NCTSN The National Child Traumatic Stress Network

GENERAL INFORMATION

TGCTA: Trauma and Grief Component Therapy for Adolescents

Treatment Description

Acronym *(abbreviation)* **for intervention:** TGCTA

Overview: TGCTA is an evidence-based, manualized intervention that addresses the complex needs of older children and adolescents contending with trauma, bereavement, or traumatic bereavement. TGCTA's modularized, flexible design allows clinicians to customize their intervention according to the specific needs, strengths, and life circumstances of specific youth and the time available. TGCTA combines state-of-the-art assessment and treatment of trauma exposure, bereavement, and the interplay between posttraumatic stress and grief reactions that can arise following traumatic bereavement. TGCTA has been widely implemented and studied both nationally and internationally. The manual and accompanying support materials offer detailed session-by-session guidance for conducting the program in either a group-based, individual, or combined modality (i.e., combined = group-based + individual pullout sessions to address highly personal/distressing material). Psychoeducational and skills-building components from Modules 1 and 4 have also been implemented successfully in classroom settings.

Although assessment tools are optional, their use is encouraged in order to derive the most benefit from TGCTA's assessment-driven, modularized design, which offers clinicians great flexibility in tailoring their treatment plan according to youths' specific assessment profiles.

Average length/number of sessions:

- TGCTA's four treatment modules permit therapists to flexibly tailor (make minor adjustments to) or adapt (make major adjustments to) their intervention plan to accommodate their client's specific needs, strengths, life circumstances, and informed preferences. Depending on which modules are implemented, the total number of sessions ranges from 8 to 24.
- Module selection and sequencing are left to the practitioner's discretion based on youth needs, strengths, and availability for treatment. This makes TGCTA highly adaptable for implementation in a variety of settings, including juvenile justice.
- Sessions are designed to take approximately 50 minutes (a standard therapeutic hour). Alternatively, individual sessions can be shortened in duration (e.g., 40 to 45 minutes) to accommodate shorter school class periods, or expanded (up to 90 minutes) as needed and if time allows, by incorporating more session activities/tools and optional exercises.

Aspects of culture or group experiences that are addressed *(e.g., faith/spiritual component, transportation barriers)***:** TGCTA is designed to accommodate individual differences in responses to trauma, bereavement, and traumatic bereavement. These differences may arise from cultural, developmental, or exposure-based influences on how children, adolescents, and their families respond to traumatic experiences. For example, many psychoeducational and skills-building exercises in Module I address culturally-linked dimensions to trauma and loss, including acknowledging and validating how different people may respond and cope differently to similar events, or

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Treatment Description continued

may be responding to different sets of trauma or loss reminders. As a second example, grief exercises in Module III are designed to address cultural, developmental, and religious/spiritually-linked differences in how youth and their families respond to the death of a loved one, including tragic deaths, stigmatized deaths, and belief or nonbelief in an afterlife.

Trauma type *(primary)*: TGCTA 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. TGCTA addresses most forms of single-event and multiple-event traumas. By implementing either or both Module 2 (trauma processing) and Module 3 (grief processing) in different configurations, TGCTA can accommodate the needs of youth who are traumatized but not bereaved (e.g., victims of physical assault), bereaved but not traumatized (e.g., grandparent died a peaceful death due to old age), or traumatically bereaved (e.g., parent died due to accidental death, homicide, suicide, overdose, or slow painful death due to cancer). Populations treated using TGCTA include youth with varying histories of:

- *trauma exposure* (e.g., community violence, gang violence, serious accidents, disasters such as hurricanes, political violence/war, illnesses, terrorist attacks, witnessing interpersonal/domestic violence, physical assaults, sexual assaults, terrorist attacks, medical trauma);
- *bereavement* (e.g., peaceful death of a beloved grandparent due to old age);
- *traumatic bereavement* (murder, suicide, car accidents, overdose).
- *Developmental disruption* in key developmental tasks (e.g., interrupted, delayed, regressed, or precociously accelerated developmental progression)

Trauma type *(secondary)*: Exposure to some forms of domestic violence and abuse; general forms of loss other than the death of a loved one (e.g. familial separation due to incarceration, deportation, or military deployment; loss of home and possessions under traumatic circumstances such as natural disasters, political violence, etc.).

Additional descriptors *(not included above)*:

- TGCTA is being implemented in such settings as school-based mental health cinics, communty mental health clinics, private practice, juvenile justice facilities, group homes, grief support facilities, and other service settings.
- The use of assessment tools (e.g., trauma exposure, bereavement, posttraumatic stress reactions, grief reactions) is strongly encouraged in order to facilitate case conceptualization, treatment planning, treatment tailoring (e.g., selecting which modules and specific exercises to implement), monitoring treatment response, and to assess treatment outcomes.

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Target Population	**Age range:** 20 (some exercises can be adapted for children younger than 12) **Gender:** ❒ **Males** ❒ **Females** ☒ **Both** **Ethnic/Racial Group** *(include acculturation level/immigration/refugee history–e.g., multinational sample of Latinos, recent immigrant Cambodians, multigeneration African Americans)*: TGCTA has been disseminated nationally and internationally. In the United States, TGCTA has been used in school, community, and residential settings with diverse populations of youth. This includes youth in poor urban and suburban communities, and youth incarcerated in juvenile justice settings. Between 2001 to 2005, TGCTA was implemented across New York City in multi-racial and ethnic communities as a primary treatment for adolescents following the September 11th terrorist attacks. Internationally, TGCTA has been used with ethnic Muslim, Croatian, and Serbian youth in post-war Bosnia, and with Armenian school students following a massive earthquake. TGCTA has also been used with undocumented and refugee youth. **Other cultural characteristics** *(e.g., SES, religion)*: TGCTA has been implemented with a variety of socioeconomic and religious/cultural/ethnic groups, as described above. This includes youth and families from socioeconomically disadvantaged high-risk neighborhoods, to more middle class lifestyles. **Language***(s)*: The manual is written in English; some materials have been translated into Spanish with plans for more. The authors are open to translating and adapting the intervention for other cultural groups as well; feel free to contact us. **Region** *(e.g., rural, urban)*: TGCTA has been implemented in inner-city, urban, suburban, and some rural settings in the United States. TGCTA was also implemented in the aftermath of the 1992-1995 Bosnian civil war, which was marked by protracted sieges, ethnic cleansing campaigns, the deliberate targeting of civilians by armed forces and paramilitary troops, genocide, massive destruction of infrastructure, and the mass exodus of internally displaced persons and war refugees. **Other characteristics** *(not included above)*: The program has been extensively implemented and evaluated in both individual and group-based modalities. An optional family-focused intervention component is also available.
Essential Components	**Theoretical basis:** TGCTA draws upon multiple theories, including developmental psychopathology, traumatic stress theory, cognitive-behavioral theory, ecological theory, social provisions theory, positive psychology/positive youth development, and multidimensional grief theory (developed by the authors), as well as more than three decades of empirical and theory-building research. It draws upon this scientific foundation to address a broad range of clinical problems and developmental challenges. These include: • learning to label and cope with distress reactions (e.g., posttraumatic stress reactions, grief reactions, depressive reactions), • managing trauma reminders (which evoke primarily posttraumatic stress reactions),

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Essential Components continued

- managing loss reminders (which evoke primarily grief reactions),
- addressing the complexity of traumatic experiences, including worst moments
- addressing the interplay between posttraumatic stress and grief reactions that can arise following traumatic bereavement
- addressing traumatic expectations, which can inhibit positive aspirations and preparations for the future,
- managing secondary adversities,
- promoting adaptive developmental progression by improving adolescents' capacity to work on developmental tasks (e.g., school work, family/peer relationships) and recover from lost developmental opportunities.

Key components:

- TGCTA is a modularized treatment manual with detailed instructions for conducting group or individual sessions.
- Each TGCTA module contains a variety of components designed to carry out specific therapeutic objectives. Each session is self-contained and follows a standard format (e.g., check in, review practice exercise, prescribed activities and learning, check out). A youth workbook is also available (see TGCTA.com). The TGCTA manual also includes a baseline (pre-treatment) clinical interview protocol.
- Based on youths' individual assessment/need profiles, it is left to the therapist's discretion which modules to select, how to sequence them, and which activities or illustrations to select. Module 1 contains eight skills/group cohesion-building sessions; Module 2 contains three trauma processing sessions that can be repeated as needed based on the number of group members/traumatic experiences processed; Module 3 contains six grief/loss processing sessions; Module 4 contains four developmental progression sessions.
- **Module 1,** *Foundational Knowledge and Skills*, includes guidance for customizing treatment planning for either an individual or group modality. Module 1 sessions focus on building group cohesion; providing psychoeducation regarding traumatic stress and grief reactions as well as trauma and loss reminders; building emotional regulation and problem-solving skills; strengthening positive coping strategies including cognitive processing skills; and developing skills to recruit social support.
- **Module 2,** *Working Through Traumatic Experiences*, provides detailed guidance for selecting an appropriate traumatic experience(s) to work on (Session 1), constructing a trauma narrative (Session 2), and processing worst moments, trauma reminders, and trauma-related hurtful thoughts (distorted cognitions and traumatic expectations) (Session 3) in either a group or individual setting.

Essential Components continued	• **Module 3,** *Working Through Grief Experiences*, includes six sessions designed to be tailored to address the three primary dimensions of multidimensional grief theory: *Separation distress, existential/identity distress, and circumstance-related distress*. These highly engaging and often-poignant sessions include psychoeducation about different grief reactions, learning how to identify and manage loss reminders, coping with angry feelings, dealing with difficult deaths, dealing with ambivalent feelings about the deceased, and using mementos for positive reminiscing about the deceased. Traumatically bereaved youth can benefit from both Modules 2 and 3, which can create a therapeutic "arc" by reducing distress over the circumstances of the death (in Module 2), reducing distress over the loss and over adversities created by the death, while promoting positive adjustment to a life in which the deceased is no longer physically present (in Module 3). • **Module 4,** *Looking to the Future*, focuses on identifying developmental disruptions, lost developmental opportunities, creating positive yet realistic future aspirations and plans, and promoting adaptive developmental progression. Sessions focus on taking positive developmental steps forward, learning to support others while not becoming overwhelmed by their problems, anticipating and planning for upcoming reminders, and preparing for upcoming developmental transitions. A final leave-taking session helps youth to distinguish between "good goodbyes" and traumatic goodbyes, and planning for future booster sessions if appropriate. • Optional **parent/caregiver sessions** are also available to coordinate and supplement youth skills (e.g., a caregiver social support *furnishing* skill to complement the social support *recruitment* skill their child has learned), and to reinforce therapeutic gains. • Although optional, the use of assessment tools (especially measures of trauma exposure/posttraumatic stress reactions, and bereavement/grief reactions) is strongly encouraged, in that it will help therapists get the most out of TGCTA's flexible, modularized design. TGCTA is designed to be assessment-driven, offering therapists the choice to select specific treatment modules based on clients' specific problems, needs, and strengths, and informed wishes. Assessment tools can guide such clinical tasks and decisions as risk screening and triage, the pre-group interview, client engagement, case formulation/diagnosis, treatment planning, *tailoring* treatment (making minor adjustments, such as selecting which exercises to use in therapeutic discussions), *adapting* treatment (making major adjustments, such as choosing which modules to implement), monitoring treatment response, providing client feedback, and assessing post-treatment outcomes.

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Clinical & Anecdotal Evidence

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

We explicitly looked for iatrogenic (adverse) outcomes in the form of stigmatization of group members by their classmates (Cox et al., 2007), reliably deteriorated cases (Layne et al., 2008), and group contagion effects (Grassetti et al., 2014; citations below) and found virtually no evidence of these negative outcomes. Rather, the program evaluation found that although some group members were subjected to teasing when TGCTA was first implemented, by the end of the school year classmates were asking how they could join the group after witnessing the group members' improvements and coping skills (Cox et al., 2007).

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

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:

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. DOI:http://dx.doi.org/10.1521/ijgp.2007.57.3.319

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.

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.

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.

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

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

Layne, C. M., Kaplow, J. B., & Saltzman, W.R. (8 May 2018). School-based intervention for youth exposed to community violence. In A. Iskandar (Moderator), The Role of Education in Addressing Violence. Panel presentation at the 7th Annual Gang Prevention and Intervention Conference, Carson, CA.

Clinical & Anecdotal Evidence continued

Saltzman, W.R., Layne, C. M., & Kaplow, J. B. (1 March 2018). Harnessing group processes for traumatized and bereaved youth. 2.5-hour workshop presented at the annual meeting of the American Group Psychotherapy Association, Houston, TX.

Kaplow, J.B., & Layne, C. M. (2017, November 18). Using theory and research to promote bereavement-informed assessment among grieving youth. Full-day invited workshop presented at the Annual Meeting of the Texas Psychological Association, Houston, TX.

Kaplow, J.B., & Layne, C. M. (2017, June 24). *Addressing the Interplay of Trauma and Grief in Bereaved Adolescents: An Overview of Trauma and Grief Component Therapy*. 90-minute workshop conducted at the 21st Annual Symposium of the National Alliance for Grieving Children, Richmond, Virginia.

Kaplow, J. B.; Layne, C. M., & Logsdon, T. (2018, June 2). Bringing Evidence-Based Interventions to Grief Support Organizations: Lessons Learned from an Academic-Community Partnership. 90-minute symposium presented at the 22nd Annual Symposium on Children's Grief, San Antonio, TX.

Kaplow, J.B., & Layne, C. M. (2017, May 12). *Becoming a Bereavement-Informed System of Care: Best Practice Assessment Models for Traumatized and Grieving Youth*. 75-minute Breakout Session conducted at the Cross-Discipline Trauma Conference of Central Texas, Austin, Texas.

Kaplow, J.B., Layne, C. M., & Oosterhoff, B. (2017, April). Building trauma- and bereavement-informed schools through assessment competency training. In J.B. Kaplow (Chair), *Promoting Bereavement-Informed Best Practices in Schools: New Research Findings and Lessons Learned*. Workshop presented at the All Network Meeting of the National Child Traumatic Stress Network, Arlington, VA.

Layne, C. M., Kaplow, J.B., & Oosterhoff, B. (2017, April). Developmentally-informed assessment of bereaved youth: Unpacking the dimensionality of grief. In J.B. Kaplow (Chair), Promoting Bereavement-Informed Best Practices in Schools: New Research Findings and Lessons Learned. Workshop presented at the All Network Meeting of the National Child Traumatic Stress Network, Arlington, VA.

Saltzman, W., Layne, C. M., Kaplow, J.B., Pynoos, R., Olafson, E., & Marrow, M. (9 November, 2016). Addressing trauma and grief in adolescence: New models, measures, and interventions. Half-day pre-meeting institute presented at the 32nd Annual Meeting of the International Society for Traumatic Stress Studies, Dallas, TX.

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

If YES, please include citation:

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.

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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, 47*, 1048-1062. (Supplement)

Olafson, E., Boat, B. W., Putnam, K. T., Thieken, L., Marrow, M.T., & Putnam, F. W. (2016). Implementing Trauma and Grief Component Therapy for Adolescents and Think Trauma for traumatized youth in secure juvenile justice settings. *Journal of Interpersonal Violence, 33*(16) 1-21. DOI: 10.1177/0886260516628287

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. (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., & 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**

School districts in Southern California, Delaware, Oakland, and Houston; clinics and community agencies in Ohio, Michigan, Minnesota, and across New York City; juvenile detention and residential centers in Ohio, Minnesota, Delaware, Kentucky, and Tennessee; academic medical centers in Michigan and Texas.

Other countries? *(please list)* Post-earthquake Armenia, and with all three major ethnic groups (Muslim Bosniaks, Serbs, Croats) in different regions of post-war Bosnia & Hercegovina (the former Yugoslavia).

Other clinical and/or anecdotal evidence *(not included above)*: A deliberate search for adverse clinical outcomes was undertaken in a program evaluation conducted by an independent team of evalautors across 10 participating secondary schools in post-war Bosnia. Very few (1 to 2%) adverse outcomes were found, either as measured using quantitative measures (PTSD symptoms, depression symptoms) or using qualitative methods (focus groups). In contrast, strong evidence of program benefit was found among the great majority of participating students—including

Clinical & Anecdotal Evidence continued	the sharing of knowledge and skills by group members that resulted in many cases of hundreds of students benefitting at each school (Cox et al., 2007; Layne et al., 2008).	
Research Evidence	**Sample Size (N) and Breakdown** *(by gender, ethnicity, other cultural factors)*	**Citation**
Pilot Trials/Feasibility Trials *(w/o control groups)* *(most recent studies are listed first)*	**N =** 33 boys and girls attending three middle schools who completed a 17-week course of group-based TGCTA. Implementation and evaluation conducted by an external team.	(Open Trial): Grassetti, S. N., Williamson, A. A., Herres, J., Kobak, R., Layne, C. M., Kaplow, J. B., & Pynoos, R. S. (2018). Evaluating referral, screening, and assessment procedures for middle school trauma/grief-focused treatment groups. *School Psychology Quarterly, 33*(1), 10-20. http://dx.doi.org/10.1037/spq0000231
	N = 44 middle school students aged 12-14 participating in an open trial of group-based Trauma and Grief Component Therapy for Adolescents (TGCTA). Implementation and evaluation conducted by an external team.	(Open Trial): Herres, J., Williamson, A.A., Kobak, R., Layne, C. M., Kaplow, J. B., Saltzman, W. R., & Pynoos, R. S. (2017). Internalizing and externalizing symptoms moderate treatment response to school-based trauma and grief component therapy for adolescents. *School Mental Health, 9*, 184-193. doi.org/10.1007/s12310-016-9204-1.
	N = 69 youth who participated in group-based TGCTA in four residential juvenile justice (JJ) facilities and completed pre-post measures of symptoms. Incident reports were gathered from facility administrators.	(Pilot/feasibility study) Olafson, E., Boat, B. W., Putnam, K. T., Thieken, L., Marrow, M.T. & Putnam, F. W. (2016). Implementing Trauma and Grief Component Therapy for Adolescents and Think Trauma for Traumatized Youth in secure juvenile justice settings. *Journal of Interpersonal Violence, 33*(16) 1-21. DOI: 10.1177/0886260516628287

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Pilot Trials/Feasibility Trials *(w/o control groups)* **continued** *(most recent studies are listed first)*	**N =** 89 7th and 8th grade (middle school) boys and girls referred by school staff as candidates for an open trial of group-based Trauma and Grief Component Therapy for Adolescents (TGCTA). Implementation and evaluation conducted by an external team.	(Open Trial): Grassetti, S. N., Herres, J., Williamson, A., Yarger, H. A., Layne, C. M., & Kobak, R. (2014). Narrative focus moderates symptom change trajectories in group treatment for traumatized and bereaved adolescents. Journal of Clinical Child & Adolescent Psychology 44 (6), 933-941. DOI:10.1080/15374416.2014.913249.
	N = 26 (Saltzman et al. open trial) Latino, African American, Caucasian, 11-14 year old low-SES youths.	(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.
	N = 87 (Layne et al. open trial) Bosnian; Severely war-exposed youths exposed to ongoing post-war adversities, trauma reminders, and loss reminders.	(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 = 6 (Layne et al. pilot/feasibility trial) Latino and African-American; Urban SES-disadvantaged high school students exposed to severe community and gang-related violence; four boys and two girls.	(Clinical-descriptive pilot study): 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.

Clinical Trials *(w/control groups)*	Boys and girls (all received services using an individual treatment modality). Regression-discontinuity study design (less distressed youth served as a contrast group for more distressed youth)	Hoagwood, K.E., Layne, C. M., Child and Adolescent Trauma Treatment and Services Consortium (2010). Implementation of CBT for children and adolescents affected by the World Trade Center disaster: Outcomes in reducing trauma symptoms. *Journal of Traumatic Stress*, 23, 699-707. (Program development described in): Hoagwood, K. E., Layne, C. M., 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.
	N = 125 adolescents assessed for PTSD and depression symptoms at 1.5 and 5 years postearthquake. At 1.5 years, a prototype of group- and individually-based TGCTA was provided over 6 weeks to a subgroup of students living in a highly exposed region of Armenia following the devastating 1988 Armenian earthquake.	Goenjian, A.K., Walling D., Steinberg, A.M., Karayan I., Najarian, L.M., & Pynoos. R: (2005). A prospective study of posttraumatic stress and depressive reactions among treated and untreated adolescents 5 years after a catastrophic disaster. *American Journal of Psychiatry, 162*, 2302-2308.
	N = 64 earthquake-exposed youth attending four severely-damaged schools following the devastating 1988 Armenian earthquake.	Goenjian, A., Karayan, I., Pynoos R, Minassian, D., Najarian, M., Steinberg, A.M, & Fairbanks, L.A. (1997). Outcome of psychotherapy among early adolescents after trauma. *American Journal of Psychiatry, 154*, 536-542.

Randomized Controlled Trials	War-exposed Bosnian secondary school students; Adolescents livinging amidst severe adversity in post-war Bosnia. Study design combined boys and girls treated in school-based group settings. **N = 79** Bosnian secondary school students received school-based TGCTA (treatment group). **N =** 96 Bosnian students attending the same schools received TGCTA psychoeducational and skills-building components selected from Modules 1 and 4 (contrast group).	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, 47*, 1048-1062.
Studies Describing Modifications	(Already cited above). This multi-year study evaluated the feasibility of flexibly using TGCTA in combination with a staff training tool (Think Trauma). Study design contrasted (a) baseline (no intervention) with (b) TGCTA alone, (c) partial TGCTA + Think Trauma training of juvenile justice staff, (d) full TGCTA + Think Trauma training with juvenile justice staff.	(Pilot/feasibility study open trial) Olafson, E., Boat, B. W., Putnam, K. T., Thieken, L., Marrow, M.T., & Putnam, F. W. (2016). Implementing Trauma and Grief Component Therapy for Adolescents and Think Trauma for Traumatized Youth in secure juvenile justice settings. *Journal of Interpersonal Violence, 33*(16) 1-21. DOI: 10.1177/0886260516628287

Studies Describing Modifications continued	Beneficial outcomes were maximized when both tools (TGCTA and Think Trauma) were used fully and in combination.	
	(Already cited above). This randomized controlled study depicts the flexible use of TGCTA's modularized structure. The contrast group received classroom-based presentations featuring psychoeducational exercises and coping tools taken from Modules 1 and 4; whereas the treatment group received the same classroom-based presentations (and in some cases actively took part in the demonstrations) plus a full course (Modules 1, 2, 3, 4) of group-based TGCTA.	(randomized controlled trial) 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, 47*, 1048-1062.

Studies Describing Modifications continued	(Already cited above). This open trial also depicts the flexible use of TGCTA's modularized structure. Due to logistical impediments in some locations, some schools implemented a full course of TGCTA (Modules 1, 2, 3, 4), and others implemented only Modules 1 and 2. Beneficial outcomes were observed in both (full and partial) treatment conditions.	(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.
Other Research Evidence	**N =** 34 war-exposed Bosnian secondary school students; both girls and boys; ethnicity was predominantly Bosnian Muslim.	Qualitative Program Evaluation: 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?

Qualitative instruments: Focus groups conducted by independent program evaluators (Cox et al., 2007).

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

Distress Reactions

- UCLA PTSD Reaction Index-Revised (Steinberg, Brymer, Decker, & Pynoos, 2004) (we now recommend the DSM-5 version).
- Persistent Complex Bereavement Disorder (PCBD) Checklist (Layne, Kaplow, & Pynoos, 2014).
- Depression Self-Report Scale (Birelson, 1987).
- Youth Outcome Questionnaire: Somatization and Social Problems Subscales (Wells, Burlingame, & Lambert, 1999).

Outcomes continued	School Behavior, Academic Performance • Student Self-Rating Scale (Hightower, 1987). Group Cohesion, Satisfaction (We now recommend the Group Questionnaire) • Self-Satisfaction Survey (Kochendorfer, 1974). • Group Climate Questionnaire (MacKenzie, 1983). • Curative Climate Inventory (Fuhriman, Drescher, Hanson, Henrie, & Rynicki, 1986). Used in Post-War Bosnia: • Pre-War Trauma and Adversities inventory (Layne, Saltzman, & Pynoos, 1997) • 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). • Loss Reminder Screening Inventory (Layne, Savjak, Steinberg, & Pynoos, 1999). **If research studies have been conducted, what were the outcomes?** Please see listing of published empirical studies above. Taken together, both open trials (Grassetti et al., 2014; Herres at al., 2017; Olafson et al., 2016; Layne et al., 2001; Saltzman et al., 2001) and a randomized controlled trial (Layne et al., 2008) found significant reductions in PTSD, depression, and maladaptive grief reactions, as well as improvements in school behavior including school attitudes, rule compliance, and withdrawn behavior at school. Others (Layne, Pynoos, & Cardenas, 2001) found indicators of positive developmental progression. Findings from the randomized controlled trial (Layne et al., 2008) 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 the percentages of reliably improved cases reported in rigorously conducted treatment efficacy trials with adults. A detailed annotated bibliography of empirical studies supporting the use of TGCTA is available on our website (TGCTA.com).
Implementation Requirements & Readiness	**Space, materials or equipment requirements?** Small office for individual work or a room to accommodate 5-10 group participants; easel and paper or drawing board, markers. **Supervision requirements** *(e.g., review of taped sessions)***?** Given that the TGCTA manual is formally published and publicly available, supervision or consultation is not mandatory. **To ensure successful implementation, support should be obtained from:** Key stakeholders. In school settings, this includes the school principal and vice-principals, teachers whose classrooms will participate in risk screening/referral for treatment, parents/caregivers (informed consent), and students (informed assent).

TGCTA: Trauma and Grief Component Therapy for Adolescents

Training Materials & Requirements

List citations for manuals or protocol descriptions and/or where manuals or protocol descriptions can be obtained.

Treatment manual:

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

How/where is training obtained?

Training can be customized according to the specific needs of the training audience, and depending on whether training in the manualized treatment will also include training in assessment tools. *Various training options are available. This includes training that focuses on combinations of the following:*

- *implementing TGCTA (standard training);*
- *adapting TGCTA for various populations and settings, including schools, community mental health clinics, and juvenile justice;*
- *using assessment tools for risk screening and triage, baseline/pre-group assessment, case formulation, treatment planning, monitoring treatment response, tailoring ongoing treatment, and assessing treatment outcomes.*

What is the cost of training? To be determined depending on the size of the trainee group, the size of the training team, and the type and degree of content coverage, and the duration of the training (various 2 and 3-day training options are available).

Are intervention materials *(handouts)* **available in other languages?**
☒ **Yes** ❒ **No**

If YES, what languages? Some materials are currently available in Spanish.

Other training materials &/or requirements *(not included above)***:** The TGTCTA manual itself; PowerPoint slides are provided. A supplemental workbook for participants is also avaible. The workbook is extensive, containing many handouts and exercises that are very popular with clinicians.

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)***?**

TGCTA:

- Is specifically developed for adolescents and adolescence by addressing adolescent risks, developmental tasks, opportunities, challenges, transitions, and trajectories.
- features a standardized, structured session-by-session format. All sessions have an initial check-in exercise, review of last week's practice exercise, new session content, assign new practice exercise, and check-out procedure.

Pros & Cons/ Qualitative Impressions continued	• is written in a clear, standardized format that is straightforward to follow. Exact prose (in italics) is suggested for key concepts, explanations, directions, and transitions to new topics, providing "TGCTA first timers" and less-professionally experienced trainees with the language needed for effective implementation. • contains initial sessions that address potential stigma for treatment and other barriers to participation. • can be effectively implemented in either individual or group-based modalities. Some psychoeducational and skills-based components from Modules 1 and 4 have been successfully implemented in classroom settings (see Layne et al., 2008). • contains an optional family/parent-focused intervention component. • contains a 6-session grief module that provides extensive grief psychoeducation. focuses on reducing maladaptive grief reactions, and encourages and facilitates adaptive grieving and mourning. • focuses specifically on identifying and remediating trauma- or loss-induced disturbances in developmental progression. • TGCTA can be used with a variety of assessment instruments that are specifically developed to support risk screening and triage, baseline clinical assessment, monitoring treatment response, and assessing post-treatment outcomes. • Guidelines are provided for adapting the program in a culturally and ecologically sensitive manner. • TGCTA is specifically designed to identify and effectively treat youths whose distress and dysfunction fall within the severely distressed, as well as moderately distressed, ranges. It is thus intended to address the needs of the most severely exposed, as well as moderately exposed, youths. **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 (e.g., more modules). • Although it adds flexibility to individual client needs and strengths, the modularized structure of TGCTA adds complexity that requires careful preparation before each session and takes time to become comfortable with. • Although TGCTA is written as a stand-alone manualized treatment with extensive built-in supports, many clinicians and agency administrators benefit from additional training to develop additional familiarity with its undergirding theory, "hands on" practice in using its many tools, and clinical/logisitical consultation regarding how to implement TGCTA with their clients in their professional settings.

TGCTA: Trauma and Grief Component Therapy for Adolescents

Pros & Cons/ Qualitative Impressions continued	• Optional assessment tools, if used, may require supplemental training. Some assessment tools with which TGCTA is being implemented and evaluated in some locations are proprietary. **Other qualitative impressions:** Our field experience has shown that one full course of implementation significantly increases clinicians' familiarity with, and self-confidence in their ability to effectively implement, TGCTA.
Contact Information	**Name:** Dawn Wood **Address:** The Childhood Trust 311 Albert Sabin Way–Floor R Cincinnati, OH 45229 **Phone number:** 513-558-9007 **Fax:** 513-558-4107 **Email:** TTTC@cchmc.org (CC: William Saltzman wsaltzman@sbcglobal.net; Christopher Layne cmlayne@mednet.ucla.edu) **Website:** For further information, including a detailed annotated bibliography of empirical studies that support the use of TGCTA, can be found at TGCTA.com
References	**Primary Reference for the TGCTA manual:** Saltzman, W. R., Layne, C. M., Pynoos, R. S., Olafson, E., Kaplow, J. B., & Boat, B. (2017). *Trauma and Grief Component Therapy for Adolescents: A Modular Approach to Treating Traumatized and Bereaved Youth*. Cambridge University Press. **Other supporting empirical and theoretical papers not cited earlier:** Benson, M. A., Compas, B. E., Layne, C. M., Vandergrift, N., Pašalić, H., Katalinksi, R., & Pynoos, R. S. (2011). Measurement of post-war coping and stress responses: A study of Bosnian adolescents. *Journal of Applied Developmental Psychology, 32*(6), 323-335. doi:10.1016/j.appdev.2011.07.001 Claycomb, M. A., Charak, R., Kaplow, J. B., Layne, C. M., Pynoos, R. S., & Elhai, J. D. (2015). 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*, 1361-73. DOI: 10.1007/s10802-015-0107-7 Davies, D. R., Burlingame, G. M., & Layne, C. M. (2006). Integrating small group process principles into trauma-focused group psychotherapy: What should a group trauma therapist know? In Schein, L. A., Spitz, H. I., Burlingame, G. M., & Muskin, P. R., (Eds.), *Group Approaches for the Psychological Effects of Terrorist Disasters* (pp. 385-424). New York: Haworth. DeRosa, R.R., Amaya-Jackson, L, & Layne, C. M. (2013). From rifts to riffs: Evidence-based principles to guide critical thinking about next-generation child trauma treatments and training. T*raining and Education in Professional Psychology, 7*, 195-204. DOI: 10.1037/a0033086

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