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Addressing Grief Reactions Among Incarcerated Adolescents and Young Adults Using Trauma and Grief Component Therapy

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Objective: To determine whether male adolescents incarcerated in a juvenile justice facility would participate in and benefit from a grief-focused, evidence-based group treatment program. Few studies have examined the effectiveness of evidence-based, grief focused treatments for incarcerated adolescents, although these youths are reported to experience higher rates of bereavement than those in the general population. ***Method:*** Between 2015 and 2020, 63 male adolescents incarcerated at a secure correctional facility in the midwestern United States received group treatment for symptoms of maladaptive grief using an evidenced-based intervention called Trauma and Grief Component Therapy for Adolescents (TGCTA; Saltzman et al., 2017). Data collection before and after treatment included a brief screening measure, demographic information on each youth, and the Persistent Complex Bereavement Disorder (PCBD) Checklist, scored according to multidimensional grief theory (Layne et al., 2017). ***Results:*** Mean PCBD grief domain scores decreased significantly for separation distress and circumstance-related distress from baseline to after TGCTA (Layne et al., 2014) group participation. After group completion, the association between PCBD grief symptoms and functional impairment was unchanged in the family domain, decreased in the school domain, and increased in the peers/friends domain. In the 5- to 15-week period after the group versus the 5- to 15-week period before the group, there was a 50% reduction in the number of behavioral incident reports involving TGCTA group participants, while 63 matched control participants had no change in behavioral incident reports. ***Conclusion:*** Study findings demonstrate the feasibility of treating maladaptive grief with youths in the juvenile justice system and provide preliminary evidence that grief-focused treatment may reduce maladaptive grief symptoms and improve behavioral functioning.

Clinical Impact Statement

Although youth in juvenile justice settings reportedly experience higher rates of bereavement and violent deaths in particular than do youth in the general population, few studies have examined the effectiveness of treatments that address grief reactions among detained youth. Using an evidence-based intervention, Trauma and Grief Component Therapy, with incarcerated adolescents, we found significant decreases in specific grief reactions, including separation distress and circumstance-related distress. We also saw decreases in the number of behavioral incidents among youth who

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participated in the treatment compared with those who did not participate. Findings speak to the utility and effectiveness of grief-focused interventions for bereaved, incarcerated adolescents.

Keywords: grief, incarcerated youth, juvenile justice, adolescents, trauma and grief component therapy

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Bereaved children and adolescents in the general population are more likely than nonbereaved youth to be at heightened risk for both mental health and behavioral health problems. In addition to depression, posttraumatic stress disorder, maladaptive grief reactions, and suicide attempts, they are also more likely to exhibit substance abuse, school problems, aggressive behaviors, and other behavioral disturbances (Hill et al., 2019; Kaplow & Layne, 2014; Kaplow et al., 2010; Oosterhoff et al., 2018). Youth in the juvenile justice system experience higher rates of bereavement than youth in the general population (Draper & Hancock, 2011; Lansing et al., 2018; Olafson et al., 2018). In fact, the vast majority of detained youth report the death of a close loved one, with over 70% experiencing at least two or more significant losses (Lansing et al., 2018). In addition, these deaths are most frequently due to violence (homicide), which can result in higher levels of posttraumatic stress and maladaptive grief (Douglas et al., 2021). Although a number of studies have examined the impact of trauma-focused treatment on this population (i.e., designed to reduce posttraumatic stress; Cohen et al., 2016; Ford & Hawke, 2012; Marrow et al., 2012; Olafson et al., 2018), no studies to our knowledge have examined the effectiveness of grief-focused treatment (designed to reduce grief-related distress) among incarcerated youth. This study begins to fill this gap by reporting on a pilot implementation of an evidence-based group treatment for 63 bereaved youth at a residential treatment facility.

Although a majority of youth in the juvenile justice system have extensive histories of both trauma and loss, more studies have examined the impact of trauma than of bereavement on behavioral health problems in this population (Charak et al., 2019; Stimmel et al., 2014). Saltzman et al. (2017) describe the differences between traumatic experiences and bereavement in the general population, including the distinct risk and protective factors associated with each, and highlight the importance and need for distinct practice elements that target posttraumatic stress versus maladaptive grief. In fact, recent research has established prolonged grief disorder (formerly known as persistent complex bereavement disorder) as distinct from posttraumatic stress disorder (Hill et al., 2019; Kaplow et al., 2018; Kaplow & Layne, 2014). The current study focuses specifically on youth who endorsed bereavement and associated grief reactions and chose to participate in a group treatment called trauma and grief component therapy for adolescents (TGCTA; Saltzman et al., 2017) to address their maladaptive grief reactions.

Grief-Focused Interventions for Bereaved Youth

Only a small number of grief-focused treatments for adolescents currently exist (for a detailed review, see Kaplow et al., 2019). The Family Bereavement Program (FBP) is a 12-session group-based treatment for bereaved caregivers and their children, ages 8 to 16, designed to promote resilience following bereavement (Ayers et al., 2014; Sandler et al., 2013). A randomized trial involving 156 parentally-bereaved families and 244 children demonstrated that youth in FBP exhibited lower levels of externalizing problems, higher self-esteem, and improved academic performance as compared with youth in the control condition at posttreatment (Sandler et al., 2003). Youth in FBP also demonstrated a lower prevalence of suicide ideation or behaviors (Sandler et al., 2016) and greater reductions in intrusive grief-related thoughts at the 6-year follow-up compared with those in the control group.

Grief-help is a treatment designed for bereaved children and adolescents aged 8 to 18 years (Boelen et al., 2006; Spuij et al., 2015) and is delivered in nine individual sessions accompanied by five individual parent/caregiver sessions. Primary intervention objectives of grief-help are to decrease symptoms of prolonged grief disorder (PGD), PTSD, and depression. A recent randomized clinical trial involving 134 bereaved youth found that Grief-Help resulted in significantly greater reductions in prolonged grief disorder symptoms at all posttreatment assessments, and it was more successful in alleviating depression, PTSD symptoms, and internalizing problems 6 and 12 months after treatment compared with a supportive counseling control group (Boelen et al., 2021).

The grief and trauma intervention (GTI) is a treatment designed for children who have experienced trauma and/or traumatic bereavement (Salloum, 2008). The primary intervention objectives of GTI are to reduce posttraumatic stress, depressive symptoms, and "traumatic grief reactions", to develop coping skills, and facilitate meaning-making. GTI was evaluated in an open trial (Salloum, 2008) and a subsequent randomized clinical trial with 56 children comparing the GTI delivered individually versus in small groups (Salloum & Overstreet, 2008). Children reported significant reductions in symptoms of posttraumatic stress, depression, traumatic grief, and global distress regardless of treatment modality (e.g., individual vs. group; Salloum & Overstreet, 2008). A third study of GTI for children who had experienced community violence, the death of someone close, and/or hurricane exposure, demonstrated similar results, with outcomes maintained up to 12 months postintervention (Salloum & Overstreet, 2012).

Trauma-focused cognitive-behavioral therapy (TF-CBT) is an evidence-based treatment for youth between the ages of 6 and 18 (Cohen et al., 2017; Ovenstad et al., 2020), with an additional grief-focused component for children experiencing childhood traumatic grief, defined as posttraumatic stress symptoms that infringe on normative grief-related tasks (Cohen et al., 2004). In a study of 22 bereaved children (aged 6 to 17 years) and their primary caregivers, children showed significant improvements in childhood traumatic grief, PTSD,

depressive symptoms, anxiety, and behavioral problems after a 16-week course of TF-CBT (Cohen et al., 2004). In a study of 39 bereaved youth aged 6 to 17 years, a 12-session protocol of TF-CBT produced significant improvements in PTSD and childhood traumatic grief symptoms (Cohen et al., 2006). Finally, among 64 orphaned children, aged 6 to 13 years in Moshi, Tanzania, results of a modified (group-based) protocol of TF-CBT for childhood traumatic grief showed improved scores on posttraumatic stress, "unresolved grief," and depressive symptoms at posttreatment and at 3- and 12-month follow-ups (O'Donnell et al., 2014).

Multidimensional grief therapy (MGT; Kaplow et al., in press) is a theoretically derived, assessment-driven intervention designed to reduce maladaptive grieving in three primary domains based on multidimensional grief theory (Kaplow et al., 2013; Layne et al., 2017): separation distress (longing for the person who died); existential/identity distress (feeling lost without the person); and circumstance-related distress (preoccupying and distressing thoughts about the manner of death) as well as facilitate adaptive grieving (e.g., finding healthy ways of feeling connected to the deceased, making meaning) in bereaved children and adolescents aged 7 to 18 years (Kaplow et al., in press). MGT is divided into two phases. Phase I, Learning About Grief, focuses primarily on psychoeducation, skill building, and identification of loss and trauma reminders. Phase II, Telling My Story, guides the client through their own loss narrative by focusing on each grief domain and promoting adaptive grief reactions. A recent open trial of MGT (Hill et al., 2019) demonstrated that bereaved youth who completed Phase I (n = 42) reported significant reductions in all three domains of maladaptive grief, posttraumatic stress symptoms, and depressive symptoms, with large to very large effect sizes (Cohen's ds = .77−1.35). Youth who went on to completed Phase II (n = 22) exhibited significant reductions from the end of Phase I, with medium to large effect sizes (range = .57–.90) for maladaptive grief, posttraumatic stress, and depression (Hill et al., 2019).

Trauma and grief component therapy for adolescents (TGCTA) is a modularized treatment for adolescents aged 11 to 18 whose histories of exposure to trauma and/or bereavement place them at high risk for severe persisting distress, functional impairment, and developmental disruption (Saltzman et al., 2017). TGCTA contains the following four modules: Foundational Knowledge and Skills; Working Through Traumatic Experiences; Working Through Grief Experiences; and Preparing for the Future. Its modular structure is designed to be flexibly delivered in either individual or group settings, with a focus on trauma, grief, or both, depending on the needs and histories of adolescents. Primary intervention objectives include reducing posttraumatic stress, maladaptive grief reactions, and depressive symptoms; facilitating adaptive grief reactions; strengthening self-regulation, problem-solving, and other coping skills; strengthening and expanding youths' social support networks; reducing risky behavior; improving school behavior and academic performance; and promoting adaptive developmental progression.

TGCTA has been implemented and evaluated in multiple settings, including in schools following a 1988 earthquake in Armenia (Goenjian et al., 1997), underserved American urban youth exposed to high rates of community violence (Saltzman et al., 2001), and following the 1992–1995 Bosnian civil war (Layne et al., 2008). In the latter study involving a randomized trial with war-exposed youth, Layne et al. (2008) found that those who received all four modules of TGCTA demonstrated greater reductions in posttraumatic stress, depressive symptoms, and maladaptive grief reactions and improved school behavior compared with a contrast group that received only the two modules focused on posttraumatic psychoeducation, coping skills, problem-solving skills, and future orientation. TGCTA was also field tested in an open trial with underserved U.S. high school students and showed effectiveness in reducing both posttraumatic stress and maladaptive grief reactions (Grassetti et al., 2015). A study of TGCTA implementation in U.S. juvenile justice facilities found significant reductions in disruptive behaviors by youth and associated reductions in incident reports, in addition to reductions in posttraumatic stress, depression, and anger (Olafson et al., 2018).

Aims of the Current Study

The current study examines the implementation of TGCTA, with a primary focus on bereavement and grief rather than trauma and posttraumatic stress, within a juvenile residential facility. This treatment was selected for a number of reasons. First, TGCTA was designed with a focus on adolescents, including their developmental needs, strengths, and for those who are bereaved, specific bereavement-related challenges that adolescents are likely to encounter. Second, TGCTA's grief module is grounded in multidimensional grief theory (Kaplow et al., 2013; Layne et al., 2017) so that sessions are designed to not only reduce maladaptive grief reactions (including those encompassed by childhood traumatic grief and prolonged grief disorder) but also to harness and facilitate adaptive grief reactions. Third, TGCTA was designed to be used in group settings, and many of the exercises are grounded in the unique peer group support aspects that are difficult to replicate in individual therapy. Fourth, TGCTA does not require the incorporation of parent/caregiver sessions, which can be challenging in residential treatment facilities. Fifth, TGCTA's modularized format allows for flexibility in meeting the needs of a particular population and setting (Saltzman et al., 2017). Based on the emphasis that TGCTA places on grief work, we hypothesized that providing TGCTA groups for bereaved juvenile justice-involved youth would result in (a) reductions in maladaptive grief reactions, (b) reductions in associated functional impairment, and (c) reductions in disruptive behaviors documented in facility incident reports.

Method

Sample

This study took place in a secure juvenile residential facility operated by a midwestern state department of corrections for juvenile justice-involved youth who are considered inappropriate candidates for local community-based corrections due to unresponsiveness to community-based interventions, seriousness of offense, or presenting a risk to public safety. Residents are males between the ages of 10 and 21 (M = 17.6 years) who are adjudicated for an act that would be a felony-level offense if committed by an adult. Their charges include but are not limited to aggravated robbery, assault, burglary, criminal sexual assault, felony theft, weapons, terroristic threats, attempted murder, and loss of life cases. This facility is one of the last opportunities for these high-risk youth to address the multiple traumas and losses that have contributed to their juvenile incarceration and to assist them in remaining out of the adult prison system.

All youth placed at the facility are provided the opportunity to engage in individual therapy, group therapy, and psychiatric care.

On average, 64% of residents meet regularly with mental health providers while being prescribed psychiatric medications, and a majority of these youth had been on psychiatric medications prior to admission. In addition, throughout placement, all residents have access to mental health therapists and psychiatric services following their initial standard diagnostic assessment; frequency of contact varies depending on youth level of need and request for services. As part of required programming at this facility, all residents are engaged in the Phoenix Curriculum group sessions 3 days per week throughout their placement. Designed specifically for at-risk youth in residential placements, the Phoenix Curriculum uses cognitive behavioral techniques to address emotional reactivity, thinking errors, and potential gang involvement.

Participants in the TGCTA grief groups consisted of (N = 63) males between the ages of 14 and 20 (M = 16.96 years). The ethnoracial distribution of these youth was American Indian/Alaskan Native (10%), African American or Black (62%), White (5%), Hispanic (5%), unknown/other (5%), and missing (13%). This distribution closely matches that of the overall facility population (i.e., American Indian/Alaskan Native (9%), African American or Black (58%), Unknown (3%), and White (30%)), except that White participants comprised only 5% of the treatment sample because most of the White residents were adjudicated sexual offenders who had not completed sexual offender treatment and were not eligible for these TGCTA groups. There were no known adjudicated sexual offenders in this TGCTA treatment sample, and these residents received behavioral health services in a separate program.

For this study, a comparison sample of youth was identified by matching each TGCTA participant with another resident to compare their incident reports within the facility. Matching was done to establish an equivalent control sample based on age, race, length of stay, and legal charges. Legal charges were matched based on adjudicated crime matches, and when that was not possible, similar level crimes, taking into consideration the violent or nonviolent nature of the crime. All control participants had continued access to individual and group therapies during and after the intervention.

Procedure

Clinical staff, case workers, and selected security staff participated in four in-person TGCTA trainings by treatment developers of 15 to 18 hr each from 2013 to 2018, and only licensed clinicians conducted treatment groups, supported by monthly clinical conference calls. Clinicians in this facility had already received two TGCTA trainings and had implemented all modules of TGCTA with developer support for two years before providing the TGCTA grief groups. They also received ongoing consultation from treatment developers throughout the course of this study.

Residents were identified for voluntary participation in the TGCTA grief groups through a recommendation made by their mental health clinician based on their standard clinical diagnostic assessments, identification of bereavement on the University of Minnesota's Traumatic Stress Screen for Children and Adolescents (TSSCA; Donisch et al., 2017) that is administered to all youth shortly after admission, referral from the youth's caseworker, and the clinical judgment of the clinician scheduled to be group facilitator. Once potential residents were identified as appropriate for the group, they completed the PCBD Checklist and attended a pregroup preparation meeting, held individually (Layne et al., 2014), to help develop goals for the group and learn about group expectations. Youths completed the PBCD Checklist immediately during the final group session as a posttest assessment.

TGCTA groups met two times per week for a period of 5 weeks, with no more than eight group members participating and two facilitators present at all sessions. Each group in this study started with 5–8 youth. In total there were 76 youth who started the TGCTA groups and 13 who did not complete (17% attrition). Three individuals completed group but did not fill out a postevaluation before they were released from the facility. Of those who did not complete the group, the reasons noted were numerous security unit placements due to problem behaviors (9 youths) or because youth stated that they did not want to process their grief in a group setting (4). Two of these youth dropped out after one session and the other two ended their participation after completing Module 1. Youth who missed three or more sessions because of security unit placements were removed from the group and were all offered the opportunity to participate in a group later or to complete the program individually. The noncompleters did not differ significantly on baseline PCBD or impairment scores from the completers.

Four sessions from Modules 1 (Foundational Knowledge and Skills), Module 3 (Working Through Grief Experiences), and selected exercises from Module 4 (Preparing for the Future) were implemented (see Table S4 in the online supplemental materials). The TGCTA groups were held in a classroom setting with two clinicians. The session format consisted of a fixed check-in ritual that included rating emotions on a feeling thermometer and a review of exercises assigned for practice between sessions. The core of content varied by session but always included psychoeducation, skills-building practice, and shared activities using handouts that youth were able to compile into journals to keep at the conclusion of TGCTA. Sessions ended with a fixed check-out ritual that included youth completion of a feedback form about the session.

Four of the Module 1 sessions were not included because the Phoenix Curriculum thoroughly covers this information. The ten-session, grief-focused version of TGCTA used for this study was field-generated in that residents explicitly asked for groups to focus on grief rather than trauma, and information/skills that were not redundant with the Phoenix Curriculum. Clinicians listened to these incarcerated adolescents, and in collaboration with developers, made use of TGCTA's modular structure to create and implement this ten-session version.

Measures

Youth maladaptive grief reactions and behavioral incidents were assessed using the following measures.

The PCBD Checklist

The PCBD Checklist is a 39-item measure of grief for youth designed to assess *DSM–5* PCBD criteria and identify youth at risk for PCBD (Layne et al., 2014). Items are rated on a 5-point Likert scale ranging from 0 (*not at all*) to 4 (*all the time*). The PCBD Checklist has demonstrated strong convergent, discriminant, and discriminant-groups validity as well as developmental appropriateness and clinical utility (Kaplow et al., 2018). The PCBD Checklist can be scored either in accordance with the proposed criteria for PCBD, or alternatively, in relation to the primary grief domains proposed by multidimensional grief theory (separation

distress, existential/identity distress, circumstance-related distress; Kaplow et al., 2013; Layne et al., 2017). Scores for impairment in three domains (i.e., family, peer/friends, and school) also are calculated based on single items rated on the PCBD Checklist.

On the PCBD Checklist, group participants were asked to identify the death that has been the hardest to deal with in the last month. Of participants, 42.8% endorsed "close friend" or "friend"; 15.9% endorsed "cousin"; 14.3% endorsed "brother"; followed by lower percentages for parents and other relatives. In addition, 68.3% endorsed "murder/homicide" as the cause of death and 17.4% endorsed "illnesses," followed by much lower percentages for accidents, suicides, war, and other.

Behavioral Incidents

Incident report data were extracted from the facility's database. Staff members write up incident reports when youth are placed on disciplinary room time because of major rule violations that often include aggressive actions. Incident reports were aggregated for seven 5-week periods: baseline assessments 5, 10, and 15 weeks before the group, the 5 weeks of group participation, and follow-up assessments 5, 10, and 15 weeks after the group.

Data Analyses

Statistical analyses were conducted with IBM SPSS Statistics (Version 27). Univariate repeated-measures analyses of variance (ANOVA) were used to compare PCBD subscale scores and the three impairment measures before and after group participation. The association of PCBD scores with functional impairment before and after TGCTA group participation was tested with logistic regression analyses, controlling for age and race/ethnicity. Finally, a series of univariate repeated-measures ANOVAs with group vs. control as a between groups independent variable were conducted to examine the relationship of group participation to behavioral incident records in a 15-week period before versus a 15-week period after the TGCTA group. ANOVAs were also conducted for each of three 5-week periods (i.e., Weeks 0 through 5, 5 through 10, and 10 through 15) before and after TGCTA to examine early change (i.e., Weeks 0 through 5), and sustained change (i.e., Weeks 5 through 10 and 10 through 15) in behavioral incidents from before versus after group participation (with data for the exact same time periods for each control youth).

Results

PCBD subscale scores and impairment scores in the family, peer/friends, and school domains are shown in Table 1. Mean PCBD grief domain scores (derived from multidimensional grief theory) decreased from baseline to after TGCTA group participation, statistically significant for separation distress and circumstance-related distress, and marginally significant (i.e., $p = .06$) for existential distress (see Table 2). Participants were less likely to report impairment in family relationships and at school after TGCTA group participation than prior to starting the group (i.e., 70% and 84% before versus 65% and 73% after), but these differences were not statistically significant. The most notable difference was that twelve youths who reported school-related impairment before the group reported no impairment after the group, while five youths who reported no school-related impairment before the group reported impairment following the group. Impairment in peer or friend relationships did not change overall from before to after the TGCTA group.

Although there were no significant changes in functional impairment following group participation, we also examined the associations between each of the three functional impairment items and maladaptive grief symptoms (see Table 3). PCBD symptoms and impairment in the family domain were significantly related both before and after the group (see Table 3). However, PCBD symptoms were not associated with impairment in the peers/friends domain before the group but were significantly associated with this domain

Table 1
Demographics, Legal History, and PCBD Baseline and Posttherapy Scores

Variable	Pre- *M* (*SD*) *n*%	Post *M* (*SD*) *n*%	Pre- *M* (*SD*) *n*%	Post *M* (*SD*) *n*%
Age	16.98 (1.08)		16.9 (1.07)	
Legal charges				
Nonviolent	43		43	
Violent	43		43	
Length of stay	369 (131.6)		371 (178.1)	
PCBD				
Separation distress	2.205 (0.790)	1.984 (.814)		
Circumstance-related distress	2.196 (.844)	1.839 (.892)		
Existential/identity distress	1.634 (.875)	1.496 (.955)		
Impairment				
Family	70	65		
Peers	73	73		
School	84	73		
Behavioral incidents	5.714 (7.330)	3.460 (4.789)	4.794 (6.305)	4.444 (7.581)
Incidents				
Time 1	1.794 (2.603)	1.365 (2.157)	1.873 (3.045)	1.429 (3.455)
Time 2	2.000 (2.806)	1.032 (2.000)	1.508 (2.539)	1.556 (3.364)
Time 3	1.921 (2.847)	1.064 (1.900)	1.413 (1.837)	1.460 (3.222)

Note. PCBD = Persistent Complex Bereavement Disorder Checklist; Time 1 = 0 to 5-week period before or after group; Time 2 = 5- to 10-week period before or after group; Time 3 = 10- to 15-week period before or after the group.

Table 2
Repeated-Measures Analyses of Variance of Outcomes at Baseline vs. Post-Therapy

Score	M^2	$F(1, 62)$	p
PCBD			
Separation distress	1.546	5.461	.023
Circumstance-related distress	4.024	14.144	<.001
Existential/identity distress	1.240	3.614	.062
Impairment			
Family	0.071	0.816	.370
Peers	0	0	1.000
School	0.389	2.973	.090

Note. PCBD = Persistent Complex Bereavement Disorder Checklist.

of impairment following the group. An opposite shift was seen in impairment in the school domain, which was significantly related to PBCD symptoms before the group but not after the group.

Both group participants and matched controls had small decreases in the number of incident reports in the 5 weeks after the group versus the 5 weeks before the group (Time 1, see Table 1). However, there was a 50% reduction in the number of behavioral incidents involving group participants in the longer term follow-up (5 to 15 weeks) period (i.e., Time 2 and Time 3) after group completion compared with 5 to 15 weeks before the group (i.e., M = 2.095, SD = 3.201 at follow-up vs. M = 3.921, SD = 5.246 before the group), $F(1, 62) = 6.671$, $p = .012$, $n^2 = .097$. In contrast, in that same 5- to 15-week period, the control participants had no change in incidents (i.e., M = 3.016, SD = 5.584 vs. M = 2.921, SD = 3.866, respectively), $F(1, 62) = .019$, $p = .892$, $n^2 = .000$. Group participants showed a larger reduction in behavioral incidents in the 5- to 15-week follow-up period than youths in the control group: the interaction of condition by time was significant, $F(1, 124) = 3.738$ $p = .0355$.

Discussion

Implementation of TGCTA with a primary focus on the Grief Module for youth in a secure residential juvenile justice facility appears to significantly reduce maladaptive grief symptoms and behavioral incidents. In particular, it appears that youths who participated in TGCTA showed reductions in separation distress (yearning and longing for the person who died) as well as circumstance-related distress (being preoccupied with the way the person died; Kaplow et al., 2013; Layne et al., 2017). These empirical findings speak to the importance of addressing not only trauma and posttraumatic stress, but also bereavement and maladaptive grief reactions in juvenile justice-involved youth. Findings also

Table 3
Logistic Regressions Testing Association of PCBD Total Score With Impairment

Variable	B	SE	$F(1)$	p	OR	95% CI	
			Family impairment				
Before group							
Black race	−1.722	1.005	2.937	.087	.179	.025	1.281
Age (in years)	−.745	1.436	.269	.604	.475	.028	7.921
Latino ethnicity	.233	.325	.514	.473	1.263	.667	2.390
PCBD	**.313**	**.151**	**4.301**	**.038**	**1.367**	**1.017**	**1.837**
After group							
Black race	−1.181	.809	2.130	.144	.307	.063	1.500
Age (in years)	−.001	1.400	.000	1.000	.999	.064	15.524
Latino ethnicity	−.159	.313	.259	.611	.853	.462	1.574
PCBD	**.417**	**.162**	**6.600**	**.010**	**1.517**	**1.104**	**2.086**
			Peer impairment				
Before group							
Black race	.025	.796	.001	.975	1.026	.215	4.884
Age (in years)	.283	.315	.809	.369	1.327	.716	2.460
Latino ethnicity	.083	1.496	.003	.956	1.087	.058	20.408
PCBD	.276	.146	3.555	.059	1.317	.989	1.754
After group							
Black race	.554	.926	.358	.550	1.740	.284	10.682
Age (in years)	−.793	.416	3.625	.057	.453	.200	1.024
Latino ethnicity	−.313	1.470	.045	.832	.732	.041	13.059
PCBD	**1.141**	**.356**	**10.292**	**.001**	**3.130**	**1.559**	**6.284**
			School impairment				
Before group							
Black race	−1.230	1.194	1.061	.303	.292	.028	3.036
Age (in years)	.292	.399	.536	.464	1.340	.613	2.929
Latino ethnicity	−1.360	1.769	.591	.442	.257	.008	8.230
PCBD	**.600**	**.219**	**7.497**	**.006**	**1.823**	**1.186**	**2.801**
After group							
Black race	.243	.705	.119	.730	1.275	.320	5.075
Age (in years)	−.503	.309	2.645	.104	.605	.330	1.109
PCBD	.218	.145	2.249	.134	1.243	.935	1.652

Note. Variables with statistically significant ($p < .05$) relationships with the impairment outcome are highlighted in bold type. PCBD = Persistent Complex Bereavement Disorder Checklist.

demonstrate the feasibility and clinical utility of using TGCTA in residential treatment facilities.

Although there were no overall reductions in grief-related impairment, after group participation maladaptive grief symptoms were no longer correlated with functional impairment at school. In contrast, maladaptive grief symptoms continued to be correlated with impairment in family relationships and became correlated with impairment in peer/friend relationships following participation in the TGCTA group. These shifts in the relationship between grief symptoms and functional impairment may be due to the participants having opportunities to apply what they were learning immediately in their ongoing school activities, whereas they had more limited opportunities to do so with family or friends because they were incarcerated. TGCTA may have enabled youths to process grief reactions that had previously led to difficulties in school, such as problems concentrating or school connectedness. Layne et al. (2008) found similar improvements in school functioning following group TGCTA treatment in their randomized study of adolescent Bosnian war survivors. Of particular relevance, a recent study found that among a nationally representative sample of approximately 10,000 adolescents, the sudden death of a loved one was the strongest predictor of poor school outcomes above and beyond any other form of trauma (e.g., sexual abuse, physical abuse, witnessing domestic violence; Oosterhoff et al., 2018), suggesting that maladaptive grief reactions may play a critical role in school-related impairment. The specific therapeutic mechanisms that help to explain reductions in the association of grief symptoms with school-related impairment warrant future research.

Based on the feedback provided by youths at the conclusion of group participation (see the following text), one possible explanation for the results with respect to family and peers is that the group may have enabled youths who experienced the deaths of family members or friends to become more aware of their own distressing grief reactions, because emotion identification and awareness are primary goals of treatment. Participants made comments about what they gained from the group such as "I was still sad but happy because I got to open up," "I like how I could relate to people in the group," "I been cool and more relaxed that I'm in this group," and "It just feels good talking about my grief." To the extent that the pre-incarceration peer relationships of these youths may have included the pressures of gang membership and engagement in delinquent behavior as a means of fitting in, the increased degree of perceived impairment related to these peer relationships for justice-involved youth may be a positive sign. While youth may have bonded about grief and loss within their TGCTA treatment groups, they may have subsequently felt more alienated or different from peers outside of the group (i.e., one youth stated, "They do not really get me anymore"). Future research is needed to examine whether changes in grief reactions are associated with changes in youths' identification with deviant peer groups.

The reduction in behavioral incidents that followed group participation was not evident until several weeks had elapsed following the group (i.e., the 5- to 15-week follow-up period). This suggests that the effect of the group may be somewhat delayed as youths adjust to using new knowledge and skills learned in the group. It also is possible that, in the immediate aftermath of the group, youths may still be processing their grief reactions and may require a longer period to experience reductions in their more maladaptive grief reactions. The fact that the change in incidents was not limited to the period of participation in group or its immediate aftermath suggests that the TGCTA grief module may provide a basis for sustained rather than merely transient improvements in behavior—potentially increasing these youths' likelihood of successfully completing their residential confinement and returning to the community. Further longitudinal studies are needed to assess the longer term behavioral and legal outcomes for these youths to determine the extent and durability of such benefits.

Two case examples of the background and response to group participation by youths illustrate how participation in the group was helpful to them. One participant experienced his best friend being shot and killed when he was thirteen years old. During this incident he was struck in the back with the bullet that killed his friend. He had been giving his friend a ride on the back of his bike, when rival gang members began shooting at them. His friend fell off the bike after being shot and the resident continued to flee on the bike. He carried significant guilt for not going back to check on his friend and believes he allowed his friend to die. He carries the bullet in his back to this day. Two weeks after the death of his friend, his cousin was shot and killed by the same gang members. He was very close to this older cousin and looked up to him. He also experienced various other losses in his life, including the murders of several of his mother's boyfriends with whom he was close. Prior to his participation in TGCTA, this youth frequently was placed in the security unit due to aggression toward peers and defiance of security staff. Once afforded the opportunity to process his losses in the TGCTA group, and normalize his thoughts and feelings, his behavior stabilized, and he was able to complete the program successfully. He reported that he learned how to plan for difficult days such as the anniversary of his cousin's death, his birthday, or even hearing about other shootings. He said these were practices and coping strategies he had not known to use prior to his participation in the group. He also was able to talk about the way he thought his cousin would want him to live, primarily by avoiding any contact with gangs, as a means of carrying on a positive legacy for his cousin.

Another resident was admitted into the program due to a manslaughter charge occurring at age sixteen that involved him providing drugs to a friend, and the friend dying from an overdose. He had been selling heroin to support his own use and did not know the heroin he sold his close friend was laced with fentanyl. Many mutual acquaintances started harassing and blaming him on social media a short time after the overdose, exacerbating his guilt. He was incarcerated in large part due to his escalating use of drugs to numb feelings of guilt and social rejection. He found that talking openly about his feelings of guilt and sadness with support from the group members and leader and learning skills to assertively cope with harassment by peers, enabled him to complete the program successfully and to acknowledge that he needed to work on achieving sobriety from a serious drug addiction.

Study limitations included the quasi-experimental design with a matched control sample for whom PBCD was not assessed. Participants also had to volunteer to take part in the groups, so they were not representative of all potentially eligible youths in the carceral facility. The sample size of 63 was relatively small, and the follow-up period was limited to 15 weeks. Data collection did not include measures of depression, suicide risk, posttraumatic stress disorder, or other behavioral health disorders.

In conclusion, this pilot study demonstrated that incarcerated youths would participate and remain engaged in grief-focused treatment with a relatively low rate of drop-out. The study further demonstrated that the implementation of TGCTA, with an emphasis on the grief module, is associated with reductions in maladaptive grief symptoms, particularly separation distress and circumstance-related distress. Maladaptive grief reactions were also less strongly related to school functioning by the end of treatment. If replicated in larger longitudinal studies, this finding suggests that grief-focused group therapy may reduce the adverse impact of maladaptive grief reactions on school functioning. Notably, group participation was associated with reductions in serious behavioral problems 2 to 4 months after the group, as measured by incident reports, against matched controls. Reductions in serious problem behavior and maladaptive grief reactions may offer promise for reduced recidivism after release from residential treatment facilities, warranting further research.

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