation of the effect size explained by the moderator. [d] PGD symptoms as inclusion criterion = the study had an explicit inclusion criterion that clinically relevant PGD symptoms had to be present before a participant was included in the study determined by, for example, cutoff values on a self-report measure of PGD symptoms. [e] The $K > 22$ is due to one three-armed study with different combinations of key CBT components (Eisma et al., 2015).

time criterion found significant positive effects (Boelen et al., 2007; Litz et al., 2014). Future studies must clarify at which point in time individuals with PGD symptoms are likely to benefit from CBTs.

Finally, CBTs appeared to yield a smaller pooled effect on PGD symptoms in studies of individuals who all lost a person to unnatural causes compared to studies of individuals who all lost someone due to natural causes. More complex symptom profiles with high severity of co-occurring PGD, PTSD, and depression have been found in individuals confronted with unnatural loss (Soydas et al., 2021). Some adaptations to grief-focused CBTs may be needed to effectively target these complex symptom profiles. It should therefore be investigated whether longer treatments with an added trauma-specific focus may be more efficacious for these individuals.

Study Limitations

While the present comprehensive review of CBTs for PGD symptoms has several strengths, some limitations should be noted. First, the studies included in the review assessed PGD symptoms with different self-report instruments with no clear definitions of minimal important differences (i.e., an effect that patients would experience as beneficial). Second, the heterogeneity and relatively broad prediction intervals indicate considerable variability in the effects. Due to the relatively few available studies, our moderator analyses may have been underpowered to detect relevant sources of heterogeneity. Third, as only a few studies had included follow-up assessments of both treatment and control groups, the long-term effects should be interpreted with caution. Fourth, few studies were from non-Western regions, limiting the generalization of the present study's findings across regions. Fifth, an issue that may influence the magnitude of the effect size estimate is the pre–post correlation, which may vary between studies, but is rarely reported (Cuijpers et al., 2017). Future research is advised to include this measure. Last, although the overall effect remained statistically significant after adjusting for small study effects, in several of the included studies, it was noted that the study was or could have been underpowered ($K = 9$; 40.9%). These small studies could potentially include biased overestimates of effect. Based on these limitations, the overall quality of the evidence provided by the present meta-analysis was moderate, indicating that there is a possibility that the "true" effect could be substantially different from the one found in the present study.

Clinical Implications

The current review highlights the efficacy of CBTs in treating bereaved adults with symptoms of PGD and promising results in addressing bereavement-related PTSD, depression, and, to a lesser extent, anxiety. CBTs can be delivered in various delivery formats, including individual and group formats, as well as online and face-to-face delivery, all of which have demonstrated efficacy. It remains unclear whether one type of delivery or format is superior to the other. Therefore, it is recommended that clinicians assess the bereaved individual's circumstances and preferences to determine the most suitable delivery format. In cases where clients have suffered from traumatic losses, it may be necessary to add sessions and interventions specifically targeting the trauma. Moreover, the review points to the importance of screening for symptoms of PGD prior to initiating treatment to ensure appropriate and timely relevant interventions, although valid and reliable structured clinical interviews and an optimal time criterion for effective treatment of PGD symptoms still need to be established.

Future Research Perspectives

The present review highlights the ongoing need for a detailed understanding of effective treatment for PGD symptoms, which has been noted by several authors (e.g., Doering & Eisma, 2016). To achieve this goal, several avenues of research must be pursued. First, RCTs comparing various delivery types, formats, and key components head-to-head are essential. Second, studies that examine the efficacy of CBTs in distinct groups of bereaved individuals will contribute to a better understanding of who benefits most from CBTs and identify cases where adjustments may be necessary. Meta-analyses with individual participant data can be used to do this with sufficient power (Fisher et al., 2017). Third, RCTs comparing CBTs with other grief-focused therapies are required to confirm whether CBTs outperform alternative treatments. Last, gaining insight into the mechanisms through which CBTs bring about change in PGD symptoms is vital for a comprehensive optimization of CBTs (Kazdin, 2007).

Conclusions

Overall, grief-focused CBTs are efficacious in reducing PGD symptoms in bereaved adults and can be delivered effectively in different formats. Additionally, grief-focused CBTs yield positive effects on symptoms of PTSD, depression, and anxiety. However, the results should be interpreted with caution due to the high level of heterogeneity and indirectness of the meta-analytical evidence. Future research needs to further examine what types of CBTs work for whom and how CBTs produce change in order to optimize future treatments of PGD symptoms.

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