

Clinical Perspectives on Bereavement & Grief: Past, Present, and Future

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AUGUST
24-25 | **2021**

*Presented by Eating Recovery
and Pathlight Foundation*



Citation for this presentation:

Layne, C. M. 2021. Clinical Perspectives on Bereavement & Grief: Past, Present, and Future.[Webinar].[Online]. Keynote address at the Eating Recovery and Pathlight Foundation Annual Conference. [August 25, 2021]

Available from: <https://psychology.nova.edu/faculty/profile/layne-christopher.html>

Before we Begin: Professional Disclosures



- **Trauma and Grief Component Therapy: A Modular Approach to Treating Traumatized and Bereaved Youth** (Saltzman, Layne, Pynoos, Olafson, Kaplow, & Boat, 2017). (Cambridge University Press)
- **Prolonged Grief Disorder Checklist** (Layne, Kaplow, & Pynoos). Available through Behavioral Health Innovations: <https://www.reactionindex.com/>
- **Multidimensional Grief Therapy** (Kaplow, Layne, Pynoos, & Saltzman, under contract, Cambridge University Press).
- **Scientific Advisor**, Behavioral Health Innovations (<https://www.reactionindex.com/>)

Presentation Summary

Although COVID-19 and other epidemics are exerting devastating effects globally, a “second wave” of secondary mental health consequences is upon us. This presentation will discuss converging demands on the mental health care system and new opportunities to raise the standard of bereavement care. It will review criteria for the new Prolonged Grief Disorder (to be released in DSM-5-TR) and key risk factors. The presentation will conclude with practical recommendations for distinguishing grief from related problems, promoting good grief, and creating risk screening and referral networks.

Before We Begin: On the Importance of Self-Care

My first lesson about self-care as a clinical psychology extern working in a school-based mental health clinic:

First try:

Student: “Who are you going to **talk** to?”

Me: *Confidentiality!*

Second try:

Student: “No...who are **you** going to talk to?”

Me: *Ahhhhh....self-care*



Self-Care: Self-Nurturing & Self-Protection

- Recognize your own **limitations** and **vulnerabilities**
- Don't push yourself beyond your ability to **tolerate witnessing intense pain**
- Listening to losses can be powerful **reminders** of our own personal losses
- Working with children whose ages are close to those of our **own children** can evoke powerful emotions and make the work more difficult
- Create a **consultation and referral network** of people you can consult with, or refer cases to, regarding cases that are difficult for you to handle
- **Take time off** in which you do things that are:
 - unrelated to bereavement work
 - health-enhancing
 - life affirming
- The NCTSN (NCTSN.org) and Core Curriculum on Childhood Trauma contain tools for addressing secondary traumatic stress reactions in learners, teams, and organizations.

Plenary Learning Objectives

1. Describe the “second wave” emerging from COVID-19 and other epidemics, and the need to create bereavement-informed systems of care.
2. Discuss risks associated with bereavement and grief across the life course: What do we know?
3. Suggest ways to see, understand, and distinguish grief from related problems: Some practical suggestions.

Key Terms

- **Bereavement:** a life event involving the loss of a loved one through death
- **Bereaved:** a person who has experienced bereavement
- **Grief:** voluntary and involuntary emotional, psychological, spiritual, and behavioral reactions to bereavement
 - (grief refers more generally to other types of loss that do not involve the death of a loved one—prolonged separation, estrangement, abandonment, former way of life)
 - Adaptive (helpful/normal) grief reactions
 - Maladaptive (unhelpful) grief reactions
 - ***(Challenge: How do we differentiate between these two sets of reactions in bereaved young people we serve?)***

Key Terms

- ***Mourning***: ritualized, often culturally-influenced ways—both public and private—of recognizing the meaning, significance, and value of the deceased person's life and death; and of acknowledging the ongoing impact of their loss in the lives of an individual, family, community, and/or nation.
- **Loss**: Deprivation of valued resources brought about by the death, separation, disappearance of, or estrangement from loved ones.
 - (Loss is a general term not specific to bereavement.)

Learning Objective



1

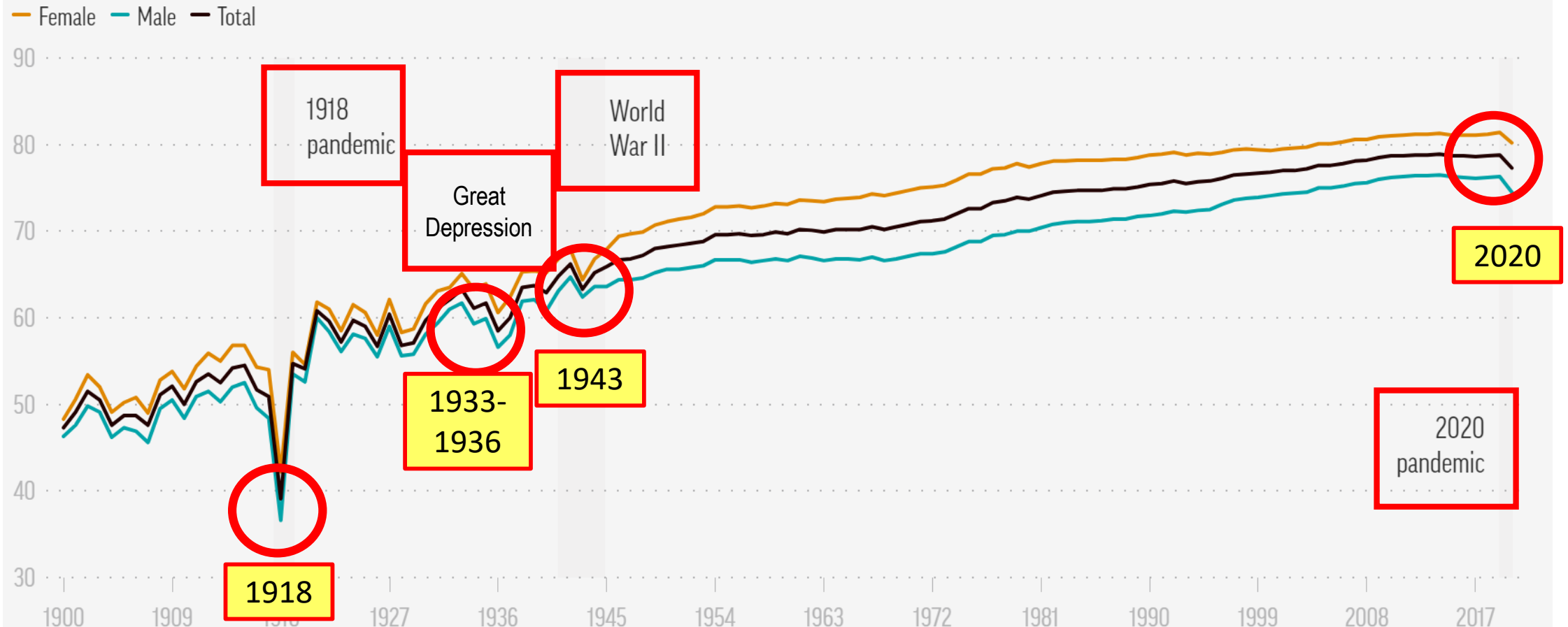
Our Modern Epidemics

Describe the “second wave” emerging from COVID-19 and other epidemics and the need to create bereavement-informed systems of care.

COVID-19 and Our National Life Expectancy

U.S. life expectancy

Life expectancy is a calculation of how long a baby born in a given year is expected to live on average.



COVID Has Widened Gaps in Health Disparities

- Life expectancy for Hispanic Americans dropped by 3 years—largest since CDC started tracking Hispanic life expectancy 15 years ago.
- Black life expectancy dropped nearly 3 years, lowest since 2000.
- White life expectancy fell by ~14 months, lowest expectancy since 2002.
- COVID-19 was responsible for:
 - 90% of decline in life expectancy among Hispanic Americans
 - 68% of decline among White Americans
 - 59% of decline among Black Americans
- Life expectancy fell nearly 2 years for men, 1 year for women, widening a longstanding gap.

<https://apnews.com/article/science-health-coronavirus-pandemic-fac0863b8c252d21d6f6a22a2e3eab86>

COVID's Second Wave (cont.)

- Each COVID-19 death leaves **~9 family members bereaved**
 - **US COVID-19 death total: 647,461**
 - **Global COVID-19 death total: 4,584,259**
 - Do the math—to date:
 - **5.8 million family members across the US bereaved by COVID alone**
 - **More Than 1.5 Million Children Globally Lost Caregivers Due to COVID-19**
 - **Other enduring adversities due to impact on schooling:**
 - lifetime income for today's students dropped
 - US economy will lose \$128-\$188 billion each year when they enter workforce.
(<https://alert.psychnews.org/2021/07/more-than-15-million-children-globally.html>)

Source: Simon, Saxe, & Marmar (2020).

COVID-19 Second Wave and Deaths of Despair

- Bereavement poses a double-barreled challenge: It is the **most common**, and the **most distressing**, form of trauma among both clinic-referred youth and youth in the general population (Kaplow et al., 2010; Pynoos et al., 2014; UNICEF, 2017).
- The pandemic and recession were associated with a 10% to 60% increase in **deaths of despair** above already-high pre-pandemic levels
 - **drug overdose**
 - **suicide**
 - **alcohol**
- Deaths of Despair are disproportionately experienced by **working aged men** (starting young--at 15 to 24 age bracket)
- **Social isolation** helps turn a pandemic into a wave of deaths of despair.

Source: Mulligan, C. (2021) <https://www.nber.org/papers/w28303>

Parental Bereavement (2012-2015)

Nationally-representative studies of bereaved youth report that:

- **1.48-1.59%** of youth report losing a **biological mother**
- **3.80% to 4.02%** report losing a **biological father** (Harris & Udry, 2008; Kessler, 2011)
- The Childhood Bereavement Estimation Model (Judi's House, 2021) estimates that:
 - **1 in 14, or 5.2 million**, children in the U.S. will experience the **death of a parent or sibling** before age 18.
 - Among average US high schoolers, **~7 out of 100 students** will have lost a parent and/or sibling by the time they graduate.
 - By age 25, 13.2 million, or **nearly 18 out of 100 young adults will have lost a parent and/or sibling by age 25.**

Sources: Kaplow, Layne, & Pynoos (2019); Layne & Kaplow (2020)

COVID's Second Wave (JAMA editorial)

- A “Second wave” is building of rising rates of mental health and substance use disorders.
- This imminent mental health surge brings further challenges for individuals, families, and communities including **increased deaths from suicide and drug overdoses**.
- As with the first COVID-19 wave, the mental health wave will **disproportionately affect Black and Hispanic individuals, older adults, lower socioeconomic groups of all races and ethnicities, and health care workers.”**
- Massive interpersonal loss is **compounded by societal disruption**. Social distancing and quarantine measures implemented as mitigation strategies have significantly **amplified emotional turmoil** by substantially **changing the social fabric** by which individuals, families, communities, and nations cope with tragedy.

Source: Simon, Saxe, & Marmar (2020).

COVID's Second Wave (cont.)

- Effect: **multidimensional disruption** of employment, finances, education, health care, food security, transportation, recreation, cultural and religious practices, and the ability of personal support networks and communities to come together and grieve.
- “Of central concern is the transformation of normal grief and distress into **prolonged grief** and **major depressive disorder** and symptoms of **posttraumatic stress disorder**.
- Once established, these conditions can become **chronic** with additional **comorbidities** such as substance use disorders.”
- Each COVID-19 death leaves an estimated **9 family members bereaved**

Source: Simon, Saxe, & Marmar (2020).

COVID-19 and Long-Term Unemployment

- Unprecedented unemployment shocks amplified by lockdowns and other government restrictions in response to COVID-19 **are predicted to cause nearly 900,000 deaths over the next 15 years.**
- **For every 10 percent increase in unemployment, the projected national mortality rate increases by 1.2 percent.**
- 1 in 5 suicides worldwide each year are due to **unemployment**
- **Employment and economic growth** are essential components of a healthy society.

Source: Bianchi, Bianchi, & Song (2021) <http://www.nber.org/papers/w28304>

Beyond COVID and Our Spiking Epidemics, What Do We Know about Bereavement Rates in General?

Death (and Taxes)

- *Bereavement under tragic and potentially traumatic circumstances* is a major mental health concern and public health emergency.
- National suicide rate in 2017 was the highest in over 50 years; consistently ranks among the 10 leading causes of death over the past decade.
- CDC Director wrote editorial on traumatic deaths: “Too many lives are being lost, too often and too early, to preventable causes, including drug overdose, suicide, motor vehicle accidents, and homicide” (Redfield, 2018)
- Self-harm was the 14th leading cause of death worldwide in 2016, and is predicted to rise to the 11th leading cause of death worldwide by 2040 (Foreman et al., 2018).
- Overdose deaths have risen dramatically over the past 18 years.

(Reviewed in Layne & Kaplow, 2020)

Learning Objective



2

Discuss risks associated with bereavement and grief across the life course: What do we know?

Question:

**What does research evidence tell us
about the effects of bereavement
across the developmental lifespan?**

Why Prioritize Bereavement?

Bereavement: High Frequency, High Potency

Keyes et al. (2014) studied a large adult sample (N = 27,534).

- **Unexpected death** of loved one (accident, murder, suicide, heart attack, terrorist attack) was:
 - the **most common** traumatic experience (~50% of respondents endorsed)
 - most likely to be rated as **worst** lifetime experience
- More respondents experienced **first unexpected death between ages 15-19 (mid- to late adolescence)** than any other age interval.
- **Dose-response relation** between number of unexpected deaths and number of lifetime psychiatric disorders. There as an increased risk after unexpected death at nearly every point across the life course for:
 - PTSD
 - Major depressive episode
 - Panic disorder

Bereavement Risks: Spouses, Parents, Siblings

- **Bereaved spouses, parents, and siblings** are at significantly increased risk of **premature death**.
- Bereaved parents who lose a child *at any age* are more likely to suffer from **cardiac problems, cancer, psychiatric hospitalization, cognitive decline, and other health complications**.
- These effects **persist for an average of 18 years** following the death.

(Reviewed in Layne & Kaplow, 2020)

Why Prioritize Bereavement Care?

Compared to non-bereaved peers, adolescents who lost a parent are at **increased risk** for many health and adjustment problems:

- lower self-esteem
- reduced resilience
- lower grades and more school failures
- reduced likelihood of graduating any grade level through college
- reduced professional income
- heightened risk for depression and anxiety
- suicide attempts
- suicide
- premature death due to any cause
- Illicit drug use
- violent crime involvement
- youth delinquency
- more, and more severe, psychiatric difficulties including psychosis
- (for girls) less likely to marry
- mortality risk due to any cause

(Reviewed in Layne & Kaplow, 2020)

Bereavement and Health Disparities

Health disparities: Differences in rates of exposure to sudden unexpected death contribute to health and mental health disparities that extend across the lifespan.

- Given disparities observed among youth in juvenile justice, there is a real risk of **misdiagnosis, mischaracterization of behavior, potential overuse of psychotropic medications.**
- Exposure to sudden death, grief reactions were disproportionately higher in a sample of **Juvenile Justice-involved adolescents** than a matched sample of high school youth (Wood et al., 2002)
- **Racial disparities** in bereavement emerge early in life, persist across the lifespan. **After accounting for loss-related disparities, the health disparities gap between Black and White Americans nearly disappeared** (Umberson, 2017).

Implications of Health Disparities

- Addressing disparities in bereavement can help to:
 - **address major disparities affecting minority and underserved groups**
 - **reduce the risk for underdetection, misdiagnosis, developmental disruption, inappropriate school discipline, mental health treatment**
- Given disparities observed among minority and/or marginalized youth, there is a real risk of misdiagnosis, mischaracterization of behavior, potential overuse of psychotropic medications.
- **Timely detection/intervention** will help to create a window of opportunity for timely remediation of developmental disruptions of bereaved youth who are at serious risk for school dropout and entry into the juvenile justice system.

(Reviewed in Layne & Kaplow, 2020)

Why Prioritize Bereavement Care?

Developmental tasks, transitions are susceptible to developmental disruptions:

A longitudinal study of 373K bereaved Norwegian youth (Burrell, Mehlum, & Qin, 2020) found that **youth bereaved by parental death due to accidents, suicides, homicides** were (compared to parentally non-bereaved peers) significantly less likely to:

- pass every grade level (elementary, junior, senior high through university)!
- effects most pronounced for **completing high school and university**.
- **marry** once they came of age (especially girls)
- **Conclusions:**
 - Parental death by external causes has powerful, long-lasting impacts on offspring's educational attainment at all levels.
 - **Bereaved youth need help with educational progress.** This goes beyond a focus on symptom reduction.

(Reviewed in Layne & Kaplow, 2020)

Why Prioritize Bereavement Care?

School impairment can have long-term developmental consequences.

- In a large nationally representative sample (>10,000; Oosterhoff et al., 2018) of US youth, **sudden loss** (accidents, murder, suicide, heart attack, stroke) was:
- the **most frequently endorsed** type of severe life event of 18 types studied,
- most likely to occur in **mid-adolescence (between 15-16 years of age)**
- inversely linked to all five indicators of **impaired school functioning** studied:
 - lower academic achievement
 - lower ability to concentrate and learn
 - less enjoyment of school
 - lower school belongingness
 - lower beliefs that teachers treat youth fairly
- **A drop in grades during a junior or senior year of high school can significantly diminish post-high school educational and professional opportunities.**

(Reviewed in Layne & Kaplow, 2020)

Summary of Key Points

- COVID exacts dual tolls: Loss of life, loss of mental health & well being
- National life expectancy just dropped by >1 year—largest in 60 years (!!)
- Bereavement poses a double-barreled challenge: It is not only the **most common**, but also the **most distressing**, form of trauma among both clinic-referred youth (Pynoos et al., 2014) and youth in the general population (Kaplow et al., 2010; UNICEF, 2017).

(Reviewed in Layne & Kaplow, 2020)

Summary of Key Points

- There can be important **developmental differences** in grief reactions, which will require developmentally-sensitive measures to clarify.
- There can be important **cultural differences** in grief reactions, which will require culturally-sensitive assessment tools to clarify. These include culturally-linked or religiously-linked:
 - mourning rituals
 - rites of passage
 - idioms of distress (i.e., particular ways of expressing grief)
 - Definitions and expectations of what “normative” behavior is and looks like
 - Understandings, interpretations of functional impairment

A Caveat against Fatalism and Alarmism

- “Increased Risk for_____” can be misleading. “Risk” refers to probability, not “fated to” or “doomed to.” In fact, most bereaved youth do **not** develop serious adjustment difficulties.
- Our best available estimates are that **10-15% of individuals develop clinically significant difficulties** (Kaplow, Saunders, Angold, & Costello, 2010; Layne, Kaplow, Oosterhoff, & Hill, 2019).
- **Thus, 85-90% of bereaved youth generally grieve within an adaptive/normal range of adjustment** (Kaplow & Layne, 2014; Kaplow, Layne, & Pynoos, 2019).
- **We need strength-based grief theory, assessment tools, interventions, public policies, and public outreach that reflect this strength-based, positive reality.**
- But the facts tell us that bereavement is a very difficult life experience to undergo, and that we should do our best to lighten its heavy load.
- **Prediction**: Youth bereaved by COVID/Deaths of Despair will have higher prevalence rates of Prolonged Grief Disorder than 10-15% (Kaplow, Howell, & Layne, 2014; Layne et al., 2017).

Learning Objective



3

Describe ways to see, understand, and distinguish grief from related problems.

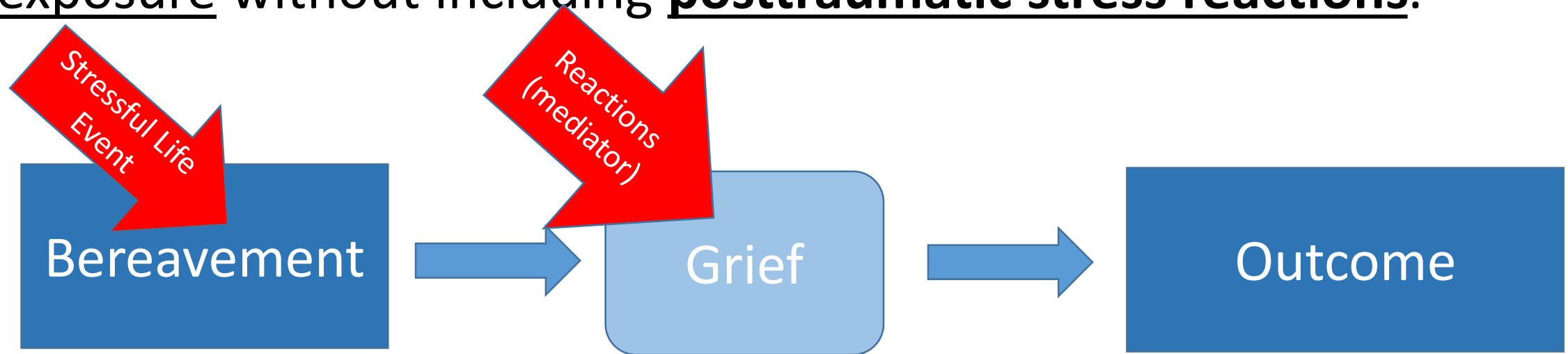
Assessment and Intervention with Grief: A Key Mediator between Bereavement and Adjustment

Why Distinguish between Bereavement and Grief?

Studying, assessing, conceptualizing, and treating bereavement without including **grief reactions**.

is like

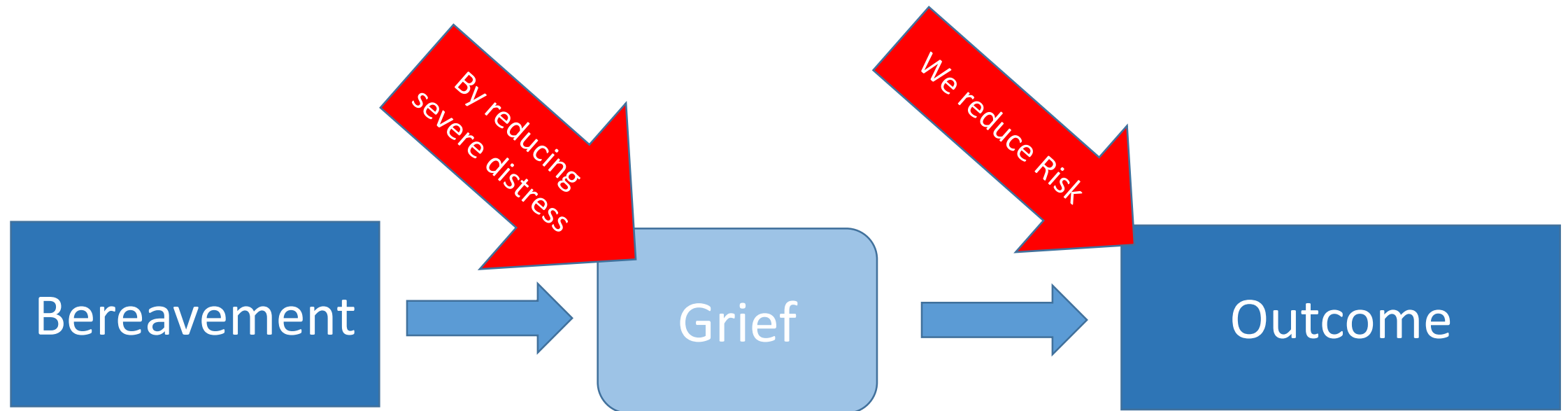
Studying, assessing, conceptualizing, and trying to treat trauma exposure without including **posttraumatic stress reactions**.



(Reviewed in Layne & Kaplow, 2020)

Why Distinguish between Bereavement and Grief?

- You **can't** treat bereavement, but you can support and treat grief.
- You are missing a huge opportunity to intervene if you focus on bereavement alone while ignoring grief reactions.
- By reducing debilitating grief reactions, we not only reduce distress in compassionate ways; **we also reduce the risk for many adverse outcomes.**



Screening for Stress-Related Disorders:

- Bereavement/Grief
- Trauma/PTSD

Presents a Double-Barreled Challenge

Dual Challenge for Assessing Causes and Effects

Centers on need to accurately assess both sides of a cause-effect equation:

1. **Exposure to the stressful events themselves** on one hand (bereavement)
2. **The consequences of that exposure** on the other hand (grief)

Assessment errors can arise on both sides of the equation, resulting in:

- **Under-detection** of exposures on one hand (e.g., failure to detect bereavement)
- **Under-diagnosis** of their effects on the other hand (e.g., failure to detect grief)
- **Failure to detect bereavement virtually guarantees that you will miss grief.**



Question:

But Don't Standard Assessment Procedures Do An Adequate Job of Detecting Stress-Related Disorders?

Under-Detection = Under-Diagnosis

Chemtob et al. (2016) evaluated the **accuracy** of clinicians working in community mental health clinics in identifying **trauma exposure and PTSD** in 157 children. Children, parents were **assessed twice**: First by a clinic practitioner using a standard intake assessment; second by a study clinician using a **structured trauma-focused assessment**.

1. Although mandated to assess trauma exposure, clinic practitioners **identified less than half** (21.2%) of the youth identified by trained study clinicians (51.3%) as having **trauma exposure**.
2. Clinic practitioners **identified PTSD in 1.9%** of sample, whereas study clinicians reported **19.1%**.
3. Although clinic practitioners had **access** to the assessment results in each client's chart and were required to **update** their treatment plans on a quarterly basis, a one-year follow up review identified **no changes** in their client's PTSD diagnosis (**i.e., assessment was one-time & static**).
4. Diagnostic signs were nevertheless apparent: Clinic practitioners and parents rated underdiagnosed children as exhibiting emotional and behavioral problems and lower functioning. **Clinicians reported seeing the indicators, but missed the diagnosis and an opportunity to prescribe appropriate treatment.**
5. **Sobering conclusion: Standard assessment procedures missed more than half the trauma exposure, missed 90% of PTSD cases, and did not course-correct even though accurate information was available and regular updates to treatment plans were required by clinic policy.**
6. **We must ask about bereavement history or we will miss both bereavement and grief.**

Bereavement, Grief, and Negative Cascades

Failure to detect (in risk screening) bereavement

**Leads
to**

Failure to detect (in risk screening/assessment) clinically severe grief reactions

**Can
Lead to**

No Grief Diagnosis

**Can
Lead to**

No Treatment

**Can
Lead to**

Misdiagnosis

**Can
Lead to**

**Inappropriate
treatment**

Question:

What Does Prolonged Grief Disorder Look Like?

DSM-5-TR Criteria (expected to be released in late 2021/early 2022)

DSM 5-TR Criteria: Prolonged Grief Disorder

As a **general (not word for word) overview** , PGD consists of six diagnostic criteria including the following (*developmental modifications are italicized*):

- **PGD Criterion A:** The death of a close person (at least 12 months ago for adults; *at least 6 months ago for children and adolescents*)
- **PGD Criterion B:** Persisting grief reactions experienced to a clinically significant degree nearly every day for at least the last month, characterized by either or both:
 - intense yearning or longing for the deceased person
 - preoccupation with thoughts or memories of the deceased person (*preoccupation may focus on the circumstances of the death in children and adolescents*)

DSM 5-TR Criteria: Prolonged Grief Disorder

- **PGD Criterion C:** At least 3 of 8 symptoms, which make up the broader constellation of PGD, experienced to a clinically significant degree nearly every day for at least the last month. These include:
 - identity disruption,
 - marked sense of disbelief about the death,
 - avoidance of loss reminders (*in children and adolescents, may be characterized by efforts to avoid reminders*),
 - intense emotional pain related to the death,
 - difficulty reintegrating into one's relationships and activities after the death,
 - emotional numbness as a result of the death,
 - feeling that life is meaningless as a result of the death,
 - intense loneliness as a result of the death.

DSM 5-TR Criteria: Prolonged Grief Disorder

- **PGD Criterion D:** Reactions are sufficiently severe and persisting that they cause clinically significant distress or functional impairment in important life domains (e.g., social functioning)
- **PGD Criterion E:** The duration and severity of reactions clearly exceed expected social, cultural, or religious norms for the individual's culture and context
- **PGD Criterion F:** Differential diagnosis reveals that the symptoms are not better explained by major depressive disorder, posttraumatic stress disorder, or another mental disorder, or physiological effects of a substance or another medical condition.

Key Takeaways with Prolonged Grief Disorder

- DSM-5-TR (American Psychiatric Association, 2022) contains a new **Prolonged Grief Disorder (PGD)**
- DSM-5-TR PGD (used in the US) is distinct from ICD-11 PGD (used elsewhere in the world), even though they share the same names. This will cause confusion.
- Prolonged Grief Disorder is **its own entity**:
 - Not “traumatic grief,” “childhood traumatic grief,” “complicated grief,” “disenfranchised grief,” “abnormal grief,” “pathological grief,” etc.
 - These other types of grief have their own theoretical baggage—explanations for how they look, their causes, course over time, therapeutic objectives for treatment
 - ***Call PGD by its real name—Prolonged Grief Disorder.*** Using any other name will introduce confusion and inaccuracy.
 - PGD is distinct from related disorders including close “cousin” disorders of depression, PTSD

Question:

What factors increase risk for PGD?

(Causal Risk Factors & Vulnerability Factors)

Key Risk Factors for Prolonged Grief Disorder

- Prior history of **depression**
- Prior history of **trauma or loss**
- **Insecure attachment style**
- **Core identity-defining/identity-affirming relationship** (helped you know who you are)
- **Death circumstances** (violent, tragic, shocking, painful/intense suffering, gruesome or mutilating disfigurement, bewildering, human negligence or malice, violates the social contract)
- **Secondary adversities** (loss of income, stability, security, social connections, sense of belongingness)
- **Compromised primary caregiver**, caregiving practices (parenting, relationship quality)
- Exposure to, inability to cope constructively with, **loss reminders**
- Exposure to, inability to cope constructively with, **trauma reminders**

Iglewicz et al. (2020); Kaplow, Layne, & Pynoos, (2019); Layne et al. (2006); Layne & Kaplow (2020); Pynoos (1992); Rynearson (2001, 2006)

Conceptual Tools for Understanding Bereavement & Grief

1. Trauma Reminders
2. Loss Reminders
3. Developmental Disruptions

Trauma Reminders

(Layne et al., 2006)

- Cues or “triggers” linked to past traumatic events (e.g., circumstances of traumatic deaths, including murders, suicides, accidents). Can also include slow painful deaths due to natural causes (Kaplow, Howell, & Layne, 2014).
- Past-focused (calls attention to past traumatic experiences)
- Can involve all the senses (sight, sound, smell, touch, kinesthetic/bodily sensations)
 - People
 - Places where bad things happened
 - Sounds (screaming, breaking glass, gunfire, screeching tires)
 - Smells
 - Bodily sensations (heart beating fast, being held down)
- Can strongly evoke posttraumatic stress reactions (PTSD symptoms)

Loss Reminders

(Layne et al., 2006)

- Reminders of the ongoing physical absence of beloved people, places, belongings one has lost
- Present and future-focused (“he’s not here, won’t be here in the future”)
- Their name, belongings, photos, places they used to be (favorite chair, room, seat at dinner table, chair in the classroom, locker at school)
- People who look like them, used to associated with them (friends, family)
- Things you used to do together
- Times when you want their company, advice, companionship, or cheerleading (life adversities, major life decisions, celebrations)
- Developmental rites of passage (graduations, going away to college, weddings, babies, job promotions)
- Can strongly evoke grief reactions (including Prolonged Grief Disorder Symptoms)

Measures of PGD Are Being Developed

- My colleagues and I are currently developing the **Prolonged Grief Disorder Checklist** (Layne, Kaplow, & Pynoos)—will be available at Behavioral Health Innovations: WWW.ReactionIndex.com.
 - (Write me if your organization is interested in collaborating on its validation) clayne@nova.edu

What Have We Learned about Assessing Grief in Bereaved Children and Adolescents?

- Grief shows **multidimensional structure** in bereaved youth (e.g., adaptive vs. maladaptive)
- Grief is linked to **impaired functioning** (with family, peers, at school) and **suicide risk**
- Grief reactions can be **assessed in reliable and valid ways** with properly-designed assessment tools administered by properly-trained clinicians
- Children can be **good self-reporters** under certain conditions (child-friendly items, prompts)
- Critical importance of **developmentally appropriate** wording, developmental vetting with experienced clinicians, iterative refinement (very time consuming!)
- Children are better reporters of “**internalizing**” problems; adults may be better reporters of “**externalizing**” problems including functional impairment at home, school
- Grief-focused intervention is linked to **significant improvements in symptoms and functioning as outcomes**

Layne & Kaplow (2020); Layne, Kaplow, Oosterhoff, & Hill (2019); Layne, Oosterhoff, Pynoos, Kaplow, & Pynoos (2020); Nader & Layne (2009)

Spotlight on Key Problems: Suicide Risk

Bereavement and Suicide Risk

Grief reactions appear to mediate the link between bereavement and suicide risk in adolescents.

- Hill and colleagues (Hill et al., 2019) found that maladaptive grief reactions predicted suicide ideation via **thwarted belongingness** (a predictor of adolescent suicidal ideation and behavior) in 58 bereaved youth.
- **Grief reactions** mediated the relation between bereavement and suicide risk.
- Because we cannot treat bereavement (only grief), **this makes grief-focused intervention a more promising therapeutic strategy than focusing only on mitigating bereavement-related stress.** Bereavement then becomes a marker of risk that helps us identify whom to screen and, if needed, assess for severe persisting grief reactions.



Bereavement and Suicide Risk

- The ability (tools, training, policies, and procedures) to detect unhelpful grief reactions is a valuable therapeutic tool for early identification and intervention among bereaved adolescents—a high-risk group for whom a link between loss and suicidal ideation/behavior is well established.
- This underscores the importance of **early risk detection, assessment/diagnosis, and intervention in the aftermath of bereavement.**
- **Middle adolescence** is the age group at highest risk for experiencing sudden loss; **risk screening of adolescents for bereavement and grief reactions is especially important.**
- It is also important to be **trained in acute suicide prevention skills** when working with bereaved youth (e.g., King, Foster, & Rogalski, 2013).
- COVID-19 and other epidemics are leaving many youth and families bereaved under **tragic and traumatic circumstances**, increasing an already widespread need.

(see also Layne & Kaplow, 2020)

Question:

How can I tell whether a child who has lost a caregiver may be experiencing severe grief reactions in need of specialized therapeutic care?

What Can a Disrupted Developmental Trajectory Look Like?

1. **Interruption** of age—appropriate developmental tasks.
2. Developmental **slowdowns** (slower rate of progress in acquiring developmental competencies)
3. Developmental **regressions** (loss of competencies)
4. **Delayed initiation** of age-appropriate developmental tasks once the youth comes of age (e.g., don't date, don't drive, excessively dependent at age 16).
5. Precocious **accelerations** in development (running away, dating older people, precocious sexual behavior).
6. Lost **developmental opportunities** (e.g., giving up on sports, socializing, dating).
7. **Odyssey** (major detour or redirection in life course, often following traumatic loss)
8. Normal sensation-seeking (exploratory) → **Risky behavior (reckless, dangerous)**.
9. Increased susceptibility to **illness** (allostatic load “wear & tear” at cellular/organ systems level).

Source: Module 4 of Saltzman, W. R., Layne, C. M., Pynoos, R. S., Olafson, E., Kaplow, J. B., & Boat, B. (2017). *Trauma and Grief Component Therapy for Adolescents: A Modular Approach to Treating Traumatized and Bereaved Youth*. Cambridge University Press.

Can I recognize (good) grief
when I see it?

The Charlie Brown Problem

Charlie Brown was right!

- There is such a thing as “good grief”.
- Adaptive grief is not studied nearly as much as “maladaptive” grief—a major shortcoming.
- However, **“good grief” is the norm.**
- The Shared Grief Project highlights “good grieving” and is a great resource for instilling hope and providing positive role models of adaptive grieving: <https://sharedgrief.org/>.

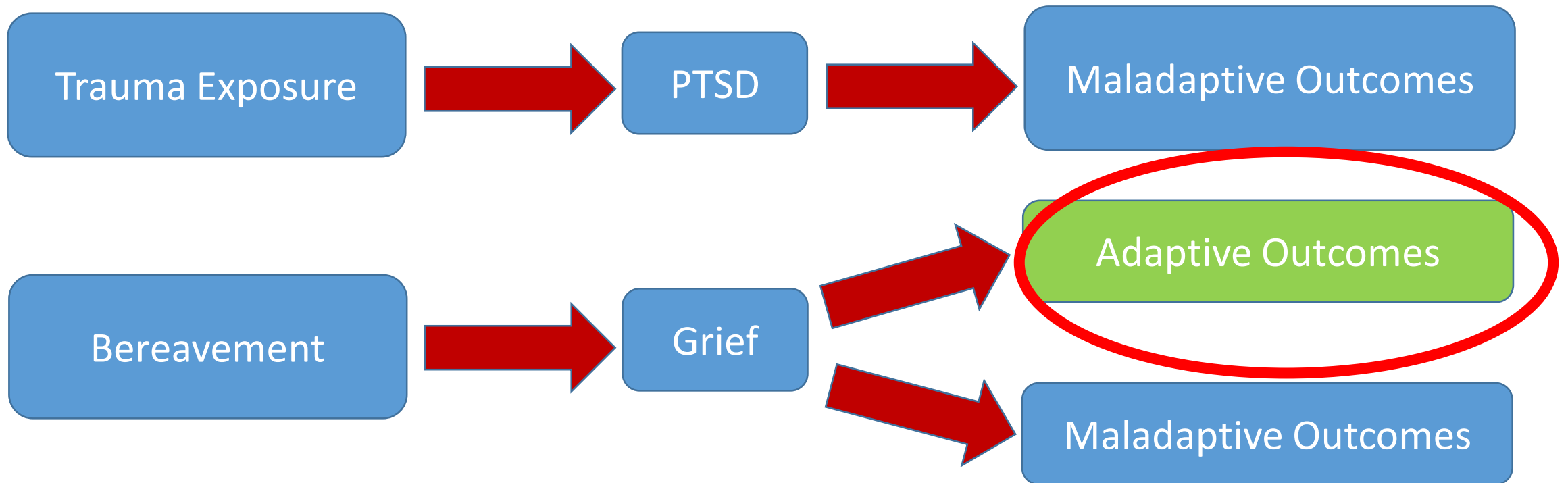
Why is Grief Different?

We don't have to explicitly distinguish between “good” versus “bad”:

- **Depression**
- **Schizophrenia**
- **Tic disorder**
- Yet, we need to distinguish between **adaptive versus maladaptive grief** when assessing grieving youth. What is helpful to them, versus what is less or not helpful?

Similarities and Differences between PTSD and Grief

(Kaplow et al., 2012; Kaplow et al., 2019; Layne, Olsen, et al., 2011; Layne et al., 2017, Saltzman et al., 2017)



Bottom Line for Assessing Grief

- Trauma-focused treatment does not typically require that you consistently distinguish between “adaptive” versus “maladaptive” PTSD symptoms.
 - Exception: Hypervigilance can be adaptive in dangerous environments
- Therapeutic treatment for Prolonged Grief Disorder does require that you distinguish between adaptive vs. maladaptive grief reactions.
- Why? Because we want to facilitate adaptive grief, and help maladaptive grief to recede. In other words, you don’t simply strive to get unhelpful grief to recede; you also want to help adaptive and helpful grief to proceed. These different intervention objectives (proceed vs. recede) often require different practice elements (tools).

Sources: Layne, 2020, 2021; Layne & Kaplow, 2020

Some Practical Guidance:
What can I as a care provider do
to help a bereaved child,
adolescent, or young adult and
their family?

Basic Recommendations for Supportive Intervention

(Kaplow, Layne & Pynoos, 2019; Saltzman et al., 2013; Shear, 2020)

- Listen empathically and non-judgmentally. Help them label and understand their emotions.
- Recognize the symbolic power of simple gifts (expressing understanding, comfort, lightening a load, helping them connect to others, sharing hope that you can help them find help)
- Reflect and paraphrase (not only what they say, but how they say it—attend to voice tone, pacing)
- Social support is a potent vulnerability factor if in deficit; a potent protective factor if present/mobilized. Be prepared to teach your clients/patients skills for how to recruit and provide social support. If appropriate, also be prepared to intervene with their broader social support network (family, friends, church community). TGCTA contains skills-building exercises to build these skills.

Basic Recommendations for Supportive Intervention (cont.)

(Kaplow, Layne & Pynoos, 2019; Saltzman et al., 2013; Shear, 2020)

- Be especially attentive to the well-being and role functioning of caregivers. Help them to help their children.
- Grief work is work! Take rest periods, focus on self-care (sleep, diet, exercise, rest, socializing).
- Bereaved people may need to suppress their grief and postpone it for later given current demands. This may induce feelings of confusion/guilt for not grieving properly. Grief reactions can be delayed by danger/survival.
- Family members may grieve in very different ways based on many factors (witnessing the death, relationship to deceased, coping strategy, age, other stressors). These can create dyssynchronies in family dynamics. TGCTA's supplementary parenting sessions can help in this regard.
- Suicide ideation can reflect deep longings to be reunited with the deceased or an existential or identity crisis. These powerful motivations can be acknowledged and integrated into suicide prevention.

The “Most But Not All” Dilemma in Grief Work

- Many (indeed most) bereaved youth grieve in a helpful/adaptive range.
- **But not all youth:** The best evidence suggests that 10-15% will experience clinically severe distress. This rate is likely higher following traumatic/deeply disturbing deaths.
- **How do we recognize, identify, and help this significant subset of bereaved youth who need specialized grief services?**
- **We need:**
 - Well-designed risk screening and assessment tools
 - Guiding theory
 - Interventions that can both support helpful grief, and address unhelpful grief.
 - Risk screening and referral networks

How Can I Distinguish between Adaptive vs. Maladaptive Grief Reactions?

- We need clinically useful grief theory and good assessment tools to make informed professional decisions about which grief reactions to facilitate, and which to reduce. Potential markers of **unhelpful grieving** include:
 - Inability to form comforting connections to the deceased
 - Struggling to create a constructive sense of purpose or meaning in relation to the death (very difficult to do after senseless or tragic deaths)
 - Struggling to form a constructive personal identity after the death (“I died with them”)
 - Distressing preoccupation over the way they died
 - Feeling overwhelmed by reminders of the ongoing loss (loss reminders) or of the way they died (potential trauma reminders)

Sources: Layne (2021); Layne, Kaplow, & Pynoos (2011); Layne et al. (2017); Layne & Kaplow (2020)

Markers of Maladaptive or Unhelpful Grief Reactions

(Layne et al., 2011; 2014; 2017)

- Severe persisting distress
- Functional impairment (underachievement, relationship problems, work quality)
- Dysregulated behavior (disruptive behavior at school, rule compliance problems)
- Risky behavior: self-neglect/harm, recklessness, substance abuse, suicide ideation

Markers of Maladaptive or Unhelpful Grief Reactions

(cont.) (Layne et al., 2014; 2017; Saltzman et al., 2014)

- Developmental disruption (developmental tasks, developmental milestones)
 - decreased school performance
 - loss of motivation to achieve age-appropriate developmental tasks
 - pessimistic future outlook
 - negative alterations in self-concept
 - diminished sense of life purpose/meaning
 - estrangements in close relationships /social withdrawal
 - negative attitudes towards family life
 - diminished or abandoned professional aspirations
 - negative attitudes towards civic involvement (volunteerism, clubs, communities)

Continuity of Bereavement-Informed Care

Grief Support Facilities

Services:

- Risk screening
- Referrals of youth who test positive to grief treatment facilities
- **Grief support services** (aim: facilitate adaptive grief reactions & positive adjustment, peer support)
- **Outcome evaluation** (individual cases)
- **Program evaluation** (pooled outcomes)
- **Public advocacy and outreach**

Referrals

Grief Treatment Facilities

Services:

- Risk screening
- Referrals of youth who test negative to grief support services/facilities
- **Grief support services** (aim: facilitate adaptive grief reactions & positive adjustment, peer support in group settings)
- **In-depth clinical assessment**, diagnosis
- **Therapeutic services** (aims: reduce clinical distress, impairment, risky/destructive behavior, developmental disruption)
- **Outcome evaluation** (individual cases)
- **Program evaluation** (pooled outcomes)
- **Public advocacy and outreach**

(Purple font):
Unique aspects
of treatment/
clinical services

Bottom Line:

If you are not in a position to provide specialized grief therapeutic services, then help to build a risk screening and referral network to provide good continuity of bereavement care!

Why do we need a theory of grief that can explicitly address both adaptive “good grief” and maladaptive grief reactions?

Overview of Multidimensional Grief Theory:

A Strength-Based, Positive Approach to Understanding, Assessing, and Intervening with Grieving Children and Families

I have been building this theory for 25+ years in collaboration with various colleagues:

Robert Pynoos

William Saltzman

Alan Steinberg

David Schuldborg

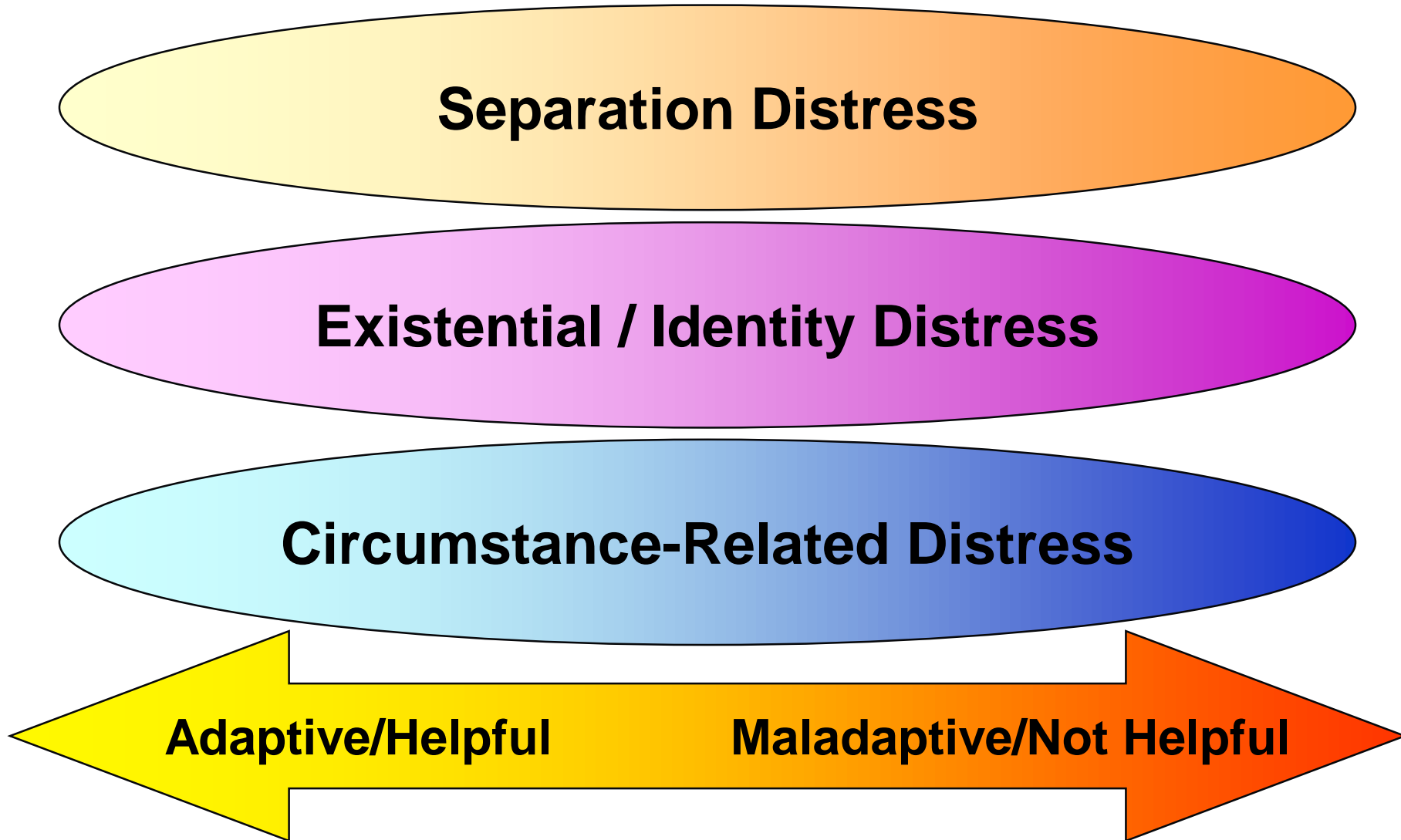
Julie Kaplow

Marit Netland

Layne Trauma & Bereavement Research Lab at Nova Southeastern University

Multidimensional Grief Model

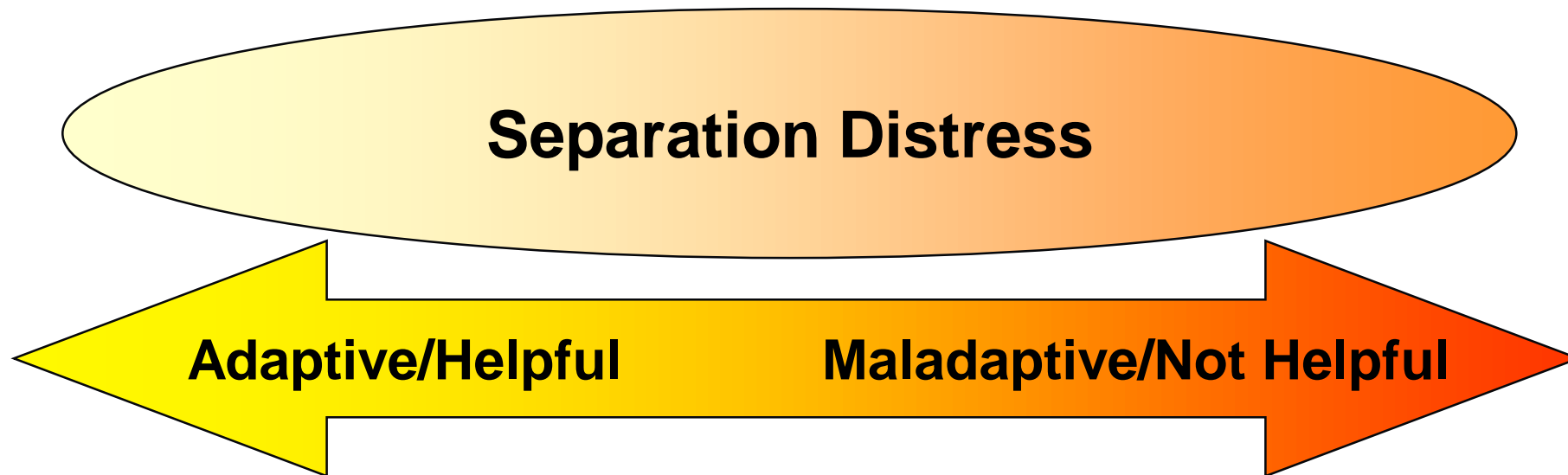
(Layne, Kaplow, & Pynoos, 2011; Layne, Kaplow, & Pynoos, 2012; Layne et al., 2017)



Central Challenge of Separation Distress

(Layne et al., 2017)

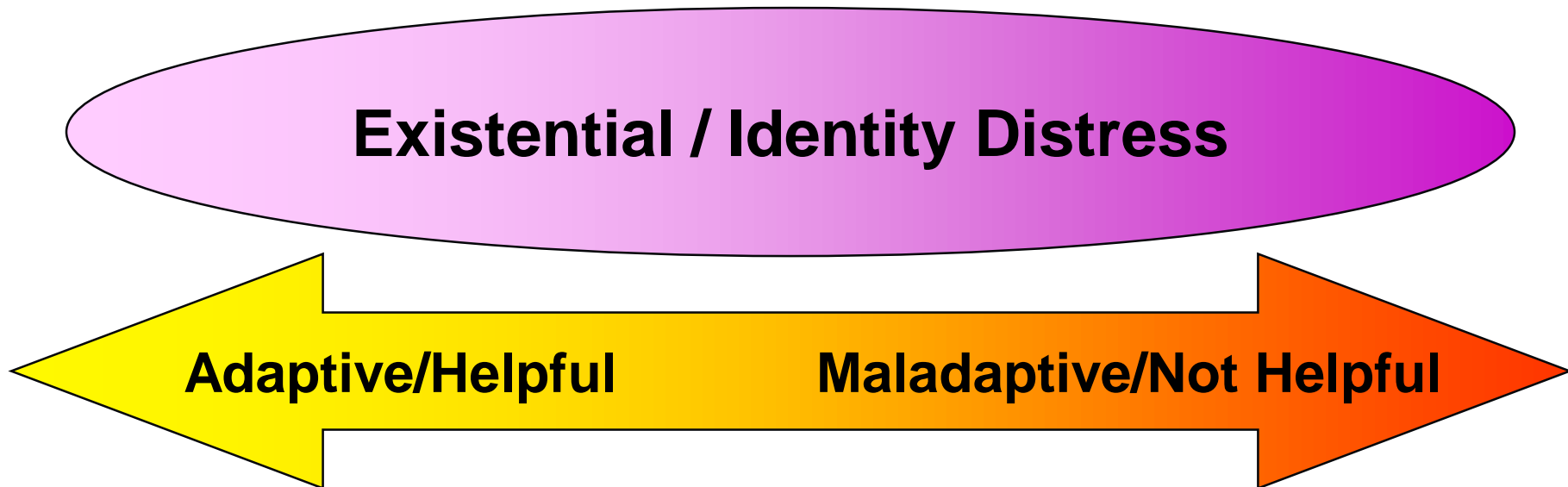
“How can I continue to feel connected to the person who died, so that they remain an important part of my life?”



Challenge of Existential/Identity Distress

(Layne et al., 2017)

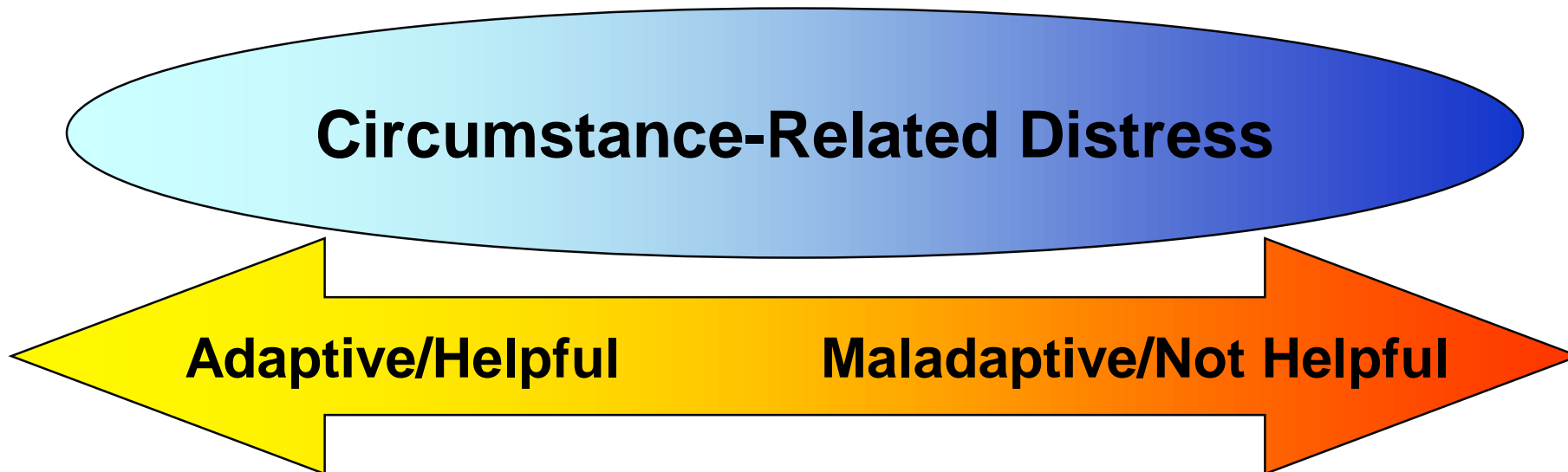
“Who am I as a person, and what is the purpose of my existence, now that this loved one is physically absent from my life?”



Challenge of Circumstance-Related Distress

(Layne et al., 2017)

“How do I manage my distressing thoughts, beliefs, wishes, fantasies, emotions, and impulses evoked by how this person died?”



Multidimensional Grief Theory Core Propositions

- Each of the three grief domains (Separation Distress, Existential/Identity Distress, Circumstance-Related Distress) encompasses both **adaptive** and **maladaptive** responses to the central coping challenge specific to that domain.
- Both maladjustment and positive adjustment can manifest within each grief domain.
- Positive and negative adjustment processes can and frequently do co-occur within a given grief domain.

Sources: Layne, Kaplow, & Pynoos (2011); Layne, Kaplow, & Pynoos (2012); Layne et al. (2017); Saltzman et al. (2017)

Multidimensional Grief Theory Core Propositions

- Multidimensional grief theory is **agnostic** (makes no assumptions) about whether the central coping challenge in each domain is “good,” “bad,” or “neutral.”
 - The coping challenge simply “is.”
 - The theory simply proposes that most bereaved people confront each coping challenge as a natural, expectable aspect of the bereavement experience (e.g., How to still feel connected to my loved one?)
- ***How* bereaved people cope with each central coping challenge, and the consequences of those coping strategies**, can be a potent contributor to each person’s grief process, adjustment, and course of grief over time.
- ***How much*** a bereaved person engages in specific grief responses—both adaptive and maladaptive—across grief domains, makes up their **individual grief profile**.
- With properly-designed grief assessment tools, we can create **individual grief assessment profiles** and use them to individually tailor our grief interventions.

Source: Layne et al. (2017)

Multidimensional Grief Theory Core Propositions

Different dimensions of grief may relate differently to different:

- **Primary correlates** (e.g., unhelpful grief correlates more strongly with PTSD, depression, school problems, than helpful grief)
- **Causal risk factors** (e.g., traumatic death)
- **Mediators** (trauma reminders, loss reminders, hardships caused/worsened by the loss)
- **Moderators**, including:
 - Demographic variables (age/developmental stage, sex, race, culture)
 - Protective factors (high social support, positive parenting, religious beliefs, high SES)
 - Vulnerability factors (low social support, low self-efficacy, low SES/community resources, prior losses)
- **Causal consequences**, both:
 - Unhelpful: (suicide ideation, depression, functional impairment, risky behavior)
 - Helpful: (prosocial behavior, adherence to school rules, positive life ambitions)

Sources: Layne, Kaplow, & Pynoos (2011); Layne, Kaplow, & Pynoos (2012); Layne et al. (2014); Layne et al. (2017)

Multidimensional Grief Theory Core Propositions

Different dimensions of grief may:

- be more **prominent in some demographic groups** than others (moderator variables)
 - Culture/ethnicity
 - Race
 - Sex
- be more prominent at **different developmental stages** (moderator variables)
 - Child (e.g., higher in Separation Distress)
 - Adolescence (e.g., higher in Existential/Identity Distress)
- be more prominent in **certain at-risk groups** (causal risk factors or vulnerability factors)
 - cause of death (Circumstance-Related Distress higher in traumatically bereaved youth)
 - Relationship to the deceased (e.g., conflictual relationship with deceased)
 - Prior history of loss
 - Prior history of psychiatric disorder (e.g., depression, PTSD)
 - Socioeconomic status (low SES)

Sources: Kaplow & Layne (2014); Layne et al. (2011, 2012); Layne et al. (2014); Layne et al. (2017)

Multidimensional Grief Theory Core Propositions

Different dimensions of grief may:

- call for dual-pronged, strength-based interventions
 - help adaptive grief reactions (good grief) to **proceed**
 - Help maladaptive grief reactions (dysregulating grief) to **recede**
- produce **different grief assessment profiles**, such as high vs. low scores on:
 - Separation Distress
 - Existential/Identity Distress
 - Circumstance-Related Distress

Sources: Layne (2021); Layne et al. (2017); Saltzman et al. (2017)

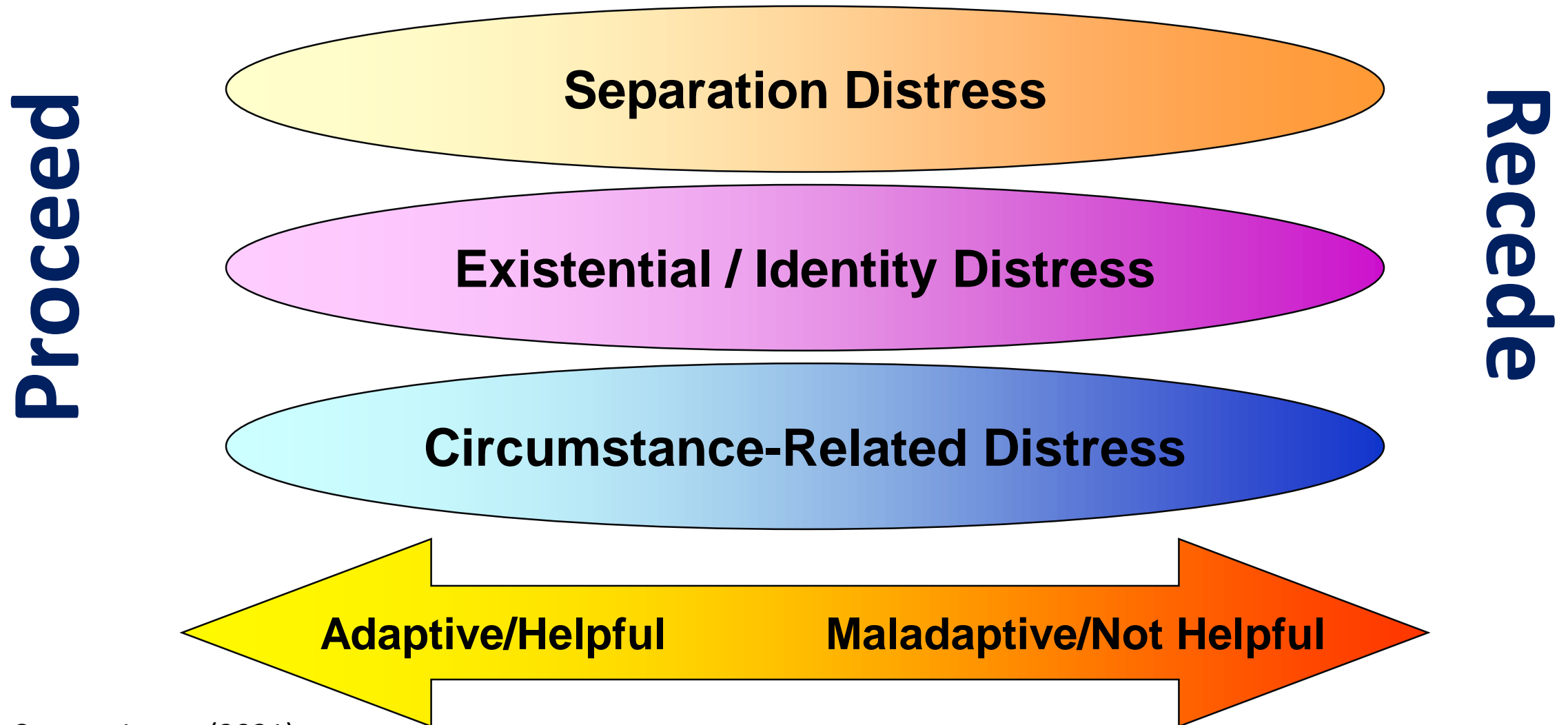
Multidimensional Grief Theory Core Propositions

Different dimensions of grief may call for:

- **different intervention objectives**—what we seek to achieve
 - Separation Distress: build a comforting sense of ongoing connection
 - Existential Distress: build a sense of life purpose and meaning
 - Identity Distress: create continuity in personal identity (who I was before vs. who I am now), enlarge personal identity (I can do things they used to do for me)
 - Circumstance-Related Distress: help distress over the manner of death to recede; develop constructive response to terrible/tragic way they died
- **different practice elements** (e.g., grief reminiscing, core values exercises)
- **assessment-driven, flexibly-tailored interventions** that both:
 - facilitate helpful, constructive grieving
 - therapeutically reduce unhelpful grieving

Sources: Layne, Kaplow, & Pynoos (2012); Layne et al. (2014); Layne et al. (2017); Saltzman et al. (2017)

A Flexible, Dual-Pronged Approach: Help Adaptive Grief to Proceed, Maladaptive Grief to Recede



Where Did Multidimensional Grief Theory Come From?

(25 years of collaborative scientific and clinical work)

The Origin of Multidimensional Grief Theory

(Layne, 2021)

- Factor analysis of UCLA Grief Screening Scale with Bosnian youth (Layne & Pynoos, 1999) yielded two factors—**Normal Grief** and **Maladaptive Grief**.
- The two grief subscales **differentially related to other variables in our classroom survey**.
 - Compared to normal grief, **maladaptive grief correlated more strongly with nearly every distress indicator**:
 - PTSD
 - depression
 - somatic problems
 - family conflict
 - impaired school functioning
 - exposure to trauma reminders
 - Compared to maladaptive grief, **normal grief correlated in a more positive direction with**:
 - Prosocial behavior
 - Positive school attitude

The Origin of Multidimensional Grief Theory

(Layne, 2021, cont.)

- Eureka!! I've found a different way to “unpack” and distinguish between **adaptive/maladaptive grief**! One that uses **differential relations** (differences in how variables relate to one another) as a tool for “dividing nature at its joints.” (Layne, Olsen, Kaplow, Shapiro, & Pynoos, 2011; Layne et al., 2014).
- This method relies heavily on both **guiding theory** and **contextual information** to distinguish between adaptive vs. less adaptive grief reactions. **These contextual variables include:**
 - Causal risk factors
 - protective factors
 - vulnerability factors
 - current functioning
 - risky behavior
 - developmental progression
 - **response to different treatment components** (e.g., Trauma-Focused vs. Loss-Focused modules in Trauma and Grief Component Therapy for Adolescents).

Theorized Primary Origin of Maladaptive Grief Reactions

(Layne, 2021; Layne et al., 2017)

Separation Distress

Attachment Relations
(THAT the person died)

Existential / Identity Distress

Meaning-Making
(THAT the person died)

Circumstance-Related Distress

Manner of Death
(HOW the person died)
(Tragic/Traumatic/Disturbing)

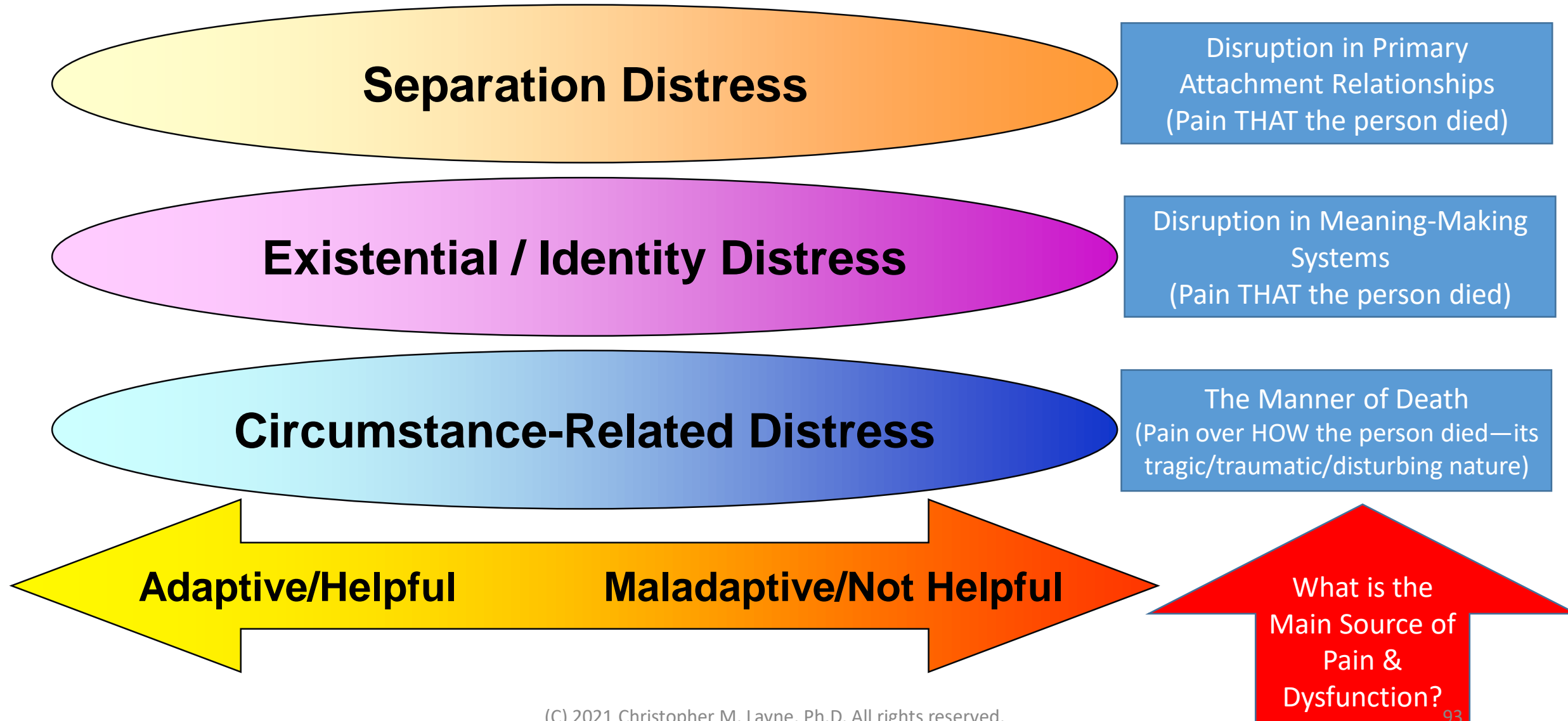
Adaptive/Helpful

Maladaptive/Not Helpful

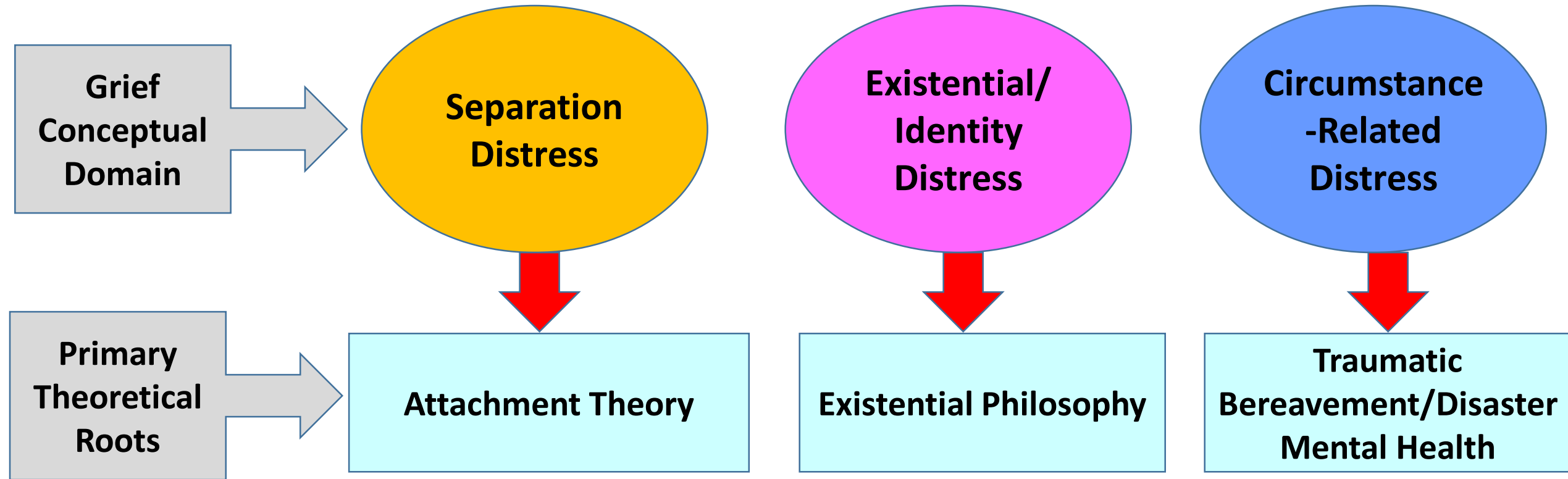
But Where Did These Key Assumptions
(about Root Causes of Grief-Related
Distress & Impairment) Come From?

Theorized Primary Origin of Maladaptive Grief Reactions

(Layne, 2021)



The Theoretical Roots of Multidimensional Grief Theory



Encouraging Good Grieving by Offering Positive Alternatives

When Theories of Therapeutic Change Go Awry

(Layne, 2021)

(Hint: They are pathology-centric—focus only on reducing bad things)

- Doughnuts are bad for you. They spike your blood sugar.
- Those spikes can lead to metabolic syndrome and, over time, to diabetes.
- Doughnuts are like a drug. You feel good for a short time, but then crash.
- So whatever you do, don't think about doughnuts.
- They are *off-limits* for sure.
- *Just Say No* to doughnuts.
- In fact, think about anything else *but* doughnuts.
- *There you go again! Why do you keep obsessing about doughnuts?!*



Eat This Instead of That! (Layne, 2021)



Dietary Sources of Naturally-Occurring Antiangiogenic Substances

Green tea	Red grapes	Lavender
Strawberries	Red wine	Pumpkin
Blackberries	Bok choy	Sea Cucumber
Raspberries	Kale	Tuna
Blueberries	Soy beans	Parsley
Oranges	Ginseng	Garlic
Grapefruit	Maitake mushroom	Tomato
Lemons	Licorice	Olive oil
Apples	Turmeric	Grape seed oil
Pineapple	Nutmeg	Dark chocolate
Cherries	Artichokes	Others

Source: Angiogenesis Foundation (www.angio.org)

We have to offer our clients a better, healthier alternative (helpful grieving) if we are to expect them to relinquish/allow unhelpful grieving to recede. (Really helps with motivational interviewing!)

Eat This Instead of That! (Layne, 2021)

We have a much better chance to shift our clients from maladaptive to adaptive grieving if we offer them clear, attractive, and realistic positive alternatives to meet their needs to:

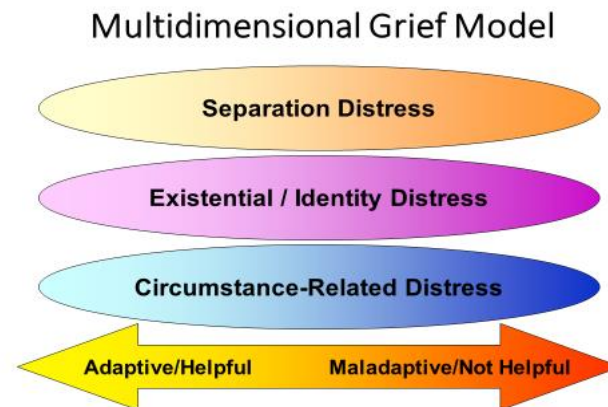
1. Feel connected to your loved one (cope adaptively with **separation distress**)
2. Find meaning and purpose in your life, preserve a sense of personal identity and personal integrity (cope with personal **existential and identity-related crises**)
3. Find constructive ways to deal with distress over how they died (cope with **circumstance-related distress**)
4. Cope with distressing trauma reminders, loss reminders, adversities, other life changes

Take-Home Message:

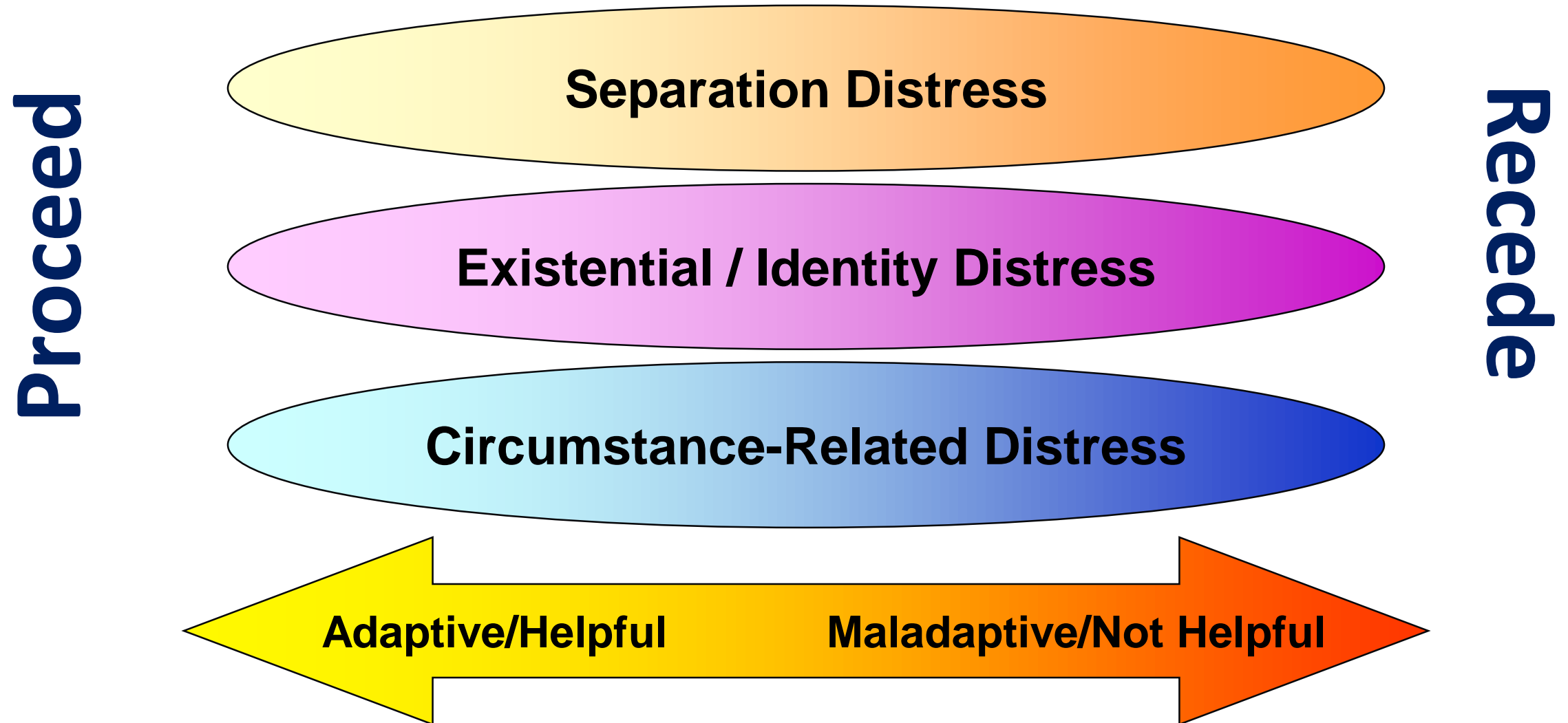
**A Multi-Dimensional Theory Offers
You Great Flexibility in
Tailoring Your Intervention!**

Having a Multidimensional Model of Grief Gives Us Lots of Flexibility in How to Intervene (Layne, 2021)

- Direct focus on **reducing maladaptive grieving**
- Direct focus on **promoting adaptive grieving**
- **Contrast** between maladaptive vs. adaptive grieving (weigh costs/benefits, consider positive alternatives) (motivational interviewing)
- **Redirect** from maladaptive to adaptive grieving (motivational interviewing)



A Flexible, Dual-Pronged Approach: Help Adaptive Grief to Proceed, Maladaptive Grief to Recede (Layne, 2021)



Integrating Grief Support with Grief Treatment to Support Continuity of Bereavement Care

Proceed

Recede

Separation Distress

Existential / Identity Distress

Circumstance-Related Distress

**Supportive
Intervention**

**Therapeutic
Intervention**

Adaptive/Helpful

Maladaptive/Not Helpful

Summary: Bereavement and Grief Intervention

(Saltzman et al., 2017)

Summary: We need to identify bereaved individuals and families, and offer timely intervention:

- Promote **adaptive grieving and positive adjustment**
- Reduce severe **distress**
- Improve **functioning** (at school, home, peers, community, etc.)
- Reduce **risky behavior** (e.g., health risk behaviors including eating disorders, drug use, suicidal ideation)
- Reduce **developmental disruptions**, make timely developmental course-corrections (e.g., salvage a school year, prevent dropout, improve grades and prospects for going to college)

Well-Evaluated, Effective Interventions Exist

- **Prolonged Grief Disorder Treatment for Adults**
(<https://complicatedgrief.columbia.edu/professionals/complicated-grief-professionals/overview/>) (primary source for my Shear & Charney citations)
- **Trauma and Grief Component Therapy for Older Children and Adolescents** (Saltzman, Layne, Pynoos, Olafson, Kaplow, & Boat, 2017)
(https://www.nctsn.org/sites/default/files/interventions/tgcta_fact_sheet.pdf)
- **Multidimensional Grief Therapy** (Kaplow, Layne, Pynoos, Saltzman, under contract with Cambridge University Press)

Effective Treatments Are Available:

Example 1

- Layne et al., (2008) 127 war-exposed secondary school students attending 10 schools in central Bosnia.
- Randomly assigned to either an active-treatment **comparison** condition (tier 1), consisting of a classroom-based psychoeducation and skills intervention alone (n = 61) or a **treatment condition** composed of both the classroom-based intervention and a 17-session manual-based group therapy intervention (tier 2) (Trauma and Grief Component Therapy for Adolescents (n = 66).
- Significant pre- to posttreatment and posttreatment to 4-month follow-up reductions in PTSD and depression symptoms in both the treatment and comparison conditions.
- **Significant pre- to posttreatment reductions in maladaptive grief reactions were found only in the treatment condition.**

Layne, C. M., et al., (2008). JAACAP.

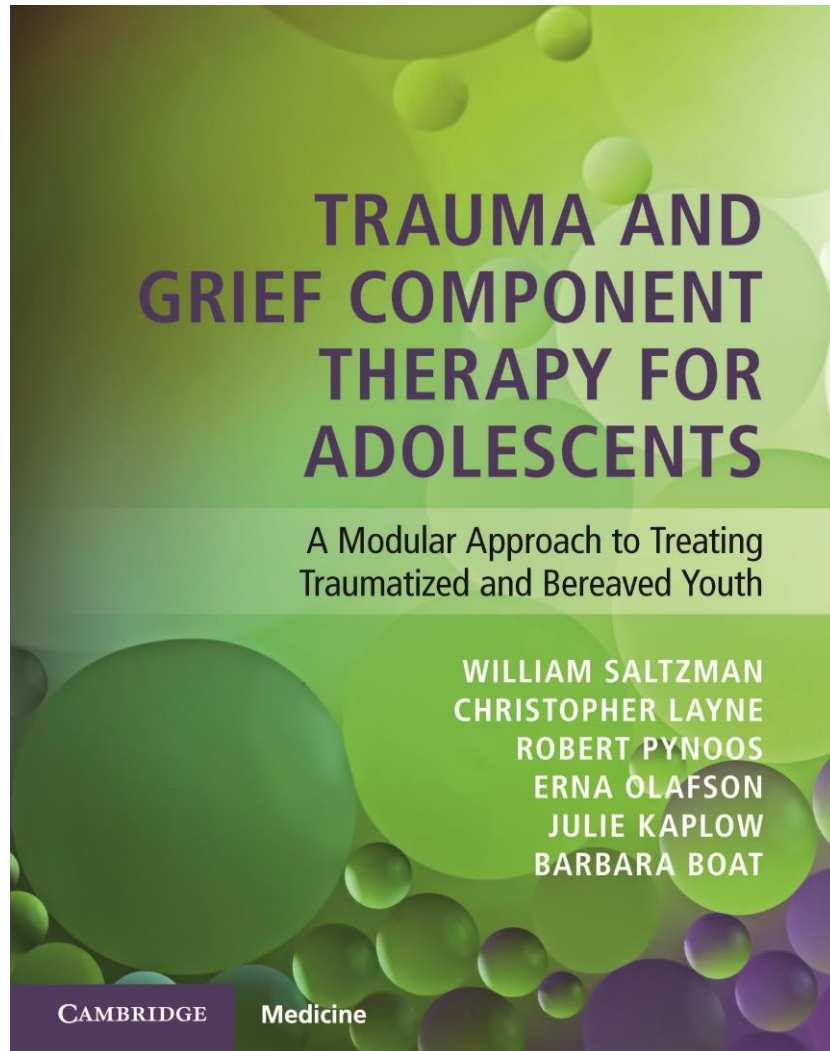
Effective Treatments Are Available:

Example 2

- Grasseti et al. (2014) 33 adolescents from three middle schools completed a 17-week course of group-based TGCTA.
- 61% of students reported reliable pre–post improvement in either PTSD symptoms or maladaptive grief reactions.
- Students whose **narratives focused on loss** both reported higher starting levels and showed **steeper rates of decline in grief reactions** than students whose narratives focused on trauma.
- In contrast, students whose narratives focused on trauma reported higher starting levels of PTSD than students who narrated loss experiences. Loss-focused narratives, in particular, appear to be associated with greater decreases in MG reactions.

What does a trauma- and
bereavement-informed
mental health intervention for
youth look like?

Trauma, Bereavement, & Traumatic Bereavement



Trauma and Grief Component Therapy for Adolescents
(Saltzman, Layne, Pynoos, Olafson, Kaplow, Boat, 2017)

- Psychoeducation
 - PTSD, grief, depression
 - Trauma reminders vs. loss reminders
 - Developmental impacts
- Skills building (cognitive restructuring, social support, coping skills)
- Trauma processing (for trauma, traumatic bereavement)
- Grief processing (for bereavement, tragic bereavement, traumatic bereavement)
- Support coping with reminders, secondary adversities
- Promote healthy developmental progression
- Promote healthy social and civil engagement
- Build resource caravans to accompany them in the future

Trauma and Grief Component Therapy for Adolescents (TGCTA)

(Saltzman, Layne, Pynoos, Olafson, Kaplow, & Boat, 2017)

Module 1	Module 2	Module 3	Module 4
-Group Cohesion -Psycho-Education -Coping Skills	Trauma Processing	Grief & Loss Processing	Promoting Adaptive Developmental Progression

Key Design Features:

- **Modularized**
- **Assessment-driven** (UCLA PTSD Reaction Index for DSM-5; Prolonged Grief Disorder Checklist)
- **Theory-based** (developmental psychopathology, multidimensional grief theory)
- Can be flexibly **tailored** to clients' particular needs, strengths, life circumstances, informed wishes
- Can be **adapted** for different modalities and settings (school, clinic, private practice, juvenile justice)

Acknowledgements to Those Who Have Contributed to Multidimensional Grief Theory

Key Milestones in Building Multidimensional Grief Theory

- 1997: Developed brief grief screening measure that assessed for both theorized adaptive and maladaptive grief reactions; used it with war-exposed Bosnian adolescents (Layne & Pynoos)
- 2000: Developed in-depth grief assessment measure containing both existential/identity and circumstance-related distress; used it with war-exposed Bosnian adolescents (Layne, Savjak, Saltzman, & Pynoos)
- 2001: Published first treatment outcome study assessing maladaptive grief reactions as a primary outcome in war-exposed Bosnian youth (Layne, Pynoos, Saltzman, et al.)
- 2001-2: Created Extended Grief Inventory to assess all three conceptual dimensions (Separation, Existential/Identity, Circumstance Distress); used with 9/11 exposed youth (Layne, Savjak, Saltzman, & Pynoos)
- 2004-11: Applied concepts of multidimensionality and differential relations to unpacking grief (Layne & Olsen)
- 2007-8: Began work on conceptualizing adaptive grief reactions, positive adjustment, in each grief conceptual domain (Layne & Schulberg)
- 2008: Building on prior measures, Layne & Pynoos began creating grief test item pool to assess adaptive & maladaptive grief reactions in each conceptual domain (Separation, Existential/Identity, Circumstance). Pool evolved into the Multidimensional Grief Reactions Scale (Layne, Kaplow, & Pynoos, 2011)
- 2008: First field training in 3-domain multidimensional grief model (Layne & Pynoos)
- 2008: Published randomized controlled trial using Existential Distress & Circumstance–Related Distress as treatment outcomes in war-exposed Bosnian youth (Layne, Saltzman, Pynoos, et al.)
- 2011: Multidimensional grief model first presented to an outside grief research team (Layne & Judi's House)

Key Milestones in Building Multidimensional Grief Theory (cont.)

- 2011: Multidimensional grief theory, differential validity matrix, their core assumptions for assessment and treatment, first presented (Layne, Kaplow, & Pynoos)
- 2012: Multidimensional grief 3-conceptual domain model, assessment-driven clinical decision-making model, first presented (Layne, Kaplow, & Pynoos)
- 2012: Basic psychometric properties of Multidimensional Grief Reactions Scale first presented (Kaplow, Layne, Howell, Lerner, & Pynoos)
- 2013: Theory applied to military families (Kaplow, Layne, Saltzman, Cozza, & Pynoos)
- 2014: Differential validity matrix, multidimensionality as foundational approaches to theory building and test construction first presented (Layne, Netland, Kaplow, Steinberg, & Pynoos)
- 2014: Persistent Complex Bereavement Disorder Checklist is published, including procedure for test scoring and interpretation that aligns with multidimensional grief theory (Layne, Kaplow, Pynoos)
- 2017: Theory applied to traumatically bereaved adolescents (Layne, Kaplow, Oosterhoff, Hill, Pynoos)
- 2017: Theory used in Module 3 (Processing Grief and Loss) of Trauma and Grief Component Therapy for Adolescents manualized treatment (Saltzman, Layne, Pynoos, Olafson, Kaplow, & Boat)
- 2019: Theory applied to treatment of bereaved youth (Kaplow, Layne, & Pynoos)
- 2020: Theory applied to evidence-based assessment of bereaved youth (Layne & Kaplow)
- 2021-2: Theory applied to constructing Prolonged Grief Disorder Checklist, including procedure for test scoring and interpretation that aligns with multidimensional grief theory (Layne, Kaplow, Pynoos)

Key Collaborative Partners

- Robert Pynoos
- William Saltzman
- Alan Steinberg
- Julie Kaplow
- Trauma and Bereavement Research Lab Members at Nova Southeastern University

Less-Known Collaborative Partners

- Nadezda Savjak, a Bosnian clinical psychologist, challenged me to distinguish between grief and PTSD, create a Loss Reminders Inventory, and expand our brief grief risk screening tool into an in-depth assessment tool.
- Joseph Olsen first introduced me to the concept of **external consistency** and its use in categorizing different types of grief reactions into different conceptual dimensions based on their differential relations with external factors.
- David Schulberg challenged me to map out the adaptive aspects of each conceptual grief dimension as an integral part of the theory, assessment tools, case conceptualization, and intervention plan.
- Marit Netland helped me to create the **Differential Validity Matrix**—a tool for differentiating between adaptive vs. maladaptive grief reactions based on their differential relations with external factors (e.g., causal risk factors, treatment components, academic performance).

Resources for COVID-19

Assessment Tools for People Bereaved by COVID-19

1. **UCLA Brief COVID-19 Screen for Child/Adolescent PTSD**
 - a. Contains exposure screen, plus the brief screening form of the PTSD Reaction Index for DSM-5 (11 items, well validated with good test accuracy/sensitivity and specificity) (available at WWW.ReactionIndex.com).
2. **Prolonged Grief Disorder Checklist** (will be available at WWW.ReactionIndex.com).
3. **Adult grief training and assessment tools:** <https://complicatedgrief.columbia.edu/>

Resources for COVID-19

Brochures from NY Life Foundation, the NCTSN, Resilient Parenting for Bereaved Families at Arizona State University (Google them)

- The power of parenting during the Covid-19 pandemic: Helping children cope with the impending death of a loved one
- The power of parenting during the covid-19 pandemic: Mourning the death of a loved one
- The power of parenting during the Covid-19 pandemic: Addressing fears and feelings from prior losses
- Speaking Grief: <https://speakinggrief.org/about>

Resources for COVID-19

Resources: For more information, visit:

- <https://www.newyorklife.com/newsroom/insights-on-covid-19>
- <https://grievingstudents.org/>
- <https://www.nctsn.org/what-is-child-trauma/trauma-types/disasters/pandemic-resources>
- <https://reachinstitute.asu.edu/programs/resilient-parenting-for-bereaved-families-from-science-to-service>
- SAMHSA Disaster Distress Helpline at 1-800-985- 5990 or text TalkWithUs to 66746.
- <https://www.dougy.org/news-events/news/supporting-children-teens-when-a-family-member-is-dying-in-a-hospital-or-ca/2164/>
- Resource-Based Internet Intervention (Med-Stress) to Improve Well-Being Among Medical Professionals (<https://www.jmir.org/2021/1/e21445/>)

Extra Help: Should reactions continue or at any point worry you or interfere with your children's/ teens' abilities to function contact your child's doctor, a mental health professional, or your local bereavement center. If you need some extra help, seek similar services for yourself. There are helplines as well as mental health professionals providing their services through telehealth.

General Bereavement Support Websites

[Childhood Bereavement Estimation Model](#)

[Family Bereavement Program](#)

[National Alliance for Grieving Children](#)

[NY Life Foundation](#)

[The Shared Grief Project](#)

[National Child Traumatic Stress Network](#)

[National Child Traumatic Stress Network Learning Center](#)

[The Trauma and Grief Center](#)

[Trauma and Grief Component Therapy \(TGCTA.com\)](#)

National Child Traumatic Stress Network website

www.NCTSN.org

NCTSN Learning Center for Child and Adolescent Trauma

<http://learn.NCTSN.org>

Psychological First Aid (PFA) online training

<https://learn.nctsn.org/course/index.php?categoryid=11>

Skills for Psychological Recovery (SPR) online training

<https://learn.nctsn.org/course/index.php?categoryid=11>

Coming Attraction for Addressing Bereavement
& Traumatic Bereavement in Children and Adolescence

Multidimensional Grief Therapy

(under contract with Cambridge University Press)

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