Personalizing and Delivering Treatment for Prolonged Grief in Youths

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In this issue, Boelen et al. (1) report a timely and important randomized clinical trial evaluating a cognitive-behavioral therapy program (CBT Grief-Help) for youths with prolonged grief disorder. Although new research paradigms and effectiveness studies are emerging, randomized clinical trials remain the methodological gold standard for determining whether a treatment can be considered en route to receiving the highly lauded label "empirically supported." Boelen et al. deserve applause for their well-designed trial that brings CBT Grief-Help closer to earning such a label. Study strengths include the use of an active supportive counseling comparison condition, appropriate developmental treatment adaptations, and adherence to key CBT ingredients (i.e., attention to cognitive processing, inclusion of behavioral strategies). The study has internal validity, and the study findings have the clinical meaningfulness to provide direction for maximally helping youths. The main question that follows from the study results is "what next?"

Personalization After Evidence of Efficacy

What works? Randomized clinical trials guide us. Which treatments for whom? Moderator analyses inform us. Identifying which treatments work best for the individual helps to facilitate precision, or personalized, treatment. Boelen et al. advance the precision medicine agenda by reporting moderation analyses examining variables of interest (sex, age, time since loss, relationship with the deceased person, and cause of death). Reports of moderator analyses examining variables that interact with treatment condition on outcome measures are rare, despite calls for all randomized clinical trials to include moderation results (2). For example, in a review of 98 randomized clinical trials for pediatric anxiety disorder treatments, Compton et al. found that only 16.3% of studies reported on moderation (3). Boelen and colleagues are to be commended for their concurrent focus on both efficacy and potential personalization in their reported results.

When moderation has been examined across randomized clinical trials, the variables are typically drawn from baseline assessments without a priori articulation of underlying theory (4). Future directions for tailored interventions are consequently imprecise. For example, readily available demographic variables such as age are frequently examined as potential moderators. In these analyses, it is unclear whether the true variable of interest is developmental stage, for which age is an imperfect proxy, or an unassessed specific variable, such as level of emotional or cognitive development. Such questions can be more efficiently addressed if a moderator theory is generated and the specific variable is assessed a priori. Attention to mutable moderator variables is especially important to tailor interventions. Sex, age, and cause of death of the deceased person cannot be directly targeted or changed by a therapist, but variables relevant to grief maintenance might be more clinically useful (e.g., high anxious avoidance might require additional exposure sessions among a subset of youths). Given the time required to complete a high-quality randomized clinical trial (e.g., between 2010 and 2015 for the present study), careful a priori thought to theory-driven and properly measured mutable moderator variables during study design will be critical in efficiently leveraging efficacy trials to inform personalized intervention.

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Last, consistent with the broader literature, the majority of variables examined in Boelen and colleagues' study did not significantly moderate outcomes. These findings may indicate that the treatment was similarly efficacious across the variables studied. However, statistical power concerns make interpretation of null findings tenuous. Given the intensity of resources required to conduct individual randomized clinical trials, adoption of a team science approach (i.e., multisite randomized clinical trials, cross-study collaborations) will be critical from the outset to mitigate power concerns (5). Such an approach will require adherence to consistent measures and attention to data harmonization, but will help to maximize the impact of already impactful studies like the one conducted by Boelen and colleagues.

Implementation Following an Efficacy Trial

Efficacy trials are a central step in learning what mental health services work and for whom. As Boelen et al.

acknowledge, it is also important to consider the implementation supports needed to integrate CBT Grief-Help into routine practice. Efficacy researchers can aid in this process by describing the implementation strategies used in the clinical trial (6). For example, Boelen et al. described the training process (i.e., 6 hours of training, regular supervision with audiotape review) and their feasible fidelity check (i.e., therapist self-report using a session goal list). They also reported two implementation outcomes related to treatment acceptability—therapist satisfaction and client dropout rates (7). Efficacy trials with specified treatment protocols are best when designed with dissemination in mind.

But what about the eventual implementation of effective manual-based treatments outside of the efficacy trial? We recommend the concept of "flexibility within fidelity" (8, 9). Under this framework, therapists implement the active core ingredients of the intervention, while allowing for variation in the specific ways that the core is used (10). One adaptation that therapists may make is to spread out the sessions into caregiver and child sessions, as five parallel child and parent sessions may pose a scheduling challenge. Another way to practice considering flexibility within fidelity is to tweak a therapy activity while adhering to the function of that activity. Therapy protocols that describe both a therapy activity and its function will help in this process of tailoring treatments to specific clients or therapy settings. Boelen et al. excellently describe both the activities involved in their intervention and the rationale behind each activity. As they note, dismantling studies can clarify which therapy components are the active ingredients in their intervention.

Future studies might examine how the CBT Grief-Help training can be tailored to therapist level of experience. For therapists with expertise in CBT, it is possible that they can implement CBT Grief-Help after only an explanation of how CBT principles are applied to prolonged grief. However, as a result of the COVID-19 pandemic, there may be an increase in complicated grief in youths who have lost caregivers to COVID-19 and a resulting high demand for care that cannot be served entirely by CBT-trained therapists. Training non–professional health workers in CBT Grief-Help may be a valuable strategy for increasing access to evidence-based treatment for complicated grief in youths. For example, one study referenced by Boelen et al. found that lay counselors already trained in trauma-focused CBT (a similar protocol) significantly improved symptoms of posttraumatic stress in youths who had experienced parental death (11). Future studies can examine the implementation supports needed for lay counselors to successfully deliver CBT Grief-Help.

In summary, Boelen et al. have taken strong steps in documenting the efficacy of CBT Grief-Help for prolonged grief disorder in youths. We maintain that the next steps should focus on personalization and on dissemination and implementation. These next steps will help to maximally leverage time-intensive randomized clinical trial data to help youths who are struggling with prolonged grief disorder and the caregivers and clinicians who want to help them.

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