Introduction

What is Trauma and Grief Component Therapy for Adolescents (TGCTA)?

Why Does TGCTA Focus on Adolescents and Adolescence?

Adolescence is, in many ways, the best of times and the worst of times. It is a developmental period of *maximum risk* – with (along with young adulthood) the highest rates of exposure of any age group to many types of violent crime, traumatic injury, and traumatic death (Layne et al., in press). Adolescence is also a highly favorable time in which to intervene, presenting a *window of opportunity* to reduce severe distress, risky behavior, functional impairment, and the risk for developmental derailment prior to early adulthood. Adolescence is a time of growth, promise, hope, and opportunity – a period in which many quasi-adult capacities emerge and quasi-adult privileges are bestowed. These include physical growth and maturation; enhanced physical and cognitive abilities; increased self-control, self-direction, and self-protection; increased autonomy; and increased participation in society. Developmental neuroscience teaches us that adolescence is a second critical period of heightened brain plasticity (a restricted developmental period during which the nervous system is especially sensitive to the effects of experience, the first being 0–3 years). Steinberg (2014) describes this increased malleability of the adolescent brain as a two-edged sword, in which adolescents are not only more adept at acquiring new information and abilities through observation and experimentation, but also more vulnerable to the effects of physical and psychological harms, including drugs, toxins, stress, and trauma. The developmental tasks of adolescence form a window of neural "re-wiring" in which brain systems that manage rewards, relationships, self-regulation, and planning for the future each mature and are highly susceptible to disruptions. These emerging strengths and privileges both set the stage for healthy developmental progression into adulthood, yet also create new risks for developmental disruption. We (the authors) find our work with adolescents – especially youth contending with trauma and bereavement – to be an endlessly challenging, stimulating, and rewarding experience. This manual represents both a distillation of our clinical insights and research efforts, and a personal invitation to join us in this deeply fulfilling and much-needed work.

Aspects of Adolescent Development that Inform TGCTA

Increased capacity to self-regulate and develop adaptive coping strategies. Adolescence is a developmental period in which a growing sense of self-efficacy in the face of danger arises in conjunction with major gains in brain cortex maturation and reorganization, cognitive abilities, and motor development. Nevertheless, adolescence is a period of increased sensation-seeking and risk-taking behavior, coupled with immature self-regulation (Steinberg, 2017). As such, adolescents – especially youth with histories of trauma and loss – benefit from adult supervision and assistance with appraising and developing appropriate responses to dangerous situations. As reflected by the fascination that many youth have with horror movies and their increase in thrill-seeking behaviors, adolescents strive to achieve two key developmental tasks: (1) *To strengthen their capacity to self-regulate their fear responses when confronting danger in the absence of adult protection*, and (2) *to build a repertoire of effective preventive and intervention strategies to cope with dangerous situations*. As they strive for independence, adolescents increasingly rely on their inexperienced peers to appraise and respond to danger, while typically depending on the guidance of parents and other mature caregivers to judge longer-term consequences and weigh important life decisions.

Increased ability to engage in complex causal reasoning. Adolescents' cognitive maturation enables them to engage in more sophisticated forms of causal reasoning. For example, they understand that *multiple converging causes* can collectively produce an outcome (e.g. "My buddy was in the wrong place at the wrong time"). Adolescents can also engage in *counterfactual reasoning* by constructing "if–then" hypo-

thetical scenarios of an event, mentally altering its presumed causes, and evaluating the effects on the outcome (e.g. "If I had been there, then my friend would still be alive"). These more advanced causal reasoning skills help adolescents to develop a more sophisticated and nuanced view of the world that can accommodate complexity, ambiguity, multiple "if–then" possibilities, and competing explanations for events. Similarly, these same reasoning skills can increase the risk that some youth will become deeply preoccupied with the belief that terrible events that *have* occurred *could and should have been prevented*. These beliefs often evoke intense negative emotions including guilt, shame, remorse, bitterness, or rage at those they perceive to be responsible, whether through acts of commission or omission.

Evolving capacity to make complex moral judgments. Adolescent moral development is also evolving beyond the capacity to make simple judgments between "good" versus "bad" behavior, towards more complex and sophisticated considerations that involve weighing the likely consequences and merits of different courses of action. Adolescents possess an increased capacity to regulate their impulses to retaliate and take revenge and, instead, to rely on social institutions (including parents, schools, community leaders, and legal and law enforcement systems) to uphold the *social contract* (a typically unspoken agreement among members of society that defines the rights and duties of each member and forms a common social bond) to ensure that justice is served. Adolescents have a deepening understanding of the social contract and its attendant considerations of the rule of law, fairness, justice, safety, the protection of individual liberties, and the rights and duties of citizens, parents and other caregivers, and social institutions. Adolescents also have an increased capacity to recognize the presence and contributions of human error, negligence, greed, and malevolence to adverse life events. Such attributions often arise in a search for meaning after the *adult protective shield* has failed and resulted in traumatic events – including deaths characterized by the "Three V's": *violence*, the *violation* of laws and of the social contract, and *volition* or malevolent intent (Rynearson, 2001).

Encountering and making judgments about different social systems. Society views adolescents as falling increasingly under the broader social contract as manifest by its extension of "semi-adult" privileges and responsibilities. For example, in some cultures, youths can earn a driver's license and are granted opportunities to spend unsupervised time with friends, join the work force, and actively participate in social and civic events. At the same time, adolescents are making judgments about the legitimacy, fairness, and protective efficacy of social, governmental, and legal institutions, including schools, law enforcement, the justice system, and the child welfare system. Adolescents' experiences with these social systems, and their judgments regarding whether these systems protect them and their loved ones from danger (and effectively address the harmful consequences when the adult protective shield fails), can powerfully shape their values, expectations, conscience formation, and actions, and carry serious repercussions for their life choices, future aspirations, and preparation for the future. Inconsistent or ineffective institutional responses to sexual and interpersonal violence may pose a special risk for adolescent girls, given that these events can further undermine their expectations of safety and equal protection under the law.

When adults fail to uphold the social contract. Adolescent moral development involves becoming more aware that one *has* a conscience (knowing the difference between right and wrong), and developing the willpower to *act* on one's conscience (having the courage and determination to do what is right). Moral development can be severely disrupted when laws are violated, people are harmed, and efforts to repair and uphold the social contract are ineffectual, inconsistent, or absent. Such failures of the "adult" world can undermine a sense of predictability and safety. Further, they can erode adolescents' capacity and motivation to regulate their vengeful desires, relegate the task of enforcing the law and upholding the social contract to the proper societal institutions, and obey the law. Conversely, failures to uphold the social contract can also increase the risk that adolescents may seek to take matters into their own hands, or enlist the help of powerful others (e.g. join a gang, take on a gang-member boyfriend) to feel safer and more secure and to avenge perceived wrongs. More broadly, major failures by the adult world to protect and nurture adolescents increases the risk of producing a "lost generation" – a cohort of youth who view the privileges and responsibilities of citizenship, work, and home life with cynicism and disillusionment, treat the social contract with skepticism or indifference, and invest little in society and in their own future (Layne et al., 2008).

Overview of TGCTA

Consistent with its assessment-driven approach, TGCTA is divided into a pre-treatment assessment interview and four flexibly tailored treatment modules. Each module begins with an overview describing its theoretical underpinnings and overarching aims. A session-by-session guide then follows, which contains specific procedures, exercises, and suggested "adolescent" language for implementing each session. Although TGCTA is designed for small groups, each module includes an appendix that contains guidelines for adapting the sessions for individual clients, as well as "copy-friendly" handouts that can be used in either group or individual settings.

The Pre-Treatment Assessment Interview

The *pre-treatment assessment interview* is preferably conducted on an *individual* basis by a clinician who will be facilitating the TGCTA sessions. Its primary goals are to determine whether TGCTA is an appropriate intervention

for the adolescent and to provide sufficient information about the program and the perceived needs of the youth so that he or she can make an informed decision about whether participation would be beneficial. During such interviews, it is helpful to remain keenly aware that the adolescent may well have undergone profoundly disempowering and deeply unsettling experiences involving such themes as extreme danger; horrific violence; innocent misjudgments gone terribly awry; extreme helplessness; disturbing encounters with human malice; violated expectations regarding the adult protective shield and the legitimacy of the social contract; powerfully contradicted assumptions about the safety, predictability, controllability, and benevolence of the world; extreme helplessness; and catastrophic loss. The clinician should also carry the realization that he or she acts as a representative of the adult world and can be a powerful force for good in helping to restore the protective shield, repair the social contract, facilitate supportive connections with others, and promote adaptive developmental progression.

To assist in these joint decisions, the clinician administers selected measures (or relies solely on the clinical interview) to gather information regarding the adolescent's functioning across a range of developmentally important life domains. Depending on the culture and setting, these typically include: current distress, role functioning (academic performance, school behavior, peer relationships, family life, and, as appropriate, romantic relationships, workforce participation, leisure), developmental progression as benchmarked against culturally appropriate developmental tasks and milestones, civic involvement, life satisfaction, risky behavior, and aspirations for the future (see the *pre-treatment assessment interview* for recommended measures). The clinician then reviews the (quickly/rough-scored) assessment results with the adolescent and uses clinical judgment in making recommendations for intervention. These recommendations may include the number and sequence of TGCTA modules to administer, and treatment modality (group, individual, or classroom-based), depending on the youth's specific needs, strengths, life circumstances, and informed personal wishes. The clinician also has an opportunity to assess for immediate risks and, as needed, provide appropriate referrals or safeguards.

The Treatment Modules

Module 1 has six primary objectives: (1) Increase understanding of common reactions to trauma and bereavement. (2) Increase understanding of what trauma reminders and loss reminders *are* and *how* they evoke posttraumatic stress and grief reactions, respectively. (3) Increase insight into personal posttraumatic stress, grief, and other reactions, especially as evoked by their personal trauma reminders and loss reminders. (4) Strengthen emotional self-regulation skills, especially skills needed to manage members' reactivity to trauma and loss reminders. (5) Improve members' abilities to problem-solve difficult or challenging situations, especially hardships created or worsened by traumatic or bereavement-related experiences (*secondary adversities*), as well as developmental challenges and daily hassles. And (6) enhance abilities to appraise stressful situations and recruit appropriate types and sources of social support to help them cope with those situations.

Module 2 is dedicated to more intensive working through of members' self-selected traumatic experiences or the traumatic circumstances of the death of a loved one. Primary objectives include: (1) Select a primary traumatic experience for therapeutic work and briefly share it with the group. (2) Construct a detailed and coherent trauma narrative of that experience that weaves together *what was happening outside of me* with *what was happening inside of me*. This includes identifying one or more *traumatic moments* (moments of experiencing or witnessing imminent threat, actual harm, terror, horror, or extreme helplessness) within each members' experience and clarifying their respective links to trauma reminders or loss reminders. (3) Identify and process the *worst moments* of each member's experiences, which consist of the parts of the experience or its aftermath that were most difficult to bear and are typically the most painful to be reminded of. (4) Identify and process *intervention fantasies* (what they wish would have happened) and accompanying intense negative emotions including extreme fear, guilt, shame, rage, and desires for revenge. TGCTA can also accommodate (especially in individual "pull-out" sessions), traumatic events in which members perpetrated violent acts that harmed others and over which they feel remorse (Kerig et al., 2015). (5) Identify *traumatic expectations*, which consist of pessimistic "lessons learned" that youths' traumatic experiences have taught them about themselves, others, and the world, and which can powerfully influence their worldview, relationship with society, and preparations for adulthood. (6) Strengthen adolescent impulse control by increasing insight into how reactions to traumatic moments, often as evoked by trauma reminders, can lead to risky and destructive behaviors (Steinberg & Chein, 2015; van den Bos et al., 2015).

Module 3 addresses bereavement (often due to violent or tragic death) and its aftermath. Primary objectives include: (1) Identify personal loss reminders and understand their role in evoking grief and other reactions. (2) Identify personal grief reactions and mourning rituals. (3) Explain how grief is a beneficial process that facilitates adjustment to bereavement, but under some conditions can go awry (lead to severe persisting distress, functional impairment, risky behavior, developmental disruption) in any of three primary domains. These domains include *separation distress, existential/identity distress*, and *distress over the circumstances of the death*. (4) Reduce maladaptive grief reactions using exercises that are specifically tailored for each of the three grief domains. And (5) promote healthy grieving and mourning within each of the three primary grief domains.

Module 4 is designed to promote adaptive developmental progression and to help youth prepare for the roles and responsibilities of young adulthood and full citizenship. Its

activities focus on helping youth contemplate, plan, and actively prepare for their futures. Objectives include: (1) Revisit *traumatic expectations* that continue to undermine adolescents' hopes, motivation, and potential, and choose in their place more constructive basic beliefs and moral principles by which to guide their lives. (2) Strengthen adolescents' capacity to problem-solve and cope with current and anticipated future life adversities. This includes developing plans to appropriately disclose their trauma- and bereavement-related experiences to important and trusted people in their lives. (3) Form positive yet realistic life ambitions and professional aspirations, and problem-solve concrete strategies to achieve those ambitions in ways that renew and promote adaptive developmental progression. And (4) promote constructive engagement in pro-social activities and investment in the social contract through such activities as public advocacy, community service, helping vulnerable others, random acts of kindness, and acting on intervention thoughts (fantasies about what they *wish* could have happened to prevent or mitigate the outcome) in positive and proactive ways. This includes reducing impulsive revenge-taking behavior by encouraging pro-social responses to traumatic events and losses (e.g. making their communities safer by taking steps to prevent future trauma; suicide prevention) (Steinberg & Chein, 2015; van den Bos et al., 2015; Layne et al., in press).

The Developmental History of TGCTA

A prototype of TGCTA was first field-tested in school settings following a devastating 1988 earthquake in Armenia. A follow-up evaluation found that treatment gains with respect to posttraumatic stress reactions, depressive symptoms, moral functioning, and adaptive behavior were retained five years later (Goenjian et al., 1997). Expanded pilot versions were subsequently implemented throughout the 1990s in diverse field settings, including underserved inner-city youth exposed to high rates of community violence (Layne et al., 2001a; Saltzman et al., 2001b). The first manualized version of TGCTA was implemented after the 1992–1995 Bosnian civil war in the first UNICEF-sponsored post-war psychosocial program for youth. TGCTA was rigorously implemented, evaluated, and refined in this post-war setting between 1997 and 2002, producing an open trial (Layne et al., 2001b), a conceptual model for multi-tiered intervention (Saltzman et al., 2003), a qualitative field evaluation (Cox et al., 2007), and a randomized controlled trial (Layne et al., 2008). Collectively, these studies produced consistent evidence of the effectiveness of TGCTA in reducing posttraumatic stress and maladaptive grief reactions, and in improving academic performance and peer relationships.

Following the September 11, 2001 terrorist attacks on the World Trade Center, TGCTA was selected by the State of New York as the primary intervention for traumatized and traumatically bereaved adolescents for the Child and Adolescent Trauma Treatments and Services Consortium (CATTS) in New York City. The intervention showed good evidence of effectiveness, producing outcomes in adolescents that were on par with those observed in children who received trauma-focused cognitive behavioral therapy (TF-CBT), the companion CATTS intervention for children (Hoagwood et al., 2007; Saltzman et al., 2006). Adaptations of TGCTA were also effectively employed with youth following major disasters, including hurricanes Katrina and Rita.

The current version of TGCTA was field-tested in an open trial with high-risk high-school students in Delaware, USA, where it showed evidence of effectiveness in reducing both posttraumatic stress and maladaptive grief reactions. The use of *grief*-focused treatment components was linked to greater decreases in maladaptive grief reactions compared to posttraumatic stress reactions (Grassetti et al., 2014). This study also found that group cohesion grew during Module 1 and increased as members engaged in trauma and grief processing work using Module 2 and Module 3 components. This finding underscores the galvanizing effects that trauma and grief work can have on group cohesion in adolescents, including youth with complex trauma histories. A follow-up study (Herres et al., in press) found that students who reported higher rates of *externalizing* symptoms improved more rapidly during the *skills-building* (Module 1 components) phase of treatment, whereas students with higher *internalizing* symptoms improved more during the *trauma and grief processing* (Modules 2 and 3) phase.

A current version of TGCTA, in combination with a trauma-informed staff training (*Think Trauma*), was tested in an open multi-year field study conducted in four residential juvenile justice facilities with traumatized youth incarcerated for felony-level offenses. Data showed that the mostly male youth in this study averaged between 10 and 11 different kinds of traumas and adverse events in their lifetimes, with well over half reporting exposure to community violence and violence in their homes as well as unexpected deaths of persons close to them. A comparison of pre- and post-treatment assessment scores found significant reductions in posttraumatic stress, depression, dissociation, and anger, but not in anxiety or sexual concerns. Further, incarcerated youth who completed all modules of group-based TGCTA reported greater reductions in posttraumatic stress symptoms compared to incarcerated youth who completed an abbreviated version. Facilities also reported large reductions in incident reports. Facility staff and leadership stated during monthly clinical conference calls with developers that trauma treatment for youth, coupled with trauma-informed training for staff, led to changes in organizational culture that made facilities safer and calmer for both youth and staff. This study also found no evidence that in-depth trauma and grief processing components of TGCTA had a destabilizing effect on these polytraumatized youth. No incidents were reported by clinicians for youth who did intensive trauma- and loss-focused narrative work when Modules 2 and 3 were implemented (Olafson et al., 2016).

Taken together, results of these studies point to four general conclusions. First, adolescents with histories of trauma and bereavement are best served when clinicians are

properly trained and equipped to distinguish between and assess trauma exposure versus bereavement, posttraumatic stress reactions versus grief reactions, and internalizing versus externalizing problems (Layne et al., in press). Second, treatment for multiply traumatized and bereaved youth can be effectively tailored by matching specific intervention components (e.g. grief- versus posttraumatic stress-focused exercises) to clients' specific needs (e.g. elevations in grief versus posttraumatic stress reactions) as identified in their assessment profiles. Third, TGCTA can be successfully implemented in both school and juvenile justice systems and produce even greater improvements in key domains of symptoms and functioning when accompanied by trauma-informed staff training; TGCTA can also promote facility safety. Fourth, TGCTA treatment outcomes generally exhibit a dose–response effect such that youth who receive the *full* treatment (especially Modules 2 and 3) show greater benefit than youth who receive an *abbreviated* treatment (skills components from Modules 1 and 4 only).

As of this publication, TGCTA is being widely disseminated in juvenile justice, school-based, and community-based mental health sites across the USA through learning collaboratives and communities, and other initiatives sponsored by the National Child Traumatic Stress Network (NCTSN). TGCTA is now being implemented in multiple state-wide juvenile justice systems, which are developing sustainable platforms using on-site trained trainers. Additional basic research and field evaluation studies are underway.

What Makes TGCTA Unique? Six Primary Strengths

TGCTA has six built-in strengths that set it apart as a cutting-edge intervention for traumatized adolescents, bereaved adolescents, or traumatically bereaved adolescents.

1. Specialized focus on adolescence. TGCTA specifically addresses the developmental needs, strengths, risks, challenges, tasks, and life circumstances of adolescents. Adolescence is characterized by increased sensation-seeking, immature self-regulation, and at times, immature appraisals of risky situations (often *downplaying* the level of danger) that can result in reckless behavior. TGCTA approaches adolescence as a brief yet highly consequential developmental period in which clusters of both beneficial resources (called *resource caravans*) and risk factors (called *risk factor caravans*) can accumulate in number, accrue in their effects, and cascade forward in ways that can powerfully influence the entire life course (Layne et al., 2014a). A primary aim of TGCTA is to prevent causal risk factors, vulnerabilities, and the risks they pose from further accumulating and cascading forward (Layne et al., 2014b). A related aim is to help youth create, preserve, and grow *resource caravans* (collections of beneficial resources including knowledge, skills, optimism, self-esteem, self-efficacy, and healthy relationships) that can continue to meet their evolving needs and sustain them in the future (Hobfoll, 2014). TGCTA is designed to help adolescents adopt a more constructive, forward-looking set of expectations and aspirations, and to acquire the knowledge and skills needed to promote their transition through the remaining years of adolescence and into young adulthood.

TGCTA also reflects the understanding that *recognizing gender differences* is essential to developmentally informed intervention with adolescents and should be an integral part of risk screening, assessment, case formulation, treatment planning, and treatment delivery. For example, girls are exposed to higher rates of sexual victimization and interpersonal trauma within the family than are boys (Finkelhor et al., 2013). Further, studies of youth involved in the juvenile justice system and in gangs report that girls experience higher rates of every form of sexual victimization and more interpersonal trauma exposure in the family and with close others than do boys, whereas boys tend to experience more exposure to community violence (Resnick et al., 2004; Kerig and Becker, 2012; Kerig & Schindler, 2013; Kerig et al., 2015). More broadly, these gender differences in trauma exposure are similar to those reported in a large US survey of youth in the general population (Finkelhor et al., 2013). Boys reported significantly higher lifetime physical assault and exposure to community violence, whereas girls reported higher levels of dating violence and higher levels of all forms of sexual victimization, including rape and sexual assault by adults and peers. Girls also reported higher levels of sexual harassment, including Internet and cell-phone harassment, and higher rates of unwanted Internet sex talk.

Studies of gender differences in posttraumatic stress reactions have long reported disproportionately more internalizing responses in females, and disproportionately more externalizing responses, including aggression, in males (Gorman-Smith & Tolan, 1998) although some recent research indicates that rates of violence perpetration by girls may be increasing (Kerig & Becker, 2012). Rates of posttraumatic stress disorder (PTSD) and complex PTSD are also higher for girls (Kerig & Becker, 2012). These gender differences may reflect, in part, findings that girls experience higher rates of sexual abuse and sexual assault than boys and are sexually victimized by trusted others more often than boys. These transgressions of the social contract may fuel a deep sense of betrayal and contribute to long-term difficulties with trusting others. Further, the stigma of sexual victimization can instill female victims with a sense of being permanently damaged and shamed (Kerig & Becker, 2012). Clinicians can draw on these insights to make better-informed decisions about whether to form TGCTA groups – including gender-specific groups – that share a common theme such as interpersonal betrayal or loss.

TGCTA also takes adolescent risky behavior and risky situations very seriously. It provides repeated opportunities to screen for and therapeutically address current and ongoing risks, especially risks for self-harm, suicide, and exposure to dangerous circumstances in the home and community. This is done in the pre-treatment assessment interview, during Modules 1–3 as different types of risk and

exposure are explored, and during Module 4 in activities that focus on helping youth to discriminate between safe versus unsafe situations and address ongoing life and developmental adversities (e.g. living with a parent with an alcohol problem).

2. Interplay between trauma and bereavement. A second strength of TGCTA is its integrative focus on trauma, bereavement, and the interplay that can arise between posttraumatic stress and grief reactions following traumatic bereavement (Layne et al., in press). Several authors of TGCTA were invited to serve as members of the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5) Posttraumatic Stress Disorder, Trauma, and Dissociative Disorders Sub-Work Group, in which capacity they provided age-specific expert recommendations for both PTSD criteria and newly proposed persistent complex bereavement disorder (PCBD) criteria (Kaplow et al., 2012b). TGCTA aligns with the latest diagnostic and treatment considerations for these particular trauma- and bereavement-related outcomes.

Whereas most interventions are designed to address *either* trauma *or* bereavement (or treat "loss" as simply another form of trauma), TGCTA approaches *both* trauma *and* bereavement as separate and distinct yet related entities. The design of TGCTA reflects a clear conceptual understanding of the interplay between *trauma* and *bereavement* as causal risk factors, and *posttraumatic stress reactions* and *grief reactions* as their respective primary causal consequences (Layne et al., 2014b; in press). Trauma and bereavement may occur in different configurations in adolescents' lives. For example, they may co-occur *simultaneously*, as in the case of *traumatic bereavement* – in which the death occurs under traumatic circumstances. Alternatively, bereaved youth may also be directly exposed to imminent life threat or serious injury (e.g. being involved in a car accident in which a loved one is killed). As a third example, trauma and bereavement may occur *separately*, in either closely or widely spaced life events (e.g. a youth experiences sexual assault followed by the death of a grandma). Regardless of their particular configuration, co-occurring trauma and bereavement each exert their own effects on distress and functioning. Their accumulation carries a risk for forming constellations of life events that accrue in their adverse effects and cascade forward across development. The resulting *risk factor caravans* can gain momentum over time, creating *resource loss cycles* that can accelerate and spiral downwards if not altered through timely and effective intervention (Hobfoll, 2014; Layneet al., 2014a).

Clinicians who use TGCTA will gain a clear conceptual understanding of key elements that make up traumatic and bereavement experiences from an adolescent perspective (Layne et al., 2001b), as well as different dimensions and aspects of bereavement, grief, and mourning as these evolve across adolescence (Kaplow et al., 2012a; Kaplow et al., 2013). The design of Modules 2 and 3 reflects the recognition that trauma and bereavement often co-occur in adolescents' lives, yet typically lead to different primary consequences (posttraumatic stress versus grief reactions, respectively), that each carry different risks, require different assessment tools, such as the University of California at Los Angeles (UCLA) Reaction Index and for DSM-5 (Ri-5; Pynoos & Steinberg, 2014) and the PCBD Checklist (Layne et al., 2014a) and call for different intervention components. TGCTA treatment planning emphasizes clarifying the respective intervention objectives for *trauma-focused* versus *bereavement-focused* therapeutic work, given that maladaptive grief reactions are theorized to have an *adaptive* "good grief" counterpart that should be recognized and facilitated (Kaplow et al., 2012a). In contrast, posttraumatic stress reactions largely lack an adaptive counterpart (although some degree of hypervigilance and arousal may be adaptive if the adolescent continues to live in a dangerous environment).

The difference between trauma-focused versus bereavement-focused therapeutic work with adolescents is reflected in the treatment objectives of each approach. The primary objective when working with traumatized adolescents is to *help posttraumatic stress reactions recede* in their frequency, intensity, duration, and disruptive impact on adolescents' daily lives and functioning. In contrast, the dual primary objectives in working with bereaved adolescents are to *help maladaptive grief reactions recede* (e.g. reducing distressing preoccupations over how the person died) and to also *facilitate adaptive grieving and mourning* (e.g. reminiscing in comforting ways and finding constructive ways to honor the memory of the deceased). TGCTA reflects the understanding that both posttraumatic stress reactions and grief reactions can each exert enormous demands on the inner resources of adolescents (Pynoos, 1992). Further, the demands of each set of reactions can reduce and intersect in complex ways with the social, physical, psychological, and spiritual resources available to cope with the other set of reactions (Layne et al., 2009).

3. Modularized, assessment-driven format. A third strength of TGCTA is its modularized format, which supports assessment-driven, flexibly tailored intervention (Layne et al., 2017). When paired with evidence-based assessment methods, TGCTA helps practitioners to carry out a central task of evidence-based practice: *to gather and use the best available evidence to tailor intervention in accordance with clients' specific needs, strengths, life circumstances, values, informed wishes, and the practitioners' clinical wisdom and expert judgment* (Layne et al., 2014c). TGCTA can be "customized" in various ways (DeRosa et al., 2013). Group-based assessment tools can be used to guide the selection of group members (Burlingame et al., 2011a). Based on assessment information gathered in the pre-session interview, the clinician can also determine whether trauma and/or bereavement are presenting issues and the degree to which posttraumatic stress and/or grief reactions currently interfere with the youth's life. This information can be used to select which TGCTA modules will be relevant and beneficial for the youth. The interview and assessment data may also be used to develop

an *individual assessment profile* that summarizes each member's degree of distress along specific dimensions of posttraumatic stress and grief reactions. This assessment profile can further inform how specific modules and sessions within those modules are selected, prioritized, and tailored. This capacity to strategically "customize" TGCTA for the needs of each group or individual client is especially helpful in settings (such as schools or juvenile justice) with severe time limits, to ensure that treatment focuses on youth's most pressing priorities and needs.

The individual assessment profile also helps to identify key benchmarks of functioning, risky behavior, and developmental progression versus derailment that can be used to evaluate *clinically significant impairment* at baseline and monitor *clinically significant improvement* as treatment progresses (Layne et al., 2010). Both the pre-treatment interview and clinician-administered measures can be used to build a working clinical theory and intervention plan that address the experiences, needs, and strengths of youths in both group (Davies et al., 2006) and individual settings (Hoagwood et al., 2007; Hoagwood and Layne, 2010; Layne et al., 2001a, 2008; Saltzman et al., 2001a, b).

4. Multi-tiered intervention framework. A fourth strength of TGCTA, also derived from its flexibly-tailored format, is its capacity to support *multi-tiered mental health and wellness interventions*. Multi-tiered interventions are especially valuable in high-risk, high-need, low-resource settings because they help service providers to balance both *program effectiveness* and *program efficiency*. TGCTA is built on a three-tiered conceptual framework (Saltzman et al., 2003) that allows practitioners to flexibly provide services ranging from general wellness promotion to specialized mental health therapeutic services (Cox et al., 2007). This conceptual framework draws on public mental health principles to help practitioners flexibly implement interventions that reach many beneficiaries while conserving and concentrating specialized services for those in greatest need. These tiers consist of *widely disseminated classroom-based psychoeducation and skills-building* (Tier 1), *specialized group-based treatment for youth with complex trauma and/or loss histories* (Tier 2), and *referral to intensive specialized psychiatric/mental health treatment* (only as needed, either as stand-alone treatment or a supplement to Tier-2 treatment) *for youth at severe risk* (Tier 3).

A randomized controlled trial with war-exposed Bosnian adolescents found that although the Tier 1 classroom-based intervention (derived from TGCTA Module 1 and Module 4 components only) produced good evidence of effectiveness and very few reliably worsened cases, the Tier 2 group-based intervention (comprising Modules 1–4) produced significantly higher rates of reliable improvement in posttraumatic stress and grief reactions and no reliably worsened cases (Layne et al., 2008). More broadly, TGCTA components can be tailored for high-risk adolescents (Olafson et al., 2016). These include youth with histories of *complex trauma exposure* – a profile characterized by multiple types of interpersonal trauma and losses (e.g. domestic violence, physical abuse, sexual abuse) during vulnerable developmental periods that increases the risk for severe emotional dysregulation, disrupted interpersonal relationships, and other forms of severe dysfunction (Cloitre et al., 2009).

5. Group-based format. A fifth strength of TGCTA is its *group-based format*, which is uniquely suited to treat groups of adolescents with significant trauma and loss histories. These include youth in such settings as school-based health clinics, juvenile justice group homes, residential care, diversion programs, and community-based mental health centers (Grassetti et al., 2014). In contrast to other treatments that originated as individual or classroom-based modalities and were later *adapted* for a group modality, TGCTA was *originally* designed for use with teens in a school-based therapeutic group setting (Layne et al., 2001a). A sizeable literature documents that groups are generally as effective as, and are more efficient than, individual treatment for many problems (Davies et al., 2006). A group-based modality can also improve access to care, especially in underserved youth, who may not receive mental health services elsewhere.

TGCTA contains field-tested recommendations for selecting appropriate group members and for facilitating beneficial group processes during adolescence. TGCTA approaches the group setting as a potent crucible for therapeutic change. Great care is taken to make the group a safe haven where adolescents work together to build cohesion, create a sense of belonging, exchange experiences, make self-enhancing comparisons, and learn how to cope with trauma, bereavement, and their aftermath. Early sessions are also vital for establishing positive group norms, clarifying group goals, and promoting group cohesion by fostering a sense of "we're all in this together" sense of solidarity, common identity, and purpose (Davies et al., 2006).

TGCTA is specifically designed to therapeutically harness three potent forces. (a) *Adolescence*, a developmental window of maximum susceptibility to peer influences. (b) *A group modality*, in recognition that *peer groups* are the self-help setting to which adolescents naturally gravitate to confront danger, mourn losses, explore the unfamiliar, make comparisons, encourage one another, and work on developmental tasks (Steinberg, 2014). Groups are an optimal setting in which to treat many adolescent problems given that the beneficial effect of group cohesion is generally *more* therapeutically potent among youth than among adults (Burlingame et al., 2011b), and skillfully facilitated *group member-to-member exchanges* generally produce more potent therapeutic effects than *group leader-to-member exchanges* (Davies et al., 2006). And (c) *confronting trauma and bereavement* – two of the most powerful and impactful experiences human beings can undergo, which naturally draw survivors together to exchange support and recover (Gottlieb, 1996; La Greca et al., 2002; Layne et al., 2001a). Groups are also potent tools for reducing loneliness – a risk

factor linked to the health of the developing brain (Cole et al., 2015).

6. Grounded in cutting-edge theoretical and empirical developments. A sixth strength of TGCTA is that it *draws on recent clinical and scientific advances in the fields of child and adolescent trauma and bereavement*. The narrative construction procedures used in Modules 2 and 3 are based on recent advances in cognitive neuroscience, including findings of potent links between memory, expectations, plans of action, and reminders. Module 1 components draw on advances in the study of *trauma reminders* and *loss reminders* and ways in which they differentially evoke posttraumatic stress and grief reactions. Module 1 and Module 4 components also draw on the study of *secondary adversities* (hardships caused or worsened by traumatic events or losses) and ways in which they generate their own consequences, thereby worsening the effects of the original trauma or loss (Layne et al., 2006). Modules 1 and 4 thus focus on coping with secondary adversities and *developmental adversities* (barriers to carrying out developmental tasks, achieving developmental milestones, and negotiating developmental transitions) with the aim of preventing accumulations of risk factors over time. Module 1 and Module 4 components also focus on cultivating *resource gain cycles* and promoting their continued growth, maturation, and forward momentum across development, by strengthening adaptive coping skills, reinforcing realistic yet optimistic expectations, and strengthening connections to healthy people and social institutions (Hobfoll, 2014; Layne et al., 2014a).

Moreover, TGCTA draws on *multidimensional grief theory* (Kaplow et al., 2012a, 2013; Layne et al., 2012, in press) to guide assessment, case formulation, treatment planning and tailoring, monitoring treatment progress, and treatment outcome evaluation. A core assumption of multidimensional grief theory is that *grief is an inherently beneficial yet often taxing process of responding to, and making ongoing efforts to adjust to, a world in which the deceased person is no longer physically present*. The theory proposes that, although primarily adaptive, grief reactions can go awry and increase the risk for prolonged severe distress, functional impairment, risky behavior, and developmental derailment. Discussions of grief reactions in Modules 1 (basic psychoeducation) and 3 (grief processing) thus emphasize *both* adaptive *and* maladaptive grief reactions with the aim of avoiding the "over-pathologizing" of normal grief reactions while also promoting positive adjustment to bereavement.

Module 3 can be tailored to address a range of theorized maladaptive and adaptive grief reactions. These include three primary dimensions proposed by multidimensional grief theory (Layne et al., 2012; Kaplow et al., 2013) consisting of *separation distress, existential/identity distress*, and ***circumstance-related distress*** (Kaplow et al., 2012a, 2013); as well as PCBD reactions proposed in DSM-5 (Kaplow et al., 2012b; Kaplow et al., 2014; Claycomb et al., 2016). Module 3 is enhanced when paired with an assessment tool – such as the *PCBD Checklist* (Layne et al., 2014d) – that can be scored in accordance with multidimensional grief theory. Understanding which specific grief dimensions are current sources of distress enables the clinician to tailor treatment according to the specific needs of bereaved youth. This is done by selecting or emphasizing therapeutic exercises (e.g. specific sketches or scenarios) that address those dimensions of grief that are elevated in the youth's assessment profile (Kaplow et al., in press). A detailed overview of multidimensional grief theory and of each session is provided in the introduction to Module 3.

Using TGCTA Modules Flexibly, to Create Multi-tiered Intervention Programs

How can I strategically use TGCTA's modularized design to promote both treatment effectiveness and treatment efficiency? The modular architecture of TGCTA enables clinicians to customize intervention for different levels and types of youths' needs, settings (e.g. school-based versus community clinic), and the intervention modality (e.g. group versus individual versus classroom-based). TGCTA's highly adaptable design allows it to be used as both a broad-spectrum tool to promote hardiness and strengthen stress resistance, or facilitate resilient recovery following large-scale events in the *general population* (e.g. providing classroom-based services to the entire student body) while also concentrating specialized services for a smaller proportion of *high-risk students* (e.g. providing highly distressed students with group or individual treatment). In particular, different combinations of TGCTA modules can be varyingly used to provide *general skills-building supportive intervention*, as well as *specialized treatment* focusing on trauma, bereavement, trauma *and* bereavement, or traumatic bereavement (Saltzman et al., 2003). Although commencing with Module 1 is always recommended, field evaluations suggest that beneficial outcomes can be obtained using a variety of different configurations of TGCTA modules depending on youth's specific needs, goals, and the time available (Cox et al., 2007; Layne et al., 2001b; Layne et al., 2008; Saltzman et al., 2001a). Table P1 presents six such options.

As shown in the table, TGCTA modules are designed to support at least five different options for intervention ranging from *general population-based intervention* consisting of basic psychoeducation and coping skills (Tier 1), to *specialized therapeutic treatment* focusing on trauma, bereavement, and the interplay between posttraumatic stress symptoms and grief reactions (Tier 2).

Tier 1 intervention. TGCTA can be configured to deliver a *general support* intervention, as implemented in a group- or classroom-based modality for the general population. The modularized design of TGCTA provides clinicians with the flexibility to implement only Modules 1 and 4 – an approach that was field-tested with war-exposed youth in a classroom setting and produced strong results (Layne et al., 2008). This (Module 1 and 4) approach efficiently furnishes youth with both a *coping skills toolkit* and a *developmental progression* toolkit, and can be used with moderately distressed youth who do not require more

Table P1 Using TGCTA modules flexibly, to tailor intervention for specific clients and settings

Tier 1: Trauma/bereavement-informed general supportive *intervention*			
Option	**Intervention aim**	**Module sequence**	**Modality**
1.	Psychoeducational and skills-building supportive intervention, plus promoting positive adjustment and adaptive development progression	1, 4	Group, classroom, or individual (e.g. teach and practice one coping skill per therapy or class session)
Tier 2: Trauma/bereavement-focused specialized *treatment*			
Option	**Therapeutic aim**	**Module sequence**	**Modality**
2.	Trauma-focused treatment	1, 2, 4	Group or individual
3.	Bereavement-focused treatment	1, 3, 4	Group or individual
4.	Integrative treatment focusing on trauma, bereavement, and their interplay; reduce posttraumatic stress reactions before addressing grief reactions (recommended "default" procedure)	1, 2, 3, 4	Group or individual
5.	Integrative treatment focusing on trauma, bereavement, and their interplay; access and construct positive memories of deceased, therapeutically harness memories to help work through traumatic experiences	1, 3, 2, 4	Group or individual
Tier 3: Referral for specialized intensive treatment for high-risk youth			
	Therapeutic aim		
6.	Referral of high-risk youth with severe problems (e.g. severe depression, severe substance abuse, suicidal ideation, intent to harm self or others) to specialized clinical services (e.g. individual treatment focusing on severe depression or anxiety; substance abuse; pharmacotherapy; inpatient or outpatient psychiatric services). These clinical services may either *replace* or *supplement* TGCTA, depending on the client's specific needs and life circumstances.		

specialized trauma- and grief-focused treatment components (contained in Modules 2 and 3, respectively). Tier 1 intervention can be delivered within a comparatively short interval (e.g. delivering Modules 1 and 4 to the student body in a classroom setting). Tier 1 intervention can also be spaced by "unpacking" Modules 1 and 4 (e.g. delivering Module 1 in the Fall of the school year to promote adaptive coping, Module 4 in the following Spring to promote developmental progression).

Tier 2 intervention. TGCTA can also be configured to provide Tier 2 intervention, which provides specialized therapeutic services in a community-based setting (e.g. school-based, juvenile justice group home, private practice, community clinic). TGCTA modules are designed and sequenced to build on one another beginning with foundational knowledge and skills (*Module 1*), working through traumatic experiences (*Module 2*), grieving losses in constructive ways (*Module 3*), and consolidating treatment gains and promoting developmental progression (*Module 4*). Evaluation studies to date placed Module 2 (trauma processing) *before* Module 3 (grief processing); this sequence thus carries the best current evidence for the treatment of youth with histories of both trauma and bereavement. Nevertheless, some youth may respond better to trauma work after they have been helped to access and/or construct a positive image of the deceased (especially if the death involved gruesome or disturbing images) that can serve as a source of comfort and support. We have also seen the benefits of sequencing Module 3 before Module 2 if youth are experiencing extremely high levels of separation distress – a grief reaction. Module 3 exercises designed to help youth strengthen healthy psychological connections to the deceased can then be therapeutically leveraged to assist the youth in conducting subsequent Module 2 trauma-focused work. Decisions regarding the sequencing of Modules 2 and 3 are thus left to the discretion of the clinician.

Notably, both general supportive intervention (Tier 1) and specialized therapeutic treatment (Tier 2) configurations of TGCTA (as implemented in *classroom- or group*-based modalities) can also be combined with *individual pull-out sessions* when needed. For example, pull-out sessions may be appropriate when working with content that

(a) is very distressing (e.g. exposure to rape, torture, gruesome details) and could vicariously distress other members, (b) is deeply private (e.g. sexual concerns, pharmacotherapy), or (c) could otherwise adversely affect vulnerable group members (e.g. suicidal ideation, sharing retaliatory fantasies).

Tier 3 intervention. TGCTA can also be used to create an interlinking *three-tiered risk screening and referral system* (Saltzman et al., 2003). Tier 1 services can be combined with risk screening to refer moderately to severely traumatized or bereaved youth to specialized (Tier 2) services, as implemented in a group or individual modality. Further, both Tier 1 and Tier 2 services can refer high risk youth to specialized and intensive (Tier 3) inpatient or outpatient psychiatric/mental health services, including youth struggling with severe psychopathology, suicide risk, or substance abuse (King et al., 2013). Our field research to date (e.g. Layne et al., 2008) suggests that cases in need of Tier 3 referral are rarely found in school settings. Nevertheless, referral networks that link Tier 1 (e.g. Modules 1 *and* 4), Tier 2 (e.g. Modules 1 *through* 4), and Tier 3 (e.g. intensive individual, outpatient, or inpatient services) levels of intervention and treatment may carry strong advantages. These include (a) providing a safety net for schools, (b) increasing school counselor confidence in screening for and working with difficult cases, (c) creating the option of continuing Tier 1 or Tier 2 services in conjunction with services provided by the Tier 3 provider (Cox et al., 2007), (d) forging ties between schools and community mental health agencies, and (e) enhancing continuity of care across multiple service systems (Ko et al., 2008).

Deciding Between a Group or Individual Treatment Modality

As noted previously, the group modality has a number of advantages over individual-based work. These advantages include greater efficiency (moderate-sized groups of five to nine members tend to benefit more from group cohesion than either smaller or larger groups) (Burlingame et al., 2011), therapeutically leveraging an increased susceptibility to peer influences during adolescence, and the potency of group cohesion and collective support in helping youth to open up and engage in meaningful psychological work. A group setting also facilitates *social referencing* as members compare themselves, their life experiences and challenges, and ways of coping, thereby helping members to reassure, teach, encourage, challenge, motivate, and inspire one another.

In contrast, *individual* treatment carries different advantages. First, it does not require clinicians to access and identify a group of youths prior to beginning treatment, as a "closed enrollment" group-based intervention like TGCTA does. Even in school settings, conducting the risk screening and pre-treatment assessment interviews needed to assemble a promising list of candidates can require considerable time and effort before group sessions begin (e.g. Saltzman et al., 2001b). Second, individual treatment provides more opportunities for in-depth therapeutic processing of the youth's traumatic and loss-related experiences, thereby allowing for a greater dose of direct exposure. Third, individual treatment helps the clinician to tailor treatment to the specific needs, strengths, life circumstances, and informed wishes of each youth. For example, individual sessions offer additional freedom to deal with sensitive or provocative content as it arises and do not require special "pull-out" sessions for group members dealing with difficult experiences (e.g. sexual assault) that are contraindicated for in-depth work in the group. Notwithstanding these potential advantages, the critical importance of the peer group in adolescence underscores the need to give special therapeutic attention in individual treatment (during coping skills exercises, social support recruitment exercises, regular session check-ins, etc.) to the status and quality of the youth's peer relationships.

Concluding Comments

Having provided our best information regarding the underlying theory, design, history, and application of TGCTA, we now conclude this introduction with our best wishes for your work with traumatized and bereaved adolescents. We hope these materials are useful tools, although we remain keenly aware that the primary resource and intervention is ***you*** – your compassion, commitment, good humor, optimism, and sincere desire to help the youth around you. In that same spirit, we hope you take good care of yourself and continue to seek out the help, support, and guidance *you* need in order to sustain your valuable and much- needed efforts.

References

Burlingame, G. M., Cox, J. C., Davies, D., Layne, C. M., & Gleave, R. (2011a). The Group Selection Questionnaire: Further refinements in group member selection. *Group Dynamics*, 15, 60–74.

Burlingame, G. M., McClendon, D. T., & Alonso, J. (2011b). Cohesion in group therapy. *Psychotherapy*, 48, 34–42.

Claycomb, M., Charak, R., Kaplow, J. B., et al. (2016). Persistent complex bereavement disorder symptom domains relate differentially to PTSD and depression: A study of war-exposed Bosnian adolescents. *Journal of Abnormal Child Psychology*, 44, 1361–1373.

Cloitre, M., Stolbach, B. C., Herman, J. L., et al. (2009). A developmental approach to complex PTSD: Childhood and adult cumulative trauma as predictors of symptom complexity. *Journal of Traumatic Stress*, 22, 399–408.

Cole, S. W., Capitanio, J. P., Chun, K., et al. (2015). Myeloid differentiation architecture of leukocyte transcriptome dynamics in perceived social isolation. *Proceedings of the National Academy of Sciences*, 112, 15142–15147.

Cox, J., Davies, D. R., Burlingame, G. M., et al. (2007). Effectiveness of a trauma/grief-focused group intervention: A qualitative study with war-exposed Bosnian adolescents. *International Journal of Group Psychotherapy*, 57, 319–345.

Davies, D. R., Burlingame, G. M., & Layne, C. M. (2006). *Integrating Small Process Principles into Trauma-focused*