Overview of Multidimensional Grief Therapy

Multidimensional Grief Therapy (MGT) is a strength-based intervention designed to carry out a range of important therapeutic tasks with bereaved children and adolescents. These tasks include (1) reducing unhelpful grief reactions (grief that keeps kids “stuck” and unable to adjust); (2) promoting adaptive grief reactions (grief that helps kids to feel and cope better after a death); (3) reducing associated symptoms of psychological distress (e.g., posttraumatic stress and depressive symptoms), and (4) helping bereaved children and adolescents to lead healthy, happy, productive lives. Consistent with its assessment-driven, flexibly tailored design, MGT is divided into a pretreatment assessment interview and an assessment feedback interview, followed by a two-phased treatment approach.

Pretreatment Assessment Interview. The pretreatment assessment interview is preferably conducted by the same clinician who will be facilitating the MGT sessions. Its primary goals are to obtain sufficient information about the perceived needs of the child or youth, determine whether MGT is an appropriate intervention, and make initial decisions regarding which dimensions of grief require clinical attention. This work is based on the assumption that children and adolescents grieve in different ways, and that “one-size-fits-all” grief treatments (which treat them as if they have the same grief reactions) often lack effectiveness (see Kaplow, Layne, & Pynoos, 2019, for a review). To assist in case conceptualization and treatment planning, the clinician interviews both the youth and their caregiver(s) and administers selected measures (reviewed in Chapter 3) to gather information regarding the client’s functioning across a range of symptom domains, especially grief reactions.

Assessment Feedback Interview. Following the pretreatment assessment interview, the clinician reviews the assessment results with the client and their caregiver(s). Using both the assessment results as well as clinical judgment, the clinician then makes recommendations for intervention using a three-tiered referral system. This system refers cases based on the seriousness and urgency of each client’s difficulties and need for general versus more specialized bereavement care (Layne et al., 2008; Saltzman et al., 2003). Different tiers of intervention include the following:

Tier 1: Use MGT Phase 1 to provide general bereavement support focused on facilitating adaptive grieving (e.g., psychoeducation, strengthening coping skills, improving family communication). This general support (i.e., MGT Phase 1 alone) can also be provided by community-based bereavement support facilities, faith-based organizations, or other youth-serving organizations (often as implemented by trained paraprofessionals – e.g., school-based or community-based grief support groups).

Tier 2: Implement a full therapeutic dose of MGT consisting of both Phase 1 (general grief support focused on facilitating adaptive grief) followed by Phase 2 (therapeutic support focused on both reducing maladaptive grief reactions and facilitating adaptive grief reactions) in a therapeutic setting. Potential therapeutic settings include school-based clinics, community mental health centers, hospitals, and clinical private-practice offices.

Tier 3: If risk screening efforts detect severe symptoms requiring urgent care (e.g., significant suicide risk), refer for emergency care (e.g., emergency room evaluation). Depending on the client’s condition, this may involve admission to inpatient treatment or enrollment in an intensive day treatment program.

We discuss how youths’ individual assessment profiles can be used to guide professional decisions about which tiers of service to offer in Chapter 3.

Regarding Tier 2, our assessment-driven, two-phased approach for implementing MGT with bereaved youth and families is based on the basic premise that not every client needs both phases of MGT (Hill et al., 2019). This determination (whether to proceed from Phase 1 to Phase 2) is made typically by readministering the assessment battery at the completion of Phase 1 and evaluating whether the client has experienced clinically significant reductions in the symptoms/diagnoses that were targeted as intervention
objectives in the treatment plan. Chapter 3 describes this decision-making process in detail.

**Phase 1 of MGT** (Sessions 1–6) focuses on teaching youth and families about the different dimensions of grief as explained by multidimensional grief theory, different grief-related challenges, ways in which grief reactions can change over time, how grief is different for each family member, how certain reminders of the deceased person or reminders of how the person died can evoke different grief reactions, and teaching coping skills to decrease unhelpful grief-related thoughts.

**Phase 2 of MGT** (Sessions 7–10), guides the client through his/her own story about the death by focusing on each dimension of grief (emphasizing those that are most problematic for the client), reducing maladaptive grief reactions, promoting adaptive grief reactions, making meaning of the death, and finding ways to move forward in life while still maintaining a healthy connection to the deceased person. MGT sessions also include a number of caregiver-child exercises that help to build positive communication and caregiver grief facilitation (caregiver behaviors or activities that help youth to grieve in adaptive ways).

Including the pretreatment assessment and assessment feedback session, the full version of MGT (both Phase 1 and Phase 2) typically takes 14 weeks to implement (given that certain sessions, such as the loss narrative, often require 2–3 weeks to complete), with each session lasting approximately 50 minutes. MGT is designed to be tailored flexibly to the specific needs and strengths of each individual client. For example, different youth may need more, or fewer, sessions depending on their individual assessment profiles. Although this manual is designed to be conducted as an individual grief-focused treatment (i.e., conducted one-on-one with a therapist), the exercises can be adapted and tailored for a group-based treatment modality. Similar grief-focused work has been implemented successfully in a group modality (i.e., see the Grief module of *Trauma and grief component therapy for adolescents* [Saltzman et al., 2017]), including with adolescents exposed to domestic violence, community violence, gang violence (Grassetti et al., 2014; Grassetti et al., 2018; Herres et al., 2017; Layne, Pynoos, & Cardenas, 2001; Saltzman et al., 2001), and war (Layne et al., 2001, 2008); and youth in the juvenile justice system (Clow et al., 2022; Olafson et al., 2018).

### What Makes MGT Unique?

It is especially reasonable to ask what makes MGT unique and how this treatment supports best-practice bereavement care – especially given the recent inclusion of prolonged grief disorder (PGD) in both *Diagnostic and statistical manual of mental disorders* (5th ed.) (DSM-5-TR) and *International statistical classification of diseases and related health problems* (11th ed.) (ICD-11) and the growing need, across the world, for child-focused grief support (e.g., at the time of writing, over 300,000 US youth had lost a parent or caregiver to COVID-19). Drawing on features and lessons learned from a companion intervention, *Trauma and Grief Component Therapy for Adolescents* (TGCTA; Saltzman et al., 2017), MGT has six built-in strengths that set it apart as a cutting-edge intervention for bereaved children and adolescents:

1. **Developmentally tailored.** MGT contains exercises that are designed to specifically address the developmental needs, strengths, risks, challenges, tasks, and life circumstances of both children and adolescents. Specific language and practice elements for each age/developmental group are provided. For example, descriptions of the various grief domains are modified according to the child's age/developmental level (e.g., use of the grief characters versus a general description of each grief domain). In addition, the grief sketches found in Session 6 are designed to represent a wide range of bereavement-related challenges that can occur among younger children as well as adolescents.

2. **Interplay between trauma and bereavement.** A second strength of MGT is its integrative focus on bereavement, trauma, and the interplay between grief reactions and posttraumatic stress reactions. Several MGT authors served on the American Psychiatric Association's DSM-5 Posttraumatic Stress Disorder, Trauma, and Dissociative Disorders Sub-Work Group, in which capacity they provided age-specific recommendations for both posttraumatic stress disorder (PTSD) criteria and newly proposed PGD criteria (Layne et al., 2019; Layne, Oosterhoff, et al., 2020). MGT aligns with the latest diagnostic and treatment considerations for these particular bereavement- and trauma-related outcomes. Although many interventions that treat grief reactions in youth are primarily designed to address trauma (treating bereavement as simply another form of trauma), or conflate PTSD with grief reactions (as in the case of "traumatic grief"), MGT approaches bereavement and trauma as related yet meaningfully distinct causal risk factors (Layne, Beck et al., 2009; Layne, Steinberg, & Steinberg, 2014). The design of MGT reflects a clear conceptual understanding of the causal links between bereavement (a causal risk factor) and grief (an outcome); trauma (a causal risk factor) and posttraumatic stress reactions (an outcome) (Layne, 2021b). Its design also reflects an understanding of the crisscrossing interplay between grief and posttraumatic stress reactions over time and the importance of this dynamic process for case conceptualization and differential diagnosis (Layne et al., 2017; Layne, Kaplow, & Pynoos, 2022b; Pynoos, 1992), as well as individually tailored treatment (Kaplow, Layne, & Pynoos, 2019; Saltzman et al., 2017).

Bereavement and trauma may occur in different configurations in youth's lives. For example, they may co-occur simultaneously, as in the case of *traumatic bereavement* – in which their loved one dies under traumatic circumstances (Layne et al., 2017). Alternatively, bereaved youth may also be directly exposed to imminent life threat or serious injury...
themselves (e.g., being involved in a car accident in which a loved one is killed) (Saltzman et al., 2017). Regardless of their particular configuration, co-occurring bereavement and trauma each exert their own effects on distress and functioning. MGT reflects the understanding that both grief reactions and posttraumatic stress reactions can exert enormous demands on the inner resources of children and adolescents (Pynoos, 1992). Further, the demands of one set of reactions can intersect in complex ways with the social, physical, psychological, and spiritual resources available to cope with the other set of reactions (Layne, Beck et al., 2009; Saltzman et al., 2017).

3. Two-phased, assessment-driven format. A third strength of MGT is its two-phased format, which supports assessment-driven, flexibly tailored intervention. When paired with evidence-based assessment methods, MGT helps practitioners to carry out a central task of evidence-based practice: to gather and use the best available evidence to tailor the intervention in accordance with clients’ specific needs, strengths, life circumstances, values, informed wishes, and the practitioners’ clinical wisdom and expert judgment (Layne, Strand, et al., 2014). Based on assessment information gathered in the pretreatment assessment interview, this data can be used to develop an individual assessment profile that summarizes the client’s degree of distress as measured along specific dimensions of grief (see Chapter 3). This information can be used to select specific practice elements (e.g., specific sketches reflecting those dimensions) that will be most relevant and beneficial for the youth. The individual assessment profile also helps to identify key benchmarks of functioning and developmental progression versus derailment that can be used to evaluate clinically significant impairment at baseline and at the completion of Phase 1, and monitor clinically significant improvement as treatment progresses (Layne et al., 2010).

Youth begin with Phase 1 and proceed through each of its sessions, after which they are reassessed to evaluate the effectiveness of treatment to that point. Youth who report few maladaptive grief reactions and/or for whom treatment goals have been met (e.g., significant reductions in PTSD and improved functioning) following completion of Phase 1 may not require additional treatment and may thus terminate therapy. In contrast, youth who manifest continued maladaptive grief reactions and/or PTSD symptoms are encouraged to continue on to Phase 2. Although the contents of Phases 1 and 2 are divided into specific sessions, MGT is designed to encourage “flexibility within fidelity” by tailoring treatment to meet each child’s needs (Kendall & Frank, 2018). As dictated by a child’s unique grief presentation, individual needs, family configuration, developmental level, and life circumstances, sessions may be expanded or condensed at the therapist’s discretion (Hill et al., 2019).

4. Multitiered intervention framework. A fourth strength of MGT, also derived from its two-phased format, is its capacity to support multitiered mental health and wellness interventions. Multitiered interventions are especially valuable in high-risk, high-need, under-resourced settings because they help service providers to balance both program effectiveness and program efficiency. MGT 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 (Layne et al., 2008). These tiers consist of grief-focused psychoeducation and skill building (e.g., Phase 1 of MGT; Tier 1), more specialized treatment for youth continuing to exhibit elevated maladaptive grief and/or posttraumatic stress reactions (Phase 2 of MGT; 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 similar multitiered system has proven effective in high-risk and resource-poor settings (Cox et al, 2007; Layne et al., 2008).

5. Individual or group-based format. A fifth strength of MGT is its flexibility with regard to treatment modality – specifically, MGT can be used individually or in groups. Although MGT has shown evidence of reducing psychological distress in youth when used in individual therapy (Hill et al., 2019), it is also ideally suited to treat groups of children or adolescents with loss histories in settings where a group-based modality is more efficient. These settings include bereavement centers, schools, juvenile justice settings, residential care, diversion programs, and community-based mental health centers (e.g., Grassetti et al., 2014). A sizable literature documents that groups are generally as effective as, and often more efficient than, individual treatment for many problems (Davies, Burlingame, & Layne, 2006). A group-based modality can also improve access to care, especially in underresourced areas where evidence-based interventions for childhood bereavement/grief may be especially difficult to find.

6. Grounded in cutting-edge theoretical and empirical developments. A sixth strength of MGT is that it draws on recent clinical and scientific advances in the field of child and adolescent bereavement. For example, Phase 1 components draw on advances in the study of loss reminders and trauma reminders, and ways in which they differentially evoke grief and posttraumatic stress reactions (Layne et al., 2006). Phase 2 components draw on advances in the study of children’s loss narratives and the most effective strategies for helping youth to process a death (Kaplow, Wardecker et al., 2018). MGT also draws heavily from multidimensional grief
Overview of Multidimensional Grief Therapy

Theory to guide assessment, case formulation, treatment planning and tailoring, monitoring treatment progress, and treatment outcome evaluation (Kaplow, Layne et al., 2013; Kaplow, Layne, & Pynoos, 2019; Layne & Kaplow, 2020; Layne, Kaplow, & Pynoos, 2022c).

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 (Layne et al., 2019). These theoretical underpinnings carry major implications for both grief-informed assessment and treatment. First, measures and interventions that address grief must acknowledge both adaptive grief reactions and maladaptive grief reactions to avoid overpathologizing normative grief reactions and set the stage for strength-based components that promote positive adjustment (Layne, 2018; Layne, 2021a). Second, interventions designed to address maladjustment and positive adjustment in bereaved youth should view children's grief reactions within a broad theoretical context comprised of both child-intrinsic and child-extrinsic socioenvironmental factors theorized to either reduce or promote these outcomes, respectively (Kaplow et al., 2012; Pynoos et al., 1995). Multidimensional Grief Therapy contains practice elements that focus explicitly on a range of child-intrinsic (e.g., developmental stage, coping strategies) and child-extrinsic factors (parent-child communication, parenting practices) that are associated with children's grief reactions.

A third implication is the need for an assessment-driven format that therapeutically leverages the "adaptive versus maladaptive" continuum proposed by multidimensional grief theory (Kaplow & Layne, 2014; Layne, 2018, 2021b; Layne et al., 2020). Multidimensional Grief Therapy matches individual or group assessment profiles with those treatment components that are most effective in therapeutically reducing (for maladaptive grief) and promoting (for adaptive grief) specific grief reactions (see also Saltzman et al., 2017). Multidimensional Grief Therapy thus invites practitioners to flexibly prescribe and tailor specific practice exercises (e.g., selecting specific sketches) within each session that carry the best theoretical rationale and empirical evidence for clients’ specific grief profiles, including the three primary dimensions proposed by multidimensional grief theory: separation distress, existential/identity distress, and circumstance-related distress. As discussed in Chapter 3, MGT also encourages practitioners to monitor each client's therapeutic progress along these conceptual dimensions in combination with PGD diagnostic status (Layne & Kaplow, 2020; Layne, Kaplow, & Pynoos, 2022c).

In closing, we know firsthand how challenging this work can be. We also recognize the immense power of an effective intervention that can ease the pain of loss and help children to lead healthy, happy, fulfilling lives in the face of tragedy. It is our hope that you will find MGT to be as user friendly, flexible, meaningful, and transformative as we have. In the next chapter, you will learn more about how MGT came to be, its theoretical underpinnings, and the ways in which multidimensional grief theory has served as the foundation for all of the practice elements found in each session.
What Is Multidimensional Grief Theory?

Both multidimensional grief theory and multidimensional grief therapy (MGT) draw upon a rich history of the clinical and scientific study of child and adolescent (hereafter youth) bereavement. This history offers a diverse array of conceptual lenses and therapeutic tools that support a broad, integrative approach to understanding, assessing, and intervening with bereaved youth and families. As a theory derived from decades of field study and clinical practice, multidimensional grief theory is both practical and powerful in its ability to describe, explain, predict, and therapeutically address a broad range of grief reactions. As we will discuss, the theory is an outgrowth of three major streams of clinical research, theory, and practice: attachment theory, existential philosophy, and disaster mental health (Layne, 2021b). Multidimensional grief theory incorporates, but also extends beyond, these three major approaches by integrating their core principles into a coherent conceptual framework, adopting a developmental and ecological emphasis, and clarifying their many implications for assessment, case conceptualization, and treatment planning. Multidimensional grief theory not only describes how grief reactions can manifest in bereaved youth (as depicted in an individual grief assessment profile (Layne, Kaplow, & Pynoos, 2022c); see Layne, Kaplow, & Pynoos, 2022c). It also facilitates a balanced, strength-based, problem-focused intervention for bereaved youth and families that offers a broad array of engaging activities for clinicians and care providers (see also Saltzman et al., 2017).

Multidimensional grief theory’s broad scope encompasses all primary features of Prolonged Grief Disorder as listed in both DSM-5-TR (American Psychiatric Association, 2022) and ICD-11 (World Health Organization, 2019) diagnostic criteria, and will help you to “see” many different facets of grief and guide you in deciding how to address them (Saltzman et al., 2017). The theory’s dual emphasis on both helping adaptive (helpful) grieving to proceed and maladaptive (unhelpful) grieving to recede (Layne et al., 2017; Layne, 2018; Layne, Kaplow, & Pynoos, 2021a, 2021b) makes it a useful framework for integrating grief-focused general support interventions found in Phase 1 (e.g., focusing on grief psychoeducation, facilitating helpful caregiver-child communication, and facilitating adaptive grieving that brings comfort); with grief-focused therapeutic interventions found in Phase 2 (e.g., utilizing different practice elements to help both maladaptive grief reactions to recede, and adaptive grief reactions to proceed). Combined with developmentally-appropriate assessment methods that align with the theory (e.g., Layne, Kaplow, & Pynoos, 2022a, 2022b), multidimensional grief theory will help you to build a grief assessment profile (Layne et al., 2022c), case conceptualization, and intervention plan that you can tailor flexibly according to each youth’s profile (Kaplow & Layne, 2019; Layne & Kaplow, 2020). This manual will help you to tailor your intervention based on such factors as each youth’s developmental level (this manual is designed for bereaved youth aged 7–18), culture, relationship to the deceased, exposure to the death, current functioning, life circumstances, strengths, and informed wishes.

We use the following terminology throughout this manual (Layne, 2021b):

- **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 (and more generally, to other forms of loss that do not involve the death of a loved one – e.g., prolonged separation, estrangement, abandonment, former way of life)
- **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
Overview of Multidimensional Grief Theory

A Model of Multidimensional Grief Theory’s Primary Conceptual Domains

Figure 2.1 is a model of the three primary conceptual domains of multidimensional grief theory. It depicts a multidimensional approach to understanding, assessing, and intervening with grief in both directions (horizontally and vertically). This three-domain model of grief has guided our assessment, intervention, training, and public advocacy efforts for over two decades (Layne, 2020, 2021b). These efforts include the authors’ early field trainings in the model (CL and RP, 2008), treatment outcome studies (Layne et al., 2008), scientific presentations (Layne, Kaplow, & Pynoos, 2012), and applications to military families (Kaplow et al., 2013) and traumatically bereaved youth (Layne et al., 2017). The model has three major distinguishing features (Layne, Kaplow, Oosterhoff, & Hill, 2019).

First, the model is multidimensional along the horizontal axis (the bottom) (Layne et al., 2019). Multidimensional grief theory proposes that grieving and mourning are generally normal, expectable processes that promote adaptive adjustment to the death of a loved one. The adaptive/helpful versus maladaptive/not helpful two-headed arrow at the base of the model is a guide to recognize – and distinguish between the helpfulness of – different grief reactions for specific individuals and their particular life context. This most basic distinction (between helpful and less helpful/unhelpful grief reactions) in multidimensional grief theory has been replicated in multiple settings (e.g., Layne et al., 2001; Layne et al., 2008; summarized in Layne et al., 2019). Nevertheless, this distinction is only conceptual and not a true “either-or” continuum. To the contrary, the theory proposes that adaptive and maladaptive grief reactions can and frequently do co-occur. For example, grieving people can shift from intense emotional pain to comforting reminiscing from one moment to the next. Further, measures of adaptive versus maladaptive grief reactions tend to correlate positively in the moderate range (Layne, Kaplow, & Pynoos, 2012; Layne et al., 2001; Layne et al., 2008; Layne et al., 2019; Layne et al., 2020). This potentially high degree of co-occurrence between adaptive versus maladaptive grief reactions can make it challenging to differentiate between these two sets of reactions in assessment (e.g., differential diagnosis), therapeutic work, and research studies (Layne, Kaplow, et al., 2014; Layne & Kaplow, 2020). We discuss this challenge and ways to address it in the next chapter on assessment.

Second, the model is multidimensional along the vertical axis (Layne et al., 2019). Multidimensional grief theory proposes that a broad range of grief reactions can arise after the death of a loved one (Kaplow, Layne et al., 2013; Layne et al., 2008; Layne et al., 2017; Pynoos, 1992), and that a given reaction can vary in its helpfulness in facilitating adaptive adjustment to a given death. The theory proposes that grief reactions generally fall within three primary conceptual domains or dimensions (which are vertically stacked in the model). These conceptual domains consist of the following:

- **Separation distress** (e.g., missing the person who died, longing for their return). Separation distress is positioned at the top of the model because it is the most easily recognized – and perhaps prototypical – grief reaction (Layne et al., 2019). It is common to all age groups (although it may be somewhat more intense in younger children; Kaplow et al., 2012) and all types of death, and commonly seen in clinical practice. Consistent with its high prevalence rate and key role as an early “gateway” grief reaction that can, if severe and persisting, lead to clinically significant distress, DSM-5-TR and ICD-11 prolonged grief disorder (Layne et al., 2019; Layne, Oosterhoff, Pynoos, & Kaplow, 2020). This potentially high degree of co-occurrence between adaptive versus maladaptive grief reactions can make it challenging to differentiate between these two sets of reactions in assessment (e.g., differential diagnosis), therapeutic work, and research studies (Layne, Kaplow, et al., 2014; Layne & Kaplow, 2020). We discuss this challenge and ways to address it in the next chapter on assessment.

- **Existential/identity distress** (e.g., diminished sense of life meaning and purpose or of personal identity). Existential/identity distress is positioned in the middle of the model because it is a common reaction to many types of deaths – both “traumatic” and otherwise – but is often less understood and less well recognized than separation distress, sometimes appearing as apathy, aimlessness, resignation, nihilism, or despair (Layne et al., 2019; Layne et al., 2020). In our experience, existential/identity distress is more likely to (1) become clinically prominent in adolescence and young adulthood following the loss of identity-defining relationships and/or relationships that provide a sense of purpose, meaning, drive to one’s life, and hope for the future; and (2) call for clinical attention due to its tendency to erode youths’ sense of optimism, life ambitions, and preparations for the future (Layne, Pynoos, & Cardenas, 2001; Layne et al., 2008; see also Saltzman et al., 2017, Module 4).

- **Circumstance-related distress** (e.g., distress over how the person died). Circumstance-related distress is positioned at the bottom of the model because it is more likely to arise in the aftermath of traumatic or tragic deaths and thus may be less commonly recognized as a form of grief that is separate and distinct from posttraumatic stress reactions/PTSD (Layne et al., 2019). Circumstance-related distress can arise after
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A Brief Review of the Scientific and Theoretical Roots of Multidimensional Grief Theory

The Scientific Roots of Multidimensional Grief Theory

Multidimensional grief theory is a direct outgrowth of decades of careful fieldwork in building assessment tools, manualized interventions, and training curricula for professionals working with youth, families, and communities bereaved under diverse conditions (Layne, 2020). Its core propositions have coevolved with the authors’ efforts to advance the fields of traumatic stress and bereavement along seven fronts (Layne, Kaplow, & Pynoos, 2012). These fronts are (1) theory building, (2) test construction, (3) naturalistic research, (4) intervention development and evaluation, (5) education and training, (6) implementation and dissemination, and (7) public outreach and advocacy. A number of relevant advances have been developed, field-tested, and refined over more than three decades:

- **Clinical-descriptive and treatment-outcome studies of bereaved youth** whose loved ones died due to community violence (Layne, Pynoos, & Cardenas, 2001; Saltzman et al., 2001), civil war (Howell, Kaplow et al., 2015; Layne et al., 2001), natural or foreseeable causes can contain highly distressing elements (e.g., witnessing a loved one’s intense suffering and progressive deterioration) that evoke more posttraumatic stress reactions than deaths due to sudden natural causes (Kaplow, Howell, & Layne, 2014). Conceptually, this dimension of the multidimensional grief model is most closely akin to – but not functionally interchangeable with, nor should be confused with – what is sometimes termed “traumatic grief” (Layne et al., 2017; Pynoos, 1992).

Third, the model is built on the proposition of **differential relations** (Layne, Kaplow, & Pynoos, 2012, 2014). That is, the distinctions between adaptive versus maladaptive grief reactions (the horizontal dimension), and between different conceptual domains of grief (the vertical dimension), are meaningfully distinct and clinically useful because they convey different types of information (e.g., create different grief assessment profiles – see Layne et al., 2022c), can arise from different causes, lead to different causal consequences, and can call for different interventions. Later in this chapter, we explain how the twin propositions of multidimensionality and differential relations guide multidimensional grief theory and our unique approach to grief-informed assessment, case conceptualization, and intervention.

Nader et al., 1990; Pynoos, 1992), and natural causes (Kaplow, Howell, & Layne, 2014; Layne et al., 2008; Saltzman et al., 2001).

- **Developmental and ecological theory** that can explain trauma-induced developmental impacts, distinctions between adaptive versus maladaptive grief, and the roles of trauma reminders, loss reminders, and secondary adversities in prolonging distress (Kaplow, Layne et al., 2013; Kaplow et al., 2006; Kaplow & Layne, 2014; Layne, Kaplow, & Pynoos, 2012; Layne, Pynoos, & Cardenas, 2001; Layne et al., 2006; Pynoos, 1992; Pynoos, Steinberg, & Wraith, 1995; Saltzman et al., 2003).

- **Theories of resilience**, including the roles of such stress-buffering resources as social support, self-efficacy, optimism, courage, and altruism (Layne et al., 2007; Layne & Hobfoll, 2020), insights into how adaptive grieving can facilitate resilience (Layne et al., 2018, 2021a, 2021b), and the roles of both promotive and protective factors in enhancing positive growth, wellness, and positive youth development (Layne, Beck et al., 2009; Layne, Ruzek, & Dixon, 2021).

- **Naturalistic studies of posttraumatic/postbereavement factors** theorized to influence the course of grief. These include circumstances of the death (Kaplow, Howell, & Layne, 2014; Kaplow et al., 2020), parenting practices in facilitating youth adjustment (Al-Sabah et al., 2015; Alvis, Dodd et al., 2022; Houston, 2006; Howell et al., 2016; Shapiro, Howell, & Kaplow, 2014; Wardecker et al., 2017), caregiver-child communication regarding the death (Shapiro, Howell, & Kaplow, 2014; children’s coping (Howell, Shapiro et al., 2015); children’s use of language in describing the loss (Kaplow, Wardecker et al., 2013); and spirituality, and religiosity (Howell, Shapiro et al., 2015; Rooney et al., 2019).


- **Theories of mechanisms of therapeutic change**, including the therapeutic alliance, parenting self-efficacy, and group cohesion (Davies, Burlingame, & Layne, 2001; Layne et al., 2006; Pynoos, 1992).

- **Adaptive and maladaptive grief** can facilitate resilience (Layne et al., 2017; Pynoos, 1992).

- **Developmental and ecological theory** that can explain trauma-induced developmental impacts, distinctions between adaptive versus maladaptive grief, and the roles of trauma reminders, loss reminders, and secondary adversities in prolonging distress (Kaplow, Layne et al., 2013; Kaplow et al., 2006; Kaplow & Layne, 2014; Layne, Kaplow, & Pynoos, 2012; Layne, Pynoos, & Cardenas, 2001; Layne et al., 2006; Pynoos, 1992; Pynoos, Steinberg, & Wraith, 1995; Saltzman et al., 2003).
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screening, psychoeducation, and coping skills; (Tier 2) school-based therapeutic care (e.g., TGCTA) for seriously distressed students by trained school counselors; and (Tier 3) referral of high-risk (e.g., suicidal) students for emergency/highly specialized treatment services (Layne et al., 2008; Saltzman et al., 2003).

- A TGCTA training curriculum covering risk screening, clinical/diagnostic assessment, case conceptualization, treatment planning, and assessment-driven individual tailoring. This curriculum has been refined over decades of trainings in such field settings and institutions as school-based health clinics, community mental health centers, juvenile justice settings, bereavement support centers, government ministries, and university training clinics. The TGCTA training curriculum has been adapted by the authors over many years to address the needs of youth and families exposed to war (CL, WS, & RP, 1997); terrorism, as well as community and domestic violence (CL, WS, & RP, 2002); rural life (CL & RP, 2008); and community, gang, and domestic violence (WS, CL, & JK, 2017). A recent edition of the training curriculum focused on fostering post-hurricane resilience (JK, CL, WS, & instructional designer Dr. Hannah Grossman).

This version integrates instructional tools and exercises from the National Child Traumatic Stress Network’s Core Curriculum on Childhood Trauma (Layne, Strand et al., 2014) to strengthen core competencies relating to trauma- and bereavement-informed assessment, case conceptualization, treatment planning, and critical reasoning (see Layne, 2022; TGCTA.com for further information about TGCTA).

Multidimensional grief theory has also guided the development of a manualized intervention for traumatized, bereaved, traumatically bereaved, and developmentally disrupted adolescents (TGCTA [Saltzman et al., 2017]) and its predecessors (Layne et al., 1997; Layne et al., 2002). These manualized interventions have been shown to reduce symptoms of psychological distress including PTSD, depression, and grief reactions; and to improve functioning, including school performance, in diverse populations and settings. Populations included youth exposed to community, gang, and domestic violence (Layne, Pynoos, & Cardenas, 2001; Saltzman et al., 2001), war (e.g., Davies et al., 2006; Layne et al., 2001; Layne et al., 2008), terrorism (Hoagwood, Layne, & CATS Consortium, 2010), and incarcerated youth with extensive histories of trauma and bereavement (Clow et al., 2002; Olafson et al., 2018). Multidimensional grief theory has been used to guide training and practice with mental health professionals serving Native American and rural youth (CL & RP, 2008), military families (Kaplow, Layne et al., 2013), and traumatically bereaved adolescents (Layne et al., 2017). An open trial of MGT with bereaved inner-city youth found significant pre- to post-treatment improvement in multiple domains of maladaptive grief reactions, PTSD, and depressive symptoms (Hill et al., 2019).

Core Propositions of Multidimensional Grief Theory and Their Scientific Roots. The foundations of multidimensional grief theory and this manualized treatment are built upon the twin propositions of multidimensionality (of grief reactions) and differential relations (between different types of grief reactions and different external factors, such as causal risk factors and treatment components) (Layne, Kaplow et al., 2014). Using correlation matrices, statistical prediction, expert ratings, factor analysis, and other test construction tools, the authors identified – through extensive field research (e.g., Layne et al., 2001; Layne et al., 2008; Layne et al., 2010; Layne, Kaplow, & Pynoos, 2012) – an increasingly broad range of grief reactions characterized by both adaptive and maladaptive responses to the deaths of loved ones. Over time, a scientific method – the differential validity matrix (Layne, Kaplow et al., 2014) – evolved. This multidimensional framework guides our approach to carrying out many bereavement research- and treatment-related tasks (Layne, Kaplow et al., 2012; Layne, Kaplow, & Pynoos, 2022):

- Building a multidimensional and clinically useful theory that can account for a broad range of grief reactions across a range of developmental periods, cultures, and ecological settings
- Constructing multidimensional measures for assessing grief reactions
- Differentiating between generally adaptive versus maladaptive grief reactions
- Differentiating between grief versus related conditions (e.g., PTSD, depression)
- Creating an individualized grief assessment profile for each client
- Using each client’s assessment data to create an individually tailored case conceptualization
- Creating supportive/therapeutic grief exercises to address different grief dimensions and the central coping challenge for each grief domain
- Using each client’s assessment data and case conceptualization to create a flexibly tailored treatment plan (Kaplow, Layne, & Pynoos, 2019; Layne, Kaplow, & Youngstrom, 2017; Layne & Kaplow, 2020; Saltzman et al., 2017)

The core propositions of multidimensional grief theory arise as direct implications of the differential validity matrix (Layne, Kaplow, & Pynoos, 2012; Layne et al., 2014, 2019; Layne, 2021a, 2021b). This scientific approach offers an ecologically grounded, contextualized, and clinically useful understanding of a broad range of grief reactions. Most relevant to MGT, this approach offers a clear rationale as to why the core propositions of multidimensional grief theory are clinically useful – that is, why these distinctions make a real-world and clinically actionable difference (Layne, Kaplow et al., 2014). As used in the theory, multidimensionality refers to basic distinctions between the horizontal axis (i.e., adaptive versus maladaptive) and vertical axis (i.e., primary conceptual domains of grief) of the multidimensional grief model (Layne et al., 2019). That is, each of these grief domains are theorized to be meaningfully distinct and clinically useful, in that they are not functionally interchangeable with one another in performing a range of important
tasks, including coping with a central coping task or challenge associated with each domain (Layne et al., 2017). The basic distinctions between adaptive versus maladaptive grief reactions (the horizontal axis of the model), and grief conceptual domains (the vertical axis: Separation Distress, existential/identity distress, and circumstance-related distress), are clinically useful because they can lead to different clinical decisions about important aspects of bereavement-informed care (Layne, Kaplow, & Youngstrom, 2017; Layne et al., 2019; Layne, 2021a, 201b), such as understanding

- which individuals, based on exposure to specific types of causal risk factors, vulnerability factors, and protective factors, are most likely to experience which types of grief reactions;
- the origin, locus, and essential nature of their grief-related distress and difficulties;
- the primary coping challenge associated with each type of grief reaction;
- intervention objectives (therapeutic goals) associated with each conceptual grief domain;
- how to help in effective, flexible ways (Kaplow, Layne, & Pynoos, 2019; Layne & Kaplow, 2020).

The differential validity matrix approach to unpacking and differentiating between grief reactions (Layne et al., 2014) demonstrates that different grief dimensions are meaningfully distinct because they relate differently to one or more of four different types of external factors: correlates, moderators, causal precursors, and causal consequences (see Layne, Beck et al., 2009, for examples). To illustrate how this guides bereavement-informed care and decision-making, Table 2.1 lists these different factors and briefly summarizes the growing scientific evidence base.

Table 2.1 Four different types of factors and their differential relations to grief domains

<table>
<thead>
<tr>
<th>Primary correlates (things that co-occur and correlate significantly with grief reactions)</th>
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</thead>
<tbody>
<tr>
<td>- <strong>Primary correlates</strong> (e.g., PTSD, depression, functional impairment, risky behavior)</td>
</tr>
<tr>
<td>- Evidence: Compared to adaptive grief reactions, maladaptive grief reactions correlate significantly more strongly with distress (e.g., depression, PTSD symptoms, somatic distress), impairment (school grades), and risky behavior (suicide ideation) (reviewed in Layne et al., 2019; Layne et al., 2020).</td>
</tr>
<tr>
<td>- Grief reactions correlate more strongly with other grief reactions than they correlate with either PTSD or depression, showing that grief reactions are internally coherent and distinguishable from other types of distress (Geronazzo-Alman et al., 2019).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moderators (protective factors and vulnerability factors that interact with bereavement to mitigate/reduce, or intensify/exacerbate, its harmful effects on a given outcome)</th>
</tr>
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<tbody>
<tr>
<td>- <strong>Protective factors and vulnerability factors</strong> can influence postdeath adjustment. These include relationship to the deceased, social support, the well-being of surviving caregivers, and parenting practices. Other potential moderating factors include age, culture/ethnicity, gender, race, socioeconomic status, and prior loss history (Coffino, 2009).</td>
</tr>
<tr>
<td>- Evidence: Bereaved children whose surviving caregivers help them to feel connected to their deceased parent (e.g., help them to reminisce, identify positive traits they share in common) report fewer maladaptive grief reactions and more adaptive grief reactions (Alvis et al., 2022; Kaplow, Layne, &amp; Pynoos, 2014a; Sandler et al. 2003; Shapiro, Howell, &amp; Kaplow, 2014).</td>
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<thead>
<tr>
<th>Causal precursors (factors that precede, and are theorized to cause, grief reactions)</th>
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<tbody>
<tr>
<td>- <strong>Causal risk factors</strong> (e.g., witnessing traumatic deaths or death scenes; exposure to traumatic details about deeply disturbing death circumstances such as eyewitness accounts, police or medical reports/photographs, legal testimony).</td>
</tr>
<tr>
<td>- Evidence: Youths exposed to violent deaths report higher levels of circumstance-related grief distress than youth exposed to nonviolent deaths (Douglas et al., 2021; Layne et al., 2019).</td>
</tr>
<tr>
<td>- Bereavement predicts grief regardless of the manner of death; many different trauma types (including nondelay-related events) predict PTSD symptoms (Layne et al., 2010).</td>
</tr>
<tr>
<td>- Mediators (e.g., trauma reminders, loss reminders, and/or secondary adversities)</td>
</tr>
<tr>
<td>- Evidence: Grief reactions correlate significantly more strongly with loss reminders; conversely, PTSD correlates more strongly with trauma reminders (Layne et al., 2006).</td>
</tr>
<tr>
<td>- Compared to severe financial hardships, interpersonal hardships (fights at home, living with a depressed or alcoholic caregiver) are a stronger mediator of the links between wartime trauma and postwar PTSD, depression, and grief five-plus years later (Layne et al., 2010).</td>
</tr>
<tr>
<td>- <strong>Treatment components/mechanisms of therapeutic change</strong></td>
</tr>
<tr>
<td>- Evidence: PTSD symptoms respond to trauma-focused treatment components; grief reactions respond better to loss-focused treatment components (Grassetti et al., 2014).</td>
</tr>
</tbody>
</table>

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<tr>
<th>Causal consequences (theorized causal effects of grief reactions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>Causal consequences</strong> (poor school grades, risky behavior, suicide ideation).</td>
</tr>
<tr>
<td>- Evidence: Reductions in maladaptive grief reactions over treatment are linked to improvements in school behavior and performance (Layne et al., 2001; Layne et al., 2008; Saltzman et al., 2001).</td>
</tr>
</tbody>
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Applying this method to drawing distinctions between different grief dimensions based on their differential relations with external factors (Layne, Kaplow et al., 2014), multidimensional grief theory proposes that different dimensions of grief may (Layne et al., 2012, 2017; Layne, 2021b):

- be more prominent at different developmental stages, such as age or gender (e.g., age may moderate the effect of bereavement on different grief domains, such that children report more separation distress than adolescents, whereas adolescents report more existential/identity distress [Layne et al., 2019, 2020]);
- be more prominent in some demographic groups (e.g., socioeconomic status [SES], gender, culture, or prior history) than others (e.g., SES may act as a vulnerability factor that moderates the effect of bereavement on different grief domains; e.g., adaptive vs. maladaptive grief, such that maladaptive grief is more prominent in low-SES groups);
- vary across different types of relationship with the deceased as a moderator (e.g., youth bereaved by the loss of a close/highly dependent relationship, such as a parent) may experience more separation and/or existential/identity distress than by the loss of a friend;
- vary across different types of bereavement as a causal risk factor (e.g., youth bereaved by traumatic deaths may experience more circumstance-related distress);
- relate differently to different causal consequences (e.g., examples, compared to adaptive grief, maladaptive grief may cause greater functional impairment, developmental disruption, or school problems) (Layne & Kaplow, 2020), and risky behavior (Hill et al., 2019);
- and most relevant to MGT, different dimensions of grief may:
  - call for different treatment components (causal precursors) – a key principle of our modularized approach to tailoring treatment flexibly using each client’s individual grief assessment profile (similar to TGCTA’s approach [Saltzman et al., 2017]);
  - produce different grief profiles that can support individually tailored intervention.

Multidimensional Grief Therapy uses individual grief assessment profiles generated using appropriately designed measures (e.g., Kaplow, Layne et al., 2018; Layne, Kaplow, & Pynoos, 2022a, 2022b, 2022c) to tailor treatment for each client. Using multidimensional grief theory as a guide, MGT aligns four levels of intervention (Layne, Strand et al., 2014). This involves using an individual’s grief assessment profile to select and align the following:

1. A given dimension of grief and its central coping task as a therapeutic focus
2. Intervention objectives (therapeutic goals) that focus on that conceptual domain/coping task
3. Practice elements (therapeutic strategies) intended to achieve those intervention objectives
4. Skills (ways of implementing practice elements to maximize their effectiveness for a client that take into account such factors as their age, culture, prior history, life circumstances, etc.)

Multidimensional Grief Therapy helps practitioners use individual assessment data to tailor their intervention plan for each client across each of these four levels (Layne & Kaplow, 2020; Layne et al., 2022c). This can be done in creative ways while adhering to the principle of flexibility within fidelity to multidimensional grief theory and to MGT (Kendall & Frank, 2018). This design feature of MGT offers practitioners great flexibility in selecting the best-fitting intervention strategies for a client’s individual grief reactions assessment profile. MGT offers the flexibility needed to address as many as three primary grief domains as require therapeutic attention. As noted in Chapter 3, the PGD Checklist has an accompanying guide for calculating grief dimension-specific scores and evaluating general severity [Layne, Kaplow, & Pynoos, 2022a, 2022b, 2022c]. As a concrete example of how multidimensional grief theory can guide treatment planning, if a youth presents with (see Layne, Strand et al., 2014):

1. prominent separation distress (conceptual grief dimension) in their assessment profile, a practitioner can then
2. focus on creating comforting ways to connect with the deceased (intervention objective) and
3. use the Good Grief Jar to collect comforting mementos and memories (practice element), and
4. implement the Good Grief Jar activity in ways that are engaging and appropriate for the client’s developmental level and cognitive ability, culture, history, and life circumstances (skills).

Multidimensional Grief Therapy can be tailored at each of the four levels, beginning with the use of client assessment data to select a grief dimension and its central coping challenge (described later), and to align it with appropriate intervention objectives, practice elements, and skills. Other brief examples can be given of ways in which MGT aligns grief domains with intervention objectives and practice elements:

- Address circumstance-related distress (intervention objective: reduce distress over the way the person died) by using the MGT loss narrative (a practice element) and empathic skills.
- Address both separation distress (intervention objective: find comforting ways to connect by working through ambivalent feelings about the deceased) and existential/identity distress (objective: identify positive attributes to integrate into one’s own maturing personal identity) by using the Sticks and Stones exercise (a practice element) and engagement/empathic skills.

The Theoretical Roots of Multidimensional Grief Theory

A recent advance in the development of multidimensional grief theory involves efforts to clarify the theoretical roots of its three conceptual dimensions (Layne, 2021a, 2021b). This recent work helps to ground and integrate the theory into the decades-deep child and adult grief literatures.