Narrative Focus Predicts Symptom Change Trajectories in Group Treatment for Traumatized and Bereaved Adolescents

Stevie N. Grassetti a, Joanna Herres b, Ariel A. Williamson a, Heather A. Yarger a, Christopher M. Layne c d & Roger Kobak a

a Department of Psychological and Brain Sciences, University of Delaware
b Couple and Family Therapy Department, Drexel University
c UCLA/Duke University National Center for Child Traumatic Stress, Los Angeles
d Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles

Published online: 13 Jun 2014.

To cite this article: Stevie N. Grassetti, Joanna Herres, Ariel A. Williamson, Heather A. Yarger, Christopher M. Layne & Roger Kobak (2014): Narrative Focus Predicts Symptom Change Trajectories in Group Treatment for Traumatized and Bereaved Adolescents, Journal of Clinical Child & Adolescent Psychology, DOI: 10.1080/15374416.2014.913249

To link to this article: http://dx.doi.org/10.1080/15374416.2014.913249

PLEASE SCROLL DOWN FOR ARTICLE

Taylor & Francis makes every effort to ensure the accuracy of all the information (the “Content”) contained in the publications on our platform. However, Taylor & Francis, our agents, and our licensors make no representations or warranties whatsoever as to the accuracy, completeness, or suitability for any purpose of the Content. Any opinions and views expressed in this publication are the opinions and views of the authors, and are not the views of or endorsed by Taylor & Francis. The accuracy of the Content should not be relied upon and should be independently verified with primary sources of information. Taylor and Francis shall not be liable for any losses, actions, claims, proceedings, demands, costs, expenses, damages, and other liabilities whatsoever or howsoever caused arising directly or indirectly in connection with, in relation to or arising out of the use of the Content.

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden. Terms & Conditions of access and use can be found at http://www.tandfonline.com/page/terms-and-conditions
Growing evidence supports the effectiveness of Trauma and Grief Component Therapy for Adolescents (TGCT-A) in reducing posttraumatic stress disorder (PTSD) symptoms and maladaptive grief (MG) reactions. This pilot study explored whether the specific focus of students’ narratives (i.e., focus on trauma vs. focus on loss) as shared by TGCT-A group members would predict initial pretreatment levels, as well as pre- to posttreatment change trajectories, of PTSD symptoms and MG reactions. Thirty-three adolescents from three middle schools completed a 17-week course of group-based TGCT-A. PTSD and MG symptoms were assessed at pretreatment, twice during treatment, and at posttreatment. The focus (trauma vs. loss) of each student’s narrative was coded using transcripts of members’ narratives as shared within the groups. The reliable change index showed that 61% of students reported reliable pre–post improvement in either PTSD symptoms or MG reactions. Students whose narratives focused on loss both reported higher starting levels and showed steeper rates of decline in MG reactions than students whose narratives focused on trauma. In contrast, students whose narratives focused on trauma reported higher starting levels of PTSD than students who narrated loss experiences. However, narrative focus was not significantly 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 associated with reduced PTSD symptoms and MG reactions. Loss-focused narratives, in particular, appear to be associated with greater decreases in MG reactions.
diagnostic entities share features and co-occur (Angold, Costello, & Erkanli, 1999). Given this observation and the risk that this burgeoning number of evidence-based interventions poses for overwhelming clinicians and clients alike, Chorpita and colleagues (Chorpita, Daleiden, et al., 2011; Chorpita, Rotheram-Borus, et al., 2011) encouraged treatment developers to identify common intervention elements and to entrust clinicians with decision-making authority in implementing specific treatment components. These common elements can be identified through a growing evidence base that is capable of substantiating the effectiveness of such treatments and predicting for whom treatments work best, thereby enhancing practitioners’ ability to individually tailor treatments (Barth et al., 2012).

Research and clinical interest in maladaptive grief (MG) is growing, as illustrated by the decision to incorporate MG in the Diagnostic and Statistical Manual of Mental Disorders (5th ed. [DSM-5]; American Psychiatric Association, 2013) in the form of a candidate disorder termed Persistent Complex Bereavement Disorder (PCBD) located in the appendix as an invitation for further investigation (Kaplow, Layne, Pynoos, Cohen, & Lieberman, 2012). Notably, symptoms of PCBD and posttraumatic stress disorder (PTSD) partially overlap, including symptoms of intrusive reexperiencing, rumination, persisting negative affect, and avoidance. These similarities, paired with calls to identify transdiagnostic “common elements” (McHugh, Murray, & Barlow, 2009) raise questions concerning which specific therapeutic components are effective for treating MG and whether they substantively differ from components that are effective in treating PTSD. Accordingly, the aim of the current study was to evaluate outcomes of Trauma and Grief Component Therapy for Adolescents (TGCT-A) as implemented with heterogeneous groups of adolescents whose presenting problems focused on personal trauma or the loss of a loved one. In particular, we used a quasi-experimental design to examine the role of two different therapeutic components—adolescents’ sharing of therapeutic narratives focused on either a traumatic experience or exploring a major loss—on pre–post treatment change trajectories in PTSD symptoms and MG reactions.

TRAUMA AND GRIEF COMPONENT THERAPY FOR ADOLESCENTS (TGCT-A)

TGCT-A (Layne, Saltzman, & Pynoos, 2002) is a modularized group intervention designed to address both PTSD symptoms and MG reactions. A series of treatment outcome studies supports the effectiveness of TGCT-A. Open trials found significant pre–post treatment reductions in PTSD, MG, and depression among war-exposed youth (Layne et al., 2001) and inner-city youth (Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001). A qualitative program evaluation in Bosnia found very few negative impacts and a broad range of positive impacts (Cox et al., 2007). Thus far, TGCT-A has been evaluated in one randomized clinical trial that compared group-based TGCT-A to a contrast condition consisting of psychoeducation and coping skills training (drawn from Modules I and IV of TGCT-A; Layne et al., 2008). Both conditions were associated with significant pre–post reductions in PTSD and depression symptoms, whereas only the full TGCT-A condition yielded significant reductions in MG reactions.

Taken together, these results support the effectiveness of TGCT-A with adolescents exposed to trauma and loss. Nevertheless, differing results found between the full course of TGCT-A versus selected skills-focused components of TGCT-A suggests that Modules II and III (which contain narrative construction) may be especially important for treating MG reactions. Narrative construction is a well-established practice element for treating PTSD symptoms (e.g., Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Layne et al., 2008; Neuner et al., 2008).

However, it has yet to be demonstrated whether narrative construction, when adapted and applied to the exploration of losses, is also effective for treating MG. Indeed, given that “yearning and preoccupation with the deceased” is a symptom of PCBD (Kaplow et al., 2012), it is conceivable that constructing loss-focused narratives could promote further preoccupation with the deceased in ways that prolong, rather than reduce, distress.

The aims of this exploratory pilot study were to evaluate the feasibility and clinical utility of TGCT-A for high-risk youth with various trauma and loss-related histories. We implemented TGCT-A in a flexible manner by selecting treatment components based on individual needs. All TGCT-A groups implemented Module I (Building Group Cohesion and Coping Skills), the intervention objectives of which focus on building group cohesion; increasing insight into common reactions to stress, loss, and trauma; strengthening emotional regulation skills; and enhancing social support. For the middle portion of treatment, clinicians and individual group members exercised discretion in tailoring treatment by selecting practice elements from either Module II (Working through Traumatic Experiences) or Module III (Working through Loss Experiences) for each group member. Intervention objectives of Module II practice elements include constructing, sharing, and working through trauma-focused narratives. Intervention objectives of Module III focus on reducing maladaptive grieving and promoting adaptive grieving by constructing and exploring loss-focused narratives. All youth
completed Module IV (Looking to the Future), that focuses on promoting adaptive developmental progression, enhancing problem-solving skills, consolidating treatment gains, and encouraging a positive orientation towards the future (Layne et al., 2008; Layne et al., 2002).

THE CURRENT STUDY

A logical next step in evaluating both TGCT-A and the empirical distinctiveness of PTSD symptoms versus MG reactions involves examining potential differences in the ways that these two diagnostic constructs respond to different treatment components (Layne, Olsen, Kaplow, Shapiro, & Pynoos, 2011). To date, most TGCT-A studies have been conducted on samples sharing a common trauma, like war or natural disaster. In contrast, less is known regarding the effectiveness of TGCT-A for heterogeneous groups of adolescents contending with various types of trauma and loss, including both traumatic and nontraumatic loss. A promising approach to identifying individuals for whom specific TGCT-A components are most likely to be beneficial is by comparing trajectories of symptom reduction for youth whose narratives focused on traumatic experiences versus youth whose narratives focused on loss. To our knowledge, this is the first pilot study to explore whether the specific focus of a constructed narrative predicts differences in change trajectories in PTSD symptoms versus MG reactions over the course of treatment. Our study focused on addressing the question, “Does participation in TGCT-A produce similar versus dissimilar treatment change trajectories in students’ PTSD symptoms and maladaptive grief reactions, and do these trajectories vary as a function of the specific focus (trauma vs. loss) of group members’ narratives?” We predicted that (a) youth who focused on traumatic experiences during the narrative construction exercise would report higher pre-treatment levels (reflecting higher motivation to focus on trauma) and greater symptom reductions (reflecting greater therapeutic benefit) in PTSD, whereas (b) youth who focused on loss would report higher pretreatment levels (reflecting higher motivation to focus on loss) and greater reductions (reflecting greater therapeutic benefit) in MG reactions.

METHOD

Participants

Participants were 89 seventh- and eighth-grade students referred for TGCT-A screening.

Figure 1 reports participation rates during each study phase. School staff from three economically disadvantaged schools referred students based on concerns that the student had experienced a trauma or a loss. With parental consent and student assent, 44 adolescents began treatment; 33 students (\(M_{\text{age}} = 13.31\) years, \(SD = 8.17\) months, 73\% female) from different ethnic backgrounds (61\% non-Latino White, 27\% African American, 12\% Latino White) completed treatment.

Measures

**PTSD symptoms.** The UCLA-RI (Pynoos, Rodriguez, Steinberg, Stuber, & Frederick, 1998) is a self-report measure based on DSM-IV PTSD criteria. The Severity Score indexes the frequency of symptoms experienced during the past month on a 5-point scale (range = 0–68). Internal consistency at baseline was good (\(z = .91\)).

**MG reactions.** We used eight grief items patterned after forthcoming DSM-5 PCBD criteria, most of which
were adapted from prior measures (Layne et al., 2001; Layne et al., 2008). The items selectively tapped into existential grief (e.g., “Life for me doesn’t have much purpose since he/she died.”) and circumstance-related distress (e.g., “Upsetting thoughts about how the person died keep me from enjoying good memories of him/her.”). Further refined versions of these PCBD prototype items now form part of the Persistent Complex Bereavement Disorder Checklist (Layne, Kaplow, & Pynoos, 2013). Reactions experienced during the past month were rated on a 5-point frequency scale (range = 0–32) and showed good internal consistency (z = .94).

Depressive symptoms. The Short Mood and Feelings Questionnaire (Angold, Costello, & Messer, 1995) is a measure of depressive symptoms with good sensitivity and specificity in identifying major depression (Angold et al., 1995; range = 0–26). Baseline internal consistency was good (z = .93).

Procedures

Referrals, screening, and selection for treatment groups. Therapists met with school staff to provide information regarding PTSD and MG and to encourage appropriate screening referrals. Referred students underwent a two-phase screening process. During Phase 1, students completed self-report questionnaires assessing PTSD symptoms and MG reactions. Students who endorsed predetermined levels of PTSD symptoms (UCLA-R total scale score ≥ 30) or MG reactions (at least one maladaptive grief item rated ≥ 2 on the PCBD prototype measure) advanced to Phase 2. In Phase 2, students underwent an individual interview with a therapist who reviewed participants’ self-reports and probed for additional trauma and loss experiences.

Implementation of TGCT-A. TGCT-A was implemented during 17 weekly 50-min sessions conducted in six groups by therapeutic teams comprised of one master’s-level graduate student and one experienced grief counselor who had been trained in the full TGCT-A model by one of the treatment developers. Given youths’ diverse histories and needs, the limited number of weekly time slots available in the school year, and TGCT-A’s modularized structure, therapists selectively and flexibly implemented components of Modules II (Trauma Processing) and III (Loss Processing). After reviewing students’ PSTD and MG scores, therapists guided each student in selecting an index trauma or loss with which to construct a narrative during the processing traumatic experiences (Module II) or exploring major losses (Module III) therapeutic tasks. Because members of each group had a mixture of index loss and trauma experiences, each member constructed either a trauma-focused or loss-focused narratives. Approximately one session was devoted to each student sharing and processing his or her narrative.

Training and supervision. A treatment developer conducted a 2-day training seminar. A licensed, doctoral-level community therapist who was trained in the full TGCT-A protocol provided weekly supervision. Live supervision occurred monthly. In addition, the treatment developer provided two 3-hr supervision calls to further monitor adherence to the manual and answer questions.

Assessment. During three assessment sessions (after Module I, Module II/III, and Module IV), an independent evaluator administered self-report measures to assess participants’ PTSD symptoms and MG reactions.

Narrative transcript coding. Verbatim narratives transcribed during therapy sessions were later classified as “trauma focused,” “loss focused,” or “other.” Criteria for categorizing trauma-focused narratives were derived from DSM-IV PTSD Criterion A1 (experiencing or witnessing a death or serious injury). Transcripts were classified as loss focused if the narrative described the loss of a close relationship. Narrative transcripts classified as “other” did not clearly meet criteria for either trauma or loss (e.g., death of distant relative, parental incarceration). Independent coders achieved 94% absolute agreement on the 33 narratives classified (intraclass correlation coefficient = .97). See Table 1 for additional details.

Data Analytic Strategy

Given the nested structure of the data, we used multilevel analyses to provide appropriate standard error and parameter estimates and account for nonindependence of reports from the same individual (Raudenbush & Bryk, 2002). We used Hierarchical Linear Modeling 7 software (Raudenbush, Bryk, Cheong, Congdon, & duToit, 2011) to test hypotheses. Our data analytic approach included three parts: (a) preliminary analyses, (b) tests of outcomes, and (c) tests of treatment focus as a hypothesized predictor of the trajectory of symptom change over treatment. Missing data resulted from participants’ absences from school on data collection day or participant refusal to complete certain measures. Less than 6.1% of participants had missing data on any variable analyzed. Missing data were handled with restricted maximum likelihood estimation, as recommended for small samples (Raudenbush & Bryk, 2002).
Preliminary analyses. We used independent samples t tests to compare trauma and loss group means for PTSD, MG reactions, and depressive symptoms. We also conducted independent-samples t tests and chi-square analyses to compare 11 treatment attriters to 33 treatment completers.

Intervention outcomes. We followed a three-step approach to evaluate whether significant reductions in PTSD symptoms and MG reactions occurred during TGCT-A. First, we compared pre- and posttreatment levels of PTSD and MG reactions using paired samples t tests. Then, we calculated reliable change index values (Tingey, Lambert, Burlingame, & Hansen, 1996) to evaluate the magnitude of change at an individual level. Finally, we specified a two-level unconditional linear growth model to evaluate the slope of pre-to posttreatment changes in PTSD symptoms and MG reactions. We measured time in weeks, with 0 (the level-1 intercept) indicating the pretreatment assessment score.

Narrative focus as a predictor. We specified narrative focus as a Level 2 predictor of rates of change in PTSD symptoms and MG reactions over the course of treatment.

RESULTS

Preliminary Analyses

Comparisons of loss and trauma. As hypothesized, youth whose narratives focused on trauma reported significantly higher pretreatment levels of PTSD symptoms ($M = 42.5, SD = 7.44$) than those who focused on loss ($M = 27.25, SD = 16.14$), $t(26) = 3.34$, $p = .003$. Also as hypothesized, youth who focused on loss reported higher pretreatment levels of MG reactions ($M = 16.69, SD = 7.26$) than those who focused on trauma ($M = 8.25, SD = 7.02$), $t(26) = 3.09$, $p = .005$. Youth who focused on trauma also reported significantly higher levels of depressive symptoms ($M = 13.42, SD = 4.03$) at baseline than youth who focused on loss ($M = 6.80, SD = 5.60$), $t(26) = 3.44$, $p = .002$.

Attrition. The 25% attrition rate in this study is comparable to other evaluations of trauma treatments with diverse youth samples (e.g., Cohen, Mannarino, & Iyengar, 2011). Independent samples t tests comparing treatment attriters ($n = 11$) versus completers ($n = 33$) revealed no significant between-group differences on age, sex, or baseline PTSD symptoms and MG reactions. A chi-square test revealed no significant association between ethnicity and attrition. Thus, we assumed attrition to be at random and calculated effects only for treatment completers.

Treatment Outcomes

A paired samples t test comparing pre- to posttreatment levels of PTSD, MG, and depressive symptoms (Table 2; Figures 2, 3) revealed significant reductions in PTSD and MG reactions with medium-large effect sizes for PTSD ($d = 0.78$) and MG ($d = 0.74$). Further, reliable change index values (Tingey et al., 1996) revealed that 61% of treatment completers reliably improved on either
PTSD symptoms or MG reactions (46% for PTSD, 39% for MG); 24% reliably improved on both outcomes.

An unconditional linear growth model estimating rates of PTSD symptom change showed that the model-implied average level of PTSD severity at baseline was 34.68 ($p < .001$). The slope coefficient indicated that PTSD scores decreased an average of 0.44 points weekly ($p < .001$), or 10.56 points over the total 24-week span of the study.

Last, an unconditional linear growth model estimating rates of change in MG reactions showed a model-implied average level of MG severity at baseline of 13.46 ($p < .001$). MG scores decreased an average of 0.21 points weekly ($p < .001$) or 5.04 points over the 24-week study.

**Narrative focus as a predictor of PTSD and MG trajectories.** We tested our primary study hypothesis using conditional linear growth models with narrative focus (loss focus = 0, trauma focus = 1) as a Level 2 predictor of Level 1 intercepts and slopes in PTSD symptoms and MG reactions (Table 3). Given between-group differences in depressive symptoms at baseline, we entered baseline levels of depressive symptoms as a Level-2 control variable. Baseline depressive symptoms were associated with higher starting levels of PTSD symptoms ($\beta = 1.28$, $p = .02$), but not with the rate of PTSD symptom reduction ($\beta = -0.03$, $p = .23$). After controlling for depressive symptoms, narrative focus (trauma vs. loss) did not predict the rate of change ($\beta = 0.38$, $p = .23$) in PTSD symptoms. This finding suggests that all participants experienced similar benefits in PTSD symptom reductions regardless of the focus of their narratives.

Baseline levels of depressive symptoms predicted higher pretreatment levels of MG reactions ($\beta = 0.62$, $p = .02$) but not for rates of change in MG reactions over the course of treatment ($\beta = -0.02$, $p = .13$). Controlling for depressive symptoms, youth who focused on losses had higher pretreatment levels ($\beta = -12.11$, $p = .001$) and faster rates of decline in MG reactions during treatment ($\beta = 0.40$, $p = .03$), which was consistent with our hypotheses. Thus, compared to youth who focused on trauma, those who focused on loss reported both higher baseline levels of MG and steeper declines in MG reactions over the course of treatment.

**Post hoc analyses.** Given that narrative focus predicted change in MG, we conducted follow up analyses to investigate whether change occurred before or after narrative construction. We segmented the study into two parts: Part 1 (baseline to Module 1) and part 2...
Fixed Effect with Narrative-Focus
(reactions. Further, students’ narrative focus predicted
symptoms, whereas students who constructed loss-focused
narratives reported higher pretreatment levels of PTSD symp-
toms; students who constructed trauma-focused narra-
tives: Students who constructed trauma-focused narra-
focus, students’ reported pretreatment levels of PTSD
validity check for our dichotomous code for narrative
(both pretreatment levels and rates of change over the
specific focus (trauma vs. loss) of students’ narratives would predict
MG reactions to evaluate whether the specific focus
pre–post treatment changes in PTSD symptoms and
(1, 31) = 2.7, p = .07. In contrast, MG showed significant
change from the beginning of Module II to post-
3.1 to posttreatment). A repeated measures
analysis of variance showed no significant change in
MG between baseline and the end of Module I; F(1, 31) = 1.27, p = .27. In contrast, MG showed significant
change from the beginning of Module II to post-
treatment, F(1, 31) = 9.49, p = .004.

**DISCUSSION**

In this exploratory evaluation of TGCT-A, we examined
pre–post treatment changes in PTSD symptoms and
MG reactions to evaluate whether the specific focus
(trauma vs. loss) of students’ narratives would predict
both pretreatment levels and rates of change over the
course of treatment. As hypothesized (and serving as a
validity check for our dichotomous code for narrative
focus), students’ reported pretreatment levels of PTSD
symptoms and MG reactions differed by narrative
focus: Students who constructed trauma-focused narra-
tives reported higher pretreatment levels of PTSD symp-
toms, whereas students who constructed loss-focused
narratives reported higher pretreatment levels of MG
reactions. Further, students’ narrative focus predicted
the rate of pre–post treatment decline in MG reactions
but not PTSD symptoms; students who constructed
loss-focused narratives reported higher rates of decline
in MG reactions. Post hoc analyses provided further
evidence that the reduction in MG reactions may have
been due to the narrative task rather than the passage
of time, given that significant decreases in MG did not
occur until the second half of treatment (after the
narrative exercise).

Results of this implementation of TGCT-A are con-
sistent with evidence concerning its effectiveness and
adaptability as described in previous studies. In parti-
cular, 61% of students showed reliable change in either
PTSD symptoms or MG reactions (46% for PTSD,
39% for MG) and 24% reported reliable improvement
on both PTSD symptoms and MG reactions. Co-occurring PTSD symptoms and MG reactions were
common in our sample, given that more than half of
the students whose narratives focused on loss described
losses that had occurred under violent or shocking
circumstances (Table 1). Nevertheless, a substantial
number of students focused on nonviolent losses and
also appeared to benefit from treatment. These results
suggest that treatments like TGCT-A that target both
trauma and violent or nonviolent loss show promise
for benefitting economically disadvantaged communities
where trauma and loss are widespread, but the resources
necessary for implementing multiple interventions
to target specific diagnoses are limited.

Given the exploratory nature and modest size of our
pilot study design, further replication concerning the
role of narrative task focus is needed. Our results are
nevertheless consistent with theoretical propositions laid
out by other research teams concerning etiologic
processes that may underlie MG and their associated
implications for treatment. For example, Boelen, van
den Hout, and van den Bout (2006) asserted that patho-
logical grief is maintained as a result of insufficient
integration of loss into the autobiographic knowledge
base, whereas Gilbert (2002) advocated for treating
MG with a narrative approach given that may facilitate
meaning-making. Examples include a study of bereaved
Afghani youth, which found that writing about loss (a
form of written narrative) was more effective in reducing
grief reactions compared to a control condition
(Kalantari, Yule, Dyregrov, Neshatdoost, & Ahmadi,
2012), as well as the incorporation of a loss-focused
element in Project LAST (Salloum & Overstreet,
2008). Thus, practice elements involving the construc-
tion of loss-focused narratives may present therapeutic
opportunities to facilitate the integration, reappraisal,
and integration of losses into autobiographic memory,
as well as to develop accounts of the loss that are
appropriate for support-seeking and self-disclosure
(Layne et al., 2008).

| Table 3: PTSD and MG Growth Models |
| --- | --- | --- | --- |
| **Coefficient** | **SE** | **t** | **p** |
| Fixed Effect Unconditional Model | | | |
| PTSD Intercept | 34.68 | 3.02 | 11.49 | <.001 |
| PTSD Rate of Change | −0.44 | 0.13 | −3.54 | <.002 |
| MG Intercept | 13.46 | 1.48 | 9.13 | <.001 |
| MG Rate of Change | −0.21 | 0.07 | −2.93 | <.007 |
| Fixed Effects with Depressive Symptoms | | | |
| PTSD Intercept | 18.62 | 4.71 | 3.96 | <.001 |
| Baseline Depressive Symptoms | 1.65 | 0.42 | 3.97 | <.001 |
| PTSD Rate of Change | −0.31 | 0.25 | −1.24 | .226 |
| Baseline Depressive Symptoms | −0.01 | 0.02 | −0.64 | .526 |
| MG Intercept | 13.14 | 2.99 | 4.39 | <.001 |
| Baseline Depressive Symptoms | 0.03 | 0.26 | 0.13 | .90 |
| MG Rate of Change | −0.17 | 0.14 | −1.22 | .23 |
| Baseline Depressive Symptoms | −0.00 | 0.01 | −0.26 | .80 |
| Fixed Effect with Narrative-Focus Moderator | | | |
| PTSD Intercept | 18.84 | 4.64 | 4.06 | <.001 |
| Baseline Depressive Symptoms | 1.28 | .50 | 2.57 | .02 |
| Narrative Classification | 7.67 | 5.80 | 1.32 | .20 |
| PTSD Rate of Change | −0.30 | 0.24 | −1.24 | .24 |
| Baseline Depressive Symptoms | −0.03 | 0.03 | −1.23 | .20 |
| Narrative Classification | 0.38 | 0.31 | 1.23 | .23 |
| MG Intercept | 12.80 | 2.35 | 5.44 | <.001 |
| Baseline Depressive Symptoms | 0.62 | 0.25 | 2.47 | .02 |
| Narrative Classification | −12.11 | 2.94 | −4.12 | <.001 |
| MG Rate of Change | −0.16 | 0.13 | −1.24 | .23 |
| Baseline Depressive Symptoms | −0.02 | 0.01 | −1.59 | .13 |
| Narrative Classification | 0.40 | 0.17 | 2.40 | .02 |

**Note.** PTSD = posttraumatic stress disorder; MG = maladaptive grief.
Study limitations include an exploratory open-trial design that lacked a control group and thus precludes causal inference concerning treatment effects in reducing PTSD symptoms and MG reactions. Nevertheless, prior research suggests that adolescents who experience trauma but do not receive treatment tend to experience increased symptoms over time (Goenjian et al., 1997) and that MG can be largely stable for years following a loss without intervention (Melhem, Porta, Shamseddien, Walker Payne, & Brent, 2011). It is thus possible that TGCT-A may be at least partly prophylactic in nature. A second study limitation limiting the generalizability of results is the nascent state of the grief field and a corresponding lack of consensus concerning how to define and assess MG (Kaplow et al., 2012). Indeed, ambiguity surrounding foundational grief-related concepts necessitated the creation of a proposed DSM-5 bereavement-related disorder (PCDB) and, by extension, the development of prototype PCBD items used in this study. Our small sample size and modest statistical power suggest that any nonsignificant findings should be considered tentatively. Last, although we found a significant link between loss-focused narratives and reductions in MG reactions, we did not specifically test loss-focused narrative construction as a mechanism of therapeutic change. Further study is thus needed directed toward identifying and therapeutically harnessing “active ingredient” mechanisms of therapeutic change for MG (e.g., hope; Gilman, Schumm, & Chard, 2012) and evaluating whether the therapeutic task of constructing a loss-focused narrative therapeutically benefits bereaved adolescents who have experienced traumatic as well as nontraumatic losses.

**FUNDING**

This study was supported with funds provided to Roger Kobak by the Delaware Division of Prevention and Behavioral Health Services. Support for this project was provided in part by the Irene Darley Fund and Peter and Helen Bing to Robert Pynoos, M.D. (UCLA Trauma Psychiatry), who also contributed expert consultation on intervention adaptations and study design. We thank William Saltzman, who served as a trainer and clinical consultant. Supporting Kids, a nonprofit agency, provided staffing and clinical supervision.

**REFERENCES**


