NCTSN The National Child Traumatic Stress Network

TGCT-A: Trauma and Grief Component Therapy for Adolescents

GENERAL INFORMATION

Treatment Description	**Acronym** *(abbreviation)* **for intervention:** TGCT-A **Average length/number of sessions:** 50 minutes/10 to 24 (Sessions can be shortened in length to accommodate school class periods. Alternatively, individual sessions can be expanded up to 90 minutes in length as needed and if time allows.) TGCT-A contains a total of four treatment modules that can be implemented in a tailored manner in accordance with client's specific needs. Depending on which modules are implemented, the total number of sessions ranges from 10 to 24. **Aspects of culture or group experiences that are addressed** *(e.g., faith/spiritual component, transportation barriers)***:** Emphasis is given throughout the intervention to individual differences in responses to trauma or traumatic loss. These differences may arise from cultural, developmental, or exposure-based influences on how children, adolescents, and their families respond to traumatic experiences and losses. Many of the psychoeducational and skill-building exercises specifically address cultural, spiritual, and/or religious dimensions to trauma and loss and how individuals respond and cope differently. Module III consists of a grief component that emphasizes particular sensitivity to cultural, developmental, or religious/spiritually-linked differences in responses to death, including grief reactions and mourning rituals. **Trauma type** *(primary)*: interpesonal violence & traumatic loss (death) **Trauma type** *(secondary)*: disasters, injuries & illness **Additional descriptors** *(not included above)***:** TGCT-A is a manualized group or individual treatment program for trauma-exposed or traumatically bereaved older children and adolescents that may be implemented in school, communty mental health, clinic, or other service settings. The program has been implemented with a wide range of trauma-exposed and traumatically bereaved older child and adolescent populations, in both the United States and international settings. These populations include youth impacted by community violence, traumatic bereavement, natural and man-made disasters, war/ethnic cleansing, domestic violence, witnessing interpersonal violence, medical trauma, serious accidents, physical assaults, gang violence, and terrorist events.
Target Population	**Age range:** 12 **to** 20 **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/ immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigenerational African Americans)***:** TGCT-A has been disseminated nationally and internationally. In the United States, it has been used in school, community, and residential settings with diverse populations of youth, including youth in poor urban and suburban communities, and youth incarcerated in juvenile justice settings. TGCT-A was also used across New York City between 2001-2005 in multi-racial/ethnic communities after the World Trade Center attack.

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Target Population continued	Internationally, TGCT-A has been used with ethnic Muslim, Croatian, and Serbian youth in post-war Bosnia & Herzegovina. Early elements of TGCT-A were first field-tested with Armenian youth and families after the massive Armenian earthquake in 1988. **Other cultural characteristics** *(e.g., SES, religion)*: TGCT-A has been implemented with a variety of socioeconomic and religious/cultural/ethnic groups, as described above. This includes youth and families from socioeconomically disadvantaged regions to more middle class lifestyles. **Language***(s)*: Currently English and Bosnian. There are plans to translate the materials into Spanish. The authors are open to translating and adapting the intervention for other cultural groups as well. **Region** *(e.g., rural, urban)*: The program has been implemented in inner-city, urban, suburban, and some rural settings in the United States and abroad. **Other characteristics** *(not included above)*: TGCT-A has been implemented and evaluated in both individual and group-based modalities. Optional family-focused intervention components are also included in the manual.
Essential Components	**Theoretical basis:** TGCT-A draws from a broad variety of theoretical perspectives, including a developmental psychopathology model of the ecology of childhood traumatic stress (Pynoos, Steinberg, & Wraith, 1995), family systems theory (Saltzman et al., 2011), small group process theory (Davies et al., 2006), ecological systems/conservation of resources theory (Layne et al., 2014), social provisions (social support) theory (Layne, Warren et al., 2009), cognitive-behavioral theory, and multidimensional grief theory as developed by the authors (Kaplow, Layne, et al., 2012). The Traumatic Stress (Module II) and Grief and Loss (Module III) modules of TGCT-A draw on guiding theory and research regarding the complex interplay between trauma and grief (Pynoos, 1992; Kaplow, Layne, et al., 2012). Components of TGCT-A also reflect an understanding of the roles of trauma and loss reminders in evoking continuing distress over time, the contributions of life adversities, the influence of traumatic expectations on current and future behavior, and the importance of promoting/restoring adaptive developmental progression. **Key components:** TGCT-A is a modularized, assessment-driven, flexibly tailored treatment manual and accompanying youth workbook that includes detailed instructions for conducting individual or group sessions. Specific treatment modules (and specific sessions within modules) are selected, prioritized, sequenced, and emphasized based on clients' specific needs, strengths, circumstances, and informed wishes. The intervention contains a variety of components organized into four modules: **Module I** components include assessment tools and guidance for tailoring treatment for the needs of individual clients or a group, psychoeducation regarding traumatic stress and grief reactions, emotional regulation skills that focus on developing effective coping strategies (e.g. addressing maladaptive beliefs relating to trauma and loss, accessing social support, problem-solving, dealing with trauma and loss reminders).

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Essential Components continued

Module II components include detailed guidelines for reflecting on ways in which traumatic experiences continue to influence clients' lives, selecting one or more traumatic experiences to work on, and facilitating a narrative construction exercise with individual or groups regarding key traumatic experiences. **Module III** components include psychoeducation regarding common grief reactions as viewed through the lens of multidimensional grief theory (Kaplow, Layne, et al., 2012; Layne, Kaplow, & Pynoos, 2012). These reactions include separation distress (e.g., sadness, anger, protest over the loss), *existential/identity distress* (e.g., feeling like part of yourself died, apathetic indifference towards the future), and where present, *circumstance-related distress* (e.g., anger, desires for revenge). Therapeutic exercises are selected depending on which grief reactions are prominent in the assessment profile. **Module IV** provides additional skill training (e.g., providing social support to others, prosocial engagement), promotes adaptive developmental progression (e.g., planning and preparing for the future), facilitate planning for upcoming stressors and developmental transitions, and focuses on consolidating treatment gains and relapse prevention. Optional family/parent sessions are available at key points in treatment and are strongly encouraged where circumstances allow. Assessment tools are available to measure all major targeted therapeutic outcomes including symptoms of PTSD and persistent complex bereavement disorder (PCBD).

Clinical & Anecdotal Evidence

Are you aware of any suggestion/evidence that this treatment may be harmful?
❒ Yes ☒ No ❒ Uncertain

We conducted a rigorous field evaluation of TGCT-A as implemented in 10 secondary schools located throughout post-war Bosnia (Layne, Saltzman et al., 2008). We deliberately searched for poor/adverse (iatrogenic) clinical outcomes using the Reliable Change Index (an individual case-level metric used to classify cases into either *reliable improvers, treatment non-responders, or reliable deteriorators*). We found very few adverse outcomes (i.e., deteriorators) in a classroom-based implementation of psychoeducational and skills-building components selectively taken from Modules I and IV. Further, we found virtually no adverse outcomes (1 to 2%) in the full group-based implementation of TGCT-A (consisting of Modules I, II, III, and IV), as measured using either quantitative measures (PTSD symptoms, depression symptoms; Layne et al., 2008) or qualitative methods (focus groups, interviews; Cox et al., 2007). In contrast, strong evidence of program benefit and spreading impact was found among the great majority of participating students and group leaders, many of whom shared their knowledge and skills with their school peers and family members.

Extent to which cultural issues have been described in writings about this intervention *(scale of 1-5 where 1=not at all to 5=all the time)*. 4

We are currently conducting research on cultural and religious/spiritual influences on the way bereaved children grieve and mourn. For example, our recent work has identified spirituality and involvement in a religious community as protective factors in a sample of bereaved children (Howell, Shapiro, Layne, & Kaplow, in press).

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Clinical & Anecdotal Evidence continued

This intervention is being used on the basis of anecdotes and personal communications only *(no writings)* **that suggest its value with this group.**
❒ **Yes** ☒ **No**

Are there any anecdotes describing satisfaction with treatment, drop-out rates *(e.g., quarterly/annual reports)***?** ☒ **Yes** ❒ **No**

If YES, please include citation:

Layne, C. M., Saltzman, W. R., Burlingame, G. M., Davies, R., Popovic, T., Durakovic, E., Music, M., Campara, N., Djapo, N., Wolfson, L., & Pynoos, R. S. (2001, November). UNICEF Technical Report: Effectiveness of the UNICEF School-Based Psychosocial Program for War-Exposed Adolescents.

Cox, J., Davies, D. R., Burlingame, G. M., Campbell, J. E., & Layne, C. M., & Katzenbach, R. J. (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.

Has this intervention been presented at scientific meetings? ☒ **Yes** ❒ **No**

If YES, please include citation*(s)* **from last five presentations:**

JB Kaplow (Chair) (2013; November). *Correlates and predictors of "good grief" in bereaved children and adolescents: Implications for intervention*. Symposium presented at the Annual Meeting of the International Society for Traumatic Stress Studies, Philadelphia, PA.

Layne, C. M., Turner, S., Deter, J., Judson, R., Legerski, J. P., Darby, R., & Money, K. (2004, November). Conceptualization and Measurement of Childhood Traumatic Grief: Research and clinical implications. In C. Layne (Chair), Conceptualization, Measurement, and Treatment of Childhood Traumatic Grief: Recent Developments and Future Directions. Symposium presented at the Annual Meeting of the International Society for Traumatic Stress Studies, New Orleans, LA, USA.

Layne, C. M., & Saltzman, W. S. (2004, April). Approaches to Treating Traumatically Bereaved Youth. In Childhood Traumatic Grief. Invited symposium conducted at the national meeting of The National Center for Mental Health Promotion and Youth Violence Prevention, Kansas City, MO.

Layne, C. M., Neibauer, N., Manwaring, A., Arslanagic, B., Saltzman, W. R., & Pynoos, R. S. (2003, November). Treating complicated bereavement in adolescents. In S. Ley (Chair), Treating Childhood Traumatic Grief: A Developmental Perspective. Pre-convention institute presented at the International Society for Traumatic Stress Studies, Chicago, IL

Saltzman, W. R., Layne, C. M., & Pynoos, R. S. (2002, May). Trauma/Grief-Focused Group Intervention for Adolescents. Invited two-hour symposium (with live actors used in role-playing exercises) conducted at the American Group Psychotherapy Association Annual Meeting, New York City.

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Clinical & Anecdotal Evidence continued

Are there any general writings which describe the components of the intervention or how to administer it? ☒ **Yes** ❒ **No**

If YES, please include citation:

CM Layne (Chair) (2012, November). Integrating Developmentally-Informed Theory, Evidence-Based Assessment, and Evidence-Based Treatment of Childhood Maladaptive Grief. Symposium presented at the Annual Meeting of the International Society for Traumatic Stress Studies, Los Angeles, CA.

Saltzman, W. R., Layne, C. M., Steinberg, A. M., & Pynoos, R. S. (2006). Trauma/Grief-Focused Group Psychotherapy with Adolescents. In Schein, L. A., Spitz, H. I., Burlingame, G. M., & Muskin, P. R., (Eds.), Group Approaches for the Psychological Effects of Terrorist Disasters. New York: Haworth.

Saltzman, W. R., Layne, C. M., Steinberg, A. M., Arslanagic, B., & Pynoos, R. S. (2003). Developing a culturally-ecologically sound intervention program for youth exposed to war and terrorism. Child and Adolescent Psychiatric Clinics of North America, 12, 319-342.

Saltzman, W. R., Layne, C. M., Steinberg, A. M., & Pynoos, R. S. (2003). School-Based Trauma- and Grief-Focused Intervention for Adolescents Exposed to Community Violence. The Prevention Researcher, 10, 8-11.

Saltzman, W. R., Pynoos, R. S., Layne, C. M., Steinberg, A., & Aisenberg, E. (2001). A Developmental Approach to Trauma/Grief Focused Group Psychotherapy for Youth Exposed to Community Violence. Journal of Child and Adolescent Group Therapy, 11(2/3), pp. 43-56.

Has the intervention been replicated anywhere? ☒ **Yes** ❒ **No**

Various school districts in Southern California and Oakland CA.

Four secondary schools located in socioeconomically disadvantaged regions in Delaware serving high-risk adolescents.

Clinics and community agencies across New York City following 9/11 terrorist attacks.

Juvenile detention and residential centers who participated in three NCTSN-sponsored learning collaboratives held in 2013-2014.

Other countries? *(please list)* **Other clinical and/or anecdotal evidence** *(not included above)*: Post-earthquake Armenia, post-war Bosnia & Hercegovina (located in the Former Yugoslavia).

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Research Evidence	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Pilot Trials/Feasibility Trials *(w/o control groups)*	**N=**6 (Layne et al. pilot trial) Latino and African-American; Urban SES-disadvantaged high school students exposed to severe gang violence.	(Pilot Trial): Layne, C. M., Pynoos, R. S., & Cardenas, J. (2001). Wounded adolescence: School-based group psychotherapy for adolescents who have sustained or witnessed violent interpersonal injury. In M. Shafii & S. Shafii (Eds.), School violence: Contributing factors, management, and prevention (pp. 163-186). Washington, DC: American Psychiatric Press.
	N=87 (Layne et al. open trial) Bosnian; War-exposed youths exposed to severe post-war adversities	(Open Trial): Layne, C. M., Pynoos, R. S., Saltzman, W. R., Arslanagic, B., et al. (2001). Trauma/Grief-Focused Group Psychotherapy: School-based post-war intervention with traumatized Bosnian adolescents. Group Dynamics: Theory, Research, and Practice, 5, 277-290.
	N=26 (Saltzman et al. open trial) Latino, African American, Caucasian; 11-14 year old SES-disadvantaged youths. **All studies**: Combined Boys and Girls	(Open Trial):Saltzman, W. R., Pynoos, R. S., Layne, C. M., Steinberg, A., & Aisenberg, E. (2001). Trauma/Grief-Focused Intervention for Adolescents Exposed to Community Violence: Results of a School-Based Screening and Group Treatment Protocol. Group Dynamics: Theory, Research, and Practice, 5, 291-303.
Clinical Trials *(w/control groups)*	**By gender:** Boys and girls (individually treated) N and ages?	1. Hoagwood, K. E., Layne, C. M., Saltzman, W. R., & Child and Adolescent Trauma Treatment and Services Consortium (2007). Implementing CBT for Children and Adolescents after September 11th: Lessons from the Child and Adolescent Trauma Treatments and Services (CATS) Project. Journal of Clinical Child and Adolescent Psychology, 36, 581-592. 2. Hoagwood KE, Vogel JM, Levitt JM, D'Amico PJ, Paisner WI, Kaplan SJ, Child and Adolescent Trauma Treatments and Services Consortium (2007). Journal of the American Academy of Child and Adolescent Psychiatry, 46, 773-779.

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Research Evidence continued	Sample Size (N) and Breakdown *(by gender, ethnicity, other cultural factors)*	Citation
Randomized Controlled Trials	79 experimental/96 control Combined boys and girls (treated in groups) War-exposed Bosnian secondary school students; Adolescents livinging amidst severe adversity in post-war Bosnia.	1. Layne, C. M., Saltzman, W. R., Poppleton, L., Burlingame, G. M., Pašalić, A. Duraković-Belko, E. Ćampara, N., Musić, M., Đapo, N., Arslanagić, B. Steinberg, A. M., & Pynoos, R. S. (2008). Effectiveness of a School-Based Group Psychotherapy Program for War-Exposed Adolescents: A Randomized Controlled Trial. *Journal of the American Academy of Child and Adolescent Psychiatry of Child and Adolescent Psychiatry, 47*, 1048-1062.
Other Research Evidence	**N=**34 Both girls and boys; Bosnian Mulsim; War-exposed secondary school students (conducted focus groups with students and Bosnian TGCT-A group leaders).	1. Cox, J., Davies, D. R., Burlingame, G. M., Campbell, J. E., & Layne, C. M., & Katzenbach, R. J. (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.

Outcomes

What assessments or measures are used as part of the intervention or for research purposes, if any?

Quantitative Instruments (used for risk screening, clinical interview, triage, monitoring, and/or for program evaluation applications):

Primary outcome measures used to tailor selection of TGCT-A treatment modules:

- UCLA PTSD Reaction Index-DSM-5 version (Pynoos & Steinberg, 2014) (posttraumatic stress symptoms).
- Persistent Complex Bereavement Disorder (PCBD) Checklist (Layne, Kaplow, & Pynoos, 2014) (maladaptive grief reactions).

Other quantitative measures varyingly used in treatment outcome studies:

- Depression Self-Report Scale (Birelson, 1987).
- Cognitive Distortions Scale (Briere, 1999).
- Student Self-Rating Scale (Hightower, 1987).
- Loss Reminder Screening Inventory (Layne, Savjak, Steinberg, & Pynoos, 1999).
- Adolescent Self-Efficacy Scale (Bandura, 1992).

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Outcomes continued

Quantitative measures used to evaluate and tailor TGCT-A when implemented in group settings:

- Group Climate Questionnaire (MacKenzie, 1983).
- Curative Climate Inventory (Fuhriman, Drescher, Hanson, Henrie, & Rynicki, 1986).
- Self-Satisfaction Survey (Kochendorfer, 1974).
- Youth Outcome Questionnaire (Wells, Burlingame, & Lambert, 1999).

Quantitative measures used in evaluations conducted in war-related settings:

- War Trauma Exposure Inventory (Layne, Djapo, & Pynoos, 1999).
- Pre-War Trauma Exposure Inventory (Layne, Djapo, & Pynoos, 1999).
- Post-War Trauma Exposure Inventory (Layne, Steinberg, & Pynoos, 1999).
- Post-War Adversities Inventory (Layne & Djapo, 1999).
- Trauma Reminder Screening Inventory (Layne, Steinberg, & Pynoos, 1999).
- Qualitative instruments: Focus groups conducted by independent program evaluators (Cox et al., 2007).

If research studies have been conducted, what were the outcomes?

Earlier open trials (Layne et al., 2001; Saltzman et al., 2001) found significant reductions in PTSD, depression, and maladaptive grief reactions, in addition to improvements in school behavior. A more recent open trial conducted by a team of external evaluators (Grassetti et al., 2014) found that 61% of high-risk secondary students who participated in TGCT-A reported reliable pre–post improvement in either PTSD symptoms or MG reactions. Students who chose to construct loss-focused narratives reported higher starting levels and showed steeper rates of decline in maladaptive grief reactions than students who chose to construct trauma narratives. In contrast, students who chose to construct trauma-focused narratives reported higher starting levels of PTSD than students who narrated loss experiences. This finding provides support that youth, if given the chance, will choose to focus on events that are most distressing to them. Notably, whether students chose to focus on trauma vs. loss in their narratives was not linked to the rate at which PTSD symptoms declined over the course of treatment. This study provides preliminary evidence that TGCT-A treatment components are linked to reduced PTSD symptoms and maladaptive grief reactions, and that constructing loss-focused narratives is associated with greater decreases in maladaptive grief reactions.

A randomized controlled field trial (Layne et al., 2008) also found significant reductions in PTSD, depression, and maladaptive grief reactions compared to an active-intervention comparison group consisting of students who received classroom-based psychoeducational and skills-building presentations. Data from the randomized controlled trial indicate that the percentages of **students** in the treatment condition who reported significant ($p < .05$) pre- to post-treatment reductions in PTSD symptoms (58% at post-treatment; 81% at 4-month follow-up) compare favorably to those reported in rigorously conducted treatment efficacy trials.

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Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Small office for individual work / room to accommodate 5-10 participants for group; easel and paper or drawing board, markers. **Supervision requirements (e.g., review of taped sessions)?** Our dissemination model currently involves weekly telephone supervision/ consultation for four months following completion of training. **To ensure successful implementation, support should be obtained from:** All appropriate pyramid heads.
Training Materials & Requirements	**List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.** Trauma and Grief Component Therapy for Adolescents (2014) is currently under contract with Cambridge University Press. Available as part of regional trainings sponsored by the NCTSN (National Child Traumatic Stress Network). **How/where is training obtained?** Contact Dr. William Saltzman at wsaltzman@sbcglobal.net **What is the cost of training?** Cost depends on multiple factors, including NCTSN status and number of trainees. **Are intervention materials** *(handouts)* **available in other languages?** ☒ **Yes** ❒ **No** **If YES, what languages?** Bosnian, Spanish is planned **Other training materials &/or requirements** *(not included above)*: 3-day training with ongoing supervision and consultation. Program includes an interview protocol and 200-page manual and workbook for participants. The participant workbook is extensive, containing many handouts and exercises that are very popular with clinicians and teens. Some measures used are free of cost, whereas others (UCLA PTSD Reaction Index and the Persistent Complex Bereavement Disorder Checklist) are copyrighted and require an individual or site license to use, again depending on NCTSN status.
Pros & Cons/ Qualitative Impressions	**What are the pros of this intervention over others for this specific group** *(e.g., addresses stigma re. treatment, addresses transportation barriers)***?** Trauma and Grief Component Therapy (Adolescent Version; TGCT-A) contains: • Initial sessions address potential stigma for treatment and other barriers to participation. • Extensive supports are built into the manual for implementing TGCT-A in either individual or group-based modalities. • TGCT-A places strong emphasis on the roles played by trauma reminders and loss reminders in evoking posttraumatic stress and grief reactions, as well as secondary adversities (Layne, Warren, et al., 2006; Pynoos et al., 1995).

Pros & Cons/ Qualitative Impressions continued

- TGCT-A contains a variety of theoretically grounded, evidence-based family/parent-focused intervention components designed to facilitate healthy parent-child communication (Al-Sabah et al., in press; Kaplow & Layne, 2014; Saltzman et al., 2011; 2013).
- A specially designed grief module (Module III) provides extensive grief psychoeducation and focuses on reducing multiple dimensions of maladaptive grief while also promoting adaptive grieving and mourning.
  - TGCT-A is the only currently available intervention for children and adolescents that specifically assesses and therapeutically treats persistent complex bereavement disorder (PCBD), a proposed diagnosis located in the appendix of DSM-5 as an invitation for further applied clinical attention and research (Kaplow, Layne, et al., 2012; 2014).
  - It is also the only currently available intervention for bereaved children and adolescents explicitly designed to reduce maladaptive grief reactions while also promoting adaptive grief reactions (Kaplow, Layne, et al., 2012; 2014).
  - TGCT-A can be readily used with the Persistent Bereavement Disorder Checklist (Layne, Kaplow, & Pynoos, 2014), a recently released test that has been carefully validated by a national expert panel and by iterative field-testing with over 160 bereaved children by trained clinicians.
- Extensive work has been conducted in developing methods for tailoring TGCT-A components to the needs of military families in general (Saltzman et al., 2011; Saltzman, Pynoos, et al., 2013) and bereaved military families in particular (Kaplow, Layne, et al., 2013).
- TGCT-A is specifically tailored to adolescent developmental issues involving trauma and loss, including an explicit focus on identifying and remediating trauma- or loss-induced disturbances (derailment) in developmental progression (Al-Sabah et al., in press; Layne, Briggs, & Courtois, 2014; Layne, Greeson, et al., 2014).
- TGCT-A is a modularized, assessment-driven, individually tailored intervention that can be used with a variety of assessment instruments specifically tailored to guide a range of therapeutic tasks. These tasks include risk screening, triage, case conceptualization, treatment planning, monitoring treatment response, and treatment evaluation (Saltzman et al., 2003).
- TGCT-A includes guidelines for adapting the intervention in developmentally, culturally, and ecologically sensitive ways. These include attending to youth/caregiver relationships and communication, recognizing culturally- and developmentally-linked differences in the ways that bereaved youth and families grieve and mourn, and recognizing dysynchronies between different family members' grieving and mourning that arise as a result of differences in their exposure to the death and their relationship with the deceased (Saltzman et al., 2011, 2013).

Pros & Cons/ Qualitative Impressions continued

- TGCT-A can be readily disseminated in conjunction with training in the Core Curriculum on Childhood Trauma, a problem-based learning tool for strengthening clinical knowledge, clinical reasoning, and clinical decision-making skills regarding the effects of traumatic stress and loss on children and families (Layne et al., 2011; 2014).
- The full TGCT-A protocol is designed to identify and effectively treat youth whose distress and dysfunction fall within the moderate to severe range of distress and dysfunction. Clients thus typically include the most severely exposed, as well as moderately exposed, youths. Nevertheless, our field effectiveness studies (Cox et al., 2007; Layne et al., 2008) and conceptual work (Saltzman et al., 2003, 2006) underscore the capacity of TGCT-A modules to be strategically "unpacked" and used to create a multi-tiered intervention framework that offers low-risk, broadly disseminable components (e.g., psychoeducation and skills selected from Modules I and IV) to low-distress youth, while concentrating more specialized components (selected from Modules I, II, III, and IV) for use with moderate- to high-distress youth. The modular, assessment-driven structure of TGCT-A thus allows the intervention to be flexibly adapted and tailored to the needs of subgroups with different levels of risk for long-term distress, functional impairment, and developmental derailment, thereby helping providers to balance and maximize both effectiveness and efficiency and conserve scarce mental health resources for subgroups in greatest need.

What are the cons of this intervention over others for this specific group *(e.g., length of treatment, difficult to get reimbursement)***?**

- Treatment length is variable, depending on the number of modules that are implemented. More distressed youths will likely require longer and more intensive intervention.
- Treatment is optimized when providers have access to and make regular use of assessment tools, which requires additional training and resources.

Other qualitative impressions: Results of our qualitative (focus group-based) program evaluation (Cox et al., 2007) indicate that some Bosnian youths felt stigmatized by their peers when they were initially selected for the group and began to attend group sessions. Some teachers were also reluctant to release students from class to attend groups (sessions were held between "morning" and "evening" schools to reduce interference with class; when sessions had to be scheduled during the school day, they were rotated across periods so students missed only one class session in that subject each month). Notably, group members reported that they soon began demonstrating and sharing their skills with other students, who also expressed a desire to join the group. Teachers were also more supportive of release time once they began noticing improvements in students' affect, school behavior (attendance, social withdrawal, acting out), and school performance (home work completion, grades, etc.). Some group leaders/school counselors expressed satisfaction that their professional status as specialized mental health service providers improved at their schools, and the nature of referrals they received changed (receiving more distressed students and fewer general discipline problems), as a result of implementing TGCT-A.

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Contact Information

Name: William Saltzman

Address: 2179 Kinneloa Canyon Rd., Pasadena, CA 91107

Phone number: (626) 840-2900

Email: wsaltzman@sbcglobal.net

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