SSM - Mental Health 5 (2024) 100325

Contents lists available at ScienceDirect

SSM - Mental Health

journal homepage: www.journals.elsevier.com/ssm-mental-health

Review

Culturally sensitive grief treatment and support: A scoping review

Anaïs Aeschlimann [a,*], Eva Heim [b], Clare Killikelly [a,c], Mariam Arafa [c], Andreas Maercker [a]

[a] Department of Psychology, University of Zurich, Zurich, Switzerland
[b] Institute of Psychology, University of Lausanne, Zurich, Switzerland
[c] Department of Psychiatry, University of British Columbia, Vancouver, Canada

ARTICLE INFO

Handling Editor: Prof B Kohrt

Keywords:
Grief
Mental health
Cultural adaptation
Bereavement care
Culturally sensitive

ABSTRACT

Objective: The goal of this scoping review was to assess the scope and nature of evidence concerning culturally sensitive grief treatment and support interventions, aiming to provide valuable insights for future research on grief intervention development.

Introduction: Prolonged grief disorder (PGD), associated with adverse psychosocial outcomes, requires treatment. The norms of a person's culture influence grief expression, mourning rituals, and perspectives on death. Despite increasing interest in culturally sensitive grief interventions, a comprehensive synthesis of evidence is lacking. A scoping review was deemed fitting to address this gap.

Inclusion criteria: This review included studies featuring participants experiencing clinically relevant grief and engaged in culturally sensitive psychosocial grief interventions. It included studies conducted in non-WEIRD contexts or those focusing on sociocultural (sub)groups distinct from the majority (in terms of age, religion, sexual orientation, etc).

Methods: Following JBI methodology for scoping reviews, 13 databases were searched (Scopus, Embase, Cochrane, Sociological Abstracts, IBSS, PTSDpubs, PsycINFO, PsycArticles, PSYNDEX, MEDLINE, CINAHL, SocINDEX, and Web of Science). Limits included language (English and German), peer-reviewed articles and publication date (from 2000). The two-step screening process (titles and abstracts, full text) was piloted, and data were extracted and collated.

Results: Eighteen studies were included, displaying diversity in geographical location, methodology, and target populations. Interventions targeted various forms of clinically relevant grief, lost relationships, and sociocultural groups. Cultural adaptation processes varied, with seven studies using a top-down approach. Sources of information for formative research involved theoretical models and empirical data, while local experts and qualitative research (e.g., key informant interviews) informed cultural adaptation. Outcome measures were diverse, with 15 studies showing significant pre-post intervention changes, while two did not.

Conclusions: The review highlighted the emerging significance of culturally sensitive interventions for PGD, emphasizing the need for standardized approaches and further research. By shedding light on gaps and providing recommendations, it offers insights for future researchers in this field.

1. Introduction

The loss of a loved one is recognized as one of life's most challenging experiences (Breslau et al., 1998). While the majority (80–90%) of those affected witness a gradual reduction in acute grief symptoms over time, approximately 10% endure a severe and prolonged grief reaction (Lundorff et al., 2017). Prolonged Grief Disorder (PGD), a newly established diagnostic category in the World Health Organization's International Classification of Diseases (ICD-11), identifies abnormally prolonged and intense grief reactions (World Health Organization, 2018). This diagnostic category has evolved through decades of attempts to define a condition characterized by severe, persistent, and debilitating grief—clinically relevant grief—known by various names such as complicated grief (CG; Shear et al., 2011), persistent complex bereavement disorder (PCBD; American Psychiatric Association, 2013), Traumatic Grief (Jacobs et al., 2000) and most commonly, prolonged grief disorder (PGD; e.g., Maercker et al., 2013b; $PGD_{ICD\text{-}11}$; Prigerson et al., 2009; PGD_{2009}). An additional PGD diagnosis is now included in

* Corresponding author. Department of Psychology, University of Zurich, Binzmühlestrasse 14/17, CH-8050, Zurich, Switzerland.
E-mail addresses: a.aeschlimann@psychologie.uzh.ch (A. Aeschlimann), eva.heim@unil.ch (E. Heim), c.killikelly@psychologie.uzh.ch (C. Killikelly), mariamarafa502@gmail.com (M. Arafa), maercker@psychologie.uzh.ch (A. Maercker).

https://doi.org/10.1016/j.ssmmh.2024.100325
Received 14 February 2024; Received in revised form 16 May 2024; Accepted 21 May 2024
Available online 23 May 2024

the text revision of the Diagnostic and Statistical Manual of Mental Disorders five in 2022 ($PGD_{DSM\text{-}5\text{-}TR}$; Boelen et al., 2020; Eisma et al., 2022; Prigerson et al., 2021). This review investigates different types of clinically relevant grief beyond $PGD_{ICD\text{-}11}$, recognizing the necessity for a comprehensive exploration due to the recent introduction of the ICD-11 criteria and the extensive preexisting research in this field.

According to ICD-11, PGD diagnosis necessitates a history of bereavement following the death of a loved one, with a persistent grief reaction lasting at least six months after the death. This reaction is characterized by a constant preoccupation or longing for the deceased, coupled with intense emotional pain, such as anger, sadness, or guilt. Furthermore, the disturbance must significantly impair crucial areas of functioning, such as social and occupational aspects (Maercker et al., 2013a). Importantly, the criteria pay special attention to cultural variations in grief expression, symptom duration, and functional impairment, emphasizing that a diagnosis should only be made if the grief reaction exceeds the expected intensity and chronicity within the individual's socio-cultural norms (Killikelly and Maercker, 2018).

Individuals who do not receive treatment for PGD may encounter not only the inherent negative psychosocial consequences of PGD symptoms but may also be confronted with additional severe health and psychosocial challenges. These problems include increased rates of cardiovascular issues, high blood pressure, substance abuse, harmful health behaviours, or even suicidal tendencies (Fujisawa et al., 2010; Kersting et al., 2011; Maercker et al., 2008; H. G. Prigerson et al., 2009). Therefore, providing the necessary treatment is crucial. Effective treatment for PGD requires interventions tailored specifically to PGD, as treatments for other bereavement-related mental health issues, such as depression, may not yield the same effectiveness (Shear et al., 2016). Grief interventions encompass various approaches such as support groups, self-help, counselling, and therapy, delivered by a range of (para)professionals (e.g., psychologists, pastoral staff, social workers, nurses, etc.) in diverse formats (internet, telephone, group or individual, etc.; Schut and Stroebe, 2011). Consequently, this review broadly uses the term "psychosocial grief intervention" to encompass this wide array of interventions. Acknowledging the broad conceptualization of "grief interventions," inclusive of diagnostic interventions (e.g., Killikelly and Maercker, 2023) and interventions that support culturally sensitive treatment negotiation within the domain of mental health care for grief and PGD (e.g., Smid et al., 2018), it is essential to elucidate the precise focus of this review. The examination centers specifically on therapeutic and supportive interventions. Thus, when referring to "interventions" throughout this review, the discourse explicitly addresses these treatment and support interventions.

As previously mentioned, the ICD-11 criteria incorporate a cultural caveat. This culturally sensitive approach aligns with recent findings in cultural clinical psychology, indicating that culture plays a significant role in how symptoms of mental health problems are expressed (cultural idioms of distress) and how individuals explain mental health problems, including their causes, course, and potential outcomes (explanatory models, e.g., Kirmayer and Bhugra, 2009; Shala et al., 2020). This is particularly relevant in the context of grief, which exhibits substantial variations across cultures, encompassing differences in grief expression, mourning rituals, practices, and the meanings and beliefs associated with death (Rosenblatt, 2008). As Rosenblatt aptly states, "No knowledge about grief is culture-free" (2008, p. 208). Hence, it is imperative to develop culturally sensitive interventions for prolonged grief. However, an overwhelming majority of the research on grief interventions has predominantly focused on Western countries, leaving a notable gap in research within other cultural groups (Johannsen et al., 2019a; Yu et al., 2022). This disparity is particularly striking, considering the higher prevalence of PGD in non-Western populations (Djelantik et al., 2020).

Psychological interventions in general have predominantly been developed within Western Educated Industrialized Rich and Democratic (WEIRD; Henrich et al., 2010) contexts and there is an ongoing debate about whether and to what degree these interventions may be applied to other socio-cultural contexts (Heim and Kohrt, 2019). Researchers have long emphasized the importance of tailoring health interventions to align with the worldviews and practices of diverse sociocultural groups (Resnicow et al., 1999). While research indicates that culturally adapted psychological interventions tend to be more effective (Hall et al., 2016), the current literature lacks conclusive evidence regarding the extent to which cultural adaptation enhances the acceptability, feasibility, and effectiveness of mental health interventions (Heim and Kohrt, 2019).

Cultural adaptation can be categorized into surface and deep structure, as proposed by Resnicow et al. (1999). Surface structure pertains to the modification of materials (such as language and illustrations) and the methods of delivering treatment. Deep structure adaptation considers social, cultural, environmental, and psychological factors that influence health behaviour (Resnicow et al., 1999). Consequently, this encompasses the consideration of a population's *cultural concepts of distress* (American Psychiatric Association, 2013), including idioms of distress and explanatory models (Heim and Kohrt, 2019). Proposing a conceptual framework, the Reporting Cultural Adaptation in Psychological Trial (RECAPT), Heim et al. (2021) advocate for tailoring psychological interventions at surface and deep structure level in a systematic manner. The approach to cultural adaptation can be classified into two distinct approaches: top-down and bottom-up (Heim et al., 2021). In top-down methodologies, pre-existing psychological interventions are adapted from their original cultural context to suit another cultural group (Heim et al., 2021). In the bottom-up approach, new psychological interventions are developed in an emic manner based on culturally specific symptoms or syndromes identified in the target population (Heim et al., 2021). According to Heim et al. (2021) the process of cultural adaptation is classified into four stages based on the RECAPT criteria: A) Set-up; B) Formative research; C) Intervention adaptation; D) Measuring outcomes and implementation (evaluation of intervention e.g., in a Randomized Controlled Trial, RCT). In the formative research stage, conducted both before and during the cultural adaptation of an intervention, pertinent information about the target population (such as main characteristics, symptoms, syndromes, and needs) is gathered through an iterative process (Heim et al., 2021). The authors state that multiple methods, such as literature reviews, quantitative, qualitative (e.g., focus groups, key informant interviews), or mixed methods, can be employed to provide a theoretically or empirically based rationale for cultural adaptations (before adaptation). Furthermore, especially qualitative methods may also be used to evaluate acceptability and feasibility of the adapted intervention during cultural adaptation in an iterative form (Heim et al., 2021).

However, the literature on cultural aspects in interventions employs diverse terminology, highlighting the need for definitions in the context of this review. To encompass a broad spectrum of studies and interventions, we adopt an expansive definition of the term "culturally sensitive", considering any intervention that places a specific emphasis on the targeted cultural group (Benuto and O'Donahue, 2015). This may encompass a variety of studies that address cultural aspects to different extents. It may involve studies that systematically adapt to the culture following frameworks such as RECAPT (Heim et al., 2021) or Bernal and colleagues' approach (2009), but also studies that simply employ "deliberate efforts to increase the appeal and effectiveness of interventions used with sociocultural groups" (Barrera et al., 2013, S. 197).

Moreover, it is imperative to provide a definition of the term "culture" for the purposes of this review. Given the objective of informing future research in the realm of culturally sensitive grief interventions for diverse sociocultural groups and subgroups, we adhere to a definition grounded in contributions from cultural clinical psychology, as recommended by the *Lancet Commission on Culture and Health*. In this context, culture is delineated as follows: "Culture, then, can be thought of as a set of practices and behaviours defined by customs, habits, language, and geography that groups of individuals share" (Napier et al., 2014, p. 1609). Consistent with the Lancet Commission's guidance and in line

with Markus and Hamedani (2007), we adopt a broad perspective of culture for this review, extending beyond a purely ethnic standpoint to encompass what is defined as a sociocultural group. Consequently, the term "culturally sensitive intervention" includes interventions directed at groups defined by factors such as religion, sexual orientation, age, language, and more.

To summarize, when employing the term "sociocultural groups" in this review, we are referring to populations outside WEIRD countries, as defined by Henrich et al. (2010), or migrant populations within WEIRD countries.[1] Furthermore, our definition encompasses subgroups that deviate from the majority groups targeted by psychological interventions, considering differences in religion, sexual orientation, age, language, and other sociocultural aspects.

Despite the increasing interest in culturally sensitive interventions for grief and the presence of various studies employing diverse methodologies on the subject, the existing literature lacks a comprehensive synthesis of evidence concerning such interventions. A preliminary search across databases such as MEDLINE, CINAHL, PROSPERO, the Cochrane Database of Systematic Reviews, JBI Evidence Synthesis, PsycINFO, SocINDEX, and Web of Science revealed no ongoing or completed systematic reviews or scoping reviews on this topic. Given this gap, a scoping review was deemed the most suitable approach to address this crucial need.

Hence, the overarching objective of this scoping review was to explore the extent, range, and nature of evidence regarding culturally sensitive psychosocial interventions for clinically relevant grief states, with a focus on grief symptoms when available. A particular aim is to provide insights from previous research to inform future studies on the development of culturally sensitive grief interventions.

1.1. Review question

What culturally sensitive psychosocial interventions are available for individuals affected by clinically relevant grief states?

- What is the content of culturally sensitive grief interventions? (e.g., including traditional breathing meditation practices in an intervention for Cambodian refugees)
- What is the general cultural adaptation process in culturally sensitive grief interventions? (e.g., key informant interviews, focus groups, pretesting)
- What are the reported outcomes in grief symptoms for bereaved individuals in studies addressing culturally sensitive grief interventions?

2. Methods

This scoping review was conducted in accordance with the JBI methodology for scoping reviews (Peters et al., 2020) and followed the Preferred Reporting Items for Systematic Reviews and Meta-Analysis extension for Scoping Reviews (PRISMA-ScR) checklist (Tricco et al., 2018). An a priori protocol was developed which is accessible through Open Science Framework (Aeschlimann et al., 2022).

2.1. Deviations from the protocol

There are some deviations from the a priori protocol. The review question was broadened to include studies on different forms of clinically relevant grief beyond $PGD_{ICD\text{-}11}$. This decision acknowledges that the ICD-11 criteria are recent, and much research in this area predates their introduction, necessitating a more comprehensive exploration of clinically relevant grief experiences. Consequently, the inclusion criteria pertaining to the participants were slightly expanded to include various further forms of clinically relevant grief. Moreover, a few minor adjustments were implemented to refine the inclusion criteria during the full text screening process, enhancing their precision and clarity. Firstly, the criteria related to the concept (see chapter 2.2.2 Concept) were refined to require explicit acknowledgment in the paper that some form of tailoring had been implemented for the targeted sociocultural group, rather than solely demonstrating a specific emphasis on that group. Moreover, we introduced an additional sentence to the criteria to provide a clear definition of what was encompassed by the term "established grief questionnaires". Furthermore, we made slight adjustments to the criteria concerning the types of sources, excluding practice guidelines and reviews. These adjustments were implemented to ensure a focus on interventions evaluated in an empirical setting and allowed for reporting from articles presenting primary data. Finally, owing to resource constraints, merely 20% instead of 100% of the full texts were screened in parallel by two reviewers.

2.2. Eligibility criteria

2.2.1. Participants

This review considered studies that focused on participants experiencing clinically relevant grief states (e.g., $PGD_{ICD\text{-}11}$, PCBD, CG, Traumatic Grief, etc.) following the death of a loved one. We excluded studies addressing grief related to various other types of loss, such as material loss, ambiguous loss, moral injury, anticipatory loss, loss of a pet, loss of a relationship, and coping with terminal illness. Additionally, we made the decision to omit studies involving perinatal loss due to inconclusive research on whether grief trajectories for perinatal losses align with those of other types of losses. For instance, existing studies suggest that perinatal loss entails diverse consequences, such as feelings of betrayal of one's body (Grauerholz et al., 2021; Lundorff et al., 2017). The review also excluded studies involving participants without a close personal relationship with the deceased person (e.g., formal caregivers, palliative care).

2.2.2. Concept

This review included culturally sensitive psychosocial interventions designed to alleviate grief symptoms in individuals dealing with bereavement. The term psychosocial intervention was expansively defined to encompass diverse approaches from various disciplines (e.g., ritual interventions, support groups, scrapbook interventions, spiritual interventions, school-based interventions). The key criterion for inclusion was that the intervention specifically targeted the reduction of grief symptoms, excluding those focusing on physical care or structural support (e.g., housing for orphaned children). Studies which evaluated interventions with multiple components, with an emphasis on grief as one of these components, were included if the grief symptom outcome was separately addressed in the results. Exclusion criteria applied to studies that did not explicitly consider grief symptoms separately in their results, as well as those with a broader focus on help-seeking or supportive factors. The term "culturally sensitive" was broadly applied to any intervention that explicitly states that the evaluated intervention was somewhat tailored to the specific target group. We excluded studies in which interventions, initially designed for a specific group, were applied to a different sociocultural group without any modifications.

Regarding quantitative studies, the review excluded those that did not utilize an established grief questionnaire. Therefore, studies using grief questionnaires exclusively created for the study at hand and not employed in any other context were excluded, unless they represented a cultural adaptation of an established questionnaire. This exclusion criterion was specific to quantitative studies and did not apply to other types of sources, such as qualitative studies.

[1] While recognizing that WEIRD contexts also constitute sociocultural groups, we intentionally exclude them from our definition in this review. Our emphasis is placed on populations that have historically received limited attention in psychological research.

2.2.3. Context

This review considered studies carried out among sociocultural groups belonging to a non-WEIRD context, including groups residing in WEIRD contexts with a migrant background. The criteria for WEIRD countries suggested by Henrich et al. (2010) were applied, including countries in the northwest of Europe (United Kingdom, Germany, Switzerland, France, the Netherlands, etc.) and British-descent societies (United States, Canada, Australia, and New Zealand). The review also considered studies involving sociocultural subgroups differing from the majority group targeted by psychological interventions, such as those based on religion, sexual orientation, age (below 18 or above 60), language, or other factors. Studies incorporating multiple cultural groups were eligible for inclusion, provided they presented separate results for each group. Conversely, studies failing to make this distinction were excluded.

2.2.4. Types of sources

This scoping review examined both quantitative and qualitative studies, along with mixed-method studies, for potential inclusion. Additionally, the review assessed the suitability of study protocols for inclusion. Only peer-reviewed articles were considered for inclusion. In the realm of quantitative studies, this encompassed various designs, such as experimental and quasi-experimental study designs.

Regarding qualitative evidence, the review included studies employing designs such as phenomenology, grounded theory, ethnography, qualitative description, action research, and feminist research. Additionally, systematic and scoping reviews meeting the inclusion criteria were taken into account in a first step to search for relevant studies in their references before being excluded at full-text stage.

On the other hand, books and book chapters, frameworks, practice guidelines, animal studies, individual case reports, book reviews, conference abstracts, commentaries, as well as text and opinion papers were excluded.

2.3. Search strategy

A three-step search strategy was conducted as recommended in the JBI methodology for scoping reviews (Peters et al., 2020). First, an initial limited search of MEDLINE (Ebsco) and PsycINFO (Ebsco) was undertaken using preliminary keywords for population, concept, and context to identify relevant articles on the topic. This was followed by an analysis of the text words contained in the title and abstract and with the support of a trained research librarian, the search strategy was subsequently refined. In a second step, the full search strategy was then applied across all included databases, with adaptations made to individual databases where necessary. In a third step, the reference lists of all included sources of evidence were screened for additional relevant articles that met inclusion criteria. Where relevant, study authors were contacted for further information (e.g., access to full text). This review included only studies published in English and German, due to limited resources. To ensure a current perspective, we considered studies published from January 1, 2000, for inclusion. Additionally, we included only articles that had undergone peer review.

The following databases were included in the search: Scopus (Elsevier), Embase (Elsevier), Cochrane, Sociological Abstracts (ProQuest), IBSS (ProQuest), PTSDpubs (ProQuest), PsycINFO (Ebsco), PsycArticles (Ebsco), PSYNDEX (Ebsco), MEDLINE (Ebsco), CINAHL (Ebsco), SocINDEX (Ebsco) and Web of Science (Clarivate). A first full search across all included databases was undertaken on December 22, 2021. The search was re-run after the completion of title and abstract screening on December 14, 2022, searching specifically for articles published since December 1, 2021, to ensure the identification of relevant articles published during the interim period. The final search strategies for the included databases may be found in Appendix A.

2.4. Study selection

After conducting the search, all identified records were uploaded to CADIMA V2.2.3 (Julius Kühn-Institut, 2017) and any duplicates were automatically removed. Before screening all titles and abstracts, a consistency check was conducted using a subset of 200 titles. This step aimed to assess the agreement between two independent reviewers regarding which entries should be included or excluded based on our pre-defined criteria. The kappa statistic was utilized to measure the level of agreement between the reviewers, with a target value set at kappa >0.6, indicating substantial agreement. Once this target level of inter-screener reliability was achieved, indicating consistent application of the inclusion and exclusion criteria, all titles and abstracts were subsequently screened by two independent reviewers (AA and one of the following: MB, NH, SP, CR, NS). This ensured continued reliability and consistency throughout the screening process.

In a next step, full texts of papers included at the stage of title/abstract screening were retrieved and uploaded into CADIMA. Efforts were made to obtain missing full texts by contacting the authors of the papers. Preceding full text screening, a further consistency check was performed, using 100 titles. Following this, the criteria were slightly adjusted. All full texts were then screened by the first author (AA) with 20% screened independently in parallel by a second reviewer (MA). Any sources of evidence that failed to meet the inclusion criteria at the full text stage were carefully examined, and the reasons for their exclusion were recorded and are listed in Fig. 1. At all screening stages, any discrepancies between reviewers were resolved through discussion until a consensus was achieved. If consensus proved elusive, an additional reviewer was consulted to assist in the decision-making process (EH or CK). A risk of bias assessment was not performed, as this is not required for scoping reviews (Peters et al., 2020).

2.5. Data extraction

A data extraction tool (see Appendix B) was developed based on the JBI data extraction form for scoping reviews (Peters et al., 2020). Initially, this established data extraction tool underwent a pilot phase where two team members (AA & MA) extracted the data for three studies. Subsequently, the tool was refined through an iterative process involving discussions. Adjustments to the data extraction tool were made as required during data extraction from each of the evidence sources included.

Thereafter, the data extraction tool was applied in parallel to all included studies by two independent reviewers (AA & MA), using Microsoft Excel V16.77.1. The extracted data encompassed specific details concerning: Author and year, study country, target sociocultural group, target problem, intervention format, therapeutic/theoretical basis, content of the intervention, cultural adaptation process, methodology, sample size, and outcome measures for grief.

For five of the included studies (Layne et al., 2008; Sandler et al., 2010; Spuij et al., 2015; Tay et al., 2020; Xiu et al., 2019), additional papers (Ayers et al., 2014; Chow et al., 2019; Layne et al., 2001a; Spuij et al., 2013; Tay et al., 2019) reporting findings from the same studies were used as supplementary information in the review process.

Furthermore, during full text screening, four articles (Layne et al., 2001a [1]; O'Donnell et al., 2014[2]; Saltzman et al., 2001 [1]; Tay et al., 2021[3]) were found to be reporting findings regarding the same intervention as other studies (Cohen et al., 2004[2]; Layne et al., 2008 [1]; Tay et al., 2020[3]). Studies reporting the same intervention are denotated with the same number in superscript. To avoid redundancy, the decision was made to include one study per intervention (the latter three) in the data extraction table, while excluding the others. If an intervention underwent adaptation for a different target group, we treated it as an independent intervention. Studies lacking cultural adaptation to the new context were considered duplicates and excluded. The excluded studies regarding the same interventions were used as supplementary

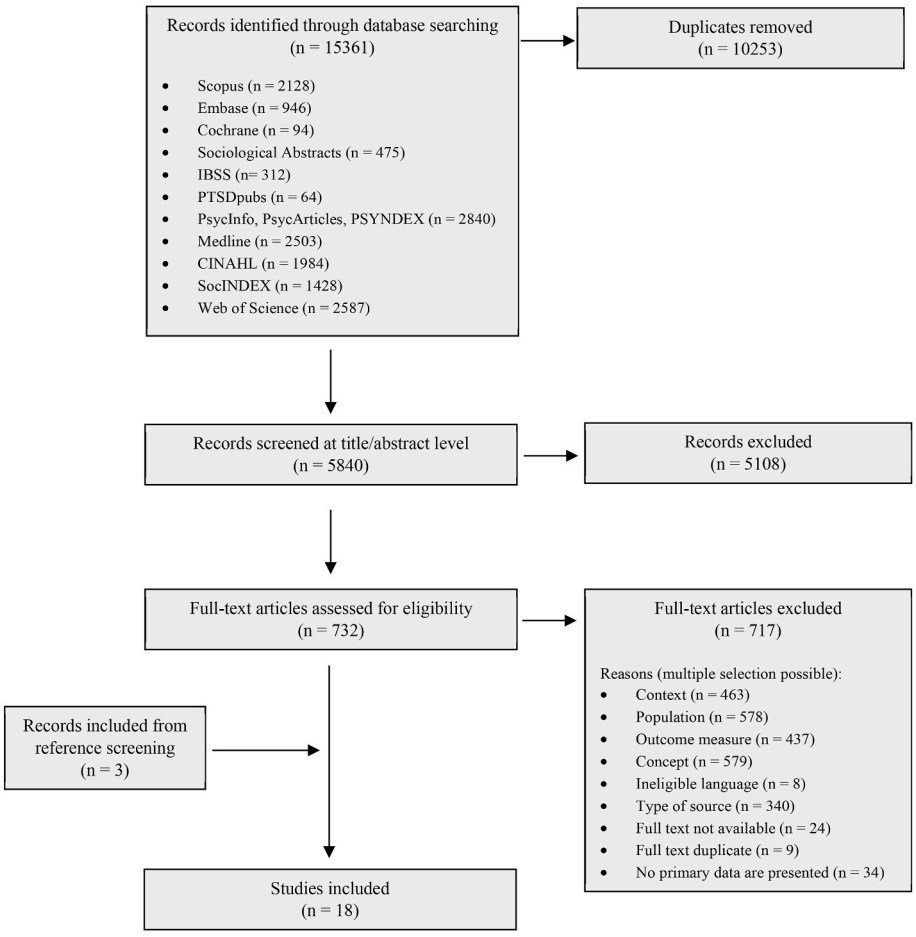

Fig. 1. PRISMA flow chart of study inclusion process.

information in the review process and any additional information (e.g., in what other contexts the intervention was applied) was reported together with the findings of studies evaluating this intervention.

Any discrepancies or conflicts that arose among the reviewers during this process were resolved through discussions until a consensus was reached. No attempts were made to contact authors to request additional data at this stage.

2.6. Data analysis and presentation

As recommended by the scoping review guidelines (Peters et al., 2020), results of the data extraction are provided through a narrative summary and in tabular form, in accordance with the review's objectives and research questions. Accordingly, the results of the scoping review are categorized and reported in five subcategories: Study characteristics, intervention characteristics, intervention content (including therapeutic/theoretical basis), cultural adaptation, outcomes.

Table 1
Study characteristics.

Author, year	Study country	Methodology	N
Barron and Abdallah (2017)	Palestine	Mixed methods quasi-experimental design; pre-post-test design	158
Bass et al. (2016)	Kurdistan, Northern Iraq	Quantitative, RCT, pre-post-test design	209
Brave Heart et al. (2019)	USA	Quantitative; pilot RCT; pre-post-test design	52
Cohen et al. (2004)	USA	Quantitative; pilot study, pre-post-test design	22
Hill et al. (2019)	USA	Quantitative, pilot open trial, pre-post-test design	65
Kalantari et al. (2012)	Iran	Quantitative; pre-post-test	61
Koda et al. (2022)	Japan	Mixed-methods, pilot, pre-post-test design	5
Layne et al. (2008)	Bosnia	Quantitative, RCT, pre-post-test design	127
Mehdipour et al. (2020)	Iran	Quantitative; quasi-experimental; pre-post-test analysis	28
Sandler et al. (2010)	USA	Quantitative, secondary analysis of data from a randomized experimental trial, longitudinal	244
Sharpe et al. (2018)	USA	Quantitative; exploratory pilot study; pre-post-test	14
Spuij et al. (2015)	Netherlands	Quantitative; pre-post-test analysis	10
Tay et al. (2020)	Malaysia	Quantitative, RCT, Pre-post-test design	170
Thamuku and Daniel (2013)	Botswana	Qualitative; intrinsic case study approach	10
Thurman et al. (2017)	South Africa	Quantitative; RCT; pre-post-test	210
Xiu et al. (2019)	Hong Kong	Quantitative, secondary analysis of RCT data, pre-post-test design	96
Xiu et al. (2020)	China	Mixed-methods, pilot RCT, Pre-post-test design	28
Yu et al. (2022)	China	Quantitative, pre-post-test design	25

3. Results

3.1. Study inclusion

The database search yielded a total of 15361 citations, of which 5840 remained after the removal of 10253 duplicates. After screening the remaining studies at title and abstract stage, 5108 studies were excluded and 732 were included for full text screening. At the stage of full text screening, 717 studies were excluded, and 15 studies included. The reasons for exclusion at full text stage were recorded and are listed in Fig. 1. Three additional papers were identified by hand-searching reference lists, thus resulting in a total of 18 included studies in the final scoping review (Fig. 1).

3.2. Characteristics of included studies/reports

The main characteristics of the included studies are presented in Table 1. The included studies were published between 2004 and 2022. Of the 18 included studies, five were conducted in Central and East Asia, five in the USA, four in the Middle East, two in Europe, and two in Africa.

There were 14 studies, which used a purely quantitative approach, three studies used a mixed-methods approach (Barron and Abdallah, 2017; Koda et al., 2022; Xiu et al., 2020) and one study was purely qualitative (Thamuku and Daniel, 2013). Of the 18 studies, 16 studies used a pre-post-test design, six studies were pilot trials (Brave Heart et al., 2019; Cohen et al., 2004; Hill et al., 2019; Koda et al., 2022; Sharpe et al., 2018; Xiu et al., 2020), and two studies performed a secondary analysis of RCT data (Sandler et al., 2010; Xiu et al., 2019).

Table 2
Intervention characteristics.

Author, year	Target cultural (sub)group	Target problem	Intervention format
Barron and Abdallah (2017)	Palestinian children and adolescents (10–18)	CG due to traumatic loss	"Children and Grief: Teaching Life Skills" (C&G) program (developed by the Children and War Foundation; 7 sessions (1xhalf day; 6 × 2h); led by 2 Palestinian school counsellors in groups of 10
Bass et al. (2016)	Adult Iraqi Kurds	Traumatic grief and depressive symptoms due to torture	Trauma-informed support, skills, and psychoeducation intervention provided by community mental health workers (CMHWs); 6–12 individual sessions
Brave Heart et al. (2019)	American indigenous adults	Depression, PTSD and unresolved grief due to Historical Trauma	Iwankapiya (Healing); 12 weekly 2-h group-sessions (5–8 participants); led by senior clinician and trainee/less experienced clinician (often community providers/tribal college students)
Cohen et al. (2004)	Children and adolescents (6–17)	Childhood traumatic grief due to loss of a relative to traumatic event	Parallel individual child and parent trauma- focused cognitive-behavioural therapy for CTG (CBT- CTG), 16 60 min-session (weekly), delivered by social worker
Hill et al. (2019)	Children and adolescents (6–17)	PCBD, depression, and PTSD due to loss of a loved one	Multidimensional Grief-Therapy; assessment-driven, phasic individual therapy; individually, once per week; MGT exercises also incorporate dyadic caregiver-child sessions designed to enhance communication and parental grief facilitation[a]
Kalantari et al. (2012)	Afghani children and adolescent (ages 12–18) refugees	Traumatic grief and war-bereaved due to loss of one or both parents	Writing for Recovery (bereavement version); group-session; six sessions of group training on 3 consecutive days in their school; Each day consists of two 15-min sessions[a]
Koda et al. (2022)	Japanese adults	CG due to loss of family member from cancer	Culturally adapted Meaning-Centred Psychotherapy (MCP); 5–60′-session monthly format; led by psychiatrist[a]
Layne et al. (2008)	War-exposed Muslim Bosnian adolescents (age 13–18)	PTSD, depression, or traumatic grief due to war-exposure	TGCT: classroom-based psychoeducation and skills intervention and 17-session (60–90min) manual-based group therapy intervention consisting of trauma and grief component therapy for adolescents; led by school counsellors over school year at 10 different schools.
Mehdipour et al. (2020)	Iranian mothers	CG due to loss of a child	Spiritual-religious intervention; eleven weekly 2-h sessions in groups[a]
Sandler et al. (2010)	Children and adolescents (ages 8–16)	Clinically significant grief due to parental loss	Family Bereavement Program (FBP): 12 2-h group sessions and two individual sessions; with individual sessions for caregivers, children and adolescents; each group was led by two counsellors with a master's degree or Ph.D. in a helping profession
Sharpe et al. (2018)	African American adults	CG due to loss of relative to homicide	Homicide Transformation Project (HTP); 10 weekly group sessions; facilitated by African American social worker
Spuij et al. (2015)	Children and Adolescents (8–18)	PGD_{2009} due to loss of close relative	Grief-Help; 9 weekly or biweekly 45 min-sessions individual treatment from a therapist combined with 5 45 min-sessions of parental counselling
Tay et al. (2020)	Rohingya, Chin, and Kachin refugees	Promotes adaptive capacity to psychosocial disruptions, including PCBD	Integrative Adapt Therapy (IAT); six weekly 45-min sessions; given by lay counsellors (eight from the Chin and Kachin and 12 from the Rohingya communities, ensuring a gender balance for each group)[a]
Thamuku and Daniel (2013)	Motswana adolescents (13-15	CG symptoms due to loss of both parents to HIV/AIDS	EARTH therapy (Empathy-based Action-oriented Relationship-building Transformative Healing therapy): combination of group & individual therapy; wilderness-based therapeutic retreat lasting 16 days for 40 children at a time from the same village, and a follow-up support program for 3 years; social workers[a]
Thurman et al. (2017)	South African (Sesotho-speaking) female adolescents (age 13–17)	CG due to loss of a loved one	Abangane; 8 sessions; weekly 90′ bereavement support group; led by social workers or social auxiliary workers
Xiu et al. (2019)	Chinese older adults (min. age 65)	$PGD_{ICD\text{-}11}$ due to loss of spouse	DPGBI; 8 2 h-group-sessions; led by experienced bereavement counsellors
Xiu et al. (2020)	Chinese parents over 49 years old.	$PGD_{ICD\text{-}11}$ due to loss of only child	Chinese brush painting group; 20 weekly 2-h sessions over a 6-month period; led by professional teacher of Chinese brush painting with over 30 years' art teaching experience who had no psychological or medical training
Yu et al. (2022)	Chinese adults	$PGD_{ICD\text{-}11}$ due to loss of a family member due to COVID-19	"Be Together Program" (BTP), internet and social media as main tools (WeChat), combined with group and individual (ca. 15 h 1-to-1 support) intervention. BTP participants to choose according to their needs, implemented by social workers teaming with mental health specialists who provided online lectures, advice, and supervision for BTP's design and process

[a] Hill et al. (2019) no information given on session duration; Kalantari et al. (2012) unclear who led the intervention; Koda et al. (2022) unclear whether intervention was delivered in group or individual format; Mehdipour et al. (2020) unclear who led the intervention; Tay et al. (2020) unclear whether intervention delivered in group or individual format; Thamuku and Daniel (2013) unclear on how long and how often sessions were.

The population size in the studies ranged from five to 244 participants included in the analysis, and the total sample size included in analysis of all studies is 1534 participants.

3.3. Review findings

We have charted and summarized the existing evidence on culturally sensitive psychosocial interventions for individuals affected by clinically relevant grief states. This includes intervention characteristics (target population, type of clinically relevant grief targeted, type of lost relationship targeted, type of loss targeted, theoretical/therapeutic basis, type of facilitator, delivery format, duration), intervention content, cultural adaptation process (methodology, extent, adapted elements), and outcomes (grief measures, reported outcomes).

3.3.1. Intervention characteristics

Intervention characteristics can be found in Table 2. Interventions in the included studies targeted a variety of sociocultural groups and subgroups (including age), such as Rohingya, Chin, and Khan refugees both in Malaysia (Tay et al., 2020) and in Bangladesh (Tay et al., 2021), Chinese parents above 49 (Xiu et al., 2020), Chinese older adults above 65 (Xiu et al., 2019), Chinese adults (Yu et al., 2022), Japanese adults (Koda et al., 2022), American Indigenous adults (Brave Heart et al., 2019), African American adults (Sharpe et al., 2018), war-exposed Muslim Bosnian adolescents (Layne et al., 2001a; Layne et al., 2008) and violence-exposed adolescents in a WEIRD context (Saltzman et al., 2001), adult Iraqi Kurds (Bass et al., 2016), Afghani children and adolescent refugees (Kalantari et al., 2012), Iranian mothers (Mehdipour et al., 2020), Palestinian children and adolescents (Barron and Abdallah, 2017), South African (Sesotho-speaking) female adolescents (Thurman et al., 2017), Tanzanian children and their guardians (O'Donnell et al., 2014) and children and adolescents from a WEIRD background (Cohen et al., 2004), Motswana adolescents (Thamuku and Daniel, 2013), and more generally, children and adolescents from a WEIRD background (Hill et al., 2019; Sandler et al., 2010; Spuij et al., 2015).

Interventions in the included studies targeted different clinically significant forms of grief, such as PCBD (Hill et al., 2019; Tay et al., 2020), $PGD_{ICD\text{-}11}$ (Xiu et al., 2019, 2020; Yu et al., 2022), PGD_{2009} (Spuij et al., 2015), CG (Barron and Abdallah, 2017; Koda et al., 2022; Mehdipour et al., 2020; Sharpe et al., 2018; Thamuku and Daniel, 2013; Thurman et al., 2017), traumatic grief (Bass et al., 2016; Cohen et al., 2004; Kalantari et al., 2012; Layne et al., 2008), unresolved grief (due to Historical Trauma; Brave Heart et al., 2019), and clinically significant grief without further specification (Sandler et al., 2010).

The types of relationship loss targeted in the included studies were children and adolescents with parental loss (Kalantari et al., 2012; Sandler et al., 2010; Thamuku and Daniel, 2013), children and adolescents with the loss of a relative (Cohen et al., 2004; Spuij et al., 2015), adults with the loss of their child (Mehdipour et al., 2020; Xiu et al., 2020), adults with the loss of a relative (Koda et al., 2022; Sharpe et al., 2018; Yu et al., 2022), and adults with the loss of a spouse (Xiu et al., 2019). The remaining studies either did not specify the lost relationship or simply referred to "a lost loved one" (Barron and Abdallah, 2017; Bass et al., 2016; Brave Heart et al., 2019; Hill et al., 2019; Layne et al., 2008; Tay et al., 2020; Thurman et al., 2017).

The specific types of losses targeted in the included studies were traumatic/violent loss (Barron and Abdallah, 2017; Bass et al., 2016; Cohen et al., 2004; Kalantari et al., 2012; Layne et al., 2008; Sharpe et al., 2018) and loss due to a disease (Koda et al., 2022; Thamuku and Daniel, 2013; Yu et al., 2022). The remaining studies did not specify the type of loss targeted (Brave Heart et al., 2019; Hill et al., 2019; Mehdipour et al., 2020; Sandler et al., 2010; Spuij et al., 2015; Tay et al., 2020; Thurman et al., 2017; Xiu et al., 2019, 2020).

Studies used different professionals to lead their interventions. Social workers were employed in five studies to facilitate the interventions (Cohen et al., 2004; Sharpe et al., 2018; Thamuku and Daniel, 2013; Thurman et al., 2017; Yu et al., 2022), four studies used counsellors or school counsellors (Barron and Abdallah, 2017; Layne et al., 2008; Sandler et al., 2010; Xiu et al., 2019), one study used lay counsellors from the respective target community (Tay et al., 2020), one study used community mental health workers (Bass et al., 2016), three studies used clinical therapists (Brave Heart et al., 2019; Hill et al., 2019; Spuij et al., 2015), one study used a psychiatrist (Koda et al., 2022), one study's intervention was led by a calligrapher with no medical or mental health background from the respective target community (Xiu et al., 2020), and two studies did not specify who led their interventions (Kalantari et al., 2012; Mehdipour et al., 2020).

Furthermore, researchers used a variety of group/individual approaches for their interventions. There were three studies, which used a combination of group and individual interventions (Sandler et al., 2010; Thamuku and Daniel, 2013; Yu et al., 2022), nine studies used only a group intervention (Barron and Abdallah, 2017; Brave Heart et al., 2019; Kalantari et al., 2012; Layne et al., 2008; Mehdipour et al., 2020; Sharpe et al., 2018; Thurman et al., 2017; Xiu et al., 2019, 2020), one study used only an individual intervention (Bass et al., 2016), three studies used a combination of individual and participant with parent interventions (Cohen et al., 2004; Hill et al., 2019; Spuij et al., 2015), and two studies did not specify whether they used a group or individual intervention (Koda et al., 2022; Tay et al., 2020). Furthermore, only one intervention included internet-based components by providing parts of their intervention via social media and the internet (Yu et al., 2022).

Interventions also varied in their session duration, frequency, and intervention duration. Six of 18 studies had 2 h sessions (Barron and Abdallah, 2017; Brave Heart et al., 2019; Mehdipour et al., 2020; Sandler et al., 2010; Xiu et al., 2019, 2020), four studies had 60–90 min sessions (Cohen et al., 2004; Koda et al., 2022; Layne et al., 2008; Thurman et al., 2017), three studies had 15–45 min sessions (Kalantari et al., 2012; Spuij et al., 2015; Tay et al., 2020), and five studies did not specify their session duration (Bass et al., 2016; Hill et al., 2019; Sharpe et al., 2018; Thamuku and Daniel, 2013; Yu et al., 2022). 10 studies held weekly sessions over 6–20 weeks (Brave Heart et al., 2019; Cohen et al., 2004; Hill et al., 2019; Mehdipour et al., 2020; Sandler et al., 2010; Sharpe et al., 2018; Spuij et al., 2015; Tay et al., 2020; Thurman et al., 2017; Xiu et al., 2020), two studies held daily sessions over 3–16 days (Kalantari et al., 2012; Thamuku and Daniel, 2013), Koda et al. (2022) held monthly sessions, and five studies did not specify the frequency of sessions and intervention duration (Barron and Abdallah, 2017; Bass et al., 2016; Layne et al., 2008; Xiu et al., 2019; Yu et al., 2022).

3.3.2. Content of the interventions

A summary of the content for each individual intervention is provided in Table 3. Interventions were based on a variety of theoretical and therapeutic approaches. A diversity of Cognitive-Behavioural Therapy (CBT)-derived interventions were used by seven studies (Barron and Abdallah, 2017; Cohen et al., 2004; Kalantari et al., 2012; Koda et al., 2022; Spuij et al., 2015; Tay et al., 2020; Thurman et al., 2017), while the following approaches were used by one study each (Barron and Abdallah, 2017; Brave Heart et al., 2019; Kalantari et al., 2012; Koda et al., 2022; Mehdipour et al., 2020): Interpersonal Therapy (IPT; Weissman et al., 2018), meaning-centred psychotherapy (Lichtenthal et al., 2019), Islamic spiritual therapy (Dashtbozorgi et al., 2016), Teaching Recovery Techniques (TRT; Barron et al., 2013), and the expressive writing paradigm (Pennebaker, 1997).

Specific grief models were the basis for four interventions: The Dual Process Model (Schut and Stroebe, 1999) formed the basis of two interventions (Xiu et al., 2019; Yu et al., 2022), one intervention (Hill et al., 2019) was based on the Multidimensional Grief Theory (Kaplow et al., 2013; Layne et al., 2017), and the contextual resilience model (Sandler et al., 2007, 2008) was the base for one intervention (Ayers et al., 2014; Sandler et al., 2010). In three studies, a form of trauma model was used as theoretical underpinning for the intervention: In one intervention (Tay et al., 2020) the psychosocial Adaptation and

Table 3
Content of the interventions.

Author, year	Therapeutic/Theoretical Basis	Content of intervention
Barron and Abdallah (2017)	Based on an existing group-based CBT program with an empirical evidence base in Palestine and other war contexts (Barron et al., 2013; TRT).	Normalize trauma response, toolbox of strategies, safe place (visual imagery), feelings thermometer, memory folder, dual attention techniques, relaxation, mindfulness, grief regulation, understanding emotions, coping strategies, positive self-statements, managing sleep, live with loss, meaning making, continuing bonds, anticipating the future
Bass et al. (2016)	Social work model of helping and support; provision of psychosocial support; Multisystem or person-in- environment approach; Strengths-based orientation	Psychoeducation (reduce stigma, explain psychological problems, explain how therapy can help), treatment planning, empowerment (develop positive attitudes and skills, reduce helplessness, focus on better parts of life), motivation, crisis and medication management, strength building (skills), stress reduction, advocacy
Brave Heart et al. (2019)	Combined Group Interpersonal Psychotherapy (IPT) and Historical Trauma and Unresolved Grief Intervention (HTUG)	Psychoeducation on collective trauma, historical unresolved grief, recent trauma and grief exposure, relationships conflicts, reducing stigma and isolation, releasing pain though group processing, traditional healing practices, including traditional songs, smudging, talking circles, "wiping of tears" exercise based upon a traditional grief ritual
Cohen et al. (2004)	Based on conceptualization of CTG, elements from CBT	Psychoeducation, emotion identification and regulation, relaxation skills, cognitive triad, coping skills, trauma narrative, joint parent–child sessions, recognizing and naming losses, positive memories of deceased/memorializing, recommitting to relationships, meaning-making, preparing for future reminders
Hill et al. (2019)	Multidimensional grief theory (Kaplow et al., 2013; Layne et al., 2017).	Psychoeducation, emotion identification, coping strategies (relaxation, cognitive), loss and trauma reminders, cognitive-behavioural triangle, positive reminiscing, loss narrative (e.g., identifying what is missed most, changes in life, making meaning, carrying on legacy, continuing bond), joint parent/guardian sessions
Kalantari et al. (2012)	Expressive writing paradigm (Pennebaker, 1997) and CBT	3 writing tasks: Unstructured writing on feelings and thoughts about traumatic event/loss, structured writing advising someone in the same situation, envisioning themselves in 10 years and reflecting on the lessons learned from this experience
Koda et al. (2022)	Meaning-centred psychotherapy (includes CBT elements)	Concepts and sources of meaning, roles/identity, sharing loss, changes after loss, accomplishments, values, coping strategies, meaning of caring for a loved one with cancer, re-establishing life goals, recognizing continuity before and after loss.
Layne et al. (2008)	TCGT is informed by a developmental model of child traumatic stress, based on a wellness-oriented public health framework.	Psychoeducation on trauma/loss, emotional and behavioural regulation, social support skills, and group cohesion-building exercises, processing grief reactions and traumatic experiences, problem-solving skills, managing distressing thoughts, reducing risky behaviour, beneficial grieving, reminiscing, developmental tasks, planning for the future
Mehdipour et al. (2020)	Based on protocol by Dashtbozorgi et al. (2016) for Islamic spiritual therapy (for loneliness and death anxiety in elderly people)	Discussion of grief and grieving process, concept of religion and God in bereavement, assessing needs and goals, values, positive thoughts, gratitude, meaningfully interpreting life events, guilt, repenting, self-forgiveness, learning how to cope, spiritual activities (Quran recitation, praying), learn how to protect others, empathy, self-care, trusting God
Sandler et al. (2010)	Based on the contextual resilience model. FBP designed to change risk and protective factors relating to the adaptation of parentally bereaved children.	Child/Adolescent Program: Caregiver-child relationship, conjoint sessions, sharing personal memento, negative esteem, threat appraisals, changing hurtful thoughts, adaptive control beliefs, positive & active coping, positive reframing, problem-solving, coping strategies, setting goals, reinforcing skills, adaptive emotional expression, bereavement discussions, I-messages[b]
Sharpe et al. (2018)	Theoretically and empirically informed[a]	Storytelling, identifying grief reactions, psychoeducation, unresolved issues (e.g., family conflicts), support systems, changes since loss, coping strategies, spirituality (support beliefs, values), future goals, preparing for future reminders
Spuij et al. (2015)	CBT theory of PGD	Sharing loss (e.g., what is missed most), psychoeducation, cognitive restructuring, maladaptive behaviours, graded exposure, problem-solving, behavioural activation, letters to friends to consolidate learnings, conjoint sessions with parents
Tay et al. (2020)	Psychosocial Adaptation and Development After Trauma and Persecution (ADAPT) model and CBT	Psychoeducation, coping skills (problem-solving, cognitive restructuring), trauma narrative/in-vivo exposure, stress management (controlled breathing, progressive muscle relaxation incorporating local metaphors) emotion regulation, cognitive reappraisal, meaning making, behavioural activation, strengthen social support[c]
Thamuku and Daniel (2013)	Group and individual counselling, art therapy	Strength-based; team building; rites of passage; goal setting; psychoeducation, healthy relationships; sharing experience; problem-solving; relaxation; role-playing, art therapy
Thurman et al. (2017)	CBT components	Psychoeducation, identifying feelings, changes since loss, problem-solving, coping skills (emotion regulation, countering negative thoughts), sharing loss story, interpersonal support, locally derived game (have fun despite loss), cultural grief rituals, songs, dance, relaxation, saying goodbye to loved one, goal setting for future, reflecting on group
Xiu et al. (2019)	Dual process model (DPM): mainly restoration focused aspects	Loss- and restoration-oriented interventions: Psychoeducation on grief reactions, continuing bonds, new relationships, relationship with self, diet, and improving health, dancing, cultural group ritual of freeing fishes[d]
Xiu et al. (2020)	New approach, rests primarily on a humanistic approach drawing on traditional Chinese culture	Chinese traditional brush painting, with the topics for painting including being close to daily life, positive or profound philosophical importance from Chinese culture, or daily subjects (e.g., Pumpkin, Chinese cabbage, maple leaf)
Yu et al. (2022)	Dual-process model. Also based on previous studies	Memory ceremony (zhongyuan festival), writing a letter to deceased, coping with the New Year, online psychoeducation, financial support, mindfulness, yoga, food and life, dancing, health lectures, offline dinner gatherings/outings

[a] Sharpe et al. (2018) unclear about therapeutic base of the intervention.
[b] Additional information retrieved from Ayers et al. (2014).
[c] Additional information retrieved from Tay et al. (2019).
[d] Additional information retrieved from Chow et al. (2019).

Table 4
Cultural adaptation process.

Author, year	Cultural adaptation process	Adaptations made
Barron and Abdallah (2017)	Based on existing group-based CBT program with empirical evidence base in Palestine (Barron et al., 2013) and other war contexts (Yule et al., 2013), involvement of Palestinian researcher	Language: Translated to Arabic, no further adaptations described
Bass et al. (2016)	Participatory action model approach including needs assessment in collaboration with Iraqi staff, interviews, piloting curriculum with trainers, ongoing evaluation and further refinement, involvement of local experienced staff	No clear description of adaptations made
Brave Heart et al. (2019)	Based on theory and previous research with HTUG and IPT in other tribal communities, developed by American Indigenous clinicians from qualitative study and immersion in their tribal communities, tribal advisory panel for feedback on cultural appropriateness of intervention	Delivery format: IPT and group modality (importance of interpersonal relationships and interdependence), focus on interpersonal triggers, explanatory model of HTUG (depression and grief as reactions to ongoing trauma and loss, collective internalized oppression and discrimination), culturally specific practices – talking circles, traditional grief rituals ("wiping of tears" exercise), songs and healing practices (smudging), using culturally appropriate language from HTR
Cohen et al. (2004)	Based on empirically validated treatment for traumatized children, adaptation based on previous research and consultation with treatment providers	Adaptations made not mentioned
Hill et al. (2019)	Based on theory	Treatment components tailored to address aspects of theoretical model (e.g., developmental level, parental involvement), no further description
Kalantari et al. (2012)	Based on previous research regarding writing interventions in refugee populations and children	No description of adaptation
Koda et al. (2022)	Based on MCP developed for WEIRD context, adaptation based on previous research on grief in Japan and on discussion of local researchers	Reduction of session number and frequency (due to unfamiliarity with concept of psychotherapy), emphasis on contents that are familiar to the Japanese, rephrasing of concepts that are unfamiliar in Japanese culture (e.g., "legacy" paraphrased as accomplishments, values, and responsibilities when addressing the historical meaning of life)
Layne et al. (2008)	Based on theory and previous research on adolescent grief and treatment, on-site needs assessment[a], local mental health professionals as cultural consultants to make adaptations to local needs	Used a group design for the intervention in order to take advantage of the peer influence of adolescents
Mehdipour et al. (2020)	Based on assumptions of local researchers regarding importance of religion in target population, based on treatment protocol developed for Iranian older adults Dashtbozorgi et al. (2016)	Inclusion of spiritual-religious elements (stories from the Quran, praying, etc.)
Sandler et al. (2010)	Based on theory and previous research regarding grief in youth; Target variables in intervention on family-level (e.g., quality of caregiver-child relationship) and child-level (e.g., positive coping)	Adaptation of content and format (materials more appealing and developmentally sensitive to children and adolescents)[b]
Sharpe et al. (2018)	Based on theory and previous research on African American coping strategies	Targets culturally relevant coping strategies (e.g., spiritual coping, collective coping)
Spuij et al. (2015)	Based on a CBT model and intervention for adult PGD, method of adaptation not mentioned, pre-tested for feasibility	Simplified treatment delivery to accommodate developmental level, intellectual and cognitive abilities of children (verbal, creative and behavioural assignments, e.g., drawing to express feelings)
Tay et al. (2020)	Based on theory (ADAPT) and research in target group; intervention previously adapted to other refugee group, review of cultural terminologies for mental health symptoms, key informant interviews (with community and clinicians) to assess cultural congruence of translation and content, pre-piloting: focus groups with Rohingya refugees and counsellors about cultural/contextual appropriateness of content, materials, tools, pilot-IAT: offered to 20 Rohingya refugees, further feedback was collected about language, format, and delivery	Language: Bangla; simplified, added colloquial terms; visual representations due to low literacy; culturally relevant stories added; intervention basis: reduce sessions, flexible treatment focus; emphasis on partnership between counsellor and participant
Thamuku and Daniel (2013)	Based on previous research on childhood grief	Delivery format: Group (importance of peer relationships, cultural practices such as initiation rite of passage), therapeutic techniques: art therapy and individual counselling (to breach cultural silence around death and loss, age-appropriate technique to express feelings)
Thurman et al. (2017)	Based on locally developed theory-based grief guide and adapted by local researchers, pre-tested for acceptability in target population	Incorporated contextually relevant indigenous stories and scenarios, songs and games, discussions of cultural rituals and traditions surrounding death
Xiu et al. (2019)	Based on previously developed intervention DPBGI for US-context, adaptation based on previous research and theory on grief in China, previous pilot study of the DPBGI-C[c]	Reduced number of sessions, inclusion of culturally relevant topics (e.g., dietary concerns and Chinese health concepts), cultural group ritual of freeing fishes, practical exercises (e.g., cooking)
Xiu et al. (2020)	Based on theory and previous research on grief in China, teacher of Chinese brush painting involved in course development	Intervention directly derived from traditional cultural practice (brush painting); aligned with cultural holistic perspective on health; intervention format: community-based, non-threatening, non-grief-focused (art-modality)
Yu et al. (2022)	Based on theory (DPM) and previous studies on DPM-based grief interventions in China	More restoration-oriented elements due to acceptability in culture, inclusion of culturally relevant topics (e.g., preservation health classes), inclusion of traditional cultural rituals

[a] Additional information retrieved from Layne et al. (2001)
[b] Additional information retrieved from Ayers et al. (2014).
[c] Additional information retrieved from Chow et al. (2019).

Development After Trauma and Persecution model (ADAPT; Silove, 2013) was used as the grounding framework, the historical trauma response conceptualization (Brave Heart, 1998; Brave Heart and Chase, 2016) provided the basis for one intervention (Brave Heart et al., 2019), and the developmental model of child traumatic stress (Pynoos et al., 1995) formed the basis one intervention (Layne et al., 2008). Furthermore, the social work model of helping and support (Hepworth et al., 2010) was employed for one study (Bass et al., 2016). It was not specified what the therapeutic/theoretical base of three interventions were (Sharpe et al., 2018; Thamuku and Daniel, 2013; Xiu et al., 2020).

The content of the studies' interventions differed greatly, however there were some common elements. Participants were taught healthy coping strategies and skills, such as emotion regulation, problem-solving or cognitive restructuring in 14 studies (Barron and Abdallah, 2017; Bass et al., 2016; Cohen et al., 2004; Hill et al., 2019; Koda et al., 2022; Layne et al., 2008; Mehdipour et al., 2020; Sandler et al., 2010; Sharpe et al., 2018; Spuij et al., 2015; Tay et al., 2020; Thamuku and Daniel, 2013; Thurman et al., 2017; Yu et al., 2022). In 14 studies psychoeducation was included in the intervention, including teaching participants about grief, understanding, and normalizing their feelings (Barron and Abdallah, 2017; Bass et al., 2016; Brave Heart et al., 2019; Cohen et al., 2004; Hill et al., 2019; Layne et al., 2008; Mehdipour et al., 2020; Sharpe et al., 2018; Spuij et al., 2015; Tay et al., 2020; Thamuku and Daniel, 2013; Thurman et al., 2017; Xiu et al., 2019; Yu et al., 2022). Storytelling or sharing of loss, verbally or through writing, was used in 10 studies as an intervention component (Brave Heart et al., 2019; Cohen et al., 2004; Hill et al., 2019; Kalantari et al., 2012; Koda et al., 2022; Sharpe et al., 2018; Spuij et al., 2015; Tay et al., 2020; Thamuku and Daniel, 2013; Thurman et al., 2017). In seven interventions, participants learned mindfulness and relaxation techniques (Barron and Abdallah, 2017; Cohen et al., 2004; Hill et al., 2019; Tay et al., 2020; Thamuku and Daniel, 2013; Thurman et al., 2017; Yu et al., 2022). Establishing continuing bonds with the deceased was addressed in five interventions, including writing a letter to the deceased (Barron and Abdallah, 2017; Hill et al., 2019; Thurman et al., 2017; Xiu et al., 2019; Yu et al., 2022).

Memorialization and positive reminiscing were employed in six interventions (Barron and Abdallah, 2017; Cohen et al., 2004; Hill et al., 2019; Layne et al., 2008; Sandler et al., 2010; Yu et al., 2022). Identifying changes post-loss was addressed in five interventions (Cohen et al., 2004; Hill et al., 2019; Koda et al., 2022; Sharpe et al., 2018; Thurman et al., 2017). Social support and strengthening social connections were a component in 11 interventions (Bass et al., 2016; Brave Heart et al., 2019; Cohen et al., 2004; Layne et al., 2008; Mehdipour et al., 2020; Sharpe et al., 2018; Tay et al., 2020; Thamuku and Daniel, 2013; Thurman et al., 2017; Xiu et al., 2019; Yu et al., 2022). In 10 interventions participants were encouraged to set goals or think about their future, including thinking about future reminders of grief (Barron and Abdallah, 2017; Cohen et al., 2004; Kalantari et al., 2012; Koda et al., 2022; Layne et al., 2008; Mehdipour et al., 2020; Sandler et al., 2010; Sharpe et al., 2018; Thamuku and Daniel, 2013; Thurman et al., 2017). In six interventions some form of meaning making was included (Barron and Abdallah, 2017; Cohen et al., 2004; Hill et al., 2019; Koda et al., 2022; Mehdipour et al., 2020; Tay et al., 2020). Conjoint parent-child sessions were included in three interventions (Cohen et al., 2004; Hill et al., 2019; Spuij et al., 2015). Finally, eight studies focused on culturally specific forms of coping and included traditional cultural practices or rituals, also considering religion and spirituality (Brave Heart et al., 2019; Mehdipour et al., 2020; Sharpe et al., 2018; Thamuku and Daniel, 2013; Thurman et al., 2017; Xiu et al., 2019, 2020; Yu et al., 2022).

3.3.3. Cultural adaptation process

Detailed descriptions of the cultural adaptation processes are provided in Table 4. There were different approaches in culturally adapting interventions. The approaches can be subdivided into top-down (culturally adapting pre-existing interventions) and bottom-up approaches (developing new interventions in an emic manner). Furthermore, the sources of information employed at different stages of the intervention development can be split into formative research before cultural adaptation and during cultural adaptation according to RECAPT (Heim et al., 2021).

Out of the 18 included studies, seven employed a top-down approach to cultural adaptation, specifically mentioning an intervention developed for another sociocultural group as their basis (Barron and Abdallah, 2017; Cohen et al., 2004; Kalantari et al., 2012; Koda et al., 2022; Spuij et al., 2015; Tay et al., 2020; Xiu et al., 2019). The remaining 11 studies lack explicit mention of a specific intervention as the foundation for their culturally adapted intervention (Bass et al., 2016; Brave Heart et al., 2019; Hill et al., 2019; Layne et al., 2008; Mehdipour et al., 2020; Sandler et al., 2010; Sharpe et al., 2018; Thamuku and Daniel, 2013; Thurman et al., 2017; Xiu et al., 2020; Yu et al., 2022). Hence, we infer the utilization of a bottom-up approach. It is worth noting, however, that certain studies may have applied a top-down methodology without explicit specification.

Regarding the sources of information for formative research employed before cultural adaptation, 10 studies (Brave Heart et al., 2019; Hill et al., 2019; Layne et al., 2008; Sandler et al., 2010; Sharpe et al., 2018; Tay et al., 2020; Thurman et al., 2017; Xiu et al., 2019, 2020; Yu et al., 2022) specifically reported that the development of their intervention was based on a theory or model, in most cases this was a model of grief developed for a specific target population (e.g., HTR in Brave Heart et al., 2019). It was mentioned in 13 studies that the cultural adaptation of the intervention was developed based on empirical results from previous research within that population or similar populations (Barron and Abdallah, 2017; Brave Heart et al., 2019; Cohen et al., 2004; Kalantari et al., 2012; Koda et al., 2022; Layne et al., 2008; Sandler et al., 2010; Sharpe et al., 2018; Tay et al., 2020; Thamuku and Daniel, 2013; Xiu et al., 2019, 2020; Yu et al., 2022).

As part of the formative research during cultural adaptation, the inclusion of local researchers or key informants and experienced clinicians in the cultural adaptation of the intervention was specifically mentioned in 10 studies (Barron and Abdallah, 2017; Bass et al., 2016; Brave Heart et al., 2019; Cohen et al., 2004; Koda et al., 2022; Layne et al., 2008; Mehdipour et al., 2020; Tay et al., 2020; Thurman et al., 2017; Xiu et al., 2020). Finally, five studies reported that they had conducted some form of qualitative research to evaluate feasibility and acceptability (e.g., focus groups, key informant interviews, etc.) with the target group in the cultural adaptation process (Bass et al., 2016; Brave Heart et al., 2019; Spuij et al., 2015; Tay et al., 2020; Thurman et al., 2017).

The extent of the cultural adaptation process reported differed between studies, from two studies basing adaptations only on one of these sources of information (Hill et al., 2019; Thamuku and Daniel, 2013), to two studies applying all six sources of information (Brave Heart et al., 2019; Tay et al., 2020). Most interventions were based on fewer sources of information, five interventions were based on two sources (Bass et al., 2016; Sandler et al., 2010; Sharpe et al., 2018; Spuij et al., 2015; Yu et al., 2022), while four studies each were based on three (Kalantari et al., 2012; Koda et al., 2022; Layne et al., 2008; Xiu et al., 2020) or four (Barron and Abdallah, 2017; Cohen et al., 2004; Thurman et al., 2017; Xiu et al., 2019). Only one study (Tay et al., 2020) employed a guideline for the systematic cultural adaptation (Bernal and Sáez-Santiago, 2006).

As a result of the cultural adaptation process, different adjustments were made to the intervention format or content to make interventions more culturally sensitive. Regarding the intervention format, three studies specified that they adapted the language, for instance by translating, simplifying or including culturally appropriate terms (Barron and Abdallah, 2017; Brave Heart et al., 2019; Tay et al., 2020), while five studies decided to deliver the intervention in a group format for cultural sensitivity (Brave Heart et al., 2019; Layne et al., 2008; Sharpe et al., 2018; Thamuku and Daniel, 2013; Xiu et al., 2020). Furthermore,

adaptations to the session length or frequency were also made for sociocultural sensitivity by three studies (Koda et al., 2022; Tay et al., 2020; Xiu et al., 2019). For interventions targeting children or adolescents, it was specified in four studies that adaptations were made to the delivery format based on their developmental level (Hill et al., 2019; Sandler et al., 2010; Spuij et al., 2015; Thamuku and Daniel, 2013).

With regard to cultural adaptation of content, seven studies reported that they had included culturally relevant topics, such as culturally relevant stories or a health focus (Brave Heart et al., 2019; Koda et al., 2022; Tay et al., 2020; Thamuku and Daniel, 2013; Thurman et al., 2017; Xiu et al., 2019; Yu et al., 2022), while six interventions included culturally relevant rituals and practices (Brave Heart et al., 2019; Thamuku and Daniel, 2013; Thurman et al., 2017; Xiu et al., 2019, 2020; Yu et al., 2022). Religious or spiritual practices were specifically included for cultural sensitivity in two studies (Mehdipour et al., 2020; Sharpe et al., 2018). Finally, five studies did not or only in a very limited manner specify what adaptations were made (Barron and Abdallah, 2017; Bass et al., 2016; Cohen et al., 2004; Hill et al., 2019; Kalantari et al., 2012).

3.3.4. Outcomes

A wide variety of grief outcome measures were utilized by the 18 studies, which are specified in detail in Table 5. The Inventory for Complicated Grief (ICG-19; Prigerson et al., 1995) including the child-version (ICG-RC; Melhem et al., 2013) was used most frequently, by six studies in total, (Koda et al., 2022; Mehdipour et al., 2020; Sharpe et al., 2018; Thurman et al., 2017; Xiu et al., 2019; Yu et al., 2022). The following measures were used by two studies each: Inventory of Traumatic Grief (ITG; Prigerson and Jacobs, 2001 in Bass et al., 2016; Sandler et al., 2010), the Intrusive Grief Thoughts Scale (IGTS; Program for Prevention Research, 1999 in Sandler et al., 2010; Thurman et al., 2017), Inventory of Prolonged Grief including both versions for children and adolescents (IPG-C and IPG-A; Spuij et al., 2012 in Barron and Abdallah, 2017; Spuij et al., 2015). The following measures were used by individual studies: Texas Revised Inventory of Grief (TRIG; Faschingbauer, 1981 in Sandler et al., 2010), Refugee Assessment Mental Health Package (R-MHAP; Tay et al., 2015 in Tay et al., 2020), Prolonged Grief Scale (PG-13; Prigerson and Maciejewski, 2006 in Xiu et al., 2020), the Lakota Grief Experience Questionnaire (Brave Heart, 1998) and the Culturally Modified Grief Questionnaire (CMGQ; Prigerson and Maciejewski, 2006; Shear et al., 2005) in the study by Brave Heart et al. (2019), UCLA Grief Inventory (Layne et al., 2000 in Layne et al., 2008), Traumatic Grief Inventory for Children (TGIC; Dyregrov et al., 2001 in Kalantari et al., 2012), PCBD Checklist (Layne et al., 2014 in Hill et al., 2019), Children's Revised Impact of Events Scale (CRIES-13; Smith et al., 2003 in Barron and Abdallah, 2017), the Grief subscale of the Core Bereavement Items (CBI-G; Burnett et al., 1997 in Thurman et al., 2017), Expanded Grief Inventory (EGI; Layne et al., 2001b in Cohen et al., 2004). For qualitative evaluation a semi-structured interview (Barron and Abdallah, 2017; Xiu et al., 2020), a semi-structured questionnaire (Thamuku and Daniel, 2013), session scripts (Koda et al., 2022) and a grief therapy workbook were employed (Thamuku and Daniel, 2013).

All studies investigated the effectiveness of their interventions through the reduction of psychological symptoms on a variety of measures, except for Thamuku and Daniel (2013) who qualitatively evaluated their intervention without the use of quantitative measures. Out of the included studies, 15 studies found a statistically significant change between participants' pre and post intervention scores, or in comparison to the control group (Barron and Abdallah, 2017; Bass et al., 2016; Cohen et al., 2004; Hill et al., 2019; Kalantari et al., 2012; Koda et al., 2022; Layne et al., 2008; Mehdipour et al., 2020; Sandler et al., 2010; Spuij et al., 2015; Tay et al., 2020; Thurman et al., 2017; Xiu et al., 2019, 2020; Yu et al., 2022). Thamuku and Daniel (2013) used a qualitative methodology of analysis and found their intervention EARTH to be effective, as they noted that adolescents developed from avoidance of their grief and trauma disclosure, to "therapeutic engagement" that brought healing. Koda et al. (2022) employed a mixed methods approach including thematic analysis of interviews pre, during, and post intervention to identify factors contributing to grief relief. They found 15 grief-related themes, and two distinct topics that lead to the relief of grief. Finally, Xiu et al. (2020) adopted a mixed-methods approach, delving into participant responses to a painting course as a complement to quantitative data. Their analysis revealed that participants not only found the course beneficial but also provided nuanced insights into its perceived helpfulness. Lastly, two studies did not find a statistically significant difference between conditions (Brave Heart et al., 2019; Sharpe et al., 2018).

4. Discussion

4.1. Summary of findings

The overall aim of this scoping review was to explore what culturally sensitive psychosocial interventions are available for clinically relevant grief states, revealing a total of 18 studies. This limited number underscores the early stage of research in the domain of culturally adapted grief interventions (Johannsen et al., 2019; Yu et al., 2022) and the recent emerging interest in cultural clinical psychology in general (Henrich et al., 2010). Interestingly, among the 18 included studies spanning the period from 2004 to 2022, there seems to be a notable upward trend in publications, particularly evident from 2013 onward. Notably, 14 of the included studies were published during or after 2013. This surge in interest may be attributed, in part, to the release of the ICD-11 criteria in the same year, which introduced a cultural caveat (Killikelly and Maercker, 2018). Hence, although the number of included studies is relatively small, this increase in research attention and the updated diagnostic criteria may reflect a growing recognition of the importance of cultural sensitivity in the field. The majority of studies utilized a strictly quantitative methodology, with only four incorporating, at least partially, qualitative methods.

4.1.1. Intervention characteristics and content

We found that the interventions in the included studies targeted a variety of sociocultural (sub)groups across different world regions. Target groups identified were sociocultural groups based on age and ethnicity. The most prevalent focus was on age groups, while generally cultural (sub)groups particularly susceptible to traumatic losses, such as refugees (e.g., Tay et al., 2020) and individuals in war-affected areas (e.g., Barron and Abdallah, 2017), were also commonly addressed. This is in line with research showing that individuals exposed to traumatic losses are more susceptible to develop forms of clinically relevant grief (Djelantik et al., 2020) and could benefit greatly from adequate treatment. Although our conceptualization of cultural groups was purposely defined broadly to encompass other cultural groups, e.g., based on language, religion, or sexuality, no interventions targeting such groups were identified. This may be on the one hand due to the keywords used in our search strategy, on the other hand there may not be any interventions targeting such groups due to the newer conceptualization of culture in such a broad sense in psychological research (Markus and Hamedani, 2007). This may indicate a research gap with these additional dimensions to be explored by future research. Additionally, there may be differences in the cultural adaptation process for various age groups compared to other sociocultural groups. For example, adapting to different age groups within the WEIRD context means targeting a group that still shares much with the majority society and will be or was at some point part of it. In the review, interventions adapting for age often included delivery formats with parallel sessions for caregivers, whereas cultural adaptations for other groups were generally done without the direct inclusion of the target group and primarily involved simplifying the content. These variations suggest that age-specific adaptations might have unique components and approaches, underscoring

Table 5
Grief outcome measures.

Author, year	Grief outcome measures
Barron and Abdallah (2017)	IPG-A; IPG-C; CRIES-13; semi-structured interview
Bass et al. (2016)	ITG
Brave Heart et al. (2019)	CMGQ; Lakota Grief Experience Questionnaire
Cohen et al. (2004)	EGI
Hill et al. (2019)	PCBD Checklist
Kalantari et al. (2012)	TGIC
Koda et al. (2022)	ICG-19; Thematic analysis of session scripts
Layne et al. (2008)	UCLA Grief Inventory
Mehdipour et al. (2020)	ICG-19
Sandler et al. (2010)	TRIG; IGTS; ITG
Sharpe et al. (2018)	ICG-19
Spuij et al. (2015)	IPG-C
Tay et al. (2020)	RMHAP
Thamuku and Daniel (2013)	Semi-structured questionnaire; grief therapy workbook
Thurman et al. (2017)	Grief subscale of the Core Bereavement Items; IGTS; ICG-C
Xiu et al. (2019)	ICG-19
Xiu et al. (2020)	PG-13, Semi-structured interview
Yu et al. (2022)	ICG-19

the importance of tailoring interventions to fit the specific needs of each subgroup. This highlights an interesting area for future research to further investigate these differences and their implications.

A broad range of clinically relevant grief concepts (CG, $PGD_{ICD\text{-}11}$, PGD_{2009}, Traumatic Grief, PCBD, etc.) were targeted across all interventions. This is reflective of the situation in the current grief research literature, which has been criticized by various researchers in the field, notably due to limited content overlap between the different diagnostic categories, causing substantial limitations in comparability and generalizability of findings and calls for convergence of diagnostic categories in future research and practice (Eisma et al., 2022). Although many studies were published after the publication of the ICD-11 criteria, surprisingly few interventions (Xiu et al., 2019, 2020; Yu et al., 2022) targeted $PGD_{ICD\text{-}11}$, while CG was targeted most frequently. This is particularly surprising in the domain of culturally sensitive interventions, since the ICD-11 criteria specifically account for cultural variations. A possible explanation for this may be the only very recent availability of measures for the ICD-11 criteria (e.g., IPGDS, Killikelly et al., 2020), due to the novelty of the diagnostic concept, while for instance the ICG is an established and frequently used instrument in grief research (Treml et al., 2020).

Some interventions (e.g., Kalantari et al., 2012) were specifically designed for losses of particular family members (parents, children, etc.), while many did not specify what kind of lost relationship was targeted. This is an interesting aspect to consider for the development of future interventions. In specific cultural contexts, it may be relevant to specify the nature of loss, given that losing a child, for instance, can carry distinct cultural implications. For example, losing a child may entail distinct cultural implications, as observed in China with the concept of Shidu parents. This term refers to parents who have lost their only child and underscores unique aspects, including heightened suicidality or potential financial challenges in old age (Ma et al., 2023; Zheng et al., 2017). Conversely, maintaining ambiguity about the type of lost relationship in interventions could also be culturally sensitive. In many cultures, close ties extend beyond immediate family to encompass more distant relatives or community members, which equally reflects in higher prevalence of PGD due to the loss of such family members in certain cultures compared to others, elevating the potential need for support (Killikelly et al., 2023).

Half of the included studies did not explicitly specify the type of loss circumstances which were addressed. This is a consideration which may be particularly pertinent for specific populations more prone to experiencing a loss under violent circumstances. Notably, included interventions aimed at groups exposed to conflict and violence (e.g., war-affected individuals; Barron and Abdallah, 2017) often emphasized traumatic loss. Consequently, this may influence the selection of certain intervention components, such as elements of exposure borrowed from PTSD treatment to specifically target more trauma-related symptoms (Acierno et al., 2021; Eddinger et al., 2021). However, it is important to note that these implications are somewhat speculative and that more research is needed to discern what treatment components are indicated for which type of loss circumstances.

Only a minority of interventions was delivered by psychotherapists or psychiatrists, while the vast majority was either delivered by other health professionals or other facilitators such as lay counsellors. This aligns with the World Health Organization's recommendation of incorporating mental health care into primary care/community-based settings, especially crucial in low- and middle-income countries (LMICs) where mental health resources are scarce (Spagnolo and Lal, 2021). Given this large overlap of culturally diverse settings and low income, providing interventions via other facilitators, may be a particularly relevant consideration when providing culturally sensitive interventions (Thomas and Markus, 2023).

Regarding the delivery format, all interventions were implemented face to face with merely one intervention including internet-based components (Yu et al., 2022). This is intriguing given the growing number of effective internet-based interventions (IBIs) for grief in WEIRD contexts (Wagner et al., 2020; Zuelke et al., 2021). Additionally, research on culturally adapted IBIs has yielded promising results and indicates that IBIs may harbor many advantages for providing treatment to populations such as for instance refugees, who experience many barriers to treatment (Harper Shehadeh et al., 2016; Spanhel et al., 2021). Therefore, exploring culturally adapted IBIs for grief could be a compelling path for future research.

The vast majority of interventions employed either group formats or a combination of group and individual approaches. Only one study exclusively utilized individual sessions. A group setting may offer several advantages, including resource efficiency and potential benefits in addressing stigma, especially in cultures where it holds significance (Tong et al., 2020). Additionally, it might be particularly effective in more community-oriented cultures, as suggested in several of the included studies (e.g., Brave Heart et al., 2019). This aspect deserves careful consideration in the design of future interventions.

Several studies specified therapeutic methods or approaches as their basis, most of which were CBT. This is in line with current research and practice guidelines, that show that CBT may be applicable across cultures, but only if it is culturally adapted (Hinton and Patel, 2018). Hence, as Hinton and Patel (2018) denote, it may for instance make sense to additionally include interventions targeting somatic symptoms (e.g., more body-oriented psychotherapy approaches), which is a common grief symptom in non-Western populations (Hennemann et al., 2023) and may possibly not be directly targeted by a CBT intervention developed in a WEIRD context. Many of the included studies presented theories as a basis for their interventions, which may be helpful as it could guide intervention development in targeting specific difficulties of the target population. Notably, several studies targeting traumatic grief employed more trauma-focused models (e.g., Cohen et al., 2004), while others employed theories that encompassed certain contextual aspects of the target group such as the ADAPT model in the case of refugees (Tay et al., 2020). Accordingly, it seems important to employ a model or theory that is culturally sensitive. In line with this, most interventions targeting children or adolescents were based on a developmental model of grief, encompassing specific developmental aspects specific to this age group, as recommended by Hughes (2000). The Dual Process Model (Schut and Stroebe, 1999) was used by two studies (Xiu et al., 2019; Yu et al., 2022). There are promising findings demonstrating the cross-cultural applicability of this model, especially its flexibility to accommodate for cultural variations may make it a useful tool in the future development of culturally sensitive interventions (Nguyen et al.,

2022). However, Nguyen et al. (2022) remind researchers to remain cautious in its application, as it was developed in a WEIRD context.

The most frequently emphasized components in the studies, mentioned 10 or more times, encompass psychoeducation, coping strategies, social support, sharing loss narratives, and envisioning the future. Most of these components, such as psychoeducation, coping strategies (e.g., cognitive reframing) or sharing loss narratives tend to be used in common grief interventions (Waller et al., 2016; Wittouck et al., 2011). Several of these components may be specifically subject to cultural variations regarding content or importance. Notably, the perceived importance of social support during bereavement in a culture may vary, which reflects for instance in more or less community involvement during mourning (Kuehn, 2013). Furthermore, the type of preferred social support in general may vary across cultures. Taylor et al. (2007) for instance, differentiate between implicit and explicit social support (e.g., seeking advice versus focusing on shared cultural values). Hence the importance of tackling the subject in an intervention, as well as the type of social support needs to be considered. Furthermore, lacking social support has been described as a risk factor for clinically relevant grief states, with many interventions failing to target this risk factor (Mason et al., 2020). This may be a particularly important subject to tackle when developing interventions for refugee populations, who may have a reduced social support network. Careful psychoeducation and normalization may emerge as particular considerations. This might be particularly relevant within communities marked by elevated stigma, which may present a barrier to treatment (Chen et al., 2020). It is crucial to note that the content of the stigma may also vary according to culture (Koschorke et al., 2017), underscoring the importance of specifically adapting normalization and psychoeducation strategies to address the stigmatizing beliefs held by individuals in that particular cultural context. Moreover, the exploration of continuing bonds emerges as a vital aspect in grief interventions, shaped by cultural nuances. It is crucial to consider that the extent and manner in which a connection is sustained vary among cultures and should be taken into account in the development of interventions (Suhail et al., 2011).

Finally, almost half of the included interventions incorporated traditional cultural practices or rituals, including religion and spirituality into their intervention. A recent review by Wojtkowiak et al. (2021) revealed that including rituals into grief therapy may improve effectiveness and provides a way to make interventions more culturally sensitive. Incorporating rituals into therapy may also be particularly important in refugee communities, as it has been suggested that not being able to perform traditional cultural rituals due to the refugee context may lead to an increase in grief symptoms (Wojtkowiak et al., 2021). Religious components, often overlooked in Western therapeutic approaches, introduce an intriguing dimension to grief interventions, as religiosity may play a more significant role in certain cultures and demonstrate efficacy in the treatment of grief (Suhail et al., 2011). This suggests the potential value of exploring and integrating religious elements in future interventions and efforts. In this context, the Bereavement and Grief-Cultural Formulation Interview (BG-CFI; Smid et al., 2018) offers a structured framework for identifying and integrating culturally appropriate into grief therapy. By leveraging such frameworks, therapists can effectively support individuals from diverse cultural backgrounds in navigating their grief experiences while honoring their religious and spiritual beliefs.

4.1.2. Cultural adaptation process

The included studies either employed a bottom-up approach, crafting novel interventions rooted in emic perspectives, or a top-down strategy, modifying existing interventions. A top-down approach offers potential resource efficiency by building upon established frameworks. Conversely, the bottom-up approach may provide the opportunity to develop interventions more directly aligned with cultural practices. This distinction underscores a strategic choice, balancing resource considerations with the potential for interventions deeply rooted in cultural contexts.

The majority of interventions grounded their adaptations in established theories and empirical evidence, showcasing a relatively robust formative research foundation. Noteworthy is the active involvement of the target community in the form of key informant interviews or native researchers in a large number of studies, which is an essential element in culturally sensitive intervention development and is in line with recommendations for the development of interventions in minority groups (e.g., Brave Heart et al., 2016). Moreover, a notable observation within the included studies is the limited documentation of qualitative evaluations for feasibility and acceptability. This aspect, emphasized in various cultural adaptation frameworks like the RECAPT (Heim et al., 2021), warrants consideration by future studies to enhance the acceptability and feasibility of culturally adapted interventions in the target population.

The studies included in the review revealed a lack of systematic approaches to cultural adaptation, with variations in extensiveness across interventions and only one (Tay et al., 2020) using a guiding framework for cultural adaptation (Bernal and Sáez-Santiago, 2006). While this review cannot make any assumptions about the impact of the extent of cultural adaptations in grief interventions on effectiveness or acceptance, it underscores the necessity for future research and systematic reviews to delve into this aspect. Existing research suggests that cultural adaptation tends to enhance the effectiveness and acceptability of interventions in general (Arundell et al., 2021; Hall et al., 2016). Hence, exploring this relationship further in future studies holds the potential to provide valuable insights into optimizing the cultural adaptation of grief interventions more specifically. However, our scrutiny suggests that several studies may not have comprehensively reported all adaptations made, including factors such as the involvement of native researchers in the cultural adaptation process (e.g., Yu et al., 2022). Consequently, the interpretation of results should be approached with caution, recognizing the potential impact of unreported or underreported elements on the overall findings. This highlights a broader issue in the realm of cultural adaptation—a pervasive lack of systematic reporting covering the adaptation process and specific areas addressed. To address this gap, it is crucial for future researchers to incorporate frameworks such as RECAPT (Heim et al., 2021) or the framework by Bernal and Sáez-Santiago (2006), not only to guide the adaptation itself but also to ensure transparent reporting and replicability.

Examining the adapted elements in the included intervention reveals the number of adaptations made regarding treatment delivery (e.g., language, session length or group/individual format) and content (e.g., rituals, religiosity), aligning with cultural adaptation frameworks such as RECAPT (Heim et al., 2021) and Bernal and Sáez-Santiago (2006), were approximately even. However, certain vital topics, which are strongly recommended in cultural adaptation, like for instance the inclusion of cultural concepts of distress (Heim and Kohrt, 2019), receive limited attention. Future research is strongly recommended to adopt guiding frameworks for the development and reporting of cultural adaptation reducing the risk of overlooking critical aspects in the cultural adaptation process.

4.1.3. Outcomes

Concerning our third research question on the outcomes of culturally sensitive grief interventions, a majority of studies employed a form of the ICG (Prigerson et al., 1995). Nonetheless, the utilization of different concepts across studies resulted in substantial variability in outcome measures. The considerable variability in outcome measures presents a challenge in generalizing findings and summarizing intervention impacts for future systematic reviews. This underscores, once again, the critical importance of achieving convergence in measures and diagnostic concepts within the research domain, as previously emphasized.

Several studies employ measures not designed for the specific concepts under investigation, such as the use of ICG or PG-13 for $PGD_{ICD\text{-}11}$ (Xiu et al., 2019, 2020; Yu et al., 2022). This presents an issue due to the

minimal content overlap between these diagnostic categories (Eisma et al., 2022). It is worth noting that researchers may have opted for these measures due to the very recent publication of the first scale aligned with ICD-11 in 2020 (Killikelly et al., 2020; Treml et al., 2020). To enhance the alignment between concept and measure, future research should consider using measures that align more closely with the investigated concepts.

A mere two studies (Brave Heart et al., 2019; Tay et al., 2020) incorporated culturally sensitive measures, a critical consideration given the pronounced cultural variations in grief symptoms (Stelzer et al., 2020). Recognizing and accommodating these variations in outcome measures is imperative for a comprehensive understanding of the subject matter and is strongly advised in the evaluation of culturally sensitive interventions (Heim et al., 2021).

Among the included studies, only few included qualitative methods in their evaluation (Barron and Abdallah, 2017; Koda et al., 2022; Thamuku and Daniel, 2013; Xiu et al., 2020). Using qualitative research more frequently could be particularly interesting in evaluating grief interventions, where dismantling studies identifying active grief intervention components are still lacking (Johannsen et al., 2019). A preliminary qualitative evaluation could provide valuable insights into what works before progressing to more intricate studies, such as dismantling studies. The emphasis on qualitative methods holds even more significance when exploring interventions with diverse cultural groups, recognizing the nuanced aspects that may not be adequately captured by quantitative measures alone (Kirmayer and Ban, 2013).

The included studies report promising results regarding efficacy, with all but two studies (Brave Heart et al., 2019; Sharpe et al., 2018) reporting significant reductions in grief symptoms. These findings reflect the clinical utility of culturally adapted interventions, as even the interventions that did not find a statistically significant effect still reported decreases in negative symptoms, and positive evaluations from participants who were in the culturally adapted condition (Brave Heart et al., 2019; Sharpe et al., 2018). However, these findings must be interpreted with caution, as the present review is not a meta-analysis and does not allow for any direct conclusions. Furthermore, we cannot draw any conclusions about the superiority of culturally sensitive over non-adapted interventions. It is crucial for future research to investigate the impact of the extent of cultural adaptation on outcomes, particularly in terms of effectiveness. Moreover, the reported qualitative results suggest that participants found the adapted interventions helpful. Brave Heart et al. (2019) for instance, found that Indigenous participants greatly valued the acknowledgment of their suffering in residential schools and intergenerational trauma through the HTUG and IPT intervention. The value of culturally adapted interventions for grief is thus suggested. Furthermore, the finding of Brave Heart et al. (2019) is in line with other research suggesting that cultural adaptation may also enhance treatment adherence (Naeem et al., 2019).

It would be interesting for future research evaluating such interventions to specifically delve into questions regarding the acceptability of the cultural adaptation and whether this aspect was perceived as helpful with qualitative methods.

4.2. Implications

The implications gleaned from this scoping review are noteworthy, especially considering the introduction of the cultural caveat for PGD in the ICD-11 (Killikelly and Maercker, 2018).

Although further studies, especially systematic reviews, are needed to draw definitive conclusions, this review hints at the efficacy and usefulness of culturally sensitive grief interventions for diverse sociocultural (sub)groups, aligning with existing research (Chowdhary et al., 2014; Naeem et al., 2023). On the long-term it will be crucial to raise awareness on the importance of culturally sensitive grief interventions among clinicians, especially those working with refugee populations. Immigrant minority groups, as highlighted in the review by Wojtkowiak et al. (2021), may exhibit more persistent symptoms of clinically relevant grief states. This underscores the relevance of offering tailored treatment for this specific group. Furthermore, the authors posit that the enduring symptoms in this population could be attributed to the inability of performing traditional grief rituals within the migration context. Consequently, culturally sensitive interventions that incorporate traditional rituals or adapted versions of traditional rituals may hold particular significance in addressing the unique needs of this demographic.

Furthermore, direct implications for future researchers developing culturally sensitive grief interventions emerge and shall be listed here as recommendations:

- Employ a framework for cultural adaptation, such as RECAPT (Heim et al., 2021), to guide and transparently report the development process.
- Strive for extensive cultural adaptation, recognizing its potential effectiveness based on existing literature, though its impact on grief interventions remains to be conclusively established.
- Employ mixed methods for evaluation, incorporating qualitative approaches to gather additional insights into the intervention's specific components' helpfulness and acceptability.
- Utilize culturally sensitive measures, such as the IPGDS (Killikelly et al., 2020), to ensure accurate and nuanced assessment.
- Preferentially adopt a grief concept that includes a cultural caveat, exemplified by $PGD_{ICD\text{-}11}$, to enhance cultural relevance.
- Consider the target group, accounting for potential cultural or contextual variations related to the circumstances of loss (e.g., traumatic experiences) or the type of relationship lost.
- Tailor the intervention format (group vs. individual) based on cultural norms and preferences, explore internet-based delivery options, and acknowledge that grief interventions can be effectively provided by various facilitators.
- Derive insights from components extracted from interventions in this review, which may potentially offer valuable guidance when developing interventions in similar contexts.
- Explore alternative approaches beyond CBT, such as for instance body-oriented approaches.
- Consider employing culturally sensitive models or theories, with the Dual Process Model (Schut and Stroebe, 1999) being a potential framework.
- Remain mindful of cultural variations regarding potential content, particularly in components like social support.
- Actively involve the targeted cultural group in both the development and evaluation phases of the intervention.

Despite the valuable insights, there remains a compelling need for more research in this area. Future investigations could delve into other sociocultural (sub)groups (for instance, based on religion), and more generally explore the role of religion in grief interventions. Understanding which components are particularly relevant for cultural adaptation in grief interventions, potentially through dismantling or qualitative studies, is an avenue for further exploration. Furthermore, our review focused solely on treatment and support interventions for grief. Hence it may be of interest for future reviews to explore the extent and nature of scientific evidence on grief interventions beyond this narrow scope, such as culturally sensitive diagnostic interventions (e.g., Killikelly and Maercker, 2023) and interventions that support culturally sensitive treatment negotiation (e.g., Smid et al., 2018).

4.3. Limitations

The present scoping review has several limitations that warrant consideration. Firstly, our broad definition of culture may have resulted in the oversight of relevant papers, as not all studies were captured by our keyword searches, for instance we did not specifically search for

countries or religious groups. Methodologically, our decision to screen 20% of full-text articles due to resource limitations may introduce bias. Caution is also advised in interpreting the effectiveness of interventions, as our review is not a meta-analysis and does not allow for direct conclusions to be drawn. Furthermore, we did not investigate adherence in reviewed studies, which could have been an interesting factor and would warrant further investigation of the impact of cultural adaptation on intervention adherence in future reviews. Moreover, the temporal scope of our review, excluding literature before 2000, may overlook foundational studies. The focus on English- and German-language publications may also introduce a language bias, potentially missing valuable insights from other linguistic sources, which may be particularly relevant when investigating culturally sensitive interventions. Exclusion criteria, such as the omission of studies without explicit grief measures and those focusing on conditions like perinatal loss or ambiguous loss may have further limited the scope of our findings, a decision driven by considerations of the review's scope and available resources. Ambiguous loss may be particularly relevant among refugee populations (Renner et al., 2021). Lastly, deviations from the protocol, such as the exclusion of grey literature and guidelines, may introduce biases in the comprehensiveness of our analysis. These limitations collectively suggest that caution is necessary when interpreting the findings, and future research should address these gaps to enhance the robustness of our understanding of cultural adaptations in grief interventions.

4.4. Conclusions

The current scoping review is the first to explore culturally sensitive interventions for clinically relevant grief. Drawing on insights from 18 studies published between 2004 and 2022, it provides a comprehensive overview of culturally sensitive psychosocial interventions for clinically relevant grief states. The limited number of identified studies underscores the nascent stage of research in this field. Despite the small sample size, the upward trend suggests a growing recognition of the significance of cultural sensitivity in addressing clinically relevant grief.

The review reveals that interventions primarily target various sociocultural (sub)groups, with a predominant focus on age and ethnicity, while there was a notable gap in interventions targeting cultural groups based on language, religion, or sexuality, suggesting a potential avenue for future research. The targeted grief concepts varied, with surprising underrepresentation of interventions aligning with the ICD-11 criteria, possibly due to the recent availability of measures for this diagnostic category. Key findings emphasize different aspects to consider in the development of future culturally sensitive interventions, including aspects regarding the cultural adaptation approaches or culturally adapted content and delivery formats. The limited use of internet-based interventions highlights potential areas for innovation and adaptation in future research. Despite promising results in terms of efficacy, the variability in outcome measures and the lack of systematic reporting of cultural adaptation processes highlight the need for standardized approaches and increased transparency in future research. The implications of this review underscore the importance of awareness and adoption of culturally sensitive grief interventions, particularly for diverse sociocultural (sub)groups such as immigrant minorities and refugee populations.

While this review contributes valuable insights, limitations such as potential oversights in search strategy, language bias, and the exclusion of certain studies warrant cautious interpretation. The identified gaps and recommendations for future research emphasize the ongoing need for systematic investigations to further refine and enhance culturally sensitive interventions for clinically relevant grief states.

Funding

The first author is funded by a doctoral scholarship from the Digital Society Initiative (DSI) of the University of Zurich. The donors played no role in the design of this review.

CRediT authorship contribution statement

Anaïs Aeschlimann: Writing – original draft, Visualization, Methodology, Investigation, Formal analysis, Conceptualization. **Eva Heim:** Writing – review & editing, Supervision, Methodology, Conceptualization. **Clare Killikelly:** Writing – review & editing, Supervision, Conceptualization. **Mariam Arafa:** Writing – original draft, Visualization, Investigation, Formal analysis. **Andreas Maercker:** Writing – review & editing, Conceptualization.

Declaration of generative AI and AI-assisted technologies in the writing process

During the preparation of this work the author(s) used ChatGPT in order to improve the grammar and avoid spelling mistakes. After using this tool/service, the author(s) reviewed and edited the content as needed and take(s) full responsibility for the content of the publication.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgements

The authors would like to thank Steffi Pannarakunnel for her help with the development of the inclusion and exclusion criteria. Furthermore, we would like to thank Chantal Ruchti, Natalie Sangiorgio, Marion Bovey and Nadine Hosny for their help with the screening process at title and abstract stage.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.ssmmh.2024.100325.

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