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Does school have a role in supporting bereaved children and young people? Exploration of school belonging, social support and school-based interventions in bereaved children and young people

by

Roseanne Frances Geradine

Thesis for the degree of Doctorate in Educational Psychology

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Abstract

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One in 20 children experience a death of a parent and more experience death of a close family member or friend (Parsons et al., 2011). The experience of loss and bereavement is stressful and can be traumatic for children. For this reason, bereavement can be considered an adverse childhood experience (ACE). ACEs have a negative impact on both immediate and long-term outcomes. Therefore, it is important that children and young people receive suitable support for their grief. Schools are well placed to offer support as it is a familiar environment and interventions can be more easily accessed (e.g., no extra travel, time constraints etc.). School-based interventions can be considered on three levels: primary, secondary, and tertiary, depending on type and amount of support required. Primary interventions are often whole-school approaches, secondary and tertiary interventions occur after the bereavement. In chapter two, a systematic literature review of school-based interventions for grief was undertaken. In total 12 studies, using quantitative methods, were identified through the systematic searches. The quality of the research was varied, many studies did not include control groups or collect follow up data which impacted the overall quality of the evidence base. Interventions were organised to type and level (primary, secondary, tertiary) to synthesize data. This research showed the evidence base is limited and does not provide a clear picture of which school-based interventions are effective. Additionally, most of the research takes place in the USA making it difficult to generalise the findings to the UK educational system. Further high-quality UK-based research is needed to understand what school-based interventions are suitable for bereaved CYP.

Chapter three of this thesis aims to investigate the relationships of different aspects of social support and grief reactions in children and young people. Social support has been shown to support children and young people following a bereavement. However, literature provides a mixed picture of which aspects of social support are most beneficial. There was a further aim to investigate the relationship of school belonging with grief which has not previously been researched despite school belonging being identified as protective factor for other ACEs. As bereavement can be considered an ACE, children and young people are at risk of developing long-term negative consequences following bereavement, particularly if they experience prolonged grief. To investigate the aims of this research, data was collected via an internet survey, from young people and their caregiver who had recently experienced a bereavement. Findings showed both school belonging and peer support had significant associations with grief reactions. These relationships indicated the higher self-reported school belonging and peer support the lower self-reported grief reactions. Regression analysis showed a further significant association with school belonging and peer support. Surprisingly, no significant relationship was found between family support and grief reactions which contradicts previous research (e.g., Biank & Werner-Lin, 2011). This research has added to literature because it highlights the potential importance of school belonging for CYP who have experienced bereavement. However, due to the small sample size further research is needed to investigate the relationships in more depth.

Keywords: school belonging, peer support, family support, grief, bereavement

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Research Thesis: Declaration of Authorship

Print name: Roseanne Frances Geradine

Title of thesis: Does school have a role in supporting bereaved children and young people? Exploration of school belonging, social support and school-based interventions in bereaved children and young people.

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. None of this work has been published before submission

Signature: Roseanne Geradine Date: 03.06.2024

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Definitions and Abbreviations

ACE(s): Adverse Childhood Experience(s)

Bereavement: term used to describe the experience of someone close to an individual dying.

CBT: Cognitive-Behaviour Therapy

CYP: children and young people

d: Cohen's effect size, *d*=.02 indicates a small effect, *d*=0.5 is a medium effect and *d*> 0.08 indicates a large effect.

EAL: English as an Additional Language

Family support: term used to describe the support received from family members, usually close family (e.g., parents, siblings).

Grief: term used to describe reactions experienced following a loss or bereavement, reactions may be behavioural, cognitive, somatic, emotional etc.

ICG: Inventory of Complicated Grief

Intervention: a term used to describe structured and specific actions taken to support a specific outcome, often has a specified duration and frequency so that is delivered consistently.

IPG: Inventory of Prolonged Grief

IPG-A: Inventory of Prolonged Grief for Adolescents

IPG-C: Inventory of Prolonged Grief for Children

K: number of studies

M: mean

n: number of total participants

p: significance level

Peer support: term used to describe the support received from peers both friendships and acquaintances.

PGD: Prolonged Grief Disorder

PICOS: Population, Intervention, Comparison, Outcome, Setting framework for search terms (Higgins & Green, 2011)

Post-grief growth: term used to describe the positive psychological changes that occur after experiencing a bereavement.

PRISMA: Preferred Reporting Items for Systematic Reviews and Meta-Analyses

Prolonged grief: a term used to describe complex, complicated, or prolonged grief, which does not improve over time (lasting longer than 6 months) and significantly impacts daily functioning.

PROMIS: Patient-Reported Outcomes Measurement Information System

PSSM: Psychological Sense of School Membership Scale

PTSS: Post-Traumatic Stress Symptoms

r: Pearson correlation coefficient, small effect r<.03, medium effect size is indicated by values between .3 and .7, large effect size is indicated by r>.7

School belonging: used to describe the sense of identification, attachment, connectedness to the individual's school environment.

SD: Standard deviation

SDQ: Strengths and Difficulties Questionnaire

SEN: Special Educational Needs

Social support: term used to describe support received from multiple sources including family, peers, community, and school.

TGCT-A: Trauma and Greif Component Psychotherapy for Adolescents

UK: United Kingdom

USA: United States of America

β: standardised coefficients beta

Chapter 1 Does school have a role in supporting bereaved children and young people? Exploration of school belonging, social support and school-based interventions in bereaved children and young people

1.1 Aims and rationale of the thesis

The overarching aim of this research was to improve understanding of the role educational settings can play for children and young people (CYP) who have experienced a significant bereavement. This was important because statistics indicate 1 in 20 children under the age of 16 experience a significant bereavement (Parsons, 2011). This is the equivalent of at least one pupil in every class experiencing a death of a loved one, therefore, death and bereavement is a common issue faced by teachers and schools across the country.

Additionally, school plays a significant role in young people's lives and Bronfenbrenner's Model of Ecological Systems argues school can act as a much needed support system for individuals. This is particularly the case for CYP whose other support systems have been interrupted (Grych et al., 2015). As many aspects of the young person's home life change due to the bereavement, schools can provide a sense of stability. Unfortunately, both my personal experience as primary school teacher and literature indicate that teachers feel ill-equipped to support bereaved pupils, with many teachers highlighting a lack of training on issues surrounding death and bereavement (Holland, 2008; Holland & Wilkinson, 2015). During my work as a teacher, I had pupils in my class who experienced bereavements. I was unsure how best to support the pupils and where to go to find advice, therefore, I took it upon myself to research best approaches. In my work as a trainee educational psychologist, I have had many school staff asking for support with bereaved pupils. This anecdotally confirms the research that indicates teachers feel ill-equipped to support bereaved pupils.

My experiences as a teacher and trainee educational psychologist motivated me to further research the support schools can provide for bereaved pupils. I feel that this is beneficial

knowledge for an educational psychologist as we are often required to work with pupils with adverse childhood experiences (ACEs) and provide support during critical incidents. There is a need to understand these experiences and their potential impacts, to guide school staff and families to best support CYP. It is important for school staff to be aware of bereavement because grief is likely to impact the pupil's whole life, including educational outcomes (Elsner et al., 2022). Therefore, despite a bereavement initially being a familial issue, teachers and other educational staff are likely to see impact of the pupil's grief at school. Thus, it is important school staff feel comfortable and equipped to support the bereaved pupil.

This training gap in bereavement is felt by pupils, with research indicating many bereaved pupils returning to school had negative experiences, including limited support or poor understanding of their circumstances (Lytje, 2018). The systematic literature review (chapter two) aims to build understanding of the evidence base of school-based interventions for bereaved pupils. This was to help guide educational professionals, both teachers and educational psychologists, in providing appropriate support for bereaved pupils.

There needs to be further understanding of the difference between typical and atypical grief trajectories and knowledge around pupils displaying signs of prolonged grief disorder (PGD). PGD is a term that describes prolonged, traumatic and/or complicated grief, that last beyond six months and has a significant impact on daily functioning. PGD can lead to long-term negative consequences including adverse peer relations and lower educational aspirations (Brent et al., 2012). The empirical research (chapter three) aimed to build understanding of protective factors against prolonged grief. The research, in particular, looked to strengthen understanding of social support systems through investigating peer relationships, family relationships and school belonging. While previous research has investigated the impact of peer and family relationships with mixed results, the relationship between grief and school belonging has not previously been researched. Given the link between school belonging and other ACEs (e.g., Bethell et al., 2019) it is plausible there is a relationship with grief reaction. Investigating this relationship can further our understanding of how to support bereaved CYP to prevent the development of PGD.

The two chapters together provide insight in how schools can support bereaved CYP. The empirical paper (chapter three) highlights relationships between grief and school belonging, as well as grief and peer relationships. This suggests school-based group interventions such as those examined in the systematic literature review may support grief reactions through building school belonging and peer relationships.

The empirical chapter uses baseline data from participants recruited through a childhood bereavement charity based in the South of England. The supervisors of this thesis plan to use longitudinal data, collected over 12 months, to gain understanding of the impact of the charity's grief groups as well as build upon the initial findings of impact of different aspects of social support on grief reactions. As of May 2024, data collection is continuing, with participants now being asked to complete the six month follow up survey.

1.2 Research Paradigm

When conducting research, there is a philosophical framework that directs the process, this is known as a research paradigm (Ulz, 2023). Within a research paradigm sits epistemology, ontology, and methodology (Hassmén et al., 2016). Ontology is the research's belief of reality. Epistemology is a researcher's belief of how knowledge is constructed. Methodology refers to the approach a researcher takes to discover the knowledge.

There are several different research paradigms. This thesis is positioned as a post-positivist paradigm with a critical realist ontology. A post-positivist research paradigm sits between a positivist and interpretivism paradigm (Grix, 2004).

Quantitative research historically uses a positivist research paradigm. A positivist paradigm states knowledge can be observed and measured, with the belief in one objective truth of the world, a realist ontology (Rehman & Alharthi, 2016). A positivist researcher believes that the truth is discoverable, independent from themselves and can be fully understood (Houghton, 2008). This contrasts with an interpretivism paradigm that views knowledge as a social construct and that there are subjective truths that differ depending on individual's experiences and understanding of the world (Willig, 2013). This is known as relativist ontology. Traditionally, interpretivism uses qualitative methodologies to understand individual experiences and reflects on the researchers' beliefs and values to understand how this may influence the understanding of the researcher's findings (Rehman & Alharthi, 2016).

Similarly to positivism, post-positivism has a realist ontology which argues that there is a reality independent from the researcher. However, post-positivism differs because it also argues that this truth can never be fully known due to the complexity of social phenomena meaning our understanding of the world will only ever be partial and that theories are likely to change as understanding develops (Haigh et al., 2019). The post-positivism paradigm encourages repetition of research to re-test hypotheses to help build understanding (Panhwar et al., 2017) however, our understanding of the truth is likely to remain limited and is seen as

changeable because the researcher's beliefs are likely to influence the interpretation of the truth (Rehman & Alharthi, 2016). Post-positivism can be described as a spectrum, with multiple realist ontologies (Ryan, 2019). One such ontology is critical realism. Research which partially answers questions or creates new questions, can be described as critical realist ontology (Cruickshank, 2012; Rehman & Alharthi, 2016). Those who use a critical realist ontology focus on having a critical view of knowledge obtained in research and encourage use of different methodologies to develop understanding (Brunson et al., 2023). Therefore, research using a post-positivist paradigm can use, and encourages, a variety of methodologies to obtain knowledge about the world.

This thesis used a post-positivism research paradigm with a critical realist ontology. As a researcher I accepted the full truth could not be found and that my research was likely to highlight further questions. For this reason, limitations and further directions of research, including repetition of the research are discussed in both chapters. Chapter two and chapter three focused on research that used quantitative methodologies, with the belief that relationships between social phenomena (e.g., grief, social support, and school belonging) could be captured to help improve understanding of these social phenomena and build on previous research. However, as a researcher I was aware that quantitative methodologies gave me a limited picture of both school-based intervention for bereaved CYP and grief experiences of CYP. Further research, using qualitative methods are likely to build on understanding and explanations for the data reported in this thesis.

1.3 Reflective learning

The thesis journey has been full of learning opportunities and developed my practise as a trainee educational psychologist. Reflecting on my previous practise as a teacher, while I aimed to be understanding, I think my practise could have been more supportive. As I have learned more about grief in childhood, I have built understanding of how behaviours may be linked with grief reactions. For example, having reflected about a previous pupil of mine, I did not link the drop in her academic performance with the death of her pet and previous family bereavement. The pupil presented happily at school, however given her young age, she had likely not yet developed full understanding of death. Therefore, she may have benefited from support to understand the concept of death.

Since the start of my thesis, I have worked with a number of CYP who have experienced bereavements. Where possible I have tried to identify links between behaviours and

bereavements with school staff and caregivers, particularly if the behaviours were not present before the bereavement. My thesis journey has guided how I understand these CYP and discuss the impact of bereavement with key adults. It has also supported my understanding of how to identify pupils who may be experiencing prolonged grief reactions and those who require specialist bereavement intervention. As part of my work as a trainee educational psychologist, I have supported the bereavement training of emotional literacy support assistants (ELSAs) in two local authorities. I have been able to disseminate research around PGD and what type of grief reactions ELSAs are equipped to support and what type of grief reactions require specialist support. In this way, my thesis journey has significantly developed my practise as an ELSA trainer and supervisor. The knowledge and understanding I have gained has been invaluable in this work.

Alongside the knowledge about grief and bereavement, the thesis has built my resilience as a practitioner. Throughout my journey, recruitment has been a challenge and I have had to spend a significant amount of time working alongside the charity to increase participation. I had to persevere with this, even when numbers of participants grew slowly. This perseverance paid off as I was able to collect data for the empirical chapter, I fully believe I would not have recruited as many participants had I not spent time working and building relationships with members of the charity. This has taught me the value of perseverance and resilience in my work as a trainee educational psychologist and as a result have become more proactive in my work. I think this has not only benefitted my ability to manage my workload but also the CYP, families and schools I work with because it enables me to gain better insight and understanding of those I work with. This ensures my advice, interventions and support are clearly guided by strong hypotheses and suited to the needs of those involved.

1.4 Dissemination plan

These two papers have been written with the intention to submit to peer reviewed journals. The intention is to submit chapter two to ‘Educational Psychology in Practice.’ This was deemed an appropriate journal for the systematic literature review due to the focus on school-based interventions for bereaved CYP. This has direct links with professional practise in schools and therefore would be of interest to professionals in the educational psychology sector. Additionally, the discussion focuses directly on implications for educational settings and staff based in the UK. As the journal ‘Educational Psychology in Practice’ is specifically targeted to those based in the UK it was felt the systematic literature review would be of interest to the journal’s target audience.

Chapter three focused upon the relationships between different aspects of social support, including school belonging, and grief in CYP. This paper had a wider scope than the systematic literature review, therefore is likely to be of interest to a wider audience. It is the intention to submit the empirical chapter to the 'OMEGA Journal of death and dying.' This journal focuses on research within the topics of grief, bereavement, death and dying. It is an international journal, and its target audience is for any professional working with issues relating to death and bereavement. The empirical chapter identified significant relationships between peer relationships, school belonging and grief reactions. This chapter is likely to be of interest of those working with bereaved CYP because it adds to the literature that helps identify those potentially at risk of prolonged grief reactions.

Alongside submission to peer-reviewed journals, the empirical study (chapter three) will be disseminated to the charity who supported with recruitment. A meeting with a senior employee of the charity to discuss initial findings took place in May 2024, during this discussion it was agreed that a copy of the empirical chapter will be provided to the charity once it has been finalised and approved by all members of the supervisory team. The charity then plans to share the paper with participants and other interested members.

Chapter 2 A systematic review of school-based interventions to support bereaved children and young people through a personal grief event.

2.1 Introduction

Parental loss is experienced by 2-6% of children under the age of 18 (Harrison & Harrington, 2001). Even more children experience bereavement of other loved ones, such as siblings, aunts, uncles, and grandparents. These statistics suggest that, by the age of 18, a significant number of children and young people (CYP) will have experienced a bereavement, making grief and bereavement a common occurrence across the United Kingdom.

Grief can be described as reactions that occur after an individual experiences a loss, such as a bereavement (Kirwin & Hamrin, 2005). Grief is a normal human reaction to loss, which most experience at some point in life. In CYP, grief can manifest in multiple ways including somatically, cognitively, emotionally, and behaviourally (Sood et al., 2006). It is common for children to internalise their grief, particularly when they have not yet developed language to help verbalise their experiences (Auman, 2007; Cerniglia et al., 2014). Externalising symptoms such as engagement in risky behaviour (e.g., drugs taking, drinking alcohol) can also be exhibited (Ferow, 2019).

The majority of CYP are able to come to terms with the death and adjust to the 'new normal' following a bereavement, and their grief will naturally improve over time (Melhem et al., 2011). However, for some, grief reactions are more intense, persist for longer than expected and can significantly impact daily functioning (Maass et al., 2022). For example, grief can impact an individual's ability to maintain relationships and cope with life stressors (Ferow, 2019). This can lead to long-term negative consequences which can persist through life (Silverman et al., 2003). Bereavement during childhood, therefore, can be considered an adverse childhood experience (ACE) which can have a long and significant impact on an individual's life (Bellis et al., 2014).

2.1.1 Risk factors

Since bereavement in childhood can be considered an ACE, it is important to understand factors that can increase the risk of developing associated negative consequences. With this understanding, support can become targeted and more appropriate to the needs of bereaved CYP.

How the death occurred can act as a risk factor in developing long-term negative consequences of grief (Feigelman et al., 2009; Nader & Salloum, 2011). Deaths that are natural or expected can be considered the least high-risk, with sudden and unexpected deaths (e.g., suicide, accident) more closely linked to prolonged grief reactions (Feigelman et al., 2009).

Another key risk factor for prolonged grief, is the CYP's developmental understanding of death (Heath & Cole, 2011). It has been reported that accurate understanding of death does not typically develop until 9 to 11 years of age (Stein et al., 2019). However, this can vary based on factors such as cognitive development, language development and cultural differences (Kenyon, 2001). As understanding with the world develops, CYP also build their ability to process grief (Heath & Cole, 2011). Children who experience a significant bereavement under the age of 5 are more likely to experience more severe consequences (Black, 1978; Ferow, 2019; Rutter, 1966). CYP are still developing language meaning grief reactions can become internalised or not verbally expressed, thus, it may appear that the CYP is coping with their grief. Additionally, at this age, children's view of the world is egocentric and they are therefore more likely to believe they had a role in the death leading to feelings of guilt, shame, and confusion (Biank & Werner-Lin. 2011).

While a unnatural death and younger age of the child are potential risk factors, they are dependent on the individual's situation and interventions cannot specifically target or change the associated risk. However, the type, timing and circumstances of the death may help identify which CYP will benefit from specialist support.

2.1.2 Protective factors

Other studies have highlighted modifiable protective factors such as social support (Biank & Werner-Lin, 2011; Dopp & Cain, 2012). Social support can come from many different sources including family, school, and peers. For example, quality of relationships with surviving

parent has been highlighted as important, particularly if there was evidence of strong and open communication (Hurd, 1999). However, family members are often experiencing their own grief and therefore can have reduced emotional capacity to provide the support required by CYP (Dopp & Cain, 2012; Reid & Dixon, 1999). This can lead to CYP becoming isolated in their grief.

While parental relationships are important, peer support has also been shown to be beneficial and becomes significantly more important during adolescence (Harris, 1991). Unfortunately, peers can lack the emotional development to understand grief or alternatively worry about saying the wrong thing, leading to the topic of the bereavement being avoided (LaFreniere & Cain, 2015a). Meaning CYP are not always accessing the peer support they need. Peer support is more beneficial when it focuses of three key functions: providing a sense of normalcy, knowing others have similar grief experiences, and opportunities to discuss bereavement and grief experiences (Dopp & Cain, 2012).

On a more individual level, a CYP's coping skills can act as protective factors. Coping skills is a broad term which includes skills such as emotional regulation, linking thoughts with emotions, talking about loss, and actively seeking support to problem-solve (Martin & Doka, 2000). Individuals who have greater skills in these areas prior to the death are less likely to experience complicated grief and the associated long-term consequences.

Following a bereavement, it is important for professionals to consider how best to assess CYP's available social support and coping skills to identify who requires further intervention. Once identified, professional should focus on improving social support, developing coping skills, and adapting interventions to an individual's level of understanding of death when needed. This would ensure children and young people can be safeguarded against the negative impacts of grief.

2.1.3 Interventions for childhood grief

Given the associated protective factors, it is unsurprising many interventions for childhood grief focus upon providing social support, normalising grief experiences, and developing coping skills (Chen & Panebianco, 2018). These interventions can be categorised into three groups (Jones et al., 2015): primary, secondary, and tertiary interventions.

Primary interventions take place on a universal level. They are targeted towards all CYP regardless if they have experienced a bereavement or not. Primary interventions aim to build skills that may function as protective factors in a variety of difficulties, among them also grief.

Such skills may be emotional literacy or coping skills. Bereavement policies of schools can also be considered a form of universal level support as they provide systems for staff to follow in case of a bereavement, giving teachers a sense of security when supporting bereaved pupils (Lytje, 2017). Bereavement policies can also target socio-economic inequities in access to bereavement support (Abraham-Steele & Edmonds, 2021). While there is a body of research examining the level of change through primary interventions, this research cannot measure whether there is significant impact on grief reactions if a bereavement does occur.

Secondary interventions, focus specifically on CYP who have experienced, or are about to experience, a bereavement. These interventions focus on normalising grief, building social support, and developing coping skills to foster resiliency against negative consequences. Research into these interventions focuses on pre-post intervention changes by measuring symptoms associated with grief (e.g., depression, anxiety, wellbeing etc.) and/or abilities in coping, processing grief or communicating about it. Interventions in this category can be delivered individually or in a group and are designed to be suitable for CYP with subclinical grief reactions (Jones et al., 2015).

Tertiary interventions are aimed at CYP who experience prolonged grief or posttraumatic stress symptoms (PTSS) following the bereavement. These interventions will only be required by a minority of CYP. They are delivered by specialist mental health providers and are more likely to be individualised to the CYP's specific needs. While tertiary interventions may target similar areas to secondary, they may also focus on improving symptoms of mental health disorders such as PTSS (Jones et al., 2015).

Previous systematic reviews of interventions for bereaved CYP, including both quantitative and qualitative research, have differed in their conclusions on the effectiveness of these interventions (Akerman & Statham, 2011; Bergman et al., 2017; Chen & Panebianco, 2018; Duncan, 2020). Alongside these systematic reviews, a few meta-analyses (Currier et al., 2007; Hanauer et al., 2024; Rosner et al., 2010) have highlighted the limited research on interventions for bereaved young people. However, there are a few promising findings. Rosner and colleagues (2010) meta-analysis showed small to medium effect sizes for grief interventions with larger effect sizes for participants with more severe grief symptoms at baseline. Of the interventions included, the most promising were music therapy (Dalton & Krout, 2005; Hilliard, 2001) alongside trauma and grief component psychotherapy (TGCT; Goenjian et al., 1997; Layne et al., 2001; Saltzman et al., 2001). Hanauer and colleagues (2024)

added to this research base by identifying that intervention effects significantly reduce when controlling for the natural trajectory of grief.

Despite these reviews, research into grief interventions faces methodological challenges that may account for some of the inconsistent results that have been reported. Children who experience a significant bereavement are a difficult population to recruit (Akard et al., 2014), resulting in confounding factors that may influence effect sizes. Firstly, the amount of time that has passed since bereavement may vary. Treatment that is provided closer to the death may yield greater improvements (Currier et al., 2007). Secondly, children with more severe grief symptoms show greater levels of improvement, suggesting the delivered intervention type should be carefully considered based on individual need (Currier et al., 2007). Thirdly, many intervention studies use a variety of outcome measures, with some focusing on symptomology (e.g., PTSS, depression) and others using grief specific measures. A recent systematic review has shown a need for more consistent use of grief specific measures to ensure the effectiveness of grief intervention studies is understood (de López et al., 2020). Outcome measures designed to identify clinically elevated symptoms or mental health difficulties can impact studies' ability to detect smaller changes in grief.

2.1.4 The role of the school in supporting grief

While there have been a number of reviews of grief interventions, there is a gap in the literature in reviewing school-based interventions. Interventions to support bereaved CYP can occur in many settings such as clinical practice (e.g., Wilkinson et al., 2007), in the community (e.g., Siddaway et al., 2015), residential camps (e.g., Hanlon et al., 2018) and schools (e.g., Riley, 2012). During a period of loss, CYP often look for support from familiar adults. However, as many bereavements are experienced by the whole family it often means family members may not have the capacity to provide the required emotional support for CYP to successfully navigate their grief (Dopp & Cain, 2012; Reid & Dixon, 1999) due to their own grief experiences.

According to Bronfenbrenner's Model of Bioecological Systems (2005), many systems influence an individual's development. It also suggests that when some systems are impacted, such as familial relationships, other systems, such as school relationships, can step up to provide support so effective development can still occur. Throughout times of loss and change for CYP, their school, and particularly their teachers, can be a constant and provide security alongside a sense of normalcy (Holland, 2008). Teachers interact with CYP daily and therefore

CYP may feel comfortable in their presence to talk about, and begin to process, their loss (Reid & Dixon, 1999).

School-based interventions thus offer specific advantages compared to interventions in other settings to bereaved CYP. School-based interventions take place in a familiar environment with known adults and are often easier for CYP to access. School-based interventions do not generally require parental involvement (beyond providing consent). This means that factors such as parental work schedules, access to transportation, and parental grief are less likely to impact access to interventions (Langely et al., 2015). Research has also shown higher rate of uptake of school-based intervention for trauma as well significantly lower attrition rates in comparison to a clinically based intervention (Jaycox et al., 2010) meaning more CYP access the intervention duration as intended.

For these reasons, school-based support for grief is key in enabling CYP to cope with significant loss. When a supportive school environment is unavailable, the risk of longer-term social, emotional, and academic difficulties increases (Cullinan, 1990). Conversely, UK-based research shows teachers often lack confidence or skills to support bereaved CYP (Holland 2001; 2008; Holland & Wilkinson, 2015) which can lead to avoidance of talking about or acknowledging the loss (Kahn, 2013). The return to school is therefore more likely to be a negative experience for CYP (Holland, 2003). This suggests a vital need for teachers and school staff to have better understanding of school-based interventions to better support bereaved CYP.

2.1.5 Objective of the current review

The purpose of this research was to systematically review the availability and effectiveness of school-based interventions aimed at improving grief reactions. This information can then be used by educational professionals such as teachers and educational psychologists to better understand the evidence base for school-based interventions for bereaved CYP. Therefore, be better placed to implement effective support for this vulnerable group.

Thus, the research question for this review was:

How can school settings support children and adolescents who have experienced a personal grief event?

2.2 Methods

2.2.1 Search terms

Search terms were initially generated from key words in the research question (Appendix A). Several scoping searches were conducted between July and October 2023 to help identify and refine search terms. Key terms from previous reviews and research on childhood and adolescent bereavement were examined to refine search terms further. Below are the final search terms used in the review:

bereave* OR grie* OR "personal grief event" OR death OR dying OR loss OR mourn*

AND

"school-based intervention" OR "school-based program*" OR "school-based support" OR "teacher support" OR "classroom intervention" OR "classroom support" OR “school-based”

2.2.2 Initial screening

The studies obtained for this review were identified by systematic search of the following databases: Psycinfo, ERIC, CINAHL, MEDLINE and Web of Science. These databases were chosen due to their links with Psychology and Education. Alongside this, Proquest Dissertation and Theses Global was searched for grey literature relevant to the topic. Additionally, references of included studies and related systematic literature reviews were manually searched to ensure search terms captured any studies that were missed from the systematic search. The research protocol was registered on PROSPERO (CRD42023455416) and the review adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses Guidelines (PRISMA, Page et al., 2021).

2.2.3 Inclusion and Exclusion Criteria

Table 1. *Inclusion and exclusion criteria for the systematic review*

Inclusion Criteria	Exclusion Criteria
Participants aged between 4 and 18 years	Adult participants
Experience of a personal grief event	Book reviews
Full text available	Systematic reviews
Paper available in English	Book chapters
Quantitative data were reported	Grief event was community/school based
Intervention used, or was based in, a school setting	Qualitative

Due to the inclusion criteria that participants had experienced a personal grief event, the focus of the review was on secondary and tertiary level interventions. Primary level interventions target all CYP regardless of loss experience, whereas secondary and tertiary level interventions support CYP who have or in the process of experiencing a loss or bereavement. Therefore, primary interventions were not deemed suitable to be included.

It was decided that included studies should focus on interventions that target personal grief events rather than collective bereavement or bereavement following a disaster (e.g., earthquake, terror attack). Collective grief can be described as the grief felt by a group or community following a loss, for example grief experienced by a school community following the death of a teacher or the experience of loss following a natural disaster. Conversely, personal grief is the experience of grief an individual may experience following a personal loss, for example the loss of a parent. Collective grief differs from personal grief because it can create a sense of belonging in a community through shared experience and emotion (Wagoner & Brescó de Luna, 2022). Group gatherings and rituals to remember loved ones help strengthen social support networks which can be key in supporting emotional wellbeing following the grief event (Ekanayake et al., 2013). These are less likely to occur in personal grief events. Therefore, this review focused on interventions for individual personal grief events rather than grief following a collective loss.

Recruiting bereaved participants can be challenging due to the nature of grief. As a result, a number of intervention studies also recruit participants that have experienced other losses or traumatic events (e.g., parental divorce, family member arrested, family member injured). It was decided that studies that included bereavement as a traumatic event and recruited a number of participants who had experienced a bereavement could be included in this systematic review. There were six studies in total that included participants who had experienced other losses or traumatic events (Grassetti et al., 2015; 2020; Herres et al., 2017; Langley et al., 2015; Tillman & Prazak, 2014; Wells, 1994). For these studies, data was extracted on number of bereaved participants and type of bereavement experienced, please refer to table 4 for this information. A recent meta-analysis (Hanauer et al., 2024) also included these types of studies but only extracted data on bereaved participants.

It was also decided to focus on quantitative studies for school-based bereavement interventions as there have been previous reviews into qualitative studies (e.g., Duncan, 2020). Further inclusion and exclusion criteria can be found in table 1. The first reviewer (author) completed all screening phases: duplicates, title, abstract and full text screening. The screening was conducted using Rayyan, a web-based application. To check for suitability of exclusion and inclusion criteria, a second independent reviewer, screened 100% of articles included at abstract phase and 50% of full text screening. If there were any disagreements during this phase, these were resolved through discussion between the two reviewers. The two reviewers had an agreement rate of 90% for abstract phase and 92% for full text screening. Cohen's kappa was calculated to assess the agreement rate between reviews for abstract phase $\kappa = 0.75$ and full text screening $\kappa = 0.76$. These values indicate substantial agreement between reviewers. The systematic search yielded 12 results (see Figure 1)

2.2.4 Data extraction and synthesis

Data extracted from the 12 studies included

(a) author information and year published

(b) participant information

(c) bereavement/grief intervention (frequency, duration, type/theoretical basis)

(d) bereavement information

(e) study design

(f) outcome measures, and;

(g) significant results/findings.

Tables 3 to 5 outline the full data extraction of all 12 studies. The extracted data was synthesised using a narrative approach due to the heterogeneity of the studies and the wide-ranging outcomes measured (Boland et al., 2017). This synthesis approach is in line with other reviews of bereavement interventions, which have used similar approaches (e.g., Ridley & Frache, 2020).

2.2.5 Quality assessment

Quality assessment was completed on all papers included in the review using the Quality Assessment Tool for Quantitative Studies (Ciliska et al., 1998). This tool was used because it can be used on a range of quantitative intervention designs including cohort study designs with no control group. The tool has a total of 21 items, spilt into eight sections: selection bias, study design, confounders, blinding, data collection methods, withdrawals and drop-outs, intervention integrity, and analyses. The first six sections were assigned a weak, moderate, or strong rating. Intervention integrity and analyses sections were used to aid the reviewer to identify if intervention integrity and analyses were appropriate but do not receive a rating. Finally, an overall study rating of weak, moderate, or strong was assigned based on how many of the first six sections received a weak rating:

Weak – two or more sections rated as weak

Moderate – one section rated as weak

Strong – no section rated as weak

To view each item of the quality assessment tool please see appendix B.

2.3 Findings

2.3.1 Systematic search

The search was initially conducted in October 2023 and re-run by a second reviewer in November 2023. The search yielded 3,502 articles. From this, articles were screened for duplicates using the automatic screener in Rayyan, and then manually double-checked. Following this, inclusion and eligibility criteria were applied to the remaining 1,959 articles. Following the abstract and full text screening, eleven articles were identified for inclusion. The reference lists of the articles and related systematic reviews were screened for further appropriate studies. From this, one further study was identified for inclusion so a total of 3503 screened for inclusion. Twelve studies were included in the review. The systematic search procedure is presented through a PRISMA flow diagram (Page et al., 2021) below (Figure 1).

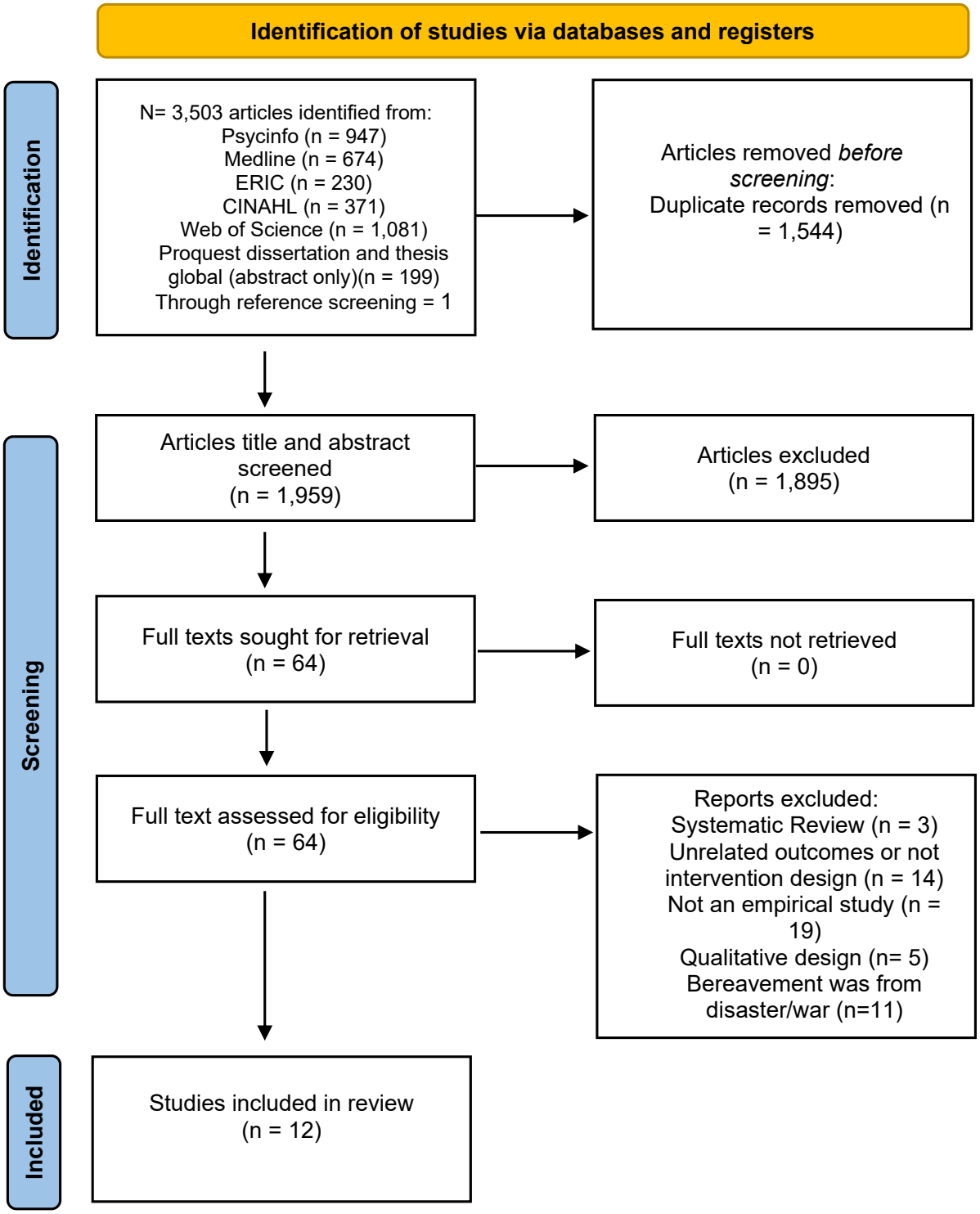

Figure 1. *PRISMA flow diagram showing the systematic search procedure (Page et al., 2021)*

2.3.2 Quality assessment

Quality assessment was completed on all papers included in the review using the Quality Assessment Tool for Quantitative Studies (Ciliska et al., 1998; Appendix B). The quality of the 12 studies varied significantly. Four were rated of strong quality, four of moderate quality and four were assigned a weak quality rating. Low quality studies lacked details about how participants were recruited, how many participants received intervention as intended, fidelity of intervention and no control group. Many of the studies provided limited information on the intervention integrity, five studies did not provide information about number of participants receiving intervention as intended. Additionally, seven studies did not measure consistency of intervention between participants. The analyses for all 12 studies were deemed appropriate. Figure two below shows the number of studies receiving a weak, moderate, and strong rating overall and for the first six sections of the tool.

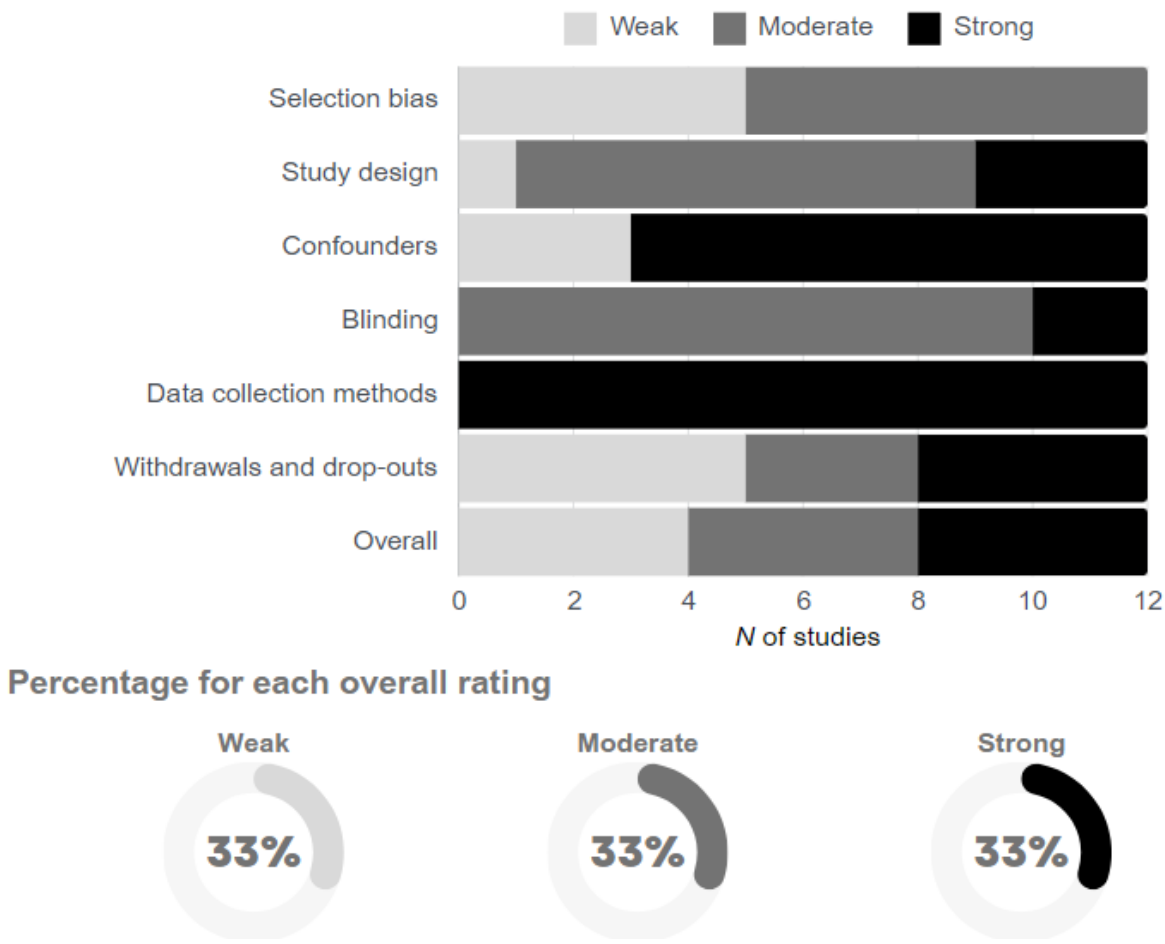

Figure 2. *Section and overall quality assessment ratings using Quality Assessment Tool for Quantitative Studies*

Table 2. *Quality assessment for each study*

Study author and year	Selection bias Q1 Target population	Q2 % agreed to participate	Study Design Q1	Q2 randomised	Q3 Randomised method described	Q4 Appropriate method	Confounders Q1 differences between groups	Q2 % confounders controlled	Blinding Q1 assessor aware of groups
Grassetti et al., 2015	2	2 MODERATE	5	No	N/A	N/A MODERATE	2	N/A STRONG	1
Grassetti et al., 2020	2	3 WEAK	5	No	N/A	N/A MODERATE	2	N/A STRONG	1
Herres et al., 2017	2	1 MODERATE	5	No	N/A	N/A MODERATE	2	N/A STRONG	1
Hilliard 2001	3	1 WEAK	2	No	N/A	N/A MODERATE	1	1 STRONG	1
Hilliard, 2007	2	1 MODERATE	2	Yes	No	N/A STRONG	1	1 STRONG	3
Langley et al., 2015	2	2 MODERATE	1	Yes	Yes	Yes STRONG	1	1 STRONG	3
Linder et al., 2022	2	5 MODERATE	5	No	N/A	N/A MODERATE	2	N/A STRONG	2
Riley 2012	2	3 WEAK	5	No	N/A	N/A MODERATE	2	N/A STRONG	1
Tillman & Prazak, 2018	3	5 WEAK	5	No	N/A	N/A MODERATE	3	N/A WEAK	1

Study author and year	Selection bias Q1 Target population	Q2 % agreed to participate	Study Design Q1	Q2 randomised	Q3 Randomised method described	Q4 Appropriate method	Confounders Q1 differences between groups	Q2 % confounders controlled	Blinding Q1 assessor aware of groups
Unterhitzenberger & Rosner, 2014	2	1 MODERATE	1	YES	YES	YES STRONG	1	4 WEAK	1
Wells, 1994	3	5 WEAK	2	No	N/A	N/A MODERATE	3	4 WEAK	1
Zebrowski, 2000	2	4 MODERATE	1	Yes	No	N/A WEAK	2	N/A STRONG	1

Study author and year	Blinding Q2 Participant aware of Research Qu	Data collection methods Q1 valid	Q2 reliability	Withdrawals and drop-outs Q1 reported	Q2 % of participant completing	Intervention integrity Q1 % exposure of interest	Q2 Consistency measured	Q3 unintended intervention	Analysis Q1 unit of allocation	Q2 unit of analysis
Grassetti et al., 2015	3 MODERATE	1	1 STRONG	1	2 MODERATE	1	1	6	individual	individual
Grassetti et al., 2020	3 MODERATE	1	1 STRONG	1	1 STRONG	1	1	6	individual	individual
Herres et al., 2017	3 MODERATE	1	1 STRONG	1	2 MODERATE	1	1	5	individual	individual
Hilliard, 2001	2 STRONG	1	1 STRONG	1	1 STRONG	4	2	5	individual	individual
Hilliard, 2007	2 MODERATE	1	1 STRONG	3	4 WEAK	4	2	6	individual	individual
Langley et al., 2015	3 MODERATE	1	1 STRONG	1	1 STRONG	1	1	6	individual	individual
Linder et al., 2022	3 MODERSATE	1	1 STRONG	1	2 MODERATE	2	2	6	individual	individual
Riley 2012	3 MODERATE	1	1 STRONG	2	4 WEAK	4	1	6	individual	individual
Tillman & Prazak, 2018	3 MODERATE	1	1 STRONG	2	4 WEAK	4	2	6	individual	individual
Unterhitzenberger & Rosner, 2014	3 MODERATE	1	1 STRONG	1	1 STRONG	1	2	5	Individual	individual

Study author and year	Blinding Q2 Participant aware of Research Qu	Data collection methods Q1 valid	Q2 reliability	Withdrawals and drop-outs Q1 reported	Q2 % of participant completing	Intervention integrity Q1 % exposure of interest	Q2 Consistency measured	Q3 unintended intervention	Analysis Q1 unit of allocation	Q2 unit of analysis
Wells, 1994	2 STRONG	1	1 STRONG	3	4 WEAK	4	2	6	individual	individual
Zebrowski, 2000	2 STRONG	1	1 STRONG	2	4 WEAK	4	2	6	individual	individual

Study author and year	Analysis Q3 Analysis method	Q4 analysis on actual intervention received	Overall rating	Notes
Grassetti et al., 2015	1	2	STRONG	
Grassetti et al., 2020	1	1	MODERATE	
Herres et al., 2017	1	1	STRONG	
Hilliard, 2001	1	6	MODERATE	
Hilliard, 2007	1	1	MODERATE	
Langley et al., 2015	1	1	STRONG	
Linder et al., 2022	1	2	STRONG	Please note that attrition rates were impacted by COVID-19
Riley 2012	1	1	WEAK	
Tillman & Prazak, 2018	1	3	WEAK	
Unterhitzenberger & Rosner, 2014	1	1	MODERATE	
Wells, 1994	1	3	WEAK	
Zebrowski, 2000	1	3	WEAK	

N.B. full appraisal tool questions can be found in appendix B

2.3.3 Description of data extraction

2.3.3.1 Study characteristics

The 12 included studies were published between 1994 and 2022, of which ten were published in peer-reviewed journals and two in grey literature (ProQuest Thesis & Dissertation Global). Most research was conducted in the United States of America (USA.; 1-7, 9, 11, 12 see table 3 for study reference numbers) with two studies conducted elsewhere, one in the United Kingdom (UK; 8) and one in Rwanda (10). A range of interventions were evaluated across the studies. All interventions were delivered in groups, eight were delivered by specialist trained professionals (e.g., counsellors, music therapists:1-7, 9, 11, 12), and two interventions (Seasons for Growth and exposure writing; 8, 10) included, or were fully implemented by, school staff.

As expected, intervention delivery differed across the studies due to the number of interventions evaluated. Majority of interventions lasted between 8 and 10 weeks (2, 4-9, 11). Three studies used interventions that lasted longer, with two lasting 17 weeks (1, 3) and one lasting for a whole academic year (12). The final intervention was much shorter in duration, as it only lasted three weeks (10). Of the studies that provided detail about length of sessions, all interventions had sessions that lasted between 30 and 60 minutes (1-8, 10-12). One study provided no information on length of sessions (9).

2.3.3.2 Study Design

Six out the 12 studies (1-3, 7-9) used a pre-post intervention design to identify the effectiveness of the intervention. The remaining six (4-6, 10-12) additionally used control or comparison groups. Of those six, two studies (5,10) employed comparison interventions. Hilliard (2007) compared music therapy to a psychoeducation intervention (referred to as a social work intervention), whereas Unterhitzenberger & Rosner (2014) compared an exposure writing task to a positive writing task (writing about hobbies). Both studies, lacked to find significant differences in favour of target intervention in comparison to an alternative one.

Only two studies (6,8) collected follow up data, these were Langley and colleagues (2015) and Riley (2012). Langley and colleagues completed a follow up six months after baseline data was collected. They found that on all measures there had been significant improvement from baseline, but that PTSS and anxiety had continued to improve after the intervention had

finished. Langley and colleagues additionally used a delayed treatment group as a comparison, leading to higher quality study design. Riley collected follow up data two months after the end of the intervention they found self- concept continued to increase and anxiety and depression continued to decrease after the intervention had ceased. Despite this, Riley's overall study design quality was impacted by not including a control or comparison group.

Table 3. *Study characteristics of included studies*

Reference number	Study authors	Date of publication	Report type	Study design	Study population	Country	Follow-up	Type of intervention	Intervention delivery	Staffs leading intervention
1	**Grassetti et al.**	**2015**	Peer-reviewed journal	Cohort study (pre/post intervention)	33	USA	No	Trauma and grief component therapy	17, 50 min sessions once a week	One grief counsellor trained in TGCT-A and one masters-level graduate student.
2	**Grassetti et al.**	**2020**	Peer-reviewed journal	Cohort study (pre/post intervention)	22	USA	No	Cognitive-behavioural therapy 'The Bounce Back Group'	10 weekly, 50 mins session alongside 1-3 parent education sessions Average of 4 per group	Doctoral-level psychologist or trainee clinical psychologist
3	**Herres et al.**	**2017**	Peer-reviewed journal	Cohort study (pre/post intervention)	33	USA	No	Trauma and grief component therapy	17, 50 min sessions once a week	One grief counsellor trained in TGCT-A and one masters-level graduate student.
4	**Hilliard**	**2001**	Peer-reviewed journal	Non-randomised controlled trial (1 intervention	18 participants 9 music therapy 9 control group	USA	No	Music therapy	8, 1-hour sessions, once a week, 4-5 per group	Music therapist

Reference number	Study authors	Date of publication	Report type	Study design	Study population	Country	Follow-up	Type of intervention	Intervention delivery	Staffs leading intervention
				and a control group)						
5	**Hilliard**	**2007**	Peer-reviewed journal	Non-randomised controlled trial (2 different interventions and a control group)	26 8 music therapy 9 social work group 9 control group	USA	No	Music therapy/ social group work	8 weeks, 1 session per week.	Music therapist and music therapy intern. Comparison intervention delivered by social worker and social work intern.
6	**Langley et al.**	**2015**	Peer-reviewed journal	Randomised controlled trial (1 immediate treatment, 1 delayed treatment)	74 participants 36 immediate treatment 38 waitlist/ delayed treatment	USA	Yes 6 months post baseline measures	Cognitive-behavioural therapy 'Bounce Back'	10 weekly, 50 mins group session alongside 1-3 parent education sessions and 3 individual sessions for narrative focus	School-based clinicians (social workers/ clinical psychologist)
7	**Linder et al.**	**2022**	Peer-reviewed journal	Cohort study (3 cohorts from 2017 – 2020)	296	USA	No	Grief support group/psycho-education	8 weekly, 50-60 min sessions 7-8 per group	Staff from partner bereavement program who ranged from bachelor-level professionals to postgraduate Marriage Family Therapists.

Reference number	Study authors	Date of publication	Report type	Study design	Study population	Country	Follow-up	Type of intervention	Intervention delivery	Staffs leading intervention
8	**Riley**	**2012**	Peer-reviewed journal	Cohort study (pre/post intervention)	12	UK	Yes 2 months (Qualitative data only)	Manualised grief education programme	8 weeks, 50 mins sessions	School staff who had received intervention training.
9	**Tillman & Prazak**	**2018**	Peer-reviewed journal	Cohort study (pre/post intervention)	14	USA	No	Grief support group/psychoeducation 'Kids supporting kids'	10 weeks	School counselling graduate student
10	**Unterhitzenberger & Rosner**	**2014**	Peer-reviewed journal	Randomised controlled trial (2 different interventions and a control group)	69 23 exposure task 23 hobby writing group 23 control group	Rwanda	No	Exposure writing task concerning grief vs writing about a hobby	30-min writing session for 3 weeks	Investigator (qualifications/ background not clear) and school staff
11	**Wells**	**1994**	Unpublished Thesis/dissertation	Non-randomised controlled trial (1 intervention and 1 control group)	34 participants 20 intervention group 14 control group	USA	No	The Grief Intervention Counselling Program, based on coping skills teaching and art therapy	Eight, one-hour session, once a week. 3-5 ppts per group	Trained school counsellors

Reference number	Study authors	Date of publication	Report type	Study design	Study population	Country	Follow-up	Type of intervention	Intervention delivery	Staffs leading intervention
12	**Zebrowski**	**2000**	Unpublished Thesis/dissertation	Randomised controlled trial (1 intervention and 1 control group)	139 114 intervention group 25 control group	USA	No	Mourning Project, manualised group therapy programme	Once a week for an academic year for 45-60 mins. 3-8 ppts per group	Independent therapists

2.3.3.3 Participant characteristics

The 12 studies included a total of 748 participants. All studies included participants that had experienced a bereavement. Half of the studies (1-3, 6, 8, 11) also recruited CYP that had experienced other traumas that evoked a trauma or grief response (e.g., parental separation, family member arrested). Of the 748 participants, 593 participants had experienced at least one bereavement of a close loved one during their childhood. Of those bereavements, the majority of studies reported that it was a close family member who had died. Two studies recruited parentally bereaved participants only (10, 11). The majority of studies did not provide detail around time since death (1-3, 6-7, 9, 11). Of the five studies that did provide data, time since death ranged from less than six months to over 13 years (4-5, 8, 10, 12). Four out of the five studies that provided data on time since death included participants who had experienced the bereavement within two years of the intervention taking place (4-5, 8, 12). Unterhitzenberger and Rosner (2014), differed as the mean time since death was 13.14 years. Similarly, to other loss-related characteristics, limited information is available on cause of death. Four studies (4-5, 10, 12) provided details around cause of death, percentage of participants experiencing a sudden loss (e.g., accident, suicide, homicide) in these studies ranged from 39 to 78%.

Participants were aged between 5 to 18 years old, five studies (1, 3, 7-8, 10) focused on participants of secondary school age (between 11 and 18 years old) and seven studies (2, 4-6, 9, 11-12) included participants of primary school age (between 5 and 11 years old). All participants were recruited through schools with most interventions located at the participants' school. A small minority of participants had to travel to a local school setting where the intervention was taking place.

Table 4. *Participant characteristics across included studies*

Reference number	Study	Age	Sex	Number of bereaved participants (% of participants)	Time since death	Type of bereavement
1	**Grassetti et al., 2015**	12 – 14 years (M= 13.31, SD= 8.17)	9 males, 24 females	18 (55%)	Not provided	Death of a close family member that had led to maladaptive grief 56% of participants reported loss as main source of distress 44% of participants had trauma unrelated to a bereavement
2	**Grassetti et al., 2020**	5 – 11 years	14 males, 8 females	10 (45%)	Not provided	All participants reported a distressing event (24 different traumatic events were recorded in total). 46% reported a significant loss.
3	**Herres et al., 2017**	12 – 14 years (M= 13.43 years, SD= 0.78)	Not provided	25 (76%)	Not provided	56% of participants reported loss as main source of distress 44% of participants had trauma unrelated to a bereavement
4	**Hilliard 2001**	6 – 11 years	Not provided	18 (100%)	Last 2 years	Terminal illness 61% Sudden death 39%
5	**Hilliard 2007**	5 – 11 years old (M= 8)	14 males, 12 females	26 (100%)	Last 2 years	Death related to terminal illness 54% Sudden death 46% 46% loss of grandparent, 38% loss of parent, 16% other
6	**Langley et al., 2015**	5 – 11 years old (M= 7.65	37 males, 37 females	10 (14%)	Not provided	Range of traumatic experiences during childhood including bereavement

Reference number	Study	Age	Sex	Number of bereaved participants (% of participants)	Time since death	Type of bereavement
		years, SD= 1.36)				
7	**Linder et al., 2022**	11 – 18 years old	123 males, 141 females, 32 did not say	296 (100%)	Not provided	Experienced at least one bereavement during childhood
8	**Riley 2012**	11 – 12 years old	6 males, 6 females	11 (92%)	6 months	Close family bereavement
9	**Tillman & Prazak, 2018**	8 – 11 years	No information available	14 (100%)	Not provided	Experienced death of a close loved one
10	**Unterhitzenberger & Rosner, 2014**	14 – 18 years old (M= 16.30, SD= 1.17)	36 males, 33 females	69 (100%)	Average 13.14 years since death	Loss of one (49.3%) or both (50.7%) parents between the ages of 1 and 4 years old. 78% experience a sudden loss, 28% experience a loss through illness
11	**Wells, 1994**	8 – 11 years old (15 participants in 3rd grade, 13 in 4th grade, 7 in 5th grade)	17 males, 17 females	6 (18%)	Not provided	Participants all experienced a loss of a parent either through divorce, separation, or death

Reference number	Study	Age	Sex	Number of bereaved participants (% of participants)	Time since death	Type of bereavement
12	**Zebrowski, 2000**	6 -12 years (M= 9.17, SD= 1.8)	62 boys, 77 girls	139 (100%)	Average 1.4 years since the death	Experienced either an expected or unexpected death of a family member at any time during childhood. 89% experience loss of a caretaker 71% of losses were reported as sudden

2.3.3.4 Interventions

The 12 included studies used 10 different intervention programmes. The interventions have been categorised based on content delivered: Cognitive Behavioural Therapy (CBT) based (interventions that use principles of CBT; k=2), psychoeducation (interventions that aimed to teach CYP about death and the process of grieving; k=5), music therapies (k=2) and exposure writing interventions (k=1). Both CBT-based interventions were evaluated in multiple studies. All interventions were delivered in a group. Nine were secondary level interventions and two were tertiary. Those listed as tertiary specifically screened and targeted individuals with clinical levels of PTSS or maladaptive grief. Both tertiary level interventions used CBT-based approaches, whereas the secondary level interventions used a variety of approaches: psychoeducation, music therapy and exposure writing task.

Table 5. *Intervention type across included studies*

Type of intervention	Name of intervention (study evaluating intervention)	Target population	Intervention level
CBT based	Bounce Back Therapy (Grassetti et al., 2020; Langley et al., 2015)	5-11 year old pupils who experienced one or more traumatic events	Tertiary
	Trauma and grief component therapy for adolescents (TGCT-A) (Grassetti et al., 2015 ; Herres et al., 2017)	12-14 year old pupils experiencing post trauma or maladaptive grief symptoms	Tertiary
Psychoeducation	School-based grief group (Linder et al., 2022)	11-18 year old pupils who experienced the bereavement of a loved one	Secondary
	Season of Growth (Riley, 2012)	6-18 year old pupils who experienced a significant	Secondary

Type of intervention	Name of intervention (study evaluating intervention)	Target population	Intervention level
		loss (e.g., death of a loved one, divorce)	
	Kids supporting kids (Tillman & Prazak, 2018)	8-11 year old pupils who experienced death of a family member.	Secondary
	Mourning Project (Zebrowski, 2000)	6-12 year old pupils who experienced death of a family member.	Secondary
	The grief intervention counselling program (Wells, 1994)	8-11 year old pupils who experienced a significant loss (e.g., death of a loved one, divorce)	Secondary
Music Therapy	Music therapy (Hilliard, 2001)	5-11 year old pupils who experienced death of a loved one	Secondary
	Orff-based music therapy (Hilliard, 2007)	6-11 year old pupils who experienced death of a loved one	Secondary
Exposure therapy	Exposure writing therapy (Unterhitzenberger & Rosner, 2014)	14-18 year old orphans who lost one or both parents between ages of 1 and 4	Secondary

2.3.3.5 Study outcomes

The study outcomes (Table 6) showed the heterogeneity in the outcome measures used in bereavement intervention studies. Most interventions showed significant improvement on at least one outcome measure post treatment. The exception to this was Unterhitzenberger and

Rosner (2014) and Wells (1994) who both reported non-significant changes between pre-post treatment for the target intervention. Unterhitzenberger and Rosner (2014) showed significant differences pre-post treatment for the comparison intervention (writing about a hobby) and control groups but not the target intervention (exposure writing task).

Outcomes were assessed in two ways, either through pre-post intervention changes or comparison of outcomes with control or other intervention comparison groups. Half of the studies used pre-post analysis to determine the effectiveness of the interventions (1-3, 7-9). Six of the studies employed control or comparison groups (4-6, 10-12).

Specific grief outcomes

Seven studies (1, 3, 4-5, 7, 9-10) used specific grief outcome measures (e.g., Prolonged Grief Questionnaire for Adolescents, Grief Symptomology Screener, Bereavement Group Questionnaire for Parents/Guardians). Out of these seven studies, four used a pre-post (1, 3, 7, 9) design and three a comparison group design (4-5, 10). Three out of the four studies using a pre-post design reported a significant effect for grief (1, 3, 7). These studies evaluated TGCT-A (1, 3) and psychoeducation (7) interventions. The significant effects were echoed by two of the comparison group designs (4, 5), showing a significant intervention effect independent of mere time effects, both studies evaluated music therapy interventions. One further study (10) that employed a comparison group design, to evaluate exposure writing intervention, did not find a significant pre-post intervention effect or a significant effect when compared to an alternative intervention and control groups. None of the studies that used a grief outcome collected follow up data. Overall, of the studies that use specific grief measures the majority (k=5) found significant intervention effects.

Behaviour outcomes

Most studies (k= 8) used outcomes relating to behaviours (e.g., Strength and Difficulties Questionnaire (SDQ; K=3, one study used the conduct scale and two studies used total SDQ), Child Behaviour Checklist, Behaviour Rating Index for Children). These measures were used to help establish grief reactions because many children display grief in multiple ways including behaviourally (Sood et al., 2006). Overall, seven studies out of eight showed significant improvements in behaviour measures following intervention (2-5, 7-8, 12). Of these seven studies, four used pre-post study design (2, 3, 7, 8) to identify the significant intervention effect on behaviour measures. Two of the studies evaluated CBT-based interventions (2, 3) and the other two evaluated psychoeducation interventions (7, 8) The remaining three studies (4, 5, 12)

used a comparison study design to show significant changes in behaviour beyond the natural trajectory of grief over time for music therapy (4, 5) and psychoeducation (12) interventions. One study (5) compared music therapy to a psychoeducational intervention and found that there was no significant difference between the two interventions on their behaviour measure, suggesting similar levels of intervention effectiveness. The study (6) that showed non-significance in behaviour measures also employed a comparison group design when evaluating a CBT-based intervention (Bounce Back therapy). Caution is needed when interpreting this result as the SDQ measures a range of concepts of which externalised behaviour is one (Conduct and hyperactivity subscales together measure externalised behaviour). The overall SDQ score is influenced by all the scales, including scales that measure emotional and peer problems and therefore the total SDQ measure is not a purely behavioural measure. The score could misrepresent the overall change in behaviour, particularly when compared with other measures that purely measure behaviour change. Bounce Back therapy was evaluated in a different study (2) using a different behavioural measure and a pre-post design and showed significant changes. This difference could be explained through the SDQ not effectively measuring behaviour in the controlled study (6) alternatively suggesting this intervention did not improve behaviour beyond the effect of time.

Internalised reaction outcomes

Eight studies (1, 3-4, 6, 8, 9-10, 12) also used outcomes relating to internalised reactions (e.g., Mood and Feelings Questionnaire, The Depression Self-Rating Scale, SCARED-C). Half of the studies (1, 3, 8, 9) used a pre-post design and all four found significant improvements in internalised reactions following the TGCT-A (1, 3) and psychoeducation (8, 9) interventions. One psychoeducation intervention (8) continued to show reduction in depression and anxiety for participants during the two month follow up. The other half of the studies (4, 6, 10, 12) utilised a comparison group design and showed more mixed findings. One study (6) evaluating a CBT-based intervention (Bounce Back therapy) showed significant reduction in anxiety and depression in the intervention group independent of time effects. This is further strengthened as reduction in anxiety in this study continued six months after baseline data was collected (three months post intervention). However, the remaining three comparison studies (4, 10, 12) did not find significant differences between intervention and control groups in internalised reactions. These studies evaluated a range of interventions: music therapy (4), exposure writing task (10) and psychoeducation (12). Therefore, ‘Bounce Back therapy’ was the sole intervention

to show significant intervention effectiveness independent of time affects for internalised reactions.

Positive outcomes

In contrast to the other measures, two of the studies (6, 8) used positive outcome measures (e.g., social adjustment, resiliency, emotional health) as a means of evaluating intervention effectiveness. From the two studies that investigated positive outcomes, both showed significant increases albeit on different measures. Riley (2012) employed a pre-post design to find their psychoeducation intervention significantly improved self-concept but not the other scales relating to resilience (resource index, vulnerability). Intervention effect of self-concept was also seen at the two month follow up. More promisingly, Langley and colleagues (2015) found significant improvements in social adjustment, emotional regulation and coping efficacy using a comparison group design for a CBT-based intervention (Bounce Back therapy). This suggests that the intervention improved these outcomes independently of time effects. However, the follow up data showed these outcomes did not significantly change after the intervention ended.

Table 6. *Key study outcomes*

Reference number	Study	Primary Outcome measure	Secondary outcome measure	Summary of key findings
1	**Grassetti et al., 2015**	Post-trauma stress symptoms (UCLA PTSD reaction index for DSM-5; UCLA-R5) Maladaptive grief reactions (MG)	Depression (Short mood and feelings questionnaire; SMFQ)	Significant reduction from pre to post intervention of MG reactions (p=.001, *d*=0.74), PTSS (p<.001, d=0.78) and depression scores (p=.026, d=0.42). Participants who had a loss-related narrative experience faster decline in MG (p=.03).
2	**Grassetti et al., 2020**	Trauma (Traumatic Events Screening Inventory for Children; TESI-C) PTSS (UCLA-R5) Top problems/behaviour (brief problems checklist; BPC)	N/A	Significant differences in pre-post-intervention PTSS (p<.001, *d*=0.98), internalising behaviour (p<.001, *d*=1.27), externalizing behaviour (p<.001, *d*=1.17) and distress (top problem; p<.001, *d*=0.66). Significant differences for pre to mid-intervention for PTSS (p<.001, *d*=0.82) and distress symptoms (top problem; p<.001, *d*=0.47).
3	**Herres et al., 2017**	TP (BPC) Depression (SMFQ) Behaviour (SDQ – conduct scale)	PTSS (UCLA-R5) Grief (MG)	Participants with higher internalising symptoms showed significant decline in distress (top problem) in module two/three (p=.014) but significantly less change in module one (p=.049). Participants with more externalised symptoms showed a slight but non-significant trend in declining distress during module one (p=.082) and no change in module two/three (p=.153). Overall, for all participants significant improvements were seen across all phases (p<.05).

Reference number	Study	Primary Outcome measure	Secondary outcome measure	Summary of key findings
4	**Hilliard, 2001**	Behaviour (Behaviour Rating Index for Children; BRIC) (home & School) Depression (The Depression Self-Rating Scale; DSRS) Grief (The Bereavement Group Questionnaire for Parents/Guardians; BP)	N/A	Behaviour (Home report) demonstrated a significant difference (p<.05) between pre- and post-intervention time points for both experimental and control groups. Behaviour decreased for experimental group (behavioural problems decreased), whereas behaviour increased for control group (behaviour problems increased) Grief measure showed significant differences for both groups (p<.05), meaning grief significantly improved for both groups. Grief decreased significant more for experimental group (p<.05). Behaviour (school report) showed no significant differences for either group. Depression score did not significantly change for the experimental or control groups.
5	**Hilliard, 2007**	Grief (BP)	Behaviour (BRIC)	Significant difference in post-test grief between control and social work (*p* <.01). Significant difference in post-test grief between control and music therapy (*p*=.01). However no significant difference in post-test grief between social work and music therapy. The pre/post-test measures showed significant difference in grief for Music therapy (p=.01) but not for the social work (p=.26) or control groups (p=.95) Significant difference in post-test behaviour between control and social work (p<.01). There was also a significant difference in post-test behaviour between the control and music therapy groups (p=.01). There was no significant difference in post-test behaviour between social work and music therapy (p=.54). The pre/post measures showed significant differences in behaviour for social work (p=.04) and music therapy (p=.01) but not the control group (p=.16)
6	**Langley et al., 2015**	PTSS (UCLA-R5)	Behaviour (SDQ)	Depression (p<.001), PTSS (p<.001) and anxiety (p<.001) significantly decreased over the course of the intervention, in both the immediate and delayed

Reference number	Study	Primary Outcome measure	Secondary outcome measure	Summary of key findings
		Depression (Children's Depression Inventory; CDI) Anxiety (SCARED-C)	Social adjustment (Social adjustment scale self-report for youth; SAS-SR-Y) Coping skills (Coping efficacy measure) Emotion regulation (emotional regulation checklist; ERC)	treatment group. There were medium to large effect size for the immediate group across depression (d=.34), PTSS (d=.80) and anxiety (d=.40). Similar effect sizes were reported when the delayed group received intervention. Significant increase in social adjustment (p<.001, d=0.24), emotional regulation (p<.05, d=0.14) and coping efficacy (p<.001, d=0.26) over the course of the intervention. Significant improvements seen in follow up for PTSS (p=.011) and anxiety (p=.027) compared to baseline measures. SDQ measures did not show any significant change. Experience of bereavement did not significantly impact response to second half of treatment as expected.
7	**Linder et al., 2022**	Grief symptomology screener (GSS)	ehaviour (SDQ-Author described as brief behavioural screening tool with equal reliability and validity to Child Behaviour Checklist. SDQ not evaluated, used as a method to check concurrent validity for other measures) Dysregulation of emotions scale	Significant reduction in grief from pre to post intervention (p<.001) Significant reduction in emotional dysregulation severity (p=.016) and frequency (p=.004) from pre to post intervention. No significant difference in dysregulation intensity over the course of the intervention. Significant increase in perceived school-based social support (p=.013) post intervention.

Reference number	Study	Primary Outcome measure	Secondary outcome measure	Summary of key findings
8	**Riley 2012**	Behaviour (Beck Youth Inventory Scales II; BYI-II) Emotional health (Resiliency Scales for Children and Adolescents; RSCA)	Qualitative interviews	Self-concept showed significant difference over course of intervention ($p<.05$, $d=0.25$) with a significant improvement between post intervention and follow up ($p<.05$). Depression (BYI-II) showed significant difference over time ($p<.05$, $d=0.31$) and at each time point (pre, post and two month follow up). Anxiety (BYI-II) showed significant difference over time ($P<.01$, $d=0.46$) with significant difference ($p<.05$) between each time point (pre, post and two month follow up). No significant differences ($p>.05$) in resource index or vulnerability scores over course of intervention (RSCA).
9	**Tillman & Prazak, 2018**	Grief (Study specific grief measure: (i) self-report (ii) parent report (iii) teacher report)	Depression (SMFQ)	No significant differences in pre and post measures of self, parent or teacher reported grief after intervention. Significant improvement in depression ($p< .05$) over the course of the intervention.
10	**Unterhitzenberger & Rosner, 2014**	Grief (Prolonged Grief Questionnaire for Adolescents; PGQ-A)	Mental Health (Mini international neuropsychiatric interview for children and adolescents, part A; MINI-KID A)	No significant differences in pre/post intervention grief symptoms for exposure writing intervention group ($p>.05$). Significant difference in pre/post intervention grief symptoms over time for group writing about hobbies ($p=.04$) and control conditions ($p=.04$) Higher grief severity predicted reduction in grief symptoms independent of experimental condition ($p=.04$) No significant differences in pre/post-depression for exposure writing and control groups. Significant difference in pre/post-depression for hobby writing group ($p=.02$) MINI-KID A showed no significant differences in mental health between control group or hobby writing groups but did show significant improvement in mental health for comparison groups compared to the exposure writing group (control $p=.01$, hobby $p=.02$).

Reference number	Study	Primary Outcome measure	Secondary outcome measure	Summary of key findings
11	**Wells, 1994**	Teacher-child rating scale (T-CRS) Individual Protective Factors Index (multiple different factors)	N/A	No significant differences in any measures between experimental and control groups. However, the scores of the treatment group had started to progress in a positive direction, but without statistical difference.
12	**Zebrowski, 2000**	Emotional problems (Human figure Drawing; HFD) Behaviour (Child Behaviour Checklist; CBCL) Depression (CDI)	N/A	Significant difference was found between control and experimental group on depression scores ($p<.05$). All other measures showed non-significant differences between control and experimental group. Only Behaviour showed significant improvement between Time 1 and Time 2 ($p<.01$) in experimental group. No significant difference for experimental group or control group in depression between Time 1 and Time 2.

2.4 Discussion

2.4.1 Discussion of findings

Discussions around findings have been grouped into level (e.g., secondary or tertiary) and type of intervention delivered in the studies. This allowed similar intervention results to be directly compared and discussion of overall impact of each intervention.

2.4.2 Tertiary level interventions

2.4.2.1 CBT-based interventions (1-3, 6)

Four studies investigated CBT-based interventions (Grassetti et al., 2015; Herres et al., 2017; Grassetti et al., 2020; Langley et al., 2015). These studies investigated two different CBT-based programmes, TGCT-A and 'Bounce Back Group Therapy.' All included participants who had experienced a traumatic event which may or may not include death of a close family member. As a result, the participants included both individuals who had and had not experienced a bereavement. This differed from other included interventions which focused on participants who experienced a bereavement or loss that led to grief. However, both CBT-based interventions included sessions specifically tailored to loss and grief.

TGCT-A was implemented through 17 50-minute sessions that occurred on a weekly basis. TGCT-A is divided into four modules, the first module focuses on building group cohesion, normalising grief reactions and improving emotional regulation. This was delivered in eight sessions. Participants then either engage with module two which develops a trauma narrative or module three which builds a loss narrative, both modules work towards sharing these narratives with other group members over six sessions. The module is chosen based on the participant's experience. Module four lasted three sessions and focused on adaptive developmental progression, problem-solving skills, building on positive future goals and aspirations, and consolidating intervention gains.

TGCT-A can be individualised during the second phase of the intervention by selecting either a trauma or loss narrative. In both, Herres et al., (2017) and Grassetti et al., (2015), participants who experienced a bereavement were grouped and received sessions tailored to

loss and grief rather than sessions tailored to trauma. Grassetti and colleagues (2015) measured maladaptive grief symptoms to evaluate the effectiveness for bereaved participants. Overall, there was a medium-large effect size on maladaptive grief reactions (*d*=0.74). It is possible that confounding factors, particularly the passing of time since the occurrence of the loss, may have exerted an influence of the grief reactions, since the study did not include a control group. This is particularly important for bereaved participants because grief reactions have been shown to improve over time, even without specific support (Melhem et al., 2011).

Herres et al. (2017), aimed to further understand the mechanisms of change of TCGT-A following the significant findings by Grassetti and colleagues. They compared internalising and externalising symptoms. They found that those with a high level of internalising symptoms significantly decreased their distress during the narrative development and sharing (module two/three). Whereas those with externalised symptoms did not show significant differences in changes in module one or module two/three. Examination of trajectories, however, showed a steeper, but non-significant, reduction of distress during module one, compared to module two/three. This indicates that those with externalised symptoms may benefit from the psychoeducation element of the intervention over creating a narrative. However, similarly to Grassetti and colleagues (2015), they found a significant difference in distress and grief when comparing pre and post intervention measures. This suggested that the mechanism for change for high internalising symptoms is creating a loss narrative. The mechanism for change is less clear for externalising symptoms. It is important to note, neither study evaluating TGCT-A used a comparison group therefore it is not known how effective the intervention is beyond time effects.

The ’Bounce Back Group Therapy’ was implemented over ten 50-minute sessions. Alongside, participants attended three additional individual sessions and parents/caregivers were invited to three parent education sessions and one joint session with their child. In each group there were an average of four participants. The intervention was split into two halves. The first half focused on psychoeducation, emotion identification, cognitive work, physiological arousal, and relaxation training. The second half focused on gradual exposure for avoidance behaviours, coping skills, and relapse prevention. The individual sessions aimed to develop and process a trauma narrative.

The ‘Bounce back group therapy’ studies showed significant improvements across a range of outcome measures including internalised (*d*=1.27) and externalised (*d*=1.17) behaviour, distress (*d*=0.66), and PTSS (*d*=0.98) as found in Grassetti et al. (2020). Additionally,

Langley et al. (2015) found significant improvements in coping skills *d*=0.26, emotional regulation (*d*=0.14) and social adjustment(*d*=0.24). Langley and colleagues also identified that measures significantly increased for the immediate intervention group compared to a delayed intervention group. The delayed intervention group showed comparable effectiveness once they had also received the intervention. They did not directly measure grief symptoms. Therefore, it is difficult to ascertain if the overall intervention's effectiveness reflected the true effectiveness of the intervention for bereaved individuals. Both 'Bounce back group therapy' studies also lack information about bereavement type and the time that had passed since the death. While initial research indicates potential benefits of the 'Bounce back group therapy' intervention, particularly given the high quality of the research, more specific investigation of the effectiveness of 'Bounce back group therapy' for bereaved CYP should be investigated, particularly as only one study (Langely et al., 2015) utilised a comparison group design, showing effects beyond the passing of time.

2.4.3 Secondary level interventions

2.4.3.1 Manualised psychoeducation programmes (7-9, 11, 12)

Five studies focused on manualised group psychoeducation programmes. All studies looked at different programmes, but the majority had comparable structure and duration (Linder et al., 2022; Riley, 2012; Tillman & Prazak, 2018; Wells, 1994) running weekly for 8 to 10 weeks. One intervention differed, Zebrowski (2000), as it was delivered to the participants weekly for the duration of an academic year. Despite the significantly longer duration of the intervention, this did not improve intervention outcomes, with only a behaviour outcome measure showing a significant change in comparison to a control group. This suggests that a psychoeducation intervention is just as effective if delivered in 8-10 weeks.

Of the four interventions that used an 8-10 week duration, all four had similar components as part of the programs. These including normalisation of grief, identification and regulating feelings, coping skills, creating grief narrative, building support systems, and remembering their loved one. Zebrowski (2000) did not provide a significant amount of detail about the intervention but specified the focus was to encourage participants to verbalise feelings and loss through different activities.

Most of the psychoeducational interventions showed improvements in at least one outcome measure when comparing pre and post intervention measures. Four studies included at least one measure of social-emotional problems (anxiety, depression, externalised symptoms) that showed significant improvement post intervention. This suggests psychoeducation was a valuable intervention for CYP who's grief reactions presented as internalised or externalised behaviours. This is in line with previous research which has identified psychoeducation as an effective intervention for CYP with anxiety (Baourda et al., 2022) and trauma (Kramer & Landolt, 2011). Similarly to TGCT-A intervention, many of the psychoeducation studies did not include a control group and focused on pre/post differences. Therefore, again confounding factors, such as the passage of time may have been responsible for the changes.

However, both Wells (1994) and Zebrowski (2000) did use a control group as part of their research design. Their results differed, with Wells finding no significant differences between intervention and control groups. Zebrowski, however, found significant difference between experimental and control groups on depression measures. Zebrowski (2000) differed in its intervention content and duration from other psychoeducation interventions, which may explain the difference between the findings. However, both Wells and Zebrowski, despite the use of control groups, had weak study quality so the results must be viewed with caution. Despite this, the lack of significance between control and experimental groups for psychoeducation interventions suggests that significant differences between pre and post measure may at least be partial explained by the natural trajectory of grief decreasing with time. This leaves an unclear picture for the use of psychoeducational interventions to support grieving pupils in school and highlights the need for more high-quality research utilising a control group.

Despite all the studies focusing on grieving participants only two included a grief outcome measure (Linder et al., 2022; Tillman & Prazak, 2018). Out of the two only one (Linder et al., 2022) found a significant improvement from pre to post intervention. This fits with previous research which has shown mixed changes in grief following interventions (Currier et al., 2007; Rosner et al., 2010). Despite the interventions having comparable components, there were differences in study design that may explain the differing findings. Differences could be explained by several confounding factors including small sample sizes, impacting the validity of the research and reduce the generalisability of findings. Small sample sizes applied to Tillman and Prazak (2018) with sample limited to fourteen participants from one specific school.

Alternatively, some outcome measures of grief were not tested for reliability or validity meaning the measures in some of the research may not have been testing grief reactions as intended. This is likely to again apply to Tillman and Prazak (2018), who found no significant reduction in grief, as limited information was available about how the grief measure was developed. It is hard, therefore, to determine whether this study specific measure was accurately testing grief reactions. Results differed from significant reductions in grief found by Linder and colleagues (2022) who provided reliability and validity information for their grief measure. Therefore, use of reliable and valid grief measures is needed to ensure grief reactions are measured as intended. Other confounding factors such as time from bereavement and baseline severity of symptoms, could have reduced overall impact of the intervention due to the smaller scale symptoms changes that may have occurred and therefore harder to statistically detect (Currier et al., 2007).

Overall, the quality of the psychoeducation studies was poorer than CBT-based interventions, with four of the five studies receiving a weak rating for study quality. The studies had a range of limitations including small sample sizes, no control groups, and no way to ensure intended delivery of intervention. The exception to this was Linder et al., 2022 who had a strong overall study design. However, like many of the studies included in this review, Linder et al. (2022) did not include a control group to ensure significant changes were a direct result of the intervention. Meaning results may have been influenced by other factors such as time, school ethos or other protective factors such as level of social support (Dopp & Cain, 2012) or prior understanding of death (Heath & Cole, 2011).

Hilliard (2007) provides evidence towards the evidence base of psychoeducation interventions as it compares a psychoeducation and music therapy intervention. Both the interventions use similar topics covered in Linder et al. (2022), Tillman and Prazak (2018) and Riley's (2012) interventions. Hilliard's (2007) study was of better quality than many of the psychoeducation intervention studies, including both Wells (1994) and Zebrowski (2000) who used control groups. The findings indicate that both music therapy and psychoeducation intervention significantly reduced grief in comparison to the control group. This suggests both music and the psychoeducation intervention reduce grief beyond the natural trajectory of grief over time. Thus, provides some support for psychoeducation interventions.

2.4.3.2 Music therapy (4,5)

Two studies evaluated interventions that utilised music therapy. The rationale for using music therapy to support bereavement, is that some CYP have not yet developed the verbal skills to express their grief. Therefore, CYP require opportunities to express their grief in through non-verbal methods (Hilliard, 2001). Authors argued that music therapy has supported the emotional health of other CYP (Giles et al., 1991) and therefore may have been beneficial for bereaved CYP. Both studies included only participants who had experienced a bereavement in the last two years. Music therapy was delivered for one hour for the duration of eight weeks. The intervention used different music activities to target topics such as normalising grief, emotional regulation, and remembering loved ones.

Music therapy showed significant improvements pre to post intervention in grief and behaviour outcome measures across both studies. Additionally, these studies employed the use of control groups, with one study (Hilliard, 2007) additionally comparing music therapy to an alternative intervention. Music therapy had significant positive impact on behaviour and grief symptoms in comparison to a control group. However, when music therapy was compared to a psychoeducational intervention (referred to 'social work intervention' in the study) there was no significant difference between behaviour and grief symptoms (Hilliard, 2007). Both interventions followed the same topics, but differed in how these topics were explored. Therefore, due to lack of significance between both interventions in post-intervention grief and behaviour measures the mechanism of change may have been the topics covered rather than music therapy approach. This suggests both music therapy and psychoeducation may be (given the somewhat mixed findings) suitable interventions for bereaved participants if topics such as normalising grief and emotional regulation are covered. However, music therapy interventions must be delivered by a trained music therapist (Hilliard, 2001; 2007), unlike the psychoeducation interventions which can be delivered by a range of professionals, including trained school staff (e.g., Riley, 2012), meaning that of the two interventions psychoeducation may be the more accessible and cost-effective option for schools.

2.4.3.3 Exposure writing intervention (10)

Unterhitzenberger & Rosner (2014) looked at impact of an exposure writing intervention with orphaned Rwandan participants. This intervention involved participants writing about their bereavement over three 30-minute sessions. Alongside the intervention group, there was also a comparison group who completed three 30-minute sessions writing about their hobbies.

Additionally, a control group was used who did not receive any writing sessions. Overall, the research showed no significant differences in outcomes between target intervention group and control group.

Conversely, the comparison group writing about a hobby and the control group showed a significant reduction in grief symptoms whereas the intervention group did not. It is possible that the time since bereavement impacted significance, with an average of 13.14 years since the death. This means it is possible the writing intervention reminded participants of events and associated grief therefore impacting overall grief symptoms. Additionally, the duration of the intervention was three weeks, much shorter than the other interventions evaluated, meaning there may have been insufficient time for the intervention to take effect. Prior research on participants with depression has shown initial increase of symptoms when engaging with exposure therapy due to distress. However, over time the symptoms decrease as ability to tolerate the distress increased (e.g., Hayes et al., 2007). Due to the short duration, participants may not have learnt to tolerate their distress and benefit from the intervention.

Additionally, the causes of death were sudden and could be considered traumatic, therefore, the participants may have benefitted more from a tertiary intervention delivered by specialist clinicians. Unfortunately, no other studies were found with a similar intervention to compare findings. Therefore, this review found no evidence to suggest exposure writing is an effective intervention for bereaved CYP.

2.4.4 Implications for Educational Psychologists and school staff

Considering the literature reviewed in this paper, school staff should be cautious about implementing school-based interventions for bereaved participants. The literature base is limited and of mixed quality. There is inconsistency between the impacts of the interventions beyond time effects, particularly for psychoeducation interventions. Music therapy has consistently shown positive impact beyond time effects, however, these interventions require a trained music therapist meaning they are less accessible options for schools. Thus, educational psychologists should be cautious when recommending school-based interventions for bereaved CYP and clearly state the limitations of the current literature base to school staff. Despite this, the interventions reviewed in these studies did not have a negative impact on participants, with the exception of exposure writing intervention. Therefore, while interventions may not consistently have positive impact above and beyond the factor of time, they are unlikely to cause harm to bereaved CYP.

For educational professionals, such as teachers and educational psychologists, it is important to highlight the implications of the review findings on their practice with CYP in the UK. Considering that this review is geared towards UK educational professionals it should be highlighted that of 12 studies included in this review, the majority were conducted in the USA with only two studies conducted elsewhere, one in Rwanda and one in the UK. Therefore, it is difficult to generalise findings to a UK population, particularly as the UK-based study (Riley, 2012) was based in one secondary school through opportunity sampling. Other research into grief interventions in the UK have used qualitative analysis methods (e.g., Holland, 2008; Costelloe et al., 2020), which were excluded in this review, or have been presented in opinion pieces that do not have specific evidence to support their implementation (e.g., Holland, 2004). Thus, there is a clear need for further research and evaluations of UK-based interventions to have a better understanding of the support currently used in UK schools.

A key consideration for schools when implementing interventions is who will deliver the interventions. Of the reviewed interventions, psychoeducation interventions are more accessible to be delivered by staff members such as teachers or teaching assistants. This is because they were all manual-based programmes and focused on teaching about grief and tools to manage grief reactions. Other interventions such as music therapy and TGCT-A require specially trained leaders, namely a music and clinical therapist. This is likely to make implementation in UK schools more challenging due to access to specialist services. Additionally, use of a specialist services increases the cost of implementation making it a less cost-effective option. Therefore, it may be more cost-effective to provide a manual-based secondary level intervention for majority of bereaved CYP and only seeking tertiary intervention delivered by a specialist (e.g., TGCT-A) when grief symptoms are more severe, complex and/or prolonged (Jones et al., 2015). This relates to previous research that shows greater effectiveness of these specialist delivered interventions for participants with more severe symptoms (Rosner et al., 2010).

In the level of grief interventions model (Jones et al., 2015), psychoeducation may also fit in well within the primary level. In this level grief related psychoeducation would be included within the curriculum for all pupils, regardless of whether they had experienced a bereavement. This would allow the psychoeducation to act as a preventive strategy against severe and prolonged grief symptoms. There is an emerging topic of grief literacy within grief research which looks at the impact of this type of prevention intervention and indicates benefits for bereaved CYP. Furthermore, addition of grief literacy to the curriculum would support

educational staffs' skills in talking to and supporting grieving CYP, ultimately normalising grief experiences (Dawson et al., 2023).

All studies reviewed took place in a group setting, which should be considered by educational professionals looking to implement a grief intervention. The group aspect of grief interventions may be important to build social support, a key protective factor, as well as provide CYP space to acknowledge and normalise their feelings (Chen & Panebianco, 2018), meaning they are less isolated in their grief. This is supported by qualitative research of grief groups for CYP that have shown better ability to communicate and understand their grief, as well as improving and expanding support networks (Newell & Moss, 2011).

Despite the positives associated with group interventions, this may not be possible in all school settings and will depend on the number of CYP who experienced a bereavement. Additionally, if the age range between the CYP is too large (e.g., 4-year-old and 11-year-old) this may impact implementation, particularly if CYP are at different developmental stages of understanding the concept of death (Heath & Cole, 2011). Therefore, school staff and educational psychologists must consider the school context before recommending or implementing a group intervention. The appropriateness to expand grief interventions to CYP who have experienced other losses must be considered, e.g., divorce, particularly as grief from a bereavement and other losses such as divorce have been shown to be comparable (Sandler et al., 2003). Riley (2012) and 'bounce Back group therapy' (Langely et al., 2015; Grassetti et al., 2020) took this approach and showed positive outcomes.

Another consideration before implementing a grief intervention should be individual factors such as special educational needs (SEN) or English as an Additional Language (EAL) as it may impact understanding of material included in the programme if differentiation or special considerations are not put in place. Previous research of CBT interventions for children with learning difficulties have been shown to be less effective because of cognitive demands such attention, executive functioning, and language skills that CBT requires (Hronis et al., 2017). For the studies included in this review, no information was provided about SEN or EAL so conclusions about impact of interventions for these groups cannot be drawn from this review. Educational psychologists are well placed to advise school staff on suitability of interventions for individual CYP and their needs.

2.4.5 Limitations of literature and future directions

Due to the nature of bereavement, bereaved CYP can be a difficult population to reach for research participation. Consequently, childhood and adolescent bereavement is a relatively under researched area. Overall, similarly to previous research and reviews of grief interventions there is a mixed picture on how effective interventions are (e.g., Hanauer et al., 2024).

There are a number of limitations that mean caution is needed when interpreting the results. Firstly, there is heterogeneity between the interventions reviewed, including the type of bereavement and length since death. A number of the interventions were only evaluated in one study, with several studies having methodological limitations that impact the quality of research. These limitations included small sample sizes, lack of intervention fidelity, and limited descriptions of intervention procedures. Small samples are common in grief literature and are seen in some studies included in this review, which can lead to underpowered statistical analysis. This limits the interpretations of findings in this review. Psychoeducation interventions in particular had mixed results, in comparison to other interventions such as 'Bounce Back therapy' and music therapy.

To improve understanding, research should look to repeat evaluation research of specific interventions, ensure it is of good quality and where possible use participants who recently experienced a bereavement. Future research should aim to use randomised controlled trials using both control and alternative treatment groups. This would strengthen the evidence base for school-based interventions for bereaved CYP. It is important, ethically, that any study that uses a control group provides treatment after the research has concluded, so a randomised-controlled crossover design may be most appropriate.

The most common method of collecting data was through parent or self-reported questionnaires, with some studies collecting purely self-reported data. Self-reported data can be subject to biases such as social-desirability bias or influenced by the individual's mood in that moment. This could be an issue with grief because it varies day to day, particularly around key anniversaries (Koblenz, 2016) meaning some self-reported data may be impacted by natural variation. Despite this, self-reported data allows for a more accurate picture of internalised grief reactions, which are not always accurately reflected through parent or teacher-reported data as shown by disagreements between different reporters (e.g., Hilliard, 2001).

Few studies asked teaching staff to provide information about participants, despite interventions taking place at school. This limits understanding of changes in participants across contexts and the impact these interventions have on educational outcomes (e.g., attainment, engagement, focus).

This review has highlighted the clear need for further research, particularly using quantitative analysis methods, on UK-based interventions for bereaved CYP. This is because there was only one UK-based study included in this review, which was small scale. There is a need for interventions currently being used in UK classrooms for bereavement to be evaluated to understand their effectiveness and build understanding of practices used in UK classrooms. Furthermore, research expanded beyond western countries (e.g., USA, UK) is needed to improve understanding of how best to support bereaved CYP in different educational systems. It is worth noting that some research from other countries may have been excluded as it was requirement for studies to be available in English, therefore some relevant interventions may be missing from this review.

Finally, many of the interventions reviewed used a specialist professional or an author of the intervention to run the intervention. Some of the studies may have been subject to researcher allegiance bias as the authors were delivering the intervention, therefore unconsciously favour findings and interpretations that support the use of the intervention. More importantly for schools, the use of external or specialist trained professionals increases challenges of implementation and can make the interventions less cost-effective. Future research could investigate how different school-based interventions for bereavement could be delivered by school staff such as teaching assistants or teachers. This would help identify if it is feasible for school staff to facilitate interventions or whether it impacts overall effectiveness.

2.5 Conclusion

Bereaved CYP are a vulnerable group and require access to beneficial support in order mitigate associated negative impacts of prolonged grief. This review has highlighted the relatively sparse and mixed evidence available for school-based interventions to support grief. School-based interventions for grief are key area of study as they have potential to provide much needed support for CYP, particularly for those who have limited support from their communities, family, and peers.

This review identified that CBT-based interventions show good effectiveness with CYP requiring tertiary level of intervention. This refers to CYP experiencing severe, complex and/or prolonged grief. Despite this, majority of the studies evaluating CBT-based interventions lacked a comparison group, therefore require caution in interpretation. The other interventions reviewed were classified as secondary level interventions. These interventions are for bereaved CYP who are experiencing grief reactions, but they are not severe, complex and/or prolonged. Music therapy has repeatedly shown positive outcomes but did not differ from a comparison psychoeducation intervention. Psychoeducation interventions have the potential to be an easily implemented and cost-effective option for school. However, the evidence base is mixed and it is unclear whether they have a significant impact on CYP's grief beyond time effects. This is likely down to several factors including overall study quality, outcome measures used and participant characteristic (e.g., severity of grief).

Due to the heterogeneity of interventions and research findings, staff school should consider the individual needs of their pupils and schools to identify suitable interventions. School staff should also be aware of the current limitations with the literature base including the lack of research based in UK schools which may impact the feasibility of intervention implementation or access to a specialist professional to deliver the intervention. Overall, it is clear from this review the need for quantitative evaluations of school-based interventions outside of the USA.

Chapter 3 The association of support systems and grief on bereaved children and young people: focus on school belonging, peer support, and family support.

3.1 Introduction

Death of a loved one can be a devasting and life-changing event. It can have significant impact on an individual's ability to function and have a long-term impact on psychological and physical wellbeing (Balk & Corr, 2001). Most of us will experience grief at some point in our lives, it is a normal human reaction to loss (Bonanno & Kaltman, 2001). Bereavement is common, around 1 in 20 children and young people (CYP) in the United Kingdom experienced the death of a parent before the age of 16 (Parsons, 2011). Additionally, as many as 78% of CYP experience the death of a close family member or friend before the age of 16 (Harrison & Harrington, 2001). Therefore, it is a common experience in schools and classrooms across the country. The experience of loss and bereavement can be traumatic for children and is considered an adverse childhood experience (ACE). ACEs have negative impact on both immediate and long-term mental health (e.g., Mosley-Johnson et al., 2021) and educational outcomes (Steward-Tufescu et al., 2022). Similarly, bereaved children are also at increased risk of mental health problems (Ayers et al., 2003) and poor educational outcomes (Elsner et al., 2022).

While most individuals who experience grief will see their grief reactions become more manageable over time and adjust to a 'new normal' without their loved one (Melham et al., 2011), approximately 10% of the population experience intense or prolonged grief symptoms which significantly impact daily functioning (Maass et al., 2022). Similarly, around ten percent of suddenly parentally bereaved children show prolonged grief reactions (Melham et al., 2011). Prolonged grief disorder (PGD) can be diagnosed once grief exceeds expected levels of separation distress or an individual experiences intense emotional pain for at least six months after the loss (Maass et al., 2022).

It is important to define the terms ‘grief’ and ‘bereavement’ so there is a joint understanding of how they will be used in this paper. Bereavement refers to experiencing a person, with whom one has an important relationship, dying. Grief can be defined as a reaction to bereavement that can encompass a wide range of responses including emotional, behavioural, cognitive, and physical (Sood et al., 2006). Therefore, bereavement refers to the experience of a loss while grief refers to the reactions to the experience. Grief can occur following several types of losses, including divorce or imprisonment of a family member (Ferow, 2019). In this paper, as the focus is CYP who have experienced a significant bereavement, grief will only refer to responses and reactions following a death. This definition of grief for adults and children is the same, while the reactions differ. Development of language, emotional regulation, and cognitive processes can lead to differences in grief reactions between adults, young people, and children (Tracewski & Scarlett, 2022).

In the literature multiple theories of grief have been proposed and its ‘normal’ trajectory. More recently, thinking around the classic theories of grief, such as Kübler-Ross’s (1969) stages of grief have begun to change towards more individualised non-linear trajectories (Tracewski & Scarlett, 2022). Instead, grief, for CYP, can be viewed as a three-step process which is dependent on factors such as the child’s developmental stage. These three steps are broad and can encompass a variety of reactions: 1. Understanding the finality that death brings, 2. Mourning the death, 3. Individual returns to a new normal (Machajewski & Kronk, 2013). PGD can be considered as a difficulty of achieving the third step and adjusting to a new normality without their loved one (LaFreniere & Cain, 2015a).

It is important to understand risks that may increase likelihood of an individual developing PGD. Research into adult bereavement has identified several predictors of PGD such as type of loss (e.g., loss of a child or partner), perceived unexpectedness of loss, and how the death occurred (e.g., violent death) (Buur et al., 2024). Conversely, it was found age was not a predictor of PGD (Doering et al., 2022). Despite the research of PGD in adults, little research has investigated risk factors of PGD in CYP. It is important to have greater understanding of risk factors for CYP, as adolescents with enduring grief of 18 months have been shown to have higher risk of long-term negative consequences (Hogan & Greenfield, 1991), including negative impact on academic progress (Elsner et al., 2022; Gray, 1987). Therefore, it is vital to understand typical grief in childhood and adolescence and identify young people with PGD who may benefit from support. Currently, there is limited research identifying predictors of PGD amongst CYP, so the condition is not well understood.

It is well documented support systems are important when experiencing a bereavement, with low social support identified as a risk factor for PGD in adults (Burke & Neimeyer, 2013). Social support has also been identified by individuals whose sibling died during childhood as a key resource while grieving (e.g., Thompson et al., 2011). Social support is a broad term that can refer to support received from several sources including peers, family, community, and school. “Social support” can be considered as assistance or comfort provided by others against life stressors (American Psychological Association; APA, Dictionary of Psychology, 2018).

A key element included within the broad term of social support, is family support. Family support can vary for bereaved CYP, as often the family also experiences the bereavement. This can lead to reduced capacity, particularly for parents, to offer emotional support (Dopp & Cain, 2012). Additionally, family environment has been shown as a significant predictor of the response of CYP to bereavement (Bugge et al., 2014). This is further supported by research showing the benefits of parental support provided to bereaved CYP (Wolchik et al., 2009). Parental support has been shown to be associated with grief reactions and post-grief growth. In Howard Sharp and colleagues (2018) research, parental support was the only form of social support (compared to peer and wider family support) that was directly associated with grief reactions and post-grief growth.

Due to the association between family support and grief measures, such as post-grief growth, it is possible lack of family support may lead to CYP to have greater risk of PGD. Lobb and colleagues (2010) found family relationships explained 43% of the variance in those with prolonged grief (referred to as complicated grief). Many factors may result in lower levels of family support such as disagreements between family members, the impact of the death on financial income (which may mean that other family members, e.g., siblings, must seek jobs), and emotional literacy skills of the family members including caregivers (Thompson et al., 1998). These factors are likely to impact emotional support received but also sense of stability within the family home (Worden, 1996). Reduced stability in the family dynamic (e.g., parental separation, unemployment, mental health needs of other family members) prior to the death led to greater disruption in academic progress (Elsner et al., 2022). Further analyses of potential factors that may impact family support and their possible effects on grief are needed. In line with Bronfenbrenner’s Model of Ecological Systems (2005), this would deepen understanding of the interaction of different systems in their impact on the family and ultimately the child’s response following bereavement.

Another aspect commonly included within the broad term of social support is peer relationships. Research has shown as CYP age, peer support becomes more crucial (Rubin et al., 2006; Thompson et al., 2006). Particularly as individuals enter adolescence, the importance of peer relationships becomes paramount, with high school students rating peer support as their preferred support system (Carter & Janzen, 1994). Therefore, for children and particularly adolescents, peer relationships hold significant importance with or without additional life stressors such as bereavement. Thus, one would assume peer relationships and the support they provide would become increasingly more important for bereaved CYP as they enter adolescence. Thus, research should show the relationship between peer support and grief to become more pronounced as children enter adolescence.

The research on peer support, however, does not show a consistent picture. While peer support is associated with positive adjustment following a bereavement (Gray, 1989), it is not clear when or whether peer support is beneficial, with qualitative research seemingly showing what one individual finds helpful another finds hurtful (LaFreniere & Cain, 2015b). Dopp and Cain (2012) argue three main functions may serve peer support: 1. Allowing CYP to experience a sense of normalcy 2. Knowing that others have shared similar experiences 3. Opportunities to discuss bereavement and the associated feelings. CYP highlighted close friendships are more likely to serve these functions and do not see general peer support as helpful when experiencing grief (LaFreniere & Cain, 2015b). Other research has highlighted some CYP withdraw completely from their peers during the grieving process due to concerns they would be teased and ridiculed (LaFreniere & Cain, 2015b).

Research has also aimed to unpick any differences in age and gender on perceptions and use of peer support. There are no consistent gender differences in the literature. Some studies have found limited gender differences in the use and perceived helpfulness of peer support (Frydenberg & Lewis, 1991) while others point to girls receiving more and viewing peer support more positively (LaFreniere & Cain, 2015a). Meanwhile, for age, adolescents have been shown to increase the amount of time they spend with their peers and increased reliance of close friendships compared to younger adolescents (Harris, 1991). However, other research points to peer support being viewed positively across age groups (LaFreniere & Cain, 2015a). Christ (2000) suggests peer relationships are important throughout childhood and adolescence but the purpose of that support changes through development, which may contribute to the differences in findings. It is clear peer relationships are an important aspect in development,

and this remains the case for those who experienced bereavement. There needs to be further research to understand how peer support can influence PGD in CYP.

If peer support does influence severity of grief symptoms, bereavement groups may be an effective way to support bereaved CYP. Bereavement groups would additionally provide opportunities for CYP to access peer support that serves the three functions highlighted by Dopp and Cain's (2012) research. The literature provides further evidence of the importance of peer support as participants reported a reduction in grief symptoms and less frequent emotional dysregulation (Linder et al., 2022). However, the literature base is again inconsistent with research in bereaved adults suggesting bereavement groups do not reduce grief severity (Maass et al., 2022) and that individual therapy may be more effective (Johannsen et al., 2019). Therefore, there needs to be better understanding of types of bereavement support for young people and its efficacy.

As bereavement can be considered an ACE, research into ACEs may also highlight further potential protective factors to reduce negative consequences of grief. Encouragingly, literature has identified protective factors which reduce the impact of ACEs (e.g., Yule et al., 2019). One such protective factor is sense of belonging (Bethell et al., 2019). Sense of belonging is identified as one of Maslow's (1954) key basic needs and if not fulfilled can lead to negative consequences (Baumeister & Leary, 1995). Baumeister and Leary (1995, pg.99) define belonging as "*a need to form and maintain at least a minimum quantity of interpersonal relationships*." Baumeister and Leary's (1995) definition refers to a general sense of belonging whereas a sense of school belonging is more specific. The most well-known definition was presented by Goodenow and Grady (1993, pg.60) who argue school belonging is "*the extent to which students feel personally accepted, respected, included, and supported by others in the school social environment.*" In the literature, school belonging is referred to by different names including school attachment (e.g., Mouton et al., 1996), school bonding (e.g., Whiteside-Mansell et al., 2015), school connectedness (e.g., Monahan et al., 2010) and school community (e.g., Osterman, 2000). For CYP, school belonging is particularly important and can impact academic achievement and wellbeing (Allen et al., 2021; Slaten et al., 2016). School belonging served as a protective factor when young people have been exposed to other ACEs, such as violence (Davies et al., 2019; Yule et al., 2019). Considering that school belonging acts as a protective factor for other ACEs, it is plausible that it may mitigate severe grief symptoms in bereaved CYP.

Previous research investigating aspects of social support for bereaved children included teacher support (Howard Sharp et al., 2018). This research found a moderate association between teacher support and grief-related growth for pupils who experienced the death of a sibling. While this research indicated school support may benefit bereaved young people, it is limited by looking at support provided specifically by teachers. Relationships with teachers play a vital role in sense of school belonging but school belonging is broader and captures multiple aspects of the school environment. Additionally, Howard Sharp and colleagues (2018) used The Social Support Scale for Children (Harter, 1985) which uses 24 items to assess all aspects of social support, with only a handful of items investigating teacher support. Therefore, there is a clear gap in literature investigating support within a school environment and its relationship with CYP's experience of grief.

3.1.1 Purpose of current study

Better understanding of different types of social support (family, peer, and school belonging) and their association with prolonged grief symptoms is required. There is limited research of PGD in CYP, particularly on potential risk and protective factors. An understanding of risk and protective factors is important, so CYP at risk of long-term negative consequences can identified and provided with adequate support. This study aims to examine the associations between self-reported prolonged grief symptoms in CYP and different aspects of social support. To date, no research has investigated relationships between CYP's grief and their school belonging. The present study aims to investigate that relationship.

3.1.2 Research questions and hypotheses

The purpose of this research was to identify variables with significant relationships to grief of CYP. Previous research has shown both peer and family support can promote post-grief adjustment, so it is expected that they will be associated with better psychosocial outcomes. There is a gap in the research whether school belonging can act as a protective factor with regard to PGD in CYP, however given the research between school belonging and other ACEs, it is expected school belonging will have a significant negative relationship with grief symptoms. Below these research hypotheses are outlined:

1) Participants with lower school belonging will report higher level of grief reactions.
2) As peer support increases, participants will experience significantly reduced grief reactions.
3) As family support increases, participants will experience significantly reduced grief reactions.

4) Higher level of social support (family, peers, and school) will significantly predict lower grief reactions.

Protective factor are characteristics or conditions that help mitigate negative consequences of ACEs and help CYP cope with life stressors. On the other hand, risk factors are characteristics or conditions that increase the chance of negative consequences of ACEs to occur and reduce the CYP's ability to cope with life stressors. In research protective factors can be conceptualised in multiple ways, including absence of a risk factor, the opposite of an established risk factor, and as factors independent of risk factors (Lee & Marsden, 2022). As lower school belonging has been shown to impact wellbeing (Allen et al., 2021; Slaten et al., 2016) it was predicted that lower school belonging would lead to higher levels of grief (i.e. absence of a protective factor). Peer and family support have shown to be important in promoting post-grief adjustment, therefore increased social support was predicted to act as a protective factor and mitigate grief reactions.

3.2 Methods

3.2.1 Participants

Participants were recruited through a bereavement charity based in the South of England. Twenty CYP aged between 4 and 18 (M=10.95 years, SD=3.68 years) took part in the study and completed an online survey. All young people attended an educational setting in the UK and spoke English as their first language. Of the young people that provided data, seven were males and five were females (missing *n*=8). All young people had attended at least one grief support session run by the charity, the number of sessions ranged from 1 to 54. The time since death ranged from 312 days to 2056 days.

Alongside the CYP, their caregivers were also asked to complete a questionnaire about their own and their child's experiences of grief, in total 12 caregivers completed the survey. Of the caregivers that provided data, ten were females and two were males. All caregivers reported they were the child's mother or father.

3.2.2 Design

Caregivers (Appendix C) and young people (Appendix D) were asked to fill in separate questionnaires. On the young persons' survey there were some question variations dependent on answers to previous questions. For example, the version of the Inventory of Prolonged Grief

was age dependent, with young people aged between eight and thirteen answering the child version and young people over 13 years old asked to complete the adolescent version of the measure. Young people under the age of eight were not asked to fill in this scale.

3.2.3 Apparatus

The survey was hosted on the online platform Qualtrics. The author and supervisors were the only people with access to questionnaires on Qualtrics. Once data had been collected, data was transferred into IBM SPSS statistics for Apple MacOS version 29.0.2.0 to complete the data analysis. Licences for both Qualtrics and IBM SPSS statistics were held by University of Southampton IT service.

3.2.4 Measures

3.2.4.1 Grief

To measure the severity of young people's grief symptoms, the Inventory of Prolonged Grief for Children (IPG-C) and the Inventory of Prolonged Grief for Adolescents (IPG-A; Spuji et al., 2012a) were used. Both versions of the measure had 30 items with a 3-point Likert scale: 1 'hardly ever', 2 'sometimes', 3 'always'. The scales have a range of scores from 30 to 90. Wording on both measures was slightly changed from the direct Dutch translation for clarity. In addition, the wording differed between the two versions to aid understanding e.g., IPG-C 'I feel confused when I think about them' IPG-A 'Thinking of them confuses me.' Currently there is no cut-off for the IPG-C or IPG-A in the literature, Spuij and colleagues (2012b) reported means of 50.8 and 50.3 respectively. Previous research has shown the IPG-C and IPG-A to have satisfactory internal consistency, stability, and concurrent validity (Spuij et al., 2012a). The Cronbach's alpha in the present sample showed good internal consistency for both the IPG-C, α=.91, and IPG-A, α=.97.

As part of the caregiver survey, the caregivers were asked to answer items about their own grief. This was measured through the Inventory of Complicated Grief (Prigerson et al., 1995), a 19-item measure that uses a 5-point Likert scale from 0 'never' to 4 'always'. Persons scoring above the 24 cut-off mark were considered to be at elevated risk of needing clinical support for prolonged or complicated grief reactions (Prigerson et al., 1996). The Cronbach's alpha for the ICG showed good levels of reliability, α=.93.

3.2.4.2 Strengths and Difficulties Questionnaire

The caregiver (Goodman, 1997) and self-report (Goodman et al., 1998) versions of the Strengths and Difficulties Questionnaire (SDQ) were used in the surveys. Both the caregiver and self-report questionnaires consist of 25 items. These 25 items are categorised into six behaviour sub-scales: emotional, conduct, hyperactivity/intention, peer relationships and prosocial behaviour. Previous research has shown the caregiver report has satisfactory reliability and validity for CYP aged between 5 and 15 years old (Goodman, 2001). The self-report questionnaire has satisfactory reliability and validity for young people aged between 9 and 15 years old (Muris et al., 2003). In our sample, the Cronbach's alpha for both the caregiver (α =.74) and self-report SDQ (α =.86) showed acceptable levels of reliability.

3.2.4.3 Peer support

To measure peer support, the Patient-Reported Outcomes Measurement Information System (PROMIS) peer relationships short form (DeWalt et al., 2013) questionnaire was used with both young people and caregivers. The self-report measure consisted of eight items where young people had to rate on a 5-point Likert scale their view of their peer relationships over the past seven days from 1 'never' to 5 'almost always'. Similarly, the caregiver version used a 5-point Likert scale but contained seven items rather than eight. Caregivers were asked to provide a rating for each item based on their child's peer relationships in the last seven days. The PROMIS peer relationship short form has been shown to meet validity and reliability thresholds for CYP aged between 8 and 18 (DeWalt et al., 2013; Luijten et al., 2021). The reliability scores in our sample showed good levels for both self-report peer support, α=.93, and caregiver-report, α=.96, scores.

3.2.4.4 Family support

Family support was measured through the caregiver and self-report PROMIS family relationship short form. The self-report version is a four-item measure that asks young people to report how much each statement relates to their family relationships over the past four weeks on a 5-point Likert scale from 1 'never' to 5 'always'. The caregiver-report used the same 5-point Likert scale to rate the child's family relationships in the past four weeks but was an eight-item measure rather than four items. The internal consistency, reliability and validity of the short form measure have previously been shown to be good for participants aged between 8 and 17 years old (Bevans et al., 2017). The same study also showed similar reliability and validity measures for the parent report for children aged between 5 and 17 years old. In the

present sample, the internal consistencies were for self-reported family support α=.86 and for the caregiver-report was α=.80, both indicating acceptable internal consistency.

3.2.4.5 School belonging

School belonging was assessed with the Psychological Sense of School Membership (Goodenow, 1993). This scale has been widely used in the literature to examine children's and adolescents' sense of school belonging, both nationally and internationally. It is an 18-item self-report questionnaire which uses a 5-point Likert scale ranging from 1 'not at all true', to 5 'completely true'. Individuals who score a mean of below three are considered to have a low sense of school belonging. Individuals with mean scores three and above indicate expected levels of school belonging. To reduce the number of items required of young people it was decided the short form version would be used. This uses 12 of 18-items of the original scale, research has shown good validity and reliability in both the 18-item scale (Goodenow, 1993) and shorter versions (Frederickson et al., 2007; You et al., 2011). Cronbach's alpha in the present sample was α=.90.

3.2.5 Ethical considerations

Ethical approval was sought from the University of Southampton School of Psychology Ethics Committee as well as the University of Southampton research integrity and governance team due to the young age and vulnerability of the target population [ERGO ID: 81215]. Due to the young age of participants, both caregiver consent and young person assent were sought. Participants aged 16 and over could provide their own consent (for caregiver consent see Appendix E and young person consent see Appendix F), those under the age of 16 were asked to provide assent. Prior to asking consent, both caregivers (Appendix G) and young people (Appendix H) were provided with information sheets. These detailed the participants' right to withdraw at any point in the study, however data collected until that point could not be withdrawn. Due to the nature of bereavement, it was possible some questions on the survey may have caused distress, particularly questions around loved ones' death. To mitigate the effects of possible psychological distress, the information sheet encouraged individuals to take a break or withdraw from the study if they felt distress. Additionally, the information sheet included contact details for mental health support hotlines, children, and adolescent mental health services (CAMHS) and specific bereavement charities (e.g., Winston's Wish, Bereavement UK). Finally, participants were debriefed once data collection was completed.

3.2.6 Procedure

Prior to ethical review, the author and the main supervisor met with the Chief Operating Officer (COO) of the charity to discuss the study. During this meeting feedback was sought regarding the ethical considerations and study procedure. Based on this meeting, suggestions from the COO were incorporated into ethical documents and questionnaires, for example wording of specific questions was changed based on their suggestion. Additionally, meetings were held throughout participant recruitment to update on recruitment and discuss potential approaches to maximise participant numbers.

The charity sent out the advertisement with the study link first via email, the author and main supervisor then attended the charity's support groups to hand out advertisements (Appendix I) and answer any questions about the study. The advertisement included information on the participant qualities required and a QR code to the information sheet and survey. Interested parties followed the link or QR code to the caregiver information sheet. Once the information sheet had been read and consent given via an online form, the caregiver filled in the survey. Once submitted, the website automatically linked to the young person's survey where the young people were asked their age. Depending on their age, they received either the young person information sheet and assent form or the standard information sheet and young person consent form. Participants over the age of 16 could provide consent without their caregivers. These participants were provided with a QR code that took them directly to the young person survey. In total each survey took the caregiver and participant 15-25 minutes to complete.

This study was embedded within a larger evaluation project. The methods and analysis presented in this study is from baseline data collection for the larger project. Participants were informed during recruitment that once data collection had been completed they would receive a total of £15 in gift vouchers for participating in the study.

3.2.7 Data analysis

Quantitative analysis was conducted in IBM SPSS statistics version 29.0.2.0. To test hypotheses one, two and three Pearson's r correlational methods investigated the relationships between peer and family relationships and grief as well as school belonging and grief. Due to the cut off of the school belonging measure, hypothesis one will also use independent t-tests to compare the means of grief and emotional responses.

For the fourth hypothesis, based on the results of the correlations, significant predicator variables will be selected for inclusion in a hierarchal regression to analyse the association between the predictor variables (school belonging, peer support, family support) and the outcome variable (level of grief as measured by the IPG-C and IPG-A). These results are presented in the section below.

3.3 Results

3.3.1 Descriptive statistics

Caregivers provided details of the nature of the death (missing *n*=8). Of those who provided data, nine participants reported the death to from natural causes e.g., disease, old age). No participants reported the death was sudden (e.g., suicide, accident), however three participants described the cause of death as 'both (natural causes and sudden) or other.' Of those who died, five were parents to the young person, four were other family members and three were friends. As part of the survey, caregivers were asked to comment on their own grief. Interestingly, all 12 report grief scores above the cut off mark, suggesting they are at elevated risk of needing clinical support. For this group of young people there was a mean of 61.18 for the IPG-C and 62.67 for the IPG-A, suggesting the participants in this research may have slightly elevated prolonged grief symptoms.

Table 7 provides further information about the sample including means, standard deviations and the number of participants who completed the measure for each variable. Missings were present for young people and their caregivers.

Table 7. *Descriptive statistics for each variable*.

Variable	Mean	Standard deviation	*N*	*Number of missing participants*	*Skewness*	*Kurtosis*
Grief (dependent)	61.71	11.75	17	3 (15%)	-.51	-.39
Age	10.95 years	3.68 years	20	0 (0%)	.13	-.93
No. of sessions	19.28	17.47	18	2 (10%)	.53	.081
Time since death	777.25 days	631.46 days	12	8 (40%)	1.52	1.11
SDQ total score (self)	26.12	7.37	17	3 (15%)	.08	-.99

SDQ total (caregiver)	25.58	5.62	12	8 (40%)	-.74	-.01
School belonging	3.49	0.82	18	2 (10%)	.43	-1.16
Peer support (self)	46.17	9.87	20	0 (0%)	.22	-.38
Family support (self)	53.07	6.28	20	0 (0%)	-.11	-.46
Peer support (caregiver)	48.94	11.35	12	8 (40%)	-.05	-.88
Family support (caregiver)	47.66	7.09	12	8 (40%)	0.21	2.69
Caregiver grief	55.33	16.03	12	8 (40%)	-.39	-.89

Caregivers and young people were asked to complete PROMIS and SDQ measures. Table 8 indicates number of young people above cut off values in the respective measures. Most young people and caregivers rated the peer and family support as good to excellent. The SDQ measure highlights that most young people had elevated SDQ total scores on the caregiver-reports and self-reports. This suggests that this sample of CYP had clinically raised emotional and behavioural problems which may indicate this sample had elevated behavioural and emotional grief reactions, this must be considered when interpreting the results.

Table 8. *Number of CYP above cut off for SDQ and PROMIS measures.*

	Caregiver report (n=12) Number above cut off (% of sample)	Self-report Number above cut off (% of sample
Peer support	1 (8.3%)	1 (5%)
Family support	0 (0%)	1 (5%)
SDQ total	11 (91.7%)	14 (82.4%)
SDQ emotional	9 (75%)	5 (29.4%)
SDQ conduct	2 (16.7%)	1 (6%)
SDQ hyperactivity	4 (33.3%)	5 (29.4%)
SDQ peer problems	3 (25%)	2 (11.8%)

SDQ prosocial	1 (8.3%)	0 (0%)

3.3.2 Hypothesis one: Young people with lower school belonging will report higher level of grief and emotional reactions.

To ensure data was appropriate for further analysis, the data set was examined to ensure it fulfilled statistical assumptions. Hair et al. (2010) and Bryne (2010) argue data can be considered normal if skewness values are between -2 and +2 and kurtosis values are between -7 and +7. Therefore using these parameters, all variables can be considered to have skewness and kurtosis values within the acceptable range, indicating normally distributed data, see table 9 for specific values. To further investigate normal distribution and to identify outliers, histograms of all variables were examined. This indicated normally distributed data, so this assumption was satisfied. This examination did not show outliers, so no values were removed.

The relationship between school belonging and grief was examined (see Table 9 for correlations between variables). Analysis showed a significant relationship, (r=-.61, p=.017) this indicated that the larger the degree of school belonging experienced by the participants, the lower was the degree of grief symptoms they reported. School belonging further correlated with self-reported SDQ score (r=-.65, p=.009), and emotional problems (r=-.82, p<.001). The emotional subscale of the SDQ measures emotional problems, previously shown to be related to prolonged grief (Weber et al., 2021) and indicates the wider emotional impact of grief.

In an exploratory analysis, participants were grouped into two based on school belonging scores: low school belonging (n=7) and high school belonging (n=11). Those with a mean score below three were classified as having low school belonging (Goodenow, 1993), those with scores of three and above were classified as having high school belonging. Independent t-tests were undertaken to compare grief and emotional problems between those with low and high school belonging. To ensure an independent t-test was appropriate, the Shapiro-Wilk's test of normality was examined, the test showed a non-significant result meaning assumption of normality was met. The t-test was significant, with a large effect suggesting a difference in grief levels between those with low and high school belonging (t(13)=2.50, p=.013, d=1.32). The indicates that those with low school belonging report higher grief levels (M=69.67, SD=10.17) than those with high school belonging (M=55.67, SD=10.92).

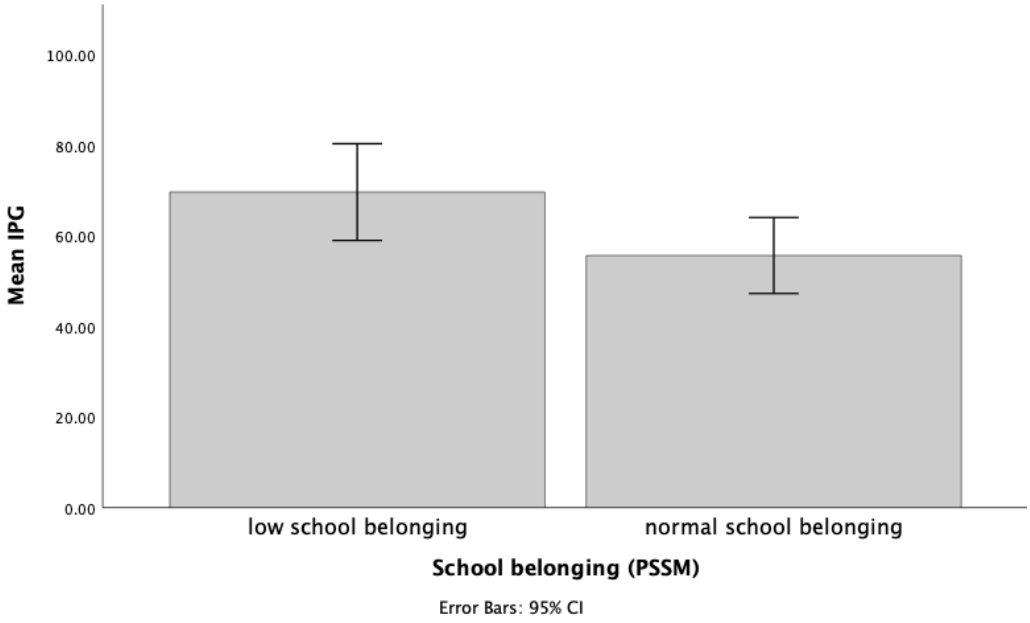

Figure 3. *Comparison of young people's grief symptoms based on level of school belonging * p<.05.*

Additionally, there was significant difference, with a large effect, in SDQ emotional scores (emotional responses) based on level of school belonging ($t(13)=5.30$, $p<.001$, $d= 2.80$). The means showed young persons with low school belonging reported higher emotional problems (M=8.50, SD=.84) compared with those with high school belonging (M=4.78, SD=1.56).

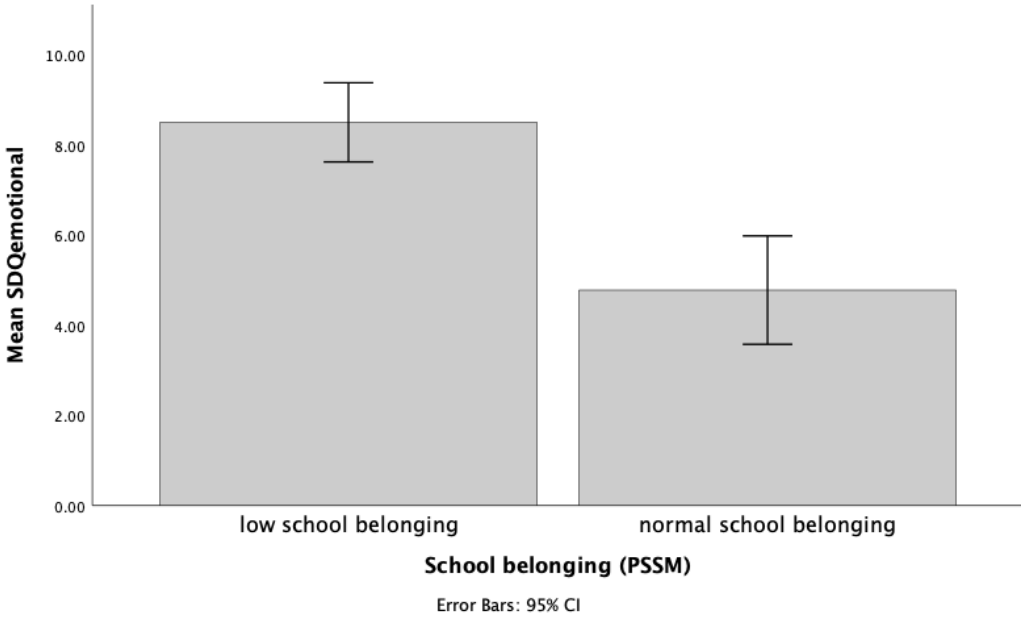

Figure 4. *Comparison of young people's emotional problems scores based on level of school belonging **p<.001.*

3.3.3 Hypothesis two: As peer support increases, participants will experience significantly reduced grief reactions.

The analysis found a significant relationship between self-reported peer support and grief (r=-.58, p=.016), indicating that as self-reported peer support increases grief decreases. This was further supported by a significant relationship between self-reported peer support and emotional problems (r=-.67, p=.003).

Caregiver-reported peer support and self-report peer support was shown to significantly correlate (r=.78, p<.001). However, there was no significant correlation between caregiver-report peer support and grief (r=-.12, p=.732).

Interestingly, a significant relationship between caregiver grief and self-reported peer support *(*r=.68, p=.015), showing the higher level of caregiver grief, the more peer support was reported by participants.

3.3.4 Hypothesis three: As family support increases, participants will experience significantly reduced grief reactions.

The relationship between self-reported family support and grief was also examined. The analysis showed a non-significant relationship, r=-.04, p=.88. This means no significant relationship between self-reported family support and grief was found for the CYP in this sample. However, there was a significant relationship, r=-.60, p= .01 between self-report family support and age. This indicated that as age increases, perceived family support decreased.

Caregiver-reported family support did not show a significant correlation with self-report family support, r=-.26, p=.41. However, similarly to self-report family support, caregiver-reported family support and grief showed a non-significant relationship, r=.14, p=.69. Therefore, showing family support, self-report or caregiver-report, did not correlate with grief.

For further information on correlations between the variables please see table 9.

Table 9 .*Pearson correlations between variables*

	IPG	School belonging	Peer support	Family support	Age	Number of sessions	Time since death	SDQ total	SDQ emotional	SDQ conduct	SDQ hyperactivity	SDQ peer problems	SDQ prosocial	Parental grief	Peer support (parent report)	Family support (parent report)
IPG																
School belonging	**-.605***															
Peer support	**-.574***	**.476***														
Family support	-.040	.171	-.068													
Age	.135	-.293	-.173	**-.596****												
Number of sessions	-.130	-.172	.108	**-.525***	**.751****											
Time since death	-.026	-.288	-.567	.424	.531	**.658***										
SDQ total	**.552***	**-.645****	**-.566***	-.092	.012	.070	.095									
SDQ emotional	**.648****	**-.819****	**-.671****	-.024	.239	.222	.328	**.852****								
SDQ conduct	.262	-.463	-.450	.067	-.105	.018	.386	**.717****	**.486***							
SDQ hyperactivity	.253	-.439	-.265	-.170	-.071	.060	-.188	**.839****	**.598***	**.496***						
SDQ peer problems	**.692****	**-.752****	**-.681****	-.008	.165	-.001	.311	**.822****	**.885****	**.539***	**.483***					
SDQ prosocial	.054	.423	.178	-.221	-.254	-.104	**-.683***	.175	-.136	-.119	.253	-.145				
Caregiver grief	-.321	-.122	**.681***	-.037	-.444	-.192	-.311	-.518	-.538	-.297	-.516	-.329	-.109			
Peer support (Caregiver report)	-.124	.278	**.780****	-.174	-.087	-.104	-.522	-.307	-.371	-.609	-.117	-523	**.821****	.222		
Family support (Caregiver report)	.144	.204	**.638***	-.262	-.351	-.483	**-.687***	.148	.014	-.192	.180	.128	**.634***	.384	.534	

*p<.05
**p<.001

3.3.5 Hypothesis four: Higher level of social support (family, peers, and school) will significantly predict lower grief reactions.

A hierarchical linear regression was conducted to explore the impact of different forms of social support on a young person's grief. All assumptions were met meaning that regression analysis was appropriate (See Appendix J).

As self-reported peer support and school belonging showed significant relationships with grief they were entered as predictor variables into a two-step hierarchical linear regression. It was decided family support would not be entered into the model because of its non-significant relationship with the outcome in the current study, despite previous research showing evidence for family support to be associated with grief measures.

In the first step of the regression analysis only school belonging was entered as a predicator variable. The overall model was significant $F(1,13)=7.49$, $p=.02$ and explained 36.6% of the variance in grief. This model indicated school belonging was a significant predictor of grief ($\beta=-.61$, $p=.02$).

Table 10. *Coefficient table showing the unstandardised and standardised beta coefficients for predictors school belonging with grief symptoms as outcome.*

	Unstandardised beta	Coefficient std. error	Standardised coefficients beta	*t*	Significance (*p*)
Constant	92.21	11.62		7.94	<.001
School belonging	-8.88	3.25	-0.61	-2.74	.02

When peer support was added as a predictor, the overall model remained significant $F(1,12)=4.70$, $p=.03$) with 43.9% of the variance explained by the model, which was a non-significant change from the previous model, $p=.234$. This indicates peer support does not significantly contribute to the model over and above school belonging.

Table 11. *Coefficient table showing the unstandardised and standardised beta coefficients for predictors school belonging and peer support with grief symptoms as outcome.*

	Unstandardised beta	Coefficient std. error	Standardised coefficients beta	t	significance
Constant	101.47	13.56		7.49	<.001
School belonging	-4.91	4.49	-0.33	-1.10	.30
Peer support	-0.53	0.42	-0.38	-1.25	.23

3.3.6 Further exploratory analysis of social support and internalised reactions to grief.

A second two-step hierarchical regression investigated whether peer support and school belonging predicted participants' emotional problems as reported on the SDQ. As mentioned above, the emotional subscale of the SDQ has previously shown to be related to prolonged grief (Weber et al., 2021) and indicates the wider emotional impact of grief. Emotional problems and grief also had a significant relationship for these participants (r=.65, p=.005). Therefore, in the second regression analysis, young persons' emotional response was entered as the outcome variable with school belonging and peer support entered as the predictor variables. These predictor variables were chosen because of their significant correlation with the dependent variable (school belonging r=-.82, p<.001, peer support r=-.67, p=.003). Again, there was no significant correlation with family support (r=-.02, p=.93) and therefore it was not entered into the model.

The results of the hierarchical regression indicated that the first model explained 67% of the variance in participants' emotional responses. This means that 67% of variance is accounted for by school belonging (R^2=.67). The overall model was significant F(1,13)=26.43, p<.001. This indicated higher reported emotional problems were statistically predicted by lower school belonging (β= .-.82, p<.001).

Peer support was entered into the second model as a predictor variable. The overall model remained significant F(1,12)=12.79, p=.001 and explained 68.1% of the variance. However, this was not a significant change from the previous model, p=.545. This indicated that peer support does not significant contribute to the model over and above school belonging. In

the second model, school belonging remained a significant predicator of emotional problems (β= .-.72, p=.01) whereas peer support did not significantly predict emotional problems (β= .-.14, p=.55). This means for a one-point increase in school belonging, SDQ emotional score decreases by 1.93.

Table 12. *Coefficient table showing the unstandardized and standardised beta coefficients for predictors school belonging and peer support with emotional problems as outcome.*

	Unstandardised beta	Coefficient std. error	Standardised coefficients beta	t	significance
Constant	14.57	1.87		7.78	<.001
School belonging	-1.93	0.62	-0.72	-3.11	.01
Peer support	-0.04	0.06	-0.14	-0.62	.55

3.4 Discussion

The aim of this research was to identify relationships between grief and different aspects of social support, in particularly school belonging. The results show there is a significant negative association between school belonging and grief. The relationship showed the lower school belonging was for the young people, the higher level of grief was reported. This supports the first hypothesis. It is possible a sense of school belonging widens CYP's social support, so they have more options to draw support from during their grief, in line with Bronfenbrenner's Model of Ecological Systems (2005). This may mean school belonging becomes increasingly important if other sources of support become unavailable.

Further to this, school belonging is associated with the development of emotional regulation (Frydenberg et al., 2009). Therefore, it is possible young people with higher levels of school belonging had better emotional regulation which supported their experiences of grief and its emotional impact. Additionally, maladaptive emotional regulation in adults is associated with development of PGD (Eisma & Stroebe, 2021). This indicates emotional regulation may play a role in the relationship between school belonging and grief, further research is needed to investigate these relationships.

The relationship between school belonging and grief reactions suggest school may act as a key resource for bereaved CYP. Therefore, school-based interventions may be an appropriate route to support bereaved pupils as an avenue to build school belonging. Bereaved pupils have reported a lack of support and acknowledgment of their loss from teachers on their return to school following bereavement, leading to adverse experiences (Holland 1999; 2001). Having school-based interventions would ensure pupils access support on their return to school and therefore feel acknowledgement of their loss. Chapter two highlighted that some school-based interventions can have positive impact on bereaved pupils, including on perceived school-based social support (Linder et al., 2022). The positive relationship seen between school belonging and grief reactions in this study also adds to the literature base that highlights importance of school belonging for all pupils but particularly those who have experienced ACEs (Allen et al., 2021; Davies et al., 2019).

This study provided further support for the importance of peer support for bereaved CYP. The results showed a significant relationship between peer support and grief reactions, with those with higher levels of peer support reporting lower levels of prolonged grief and emotional problems. This supports the second hypothesis and is in line with previous research that has indicated peer support is beneficial for parentally bereaved CYP (Christ, 2000; Dopp & Cain, 2012). Additionally, this research may provide further evidence that peer support may be

important throughout childhood (Christ, 2000) as the analysis did not find a significant relationship between age and peer support.

However, due to the nature of correlational analysis, it is possible those with higher grief withdrew from their peers and therefore had lower peer support. Research noted bereaved CYP worry about negative peer reactions about their loss (e.g., teasing) with only 23% of participants desiring peer support for their bereavement (LaFreniere & Cain, 2015a). Qualitative research shows worries about emotional responses play a key role in avoiding peers (LaFreniere & Cain, 2015b). The findings in this research indicate a relationship between emotional problems and peer support, additionally peer support correlated with peer problems. This suggests those with more emotional problems experience lower peer support, and those with lower peer support experience more peer problems. It is possible CYP with more emotional problems are more socially vulnerable.

The analysis of the fourth hypothesis showed the overall model with school belonging and peer support as predictor variables was significantly associated with young people's grief. In the first step of the regression, school belonging significantly explained the overall variance of the model. However, when school belonging and peer support were both entered during the second step, despite the overall significant model, neither individually explained a significant portion of the variance. Therefore, it can be cautiously inferred that the peer support element of school belonging was contributing to the significant effect of school belonging on grief symptoms in the first step of the regression model. Given this tentative conclusion, educational professionals should be encouraged to implement additional opportunities for bereaved CYP to access peer support within the school environment. Peer support programs such as buddy programs are likely to be beneficial because there is evidence of positive impact for individuals who have experienced traumatic events (Turunen & Punamäki, 2016) as well as increase school belonging (Ercan et al., 2017). There is limited research on bereaved pupils, however given the significant relationships between school belonging, peer support and grief reactions in this study it is likely they would benefit pupils who are experiencing low school belonging or peer support. Similarly, as discussed in chapter two, school-based grief groups have been shown to improve perceived level of peer support and coping skills in bereaved pupils (e.g., Linder et al., 2022; Rosner et al., 2010). This study provides further evidence for the importance in creating opportunities to build social support within the school environment for pupils who have experienced a bereavement.

Conversely, family support did not significantly correlate with prolonged grief reactions or emotional problems. This suggested for participants in this study family support was not a significant predicator in their grief reactions as hypothesised. This contradicts some of the previous literature (Bugge et al., 2014; Howard Sharp et al., 2018; Wolchik et al., 2009) that has

suggested family support can influence bereaved CYP's ability to adjust following the death. There are some possible reasons for this finding. Firstly, all caregivers in this research had prolonged grief reactions above the cut off, suggesting they were experiencing elevated levels of grief themselves. This could suggest caregivers may have been less able to provide emotional support needed (Chen & Panebianco, 2018) possibly forcing CYP to seek support from peers and schools.

Secondly, the study participants were recruited though a bereavement charity that provided support groups. Interestingly, there was negative correlation between family support and number of sessions attended. This is consistent with the interpretation that as family support decreased, number of support sessions attended increased. It is possible, the attendance of support sessions was seen as a key aspect of support for bereaved CYP by their caregivers. Previous literature has argued family support relies on factors such as communication and discussion of emotions (Balk, 1991). The support sessions provided CYP space to discuss and engage in activities about their emotions and experiences in relation to grief. Therefore, caregivers may have not engaged with conversations around the bereavement at home, leading participants to feel a reduced levels of family support.

Lastly, there may have been a limited relationship between family support and grief reactions because of the age of the CYP. There was a correlation that showed family support reduced with age, which is in line with previous research that shows peer support becoming more important as individuals enter adolescence (Rubin et al., 2006; Thompson et al., 2006). Most participants were older than ten suggesting a lack of relationship between family support and grief may be a product of having a majority adolescent sample. Research investigating family support in younger children is needed to understand the influence of age on the importance of family support on grief reactions.

The data in this research was collected from a bereavement charity which offer support session to CYP. Analysis of this sample showed a non-significant relationship between number of sessions attended and grief reactions. Firstly, it is important to note this data was taken once, so it is possible grief has reduced since participants began attending sessions. The participants are providing further longitudinal data so change in grief over time can be further investigated in future research. It is also possible those who have benefitted most from the support sessions no longer attend and therefore were not recruited as participants. This result may also reflect a non-linear trajectory of grief over time (e.g., Tracewski & Scarlett, 2022). Again, the further investigation on the longitudinal data will be able to provide further insight into whether the grief support sessions reduce grief reactions.

Despite the non-significant relationship, it is possible the charity support groups are providing much needed peer support to bereaved participants. The support group sessions are based on themes often relating to emotions (e.g., sadness, anger), with activities and discussions planned accordingly. CYP are encouraged to share their experiences of these emotions related to grief when they feel comfortable. The support groups provide the opportunity to develop the main functions of peer support which Dopp and Cain (2012) describe as most beneficial. These functions are sense of normalcy, shared experiences of grief, and opportunities to discuss bereavement and associated feelings. These functions are provided through the support groups, firstly by providing CYP opportunities to engage in play activities (e.g., Lego, ping pong) which will allow for a sense of normalcy. Secondly, the groups provide the opportunity for young people to engage with other CYP who have also experienced a bereavement, this allows them to know they are not alone in experiencing a bereavement during childhood. Finally, the sessions provide structured opportunities to engage with discussions around bereavements and associated feelings. It is possible as they have access to high quality peer support, that this plays a more important role in the adjustment following a bereavement for these CYP. It is less about quantity (number of sessions attended) but the quality (peer relationships) of support that is associated with grief reactions. Further research comparing the impact of peer support between those who attend grief support groups and those who do not, would provide more evidence for this argument. It is intended the wider project will investigate this.

3.4.1 Limitations

While this paper has identified novel findings, there are some limitations that must be considered. Firstly, the study has a small sample size, which means the analysis was likely underpowered and therefore should be interpreted cautiously, particularly analysis of subgroups (e.g., low vs expected school belonging). Firstly, the study has a small sample size, which means the analysis was likely underpowered. Literature has highlighted that researchers should aim for a minimum sample size of 30 participants for Pearson correlation analysis (Fraenkel et al., 2012), while for multiple regression analysis it is suggested between 10 to 15 participants per predictor variable (Field, 2024).' The results should therefore be interpreted cautiously, particularly the analysis of subgroups (e.g., low vs expected school belonging). It is worth noting that it has been documented that bereaved CYP are a difficult population to recruit for research (Akard et al., 2014; Penny, 2020). They are often a hard to identify group, particularly those who are not involved in services (Akard et al., 2014). This was demonstrated in this research as recruitment of a control group who had not accessed services was unsuccessful and recruitment relied on those who attended the charity's grief support groups.

Further to this, other studies using bereaved children as participants have used similar sample sizes (e.g., Cohen et al., 2004; Kalter et al., 2003; Kaplow et al., 2013; Wilson, 1995). For these reasons, it was deemed appropriate to proceed with data analysis.

As common in questionnaires methodologies, there was some missing data for some participants, particularly in relation to caregiver data. This is likely to have impacted the analysis of caregiver data which could have led to unintended bias in the reported findings. The regression and correlation analysis focusing on young people's data, which was used to investigated the hypotheses, were less impacted by missing data. The data missing on grief was for the youngest three participants so it is possible that the findings reported here do not reflect the experiences of participants under the age of eight.

A third limitation was that the large variability in time since death, ranging from just under a year (312 days) to over 5 years since death (2056 days). This may have acted as a confounding variable influencing the relationships detected in this research. It is possible that those with longer time since their loved ones died had more severe grief reactions that may have impacted levels of social support and school belonging over time. It is also possible, that because all caregivers met the cut off on the Inventory of Complicated Grief indicating higher risk of PGD, that caregivers may also be accessing support from the charity's sessions and influenced support sought by the CYP in this research.

Because of the way the sample was recruited, all participants were receiving support sessions for their grief. Therefore, the relationships with peer support and school belonging may differ for bereaved CYP who were not accessing support. In particular peer support, as it is possible that due to attendance of grief support session, CYP were accessing high quality peer support as described by Dopp and Cain (2012) which could have influenced the relationship between peer support and grief reactions. Thus, there is limited generalisability of the findings to bereaved CYP who have not accessed specific bereavement support.

Further to this, generalisability is likely to be limited as participant demographic information was not collected, due to ethical considerations, meaning that it is not known how representative the sample was in relation to the local area or nationally. Additionally, as the survey was created on an online platform, those who did not have access to an electronic device or internet would have inadvertently been excluded from participating in this research.

The methodology of this study meant that it was not possible to know how the caregivers and young people interacted with the survey. The young people in this study may have required support to answer survey items or use electronic devices needed for the survey. It is therefore

possible that some participants were subject to social desirability bias and had been influenced by their caregivers' interpretation of survey items.

3.4.2 Implications for educational staff

It is important to understand these findings and the implications they may have for educational staff, as CYP spend a considerable proportion of their time at school. Firstly, the findings in this research have added to the body of literature showing the importance of school belonging, particularly for those who have experienced ACEs (Allen et al., 2021). Educational psychologists have good understanding of the impact of low school belonging and can provide schools with guidance and support in implementing interventions and school policies that work to improve school belonging for all pupils. Improving school belonging for all pupils would see benefits in pupils' social and emotional development (Arslan et al., 2020) as well as increasing successful school experiences (Korpershoek et al., 2020). Trauma-informed approaches are likely to be suitable as they have been shown to improve school belonging for all pupils (Rowe et al., 2007). These approaches would also ensure that young people who experience ACEs, including bereavement, have a stable support system in place. This will be vital for pupils who experience a change in their other support systems due to the bereavement and other family members' grief.

As mentioned previously, the findings in this paper suggest that both peer support and school belonging have a relationship with grief reactions. This means educational professionals should consider interventions focusing on peer support such as buddy programs and peer support groups when working with bereaved CYP. This is further supported by evidence that has shown positive outcomes from these types of interventions for bereaved CYP (Linder et al., 2022; Turunen & Punamäki, 2016).

Many participants in this paper listed their most significant bereavement as happening over a year ago yet reported continued grief and emotional reactions. Previous research has highlighted 'sympathy fatigue' where support systems stop providing emotional support required by the bereaved individual (Koblenz, 2016). It is important that educational staff are aware of this and work to ensure that bereaved young people are consistently supported over time. One way to do this is ensure that educational settings are aware of charities that provide grief groups, like those attended in this research. By signposting caregivers and young people, educational settings can ensure that caregivers and young people have the tools to seek specific longer-term grief support.

While many educational professionals are aware that grief reactions can significantly impact a young person and their development in the short term, there is less understanding of conditions such as PGD. As young people spend a significant amount of their time at educational settings it is important that educational staff are aware of the difference between PGD and common grief trajectories so that they can identify bereaved CYP who may need more specialist intervention to manage their grief. This could be done through bereavement policies, continued professional development sessions on bereavement or during teacher training programs. It is important that all educational staff are aware of the differences because of how common childhood bereavement is, but also because the prevalence of PDG in young people is not yet fully established (Falala et al., 2024).

3.4.3 Future directions

Research into grief reactions in CYP is of the utmost importance so that there is clear knowledge and understanding of the impact a bereavement during childhood can have. While this research has identified a relationship between peer support and school belonging on grief reactions, further research is needed to identify risk factors of PGD in CYP. This research would allow early identification of young people at risk so that they can access the support they need or allow for preventive action to take place.

There needs to be further understanding of family support. The findings presented in this research do not provide evidence for a relationship between family support and grief reactions, however this is contrary to previous research that has indicated that more family support can lead to better post-grief adjustment (Bugge et al., 2014). Therefore, further research is needed to better understand the association between family support and grief reactions. It is possible that importance of family support may differ between young people who have access to specialist grief support and those who do not.

Wherever possible future research should aim to recruit larger sample size to not only ensure that analysis has enough power but also so that analysis of subgroups (e.g., gender, age) can take place. This will contribute to our understanding of how different forms of social support can impact grief reactions across different age groups and genders. This would further support identification of appropriate interventions for bereaved young people so that negative consequences associated with PGD and ACEs can be reduced.

It is important to understand how the relationships between grief reactions, social support, attendance of grief support sessions and parental grief can change over time, therefore longitudinal data needs to be collected. This would allow for better understanding of different

grief trajectories amongst young people and therefore build further understanding of the long-term impact of young people who experience PGD. Additionally, longitudinal data would provide clearer understanding of the impact of the charity grief support sessions on grief reactions of both young people and their caregivers.

3.5 Conclusions

This research aimed to investigate the different aspects of social support and school belonging and their relationship with CYP's grief. It is believed that this is the first paper to investigate the relationship between school belonging and grief. Literature into other ACEs has indicated that school belonging can act as a protective factor, therefore, as childhood bereavement can be considered an ACE, it is logical to hypothesise a relationship between school belonging and grief. The findings of this paper highlighted the significant association between peer support, school belonging and grief. Conversely, the findings also highlighted a non-significant relationship between family support and grief, which was surprising considered previous literature has argued the importance of family support. The discussion examined possible explanations for this difference. While these findings are promising and provide evidence toward the previously unexamined relationship of school belonging and grief, the findings must be interpreted with caution due to the small sample size. Further research with a larger sample size and examining the relationships between variables over time is needed to better understand the findings in this research. Despite this, the results suggest the importance of social support from a wide range of sources, including school, when experiencing a bereavement.

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Appendix A Systematic search strategy

Initial scoping searches were conducted using ‘library search’ (University of Southampton’s search system) and ‘Google scholar’. Following initial scoping searches the ‘PICOS’ framework (Higgins & Green, 2011) was used to identify possible key search terms to answer the research question ‘How can school settings support children and adolescents who have experienced a personal grief event?’.

The databases ‘PsycINFO’, ‘MEDLINE’, ‘CINAHL’ and ‘ERIC’ were selected due to the focus on education and psychology. ‘ProQuest Dissertation and These Global database’ was used to search for grey literature. Alongside the database searches, research was also identified through wider scoping search on Google scholar and Web of Science.

The literature found through the database search had the inclusion and exclusion criteria (Table 1) applied.

Appendix B Quality Assessment Tool for Quantitative Studies (Ciliska et al., 1998)

Quality Assessment Tool for Quantitative Studies (Ciliska et al., 1998)

A) Selection bias
    a. Are the individuals selected to participate in the study likely to be representative of target population?
    b. What percentage of selected individuals agreed to participate?
B) Study Design
    a. Indicate the study design.
    b. Was the study described as randomised? If no, go to section C.
    c. If yes, was the method of randomisation described?
    d. If yes, was the method appropriate?
C) Confounders
    a. Were there important differences between groups prior to the intervention?
    b. If yes, indicate the percentage of relevant confounders that were controlled (either in the design (e.g., stratification, matching) or analysis)?
D) Blinding
    a. Was (were) the outcome assessor(s) aware of the intervention or exposure status of participants?
    b. Were the study participants aware of the research question?
E) Data collection methods
    a. Were data collection tools shown to be valid?
    b. Were data collection tools shown to be reliable?
F) Withdrawals and drop-outs
    a. Were withdrawals and drop-outs reported in terms of numbers and/or reasons per group?
    b. Indicate the percentage of participants completing the study. (If the percentage differs by groups, record the lowest).
G) Intervention integrity
    a. What percentage of participants received the allocated intervention or exposure of interest?
    b. Was the consistency of the intervention measured?
    c. Is it likely that subjects received an unintended intervention (contamination or co-intervention) that may influence the results?
H) Analyses
    a. Indicate the unit of allocation
    b. Indicate the unit of analysis
    c. Are the statistical methods appropriate for the study design?
    d. Is the analysis performed by intervention allocation status (i.e. intention to treat) rather than the actual intervention received?

Each section is rated strong, moderate or weak

Global rating:

Strong (no weak section ratings)

Moderate (one weak section rating)

Weak (two or more weak section ratings)

Appendix C Caregiver Questionnaire

Eligibility to take part

Have your child used professional support services because of their grief beyond what was offered as standard of care by their nursery/ school or the hospital/ hospice where the loved one passed away (e.g., additional support from mental health services or bereavement support services from charities)?

Yes/ No

If "Yes", a thank you message will appear:

Thank you very much for considering taking part in this study. To come to meaningful conclusions, research studies have very specific criteria of who can and cannot take part. In this instance, your answer indicated that you are not eligible to take part in this study. Again, thank you very much for your interest in our study.

Demographic information

First, we would like to ask you a few questions concerning your own person.

What is your personal status:
single/ married/ widowed/ divorced

Please indicate your living arrangements: Do you live
alone/ with a partner/ separated

Please indicate your relationship towards the child who is about to enter/ already engaged with the bereavement service (Simon Says):
I am the child's mother/ father/ other family relation (If so, please specify the relation? TEXT)/ no family relation (If so, please specify the relation? TEXT)

Please refer in the following sections to the child who has experienced the loss of a loved one. If you have multiple children, please refer to the child who is engaged with/ about to enter the bereavement service (Simon Says).

Please indicate the gender of the child:
female/ male/ non-binary/ other

If 'other', please clarify:

Please indicate the child's age:

age in years

Please indicate the child's native language:

English/ other

Please indicate your role to the child

Mother / father / alternative caregiver / other.....

Has the child lived with you since birth? Yes ... if no: How long has the child lived with you?...

Other situation: please clarify:

_____

_____

How often has your child been at Simon Says?

Loss-related information

Please refer in the following to the bereavement, which is most distressing to the child.

When did the person die?
DD/MM/YYYY

What was the relationship between the child and the loved person?
The person was their parent/ sibling / grandparent/ other family member (if so, please specify the relation: TEXT)/ other relationship (if so, please specify the relation: TEXT)

Please indicate the deceased person's gender:
female/ male/ non-binary/ other

If 'other', please specify:

How old was the deceased person at the time of death?
(age in years)

Please indicate the cause of death:
natural (e.g., disease, old age)/ unnatural (e.g., accident, suicide, homicide)/ Both or none (if so, please specify: TEXT)

Does the child currently receive any professional bereavement support?

Yes/ No [If 'Yes'] Please specify:

Has the child taken any medication since the loss due to psychological distress?
No/ Yes (if so, can you specify the medication? TEXT)

Has the child experienced other bereavement previously to this one?
No/ Yes (if so, please specify the number of bereavements)

> CONDITIONAL QUESTION: Did the child receive any professional bereavement support after these previous losses?
> Yes/ No

About your child's feelings and behaviours

Overall, how distressed is your child currently due to the loss?

0 (not at all distressed) - 100 (extremely distressed)

[Strengths and Difficulties Questionnaire]

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of the child's behaviour over the last six months

Date of Birth.....

	Not True	Somewhat True	Certainly True
Considerate of other people's feelings	☐	☐	☐
Restless, overactive, cannot stay still for long	☐	☐	☐
Often complains of headaches, stomach-aches or sickness	☐	☐	☐
Shares readily with other children (treats, toys, pencils etc.)	☐	☐	☐
Often has temper tantrums or hot tempers	☐	☐	☐
Rather solitary, tends to play alone	☐	☐	☐
Generally obedient, usually does what adults request	☐	☐	☐
Many worries, often seems worried	☐	☐	☐
Helpful if someone is hurt, upset or feeling ill	☐	☐	☐
Constantly fidgeting or squirming	☐	☐	☐
Has at least one good friend	☐	☐	☐
Often fights with other children or bullies them	☐	☐	☐
Often unhappy, down-hearted or tearful	☐	☐	☐
Generally liked by other children	☐	☐	☐
Easily distracted, concentration wanders	☐	☐	☐
Nervous or clingy in new situations, easily loses confidence	☐	☐	☐
Kind to younger children	☐	☐	☐
Often lies or cheats	☐	☐	☐
Picked on or bullied by other children	☐	☐	☐
Often volunteers to help others (parents, teachers, other children)	☐	☐	☐
Thinks things out before acting	☐	☐	☐
Steals from home, school or elsewhere	☐	☐	☐
Gets on better with adults than with other children	☐	☐	☐
Many fears, easily scared	☐	☐	☐
Sees tasks through to the end, good attention span	☐	☐	☐

Do you have any other comments or concerns?

Overall, do you think that your child has difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes-minor difficulties	Yes-definite difficulties	Yes-severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress your child?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your child's everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties put a burden on you or the family as a whole?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

[Parent Proxy Peer Relationships- Short Form 7a]

Please respond to each question or statement by marking one box per row.

In the past 7 days…	Never	Almost Never	Sometimes	Often	Almost Always
My child felt accepted by other kids his/her age	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child was able to count on his/her friends	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child was good at making friends	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My child and his/her friends helped each other out	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Other kids wanted to be my child's friend	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Other kids wanted to be with my child	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Other kids wanted to talk to my child	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

[PROMIS Family relationships- Short Form 8a]

In the past 4 weeks...	Never	Rarely	Sometimes	Often	Always
My child felt he/she had a strong relationship with our family	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4
My child felt he/she was really important to our family	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4
My child felt he/she got all the help he/she needed from our family	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4
Our family and my child had fun together.	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4
People in our family made my child feel good about himself/herself	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4
My child felt our family treated him/her fairly	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4
We (parents) listened to our child	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4
Our family paid a lot of attention to my child	☐ 1	☐ 1	☐ 2	☐ 3	☐ 4

About your feelings and behaviours

[Inventory of Complicated Grief]

Please select the answer which best describes how <u>you</u> feel right now.

1. **I think about this person so much that it's hard for me to do the things I normally do...**
   never rarely sometimes often always
2. **Memories of the person who died upset me...**
   never rarely sometimes often always
3. **I feel I cannot accept the death of the person who died...**
   never rarely sometimes often always
4. **I feel myself longing for the person who died...**
   never rarely sometimes often always
5. **I feel drawn to places and things associated with the person who died...**
   never rarely sometimes often always
6. **I can't help feeling angry about his/her death...**
   never rarely sometimes often always
7. **I feel disbelief over what happened...**
   never rarely sometimes often always
8. **I feel stunned or dazed over what happened...**
   never rarely sometimes often always
9. **Ever since s/he died it is hard for me to trust people...**
   never rarely sometimes often always
10. **Ever since s/he died I feel like I have lost the ability to care about other people or I feel distant from people I care about...**
    never rarely sometimes often always

11. I have pain in the same area of my body or have some of the same symptoms as the person who died...

never rarely sometimes often always

12. I go out of my way to avoid reminders of the person who died...

never rarely sometimes often always

13. I feel that life is empty without the person who died...

never rarely sometimes often always

14. I hear the voice of the person who died speak to me...

never rarely sometimes often always

15. I see the person who died stand before me...

never rarely sometimes often always

16. I feel that it is unfair that I should live when this person died...

never rarely sometimes often always

17. I feel bitter over this person's death...

never rarely sometimes often always

18. I feel envious of others who have not lost someone close...

never rarely sometimes often always

19. I feel lonely a great deal of the time ever since s/he died...

never rarely sometimes often always

Appendix D Child and Young Person Questionnaire

[Icebreaker Items]

We would like to get to know you a little bit.

How old are you?

If you could only eat one thing for dinner for the rest of your life, what would it be?

If you could have any superpower, which would you choose and why?

Loss-related information

How often have you been at Simon Says?

Whose idea was it to go to Simon Says?
Mum or dad / someone else / my own idea

When the person died, did you expect that to happen?

Yes, the person had been ill.

No, it came out of the blue.

I cannot say.

About your feelings

[Inventory of Prolonged Grief (Children 8-12, Adolescents 13-18), items have been slightly rephrased for understanding, original items are provided in brackets]

IF children are at least 8 years old and younger than 13 years, they are completing this version (display rule depending on answer to age question):

We listed some ways people can feel after the loss of a loved one. Please let us know how often you are feeling like this.

Response scale: 1 almost never, 2= sometimes, 3= always

Since they have died, it feels like my life has been torn apart (That s/he died, feels as something that has torn everything apart.)

When I think about them I find it hard to do normal things (I find it hard to do the things I normally do because I think of him/her so much.)

I feel confused when I think about them (Thinking of him/her confuses me.)

It is not fair that they died (It feels difficult that s/he died; I think it's not fair.)

I wish I could be with them (I would like to be with him/her.) I

I like to go to places that remind me of them (I want to go to places that are related to him/her.)

I am angry about their death (I am angry about his/her death.)

I cannot believe that they have died (I cannot believe that s/he died.)

Their death has made me feel scared and upset (His/her death has scared me; I am totally upset by it.)

After their death I find it difficult to trust people (I find it difficult to trust other people since s/he has died.)

Since they died I find it difficult to love other people (I find it difficult to love other people since s/he died.)

I try to do the same things or feel like how they did (I do or feel the same things as s/he did.)

I don't want to think about their death (I don't want to think about the fact that s/he is dead.)

Since they died I do not feel interested in things (I feel no interest in things since s/he died.)

I still hear them speaking to me (I hear his/her voice speak to me.)

I sometimes see them standing in front of me (I see him/her stand in front of me.)

I do not care about things anymore (It feels as if nothing really touches me.)

That I am alive and they died is unfair and makes me feel guilty (It feels unfair that I am still alive while s/he is dead; I feel guilty about that.)

I am still angry about their death (I continue to feel angry about his/her death.)

I am jealous of people who did not lose someone. Feel jealous of others who haven't lost someone

I think that there is no point to the future without them (I think that the future has no purpose without him/her.)

I feel very lonely since they died (I feel very alone since s/he died.)

My life can only be good if they are with me (My life can only be pleasant if s/he is around.)

When they died, it felt like a part of me died (It feels as if a part of me is dead.)

Everything has changed since they died (It feels as if his/her death has changed everything)

After their death I do not feel safe (I feel less safe since s/he died.)

I have no control over things happening in my life.

Since they died, I am not doing well at school or playing with my friends (I am doing worse (in school and with friends) since s/he died.)

Since they died, I often feel angry, nervous or scared (I am more easily angry, nervous and scared since s/he died.)

After they died, I find it difficult to sleep (I sleep poorly, since s/he died.)

IF children are 13 years or older, they are completing this version (display rule depending on answer to age question):

We listed some ways people can feel after the loss of a loved one. Please let us know how often you are feeling like this.

Response scale: 1 almost never, 2= sometimes, 3= always

Since they have died, it feels like my life has been torn apart (That s/he died, feels as something that has torn everything apart.)

All I think about is them and it makes it hard for me to do things I normally would do (I think off him/her so often, that it's hard for me to do the things I usually do)

Memories of them upsets me (memories of him/her upset me)

I find it hard to accept that they are dead

I miss them (I long or him/her)

I often look for or go to places that remind me of them (I seek out and feel attracted to places and things that are associated with him/her)

I am angry about their death (I am angry about his/her death.)

I cannot believe that they have died (I can hardly believe that s/he died)

Their death has made me feel numb or overwhelmed (I feel numb or overwhelmed by his/her death; I am totally upset by it)

After their death I find it difficult to trust people (I find it difficult to trust other people since s/he has died.)

I feel distant and unable to love other people since they have died (I feel unable to love other people or feel distant from other people, since s/he died)

I try to do the same things or feel like how they did (I do or feel the same things as s/he did.)

I try to avoid thinking about the fact they have died (I do everything to avoid thinking about the fact that s/he is dead)

Life feels empty or meaningless without them (life feels empty or meaningless since s/he died)

I still hear them speaking to me (I hear his/her voice speak to me.)

I sometimes see them standing in front of me (I see him/her stand in front of me.)

I do not care about things anymore (It feels as if nothing really touches me.)

I feel guilty that I am alive and they are dead (I feel guilty about the fact that I am still alive while s/he is dead)

I feel bitter and angry because they are dead (I feel bitter and angry inside, because of his/her death)

I am jealous of people who did not lose someone.

I think that there is no point to the future without them (I think that the future has no purpose without him/her.)

I feel lonely since they died (I feel lonely since s/he died)

Life feels meaningless without them (Life feels meaningless without him/her)

It feels like a part of me died when they died (It feels as if part of me has died with his/her death)

Their death has changed everything (It feels as if his/her death has changed everything.)

After their death I do not feel safe (I feel less safe since s/he died.)

I feel like I cannot control the things happening in my life since they died (since s/he died, it feels as if I cannot control things happening in my life)

Since they have died, I find I am not doing as well in different aspects of my life (e.g., in schoolwork, with your friends) (since s/he died, my functioning in different areas is impaired (for instance my functioning in school, with friends, in my job)

I feel tense and get easily annoyed since they died (I feel tensed and easily annoyed since s/he died)

After they died, I find it difficult to sleep (I sleep poorly, since s/he died.)

Strengths and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

Your Name ..... Male/Female

Date of Birth.....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others (food, games, pens etc.)	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I am usually on my own. I generally play alone or keep to myself	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, down-hearted or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often volunteer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get on better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

Do you have any other comments or concerns?

Overall, do you think that you have difficulties in one or more of the following areas: emotions, concentration, behaviour or being able to get on with other people?

No	Yes- minor difficulties	Yes- definite difficulties	Yes- severe difficulties
☐	☐	☐	☐

If you have answered "Yes", please answer the following questions about these difficulties:

- How long have these difficulties been present?

Less than a month	1-5 months	6-12 months	Over a year
☐	☐	☐	☐

- Do the difficulties upset or distress you?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

- Do the difficulties interfere with your everyday life in the following areas?

	Not at all	Only a little	Quite a lot	A great deal
HOME LIFE	☐	☐	☐	☐
FRIENDSHIPS	☐	☐	☐	☐
CLASSROOM LEARNING	☐	☐	☐	☐
LEISURE ACTIVITIES	☐	☐	☐	☐

- Do the difficulties make it harder for those around you (family, friends, teachers, etc.)?

Not at all	Only a little	Quite a lot	A great deal
☐	☐	☐	☐

[PROMIS-child version]

Please respond to each question or statement by marking one box per row.

In the past 7 days…	Never	Almost Never	Sometimes	Often	Almost Always
I felt accepted by other kids my age.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I was able to count on my friends.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I was able to talk about everything with my friends.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I was good at making friends.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My friends and I helped each other out.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Other kids wanted to be my friend	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Other kids wanted to be with me.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Other kids wanted to talk to me.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

[PROMIS-Family relationships]

Please respond to each item by marking one box per row.

In the past 4 weeks...	Never	Rarely	Sometimes	Often	Always
I felt I had a strong relationship with my family	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I felt really important to my family.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
I got all the help I needed from my family..	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
My family and I had fun together..... .	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

[The Psychological Sense of school membership scale- short version (Goodenow, 1993)]

Select the answer for each statement that is most true for you.

To be answered on a Likert scale from 1 (not true at all) to 5 (Completely true)

I feel like a real part of my school

People at my school notice when I'm good at something

It is hard for people like me to be accepted at school

Most teachers at my school are interested in me

Sometimes I feel as it I don't belong at school

There's at least one teacher or adult in my school I can talk to if I have a problem

People at my school are friendly to me

Teachers are not interested in people like me

I feel very different from most other students at my school

I wish I were in a different school

I feel proud of belonging to my school

Other students at school like me the way I am

Appendix E Caregiver Consent

CONSENT FORM

Study title: What helps bereaved children and young people to deal with grief?

Researcher name: Dr Dennis Golm, Dr Antonia Barke, Dr Bettina Doering and Rosie Geradine (DEdPsych student)

ERGO number: **81215**

I have read and understood the information sheet (*V3, 16/06/2023)* and have had the opportunity to ask questions about the study.
I agree for my child(ren) and me to take part in this research project and agree for our data to be used for the purpose of this study.
I understand that my and my child(ren)'s participation is voluntary, and I may withdraw at any time for any reason without our participation rights being affected.
I understand that should I withdraw my child and me from the study then the information collected up to this point may still be used for the purposes of achieving the objectives of the study only.
I have explained this study to my child, and they have understood and agreed to give assent to take part in this project.
I understand that my child may be quoted directly in reports of the research but that me or my child will not be directly identified (e.g., that my name/ my child's name will not be used).

☐ Please tick (check) this box to indicate that you consent to taking part in this survey.

Appendix F Young People (16 and older) Consent

CONSENT FORM

Study title: What helps bereaved children and young people to deal with grief?

Researcher name: Dr Dennis Golm, Dr Antonia Barke, Dr Bettina Doering and Rosie Geradine (DEdPsych student)

ERGO number: **81215**

I have read and understood the information sheet *(V3, 16/06/2023)* and have had the opportunity to ask questions about the study.
I agree to take part in this research project and agree for my data to be used for the purpose of this study.
I understand my participation is voluntary, and I may withdraw them at any time for any reason without my participation rights being affected.
I understand that should I withdraw from the study then the information collected up to this point may still be used for the purposes of achieving the objectives of the study only.
I understand that I may be quoted directly in reports of the research but that me or my caregiver will not be directly identified (e.g., that my name will not be used).

☐ Please tick (check) this box to indicate that you consent to taking part in this survey.

Appendix G Caregiver Information sheet

Caregiver Information Sheet

Study Title: **What helps bereaved children and young people to deal with grief?**

Researchers: Rosie Geradine, Dr Dennis Golm, Dr Antonia Barke & Dr Bettina Doering

ERGO number: 81215

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to provide consent by checking a box.

What is the research about?

The study is conducted by an international team of researchers based at the University of Southampton and two Universities in Germany (Essen and Brandenburg).

The study is trying to find out how different types of bereavement support and experiences affect wellbeing in bereaved children and teenagers.

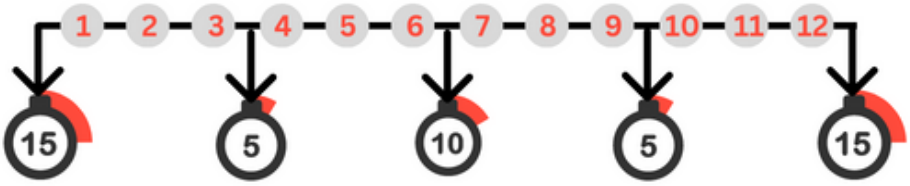
Why have I been asked to participate?

We are looking for school-aged (4-18) children and young people who recently lost a loved one and their caregivers. You have been approached as you are attending bereavement groups from Simon Says.

What will happen to me if I take part?

If you decide to take part, we will ask you to provide online consent by checking a box. We will then ask you to complete an online questionnaire about your child and your child to complete some questions about themselves.

If your child is above the age of 8,we will ask you and your child to each complete a 15-minute online questionnaire at the start and end of the study and a 10-minute questionnaire after 6 months. Additionally, we will email you a link to a shorter questionnaire for your child to complete at two additional time points. The final questionnaire will be completed one year after the first questionnaire. If your child is under the age of 8 only you will be asked to complete questionnaire. It is important that you try and complete all questionnaires, so that we can track your child's wellbeing across the whole one-year period. Please see *"What data will be collected?"* for further details.



Are there any benefits in my taking part?

There are no immediate benefits for you participating in the project. Your participation may however help us further our knowledge on the type of support bereaved children and young people require. As a reimbursement for your time, we will give you a £5 Amazon voucher and a £10 One4All voucher at the end of the study.

Are there any risks involved?

Depending on your individual circumstances you or your child might find it upsetting to think about their grief and wellbeing. You and your child can take a break at any time. If you feel you need to talk to someone, you can contact the Samaritans: Phone: 116 123, Email: jo@samaritans.org or speak to your GP.

What data will be collected?

Caregivers will be asked to answer some demographic questions (your child's age and gender and native language, your role towards the child and your personal circumstances). We will ask you some questions about the loved one (you and) your child lost (gender, date of passing, age at passing, circumstances of the death). The main set of questions are about your grief, parenting strategies, your child's feelings, mental health, friendships and Simon Says.
Children and young people will be asked about their grief, mental health, their feelings, friendships and their time at Simon Says.

Will my participation be confidential?

Your participation and the information we collect about you and your child during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Upon download, data will be saved on password protected computers and/ or secure university servers. Email addresses will be replaced with a unique identifier in the data files. A document containing email addresses and unique identifiers will be saved in a password protected file in a separate location to the data. All personal data – including emails – will be deleted at the end of the study, in line with GDPR.

Please note that safeguarding issues reported by you or your child may have to be reported to the local authority.

Do I have to take part?

No, it is entirely up to you and your child to decide whether or not to take part. If you decide you want to take part, you will need to provide online consent to show you have agreed to take part.

Your child will be asked to provide online assent. Please see the child information sheet.

What happens if I change my mind?

You have the right to change your mind and withdraw at any time without giving a reason and without your participant rights being affected. If you withdraw from the study, we will keep the information about you and your child that we have already obtained for the purposes of achieving the objectives of the study only. After the study has been completed your data will be deleted so it cannot be used in any further research and you will receive an email confirmation of the deletion. Please note that vouchers can only be given to participants who complete the study. If you wish to withdraw, just email the study team: BeravementStudy@soton.ac.uk.

What will happen to the results of the research?

Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent.

All data will be saved on password protected computers and/ or secure university servers.

Data may be published as part of scientific publications or presented at conferences workshop or public engagement events. This may include sharing of anonymised quotes from free text answers. Pseudonymised data may be deposited in the University of Southampton Institutional Repository (if you withdraw this does not apply as the data will be deleted after the study is completed). Data sharing enables other researcher to use the data or combine data across different data sets which saves resources and enables scientific progress. Please see above ('Will my participation be confidential?') for details.

Where can I get more information?

Please email BeravementStudy@soton.ac.uk for more information.

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researchers who will do their best to answer your questions (BeravementStudy@soton.ac.uk).

If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Head of Ethics & Clinical Governance (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly-funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research

study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you for reading the information sheet and for considering taking part.

Appendix H Child and Young Person Information Sheet

Version 3, 16/06/2023, ERGO number: 81215

University of Southampton

Study title: What helps bereaved children and young people to deal with grief?

Hello!

Our names are Dennis, Antonia, Bettina and Rosie.

We are doing research with children and young people (aged 4-18) about their experience of having an important person die to better understand how to support young people after the death of a loved one.

What will I have to do?

There will questions to answer on your laptop/tablet/computer. These questions are for both you and who ever looks after you. The questions will be on different things such as:

- What grief feels like for you
- Your family and friendships
- What you think about school

You can take a break at anytime, especially if you feel upset. You can finish the questions at another time or you may want to stop answering questions altogether. This is okay just tell your parent or caregiver. We will not ask for your name so no one will know the answers you give are yours.

How many times will I have to answer questions?

You will be asked questions at 4 different times over the next year.

Do I get something if I agree to answer the questions?

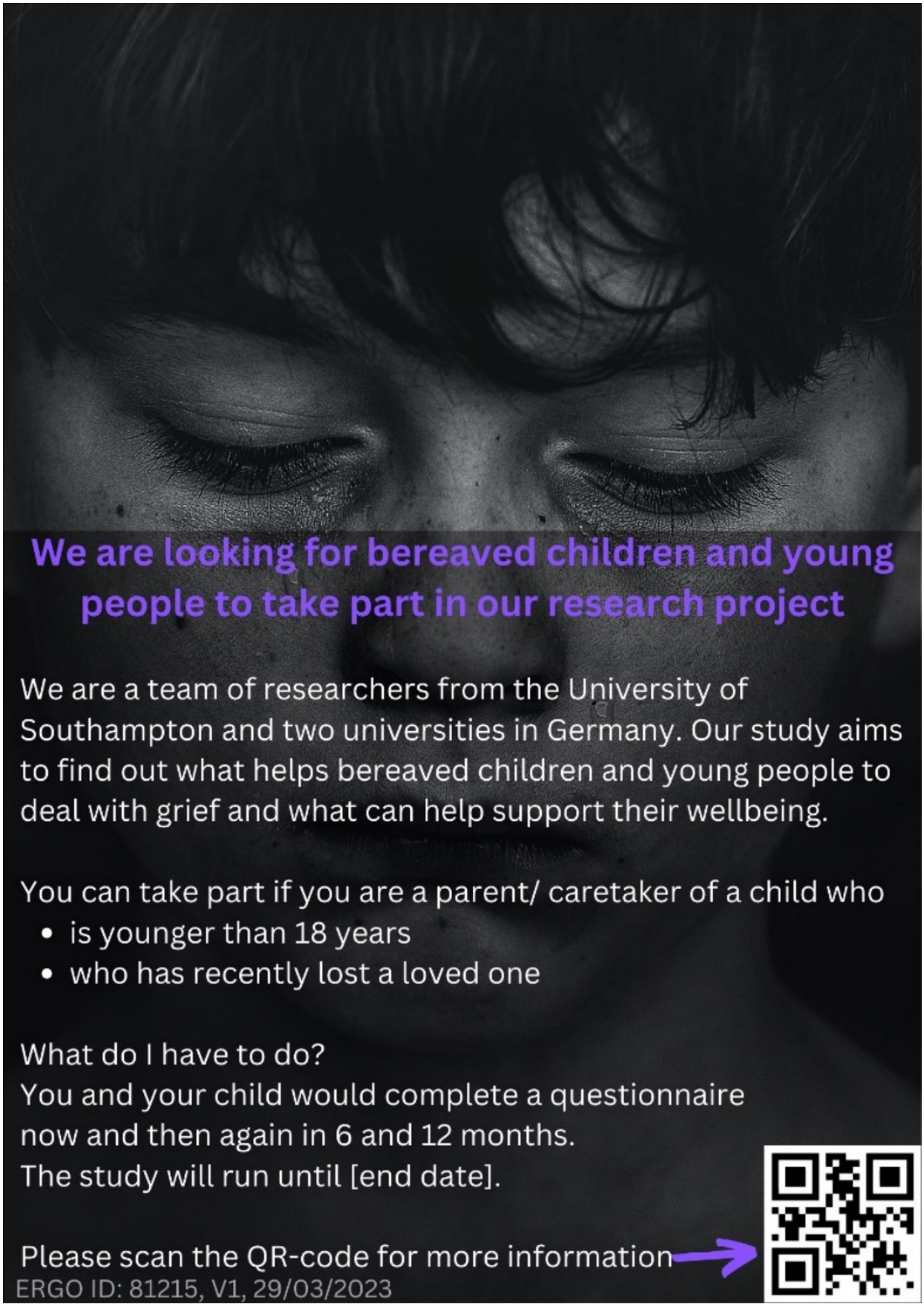
If you complete the questions at all four times we will give whoever looks after you a £5 Amazon voucher and a £10 One4All voucher (can be used in lots of shops!).

The vouchers will only be given at the end, so in a year's time.

What if I don't understand or want more information?

Your parent or caregiver can help explain more about what will happen if you want to take part.

Appendix I Questionnaire Advertisement



Appendix J Assumptions for regression

To ensure the data set met assumptions to carry out a linear regression analysis, multicollinearity was checked by assessing the tolerance and VIF values. All values for the predictor values were within acceptable ranges (VIF values were below 10 and tolerance values were above 0.1). Therefore, the assumption for collinearity was satisfied.

Next the assumption of independent errors was analysis using the Durbin-Watson value. The values for both regressions were within the acceptable range of values between 0 and 4. Therefore the data met the assumption of independent errors.

Finally, scatterplots were examined in order to identify if the data shows linearity and homoscedasticity. The scatterplot of standardised predicted values showed the data was evenly spread indicating homoscedasticity and linearity. Therefore, the assumptions of homoscedasticity and linearity were met.