1 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

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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 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

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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 I), 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

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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.

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