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Caregiver behaviors and childhood maladaptive grief: Initial validation of the Grief Facilitation Inventory

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ABSTRACT

The Grief Facilitation Inventory (GFI) is a newly-developed measure of caregiver behaviors theorized to facilitate or hinder children's adaptive grief reactions. We examine its factor structure, reliability, and validity. An exploratory factor analysis identified four factors: *Ongoing Connection*, *Existential Continuity/Support*, *Caregiver Grief Expression*, and *Grief Inhibition/Avoidance*. Both child- and caregiver-report versions had adequate-to-good internal consistency. The child-report GFI showed evidence of criterion-referenced validity via significant correlations with measures of child maladaptive grief and other psychological symptoms. Results provide preliminary evidence of the reliability, validity, and clinical utility of the GFI as a measure of caregiver grief-facilitation behaviors.

The death of a caregiver, sibling, or loved one is one of the most commonly reported and most distressing forms of trauma among youth (Kaplow et al., 2010). Approximately 78% of youth report having experienced the death of a close relative or friend by age 16 (Harrison & Harrington, 2001). Childhood bereavement is associated with a range of mental and behavioral health problems, including depression, posttraumatic stress reactions, substance use, decreased academic performance, and suicide-related behaviors (Cerel et al., 2006; Hill et al., 2019; Layne & Kaplow, 2020; Oosterhoff et al., 2018). Despite these findings, most bereaved children grieve adaptively and maintain normal functioning across life domains (Kaplow et al., 2010; Keyes et al., 2014). Nevertheless, a subgroup of bereaved children experiences clinically significant distress and impaired functioning, with estimates ranging from 10% in population-based epidemiological studies (Melhem et al., 2011) to 18% in youth referred for therapeutic services (Kaplow et al., 2018). Expanding our theoretical understanding of the various processes through which bereaved youth may eventuate in maladaptive or adaptive outcomes is a necessary step toward identifying and responding to at-risk bereaved youth.

Multidimensional grief theory is an explanatory framework created to assist in differentiating between adaptive versus maladaptive grief reactions (i.e. Kaplow et al., 2013). Multidimensional grief theory proposes that grief reactions generally fall within three primary conceptual domains: *Separation Distress*, *Existential/Identity Distress*, and *Circumstance-Related Distress*. Separation Distress centers on reactions to the continuing physical absence of, and the inability to physically reunite with, the deceased person (e.g. sadness over the persisting separation). Existential/Identity Distress arises from challenges to either one's personal identity or to the existential meaning one attributes to one's own life. Maladaptive reactions to existential/identity-related challenges may manifest as severe disruptions in one's sense of self, or one's sense of purpose and meaning (e.g. life aspirations, future plans and ambitions). Circumstance-related Distress involves troubling thoughts and emotional pain over the particular manner of death and is theorized to increase in response to deaths that have occurred under tragic and potentially traumatic conditions (e.g. fatal accidents, homicide, suicide, neglect; Kaplow et al., 2014). Multidimensional grief theory also nests grief-related constructs within a broader context

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of socioenvironmental factors postulated to influence children's reactions to a loved one's death. These include such factors as trauma reminders, loss reminders, and secondary adversities; and (most relevant to the present study), the immediate caretaking environment (Layne et al., 2006).

In addition to multidimensional grief theory, empirical studies focusing on parenting behaviors in the context of bereavement help to explicate the ways caregivers can help reduce children's distress over time (Shapiro et al., 2014; Wardecker et al., 2017) or potentially evoke maladaptive grief reactions (Shear, 2012). Surviving adult caregivers play an integral role in assisting and supporting children in the aftermath of a death (Shapiro et al., 2014; Wardecker et al., 2017). Several studies have identified associations between a positive caregiver-child relationship and improved child outcomes following the death of a loved one (e.g. Haine et al., 2008). Additionally, interventions that strengthen caregiver-child relationships and foster emotional expression promote resilience among bereaved youth (e.g. Ayers et al., 2014; Sandler et al., 2013). In contrast, caregivers may also engage in behaviors that contribute to maladaptive grieving. Few studies have examined specific behaviors that caregivers may engage in (or conversely, refrain from engaging in) to reduce children's distress following the death of a loved one.

Positive caregiver behaviors may facilitative adaptive grieving and reduce post-bereavement distress. These behaviors include scheduled positive family activities (e.g. games, cooking together, watching a family movie) that build family cohesion and help children and caregivers to "take a break" from grieving, enhancing family identity, and increasing warmth and communication (Haine et al., 2008; Sandler et al., 2003). Maintaining continuity in family routines and activities may also help to establish a sense of stability and order (Walsh, 2007). Although increased caregiver-child communication is generally helpful in the face of bereavement (e.g. Horsley & Patterson, 2006), current research suggests that it is not only *what* caregivers say to the child, but also *how* they say it that matters most. For example, physical affection, smiling, and consistent eye contact with bereaved children are associated with lower child maladaptive grief and depressive symptoms (Shapiro et al., 2014). Caregiver warmth, is also consistently associated with lower mental health problems in bereaved children (Kaplow et al., 2014). Conversely, other behaviors may exacerbate negative outcomes in bereaved youth. For instance, avoidant coping (among both caregivers and

children) is theorized to interfere with adaptive grief (Kaplow et al., 2019). Avoidance and emotional suppression are related to poorer mental health outcomes and complicated grief (e.g. Dodd et al., 2020).

Taken together, these data indicate that certain parental behaviors after the death of a loved one may play a significant role in influencing how children cope in the aftermath of a death. A more nuanced understanding of caregiver grief facilitation may assist in the identification of risk markers for poor child outcomes that could be incorporated into early risk detection efforts.

To support efforts to evaluate the familial context in which maladaptive grief responses may develop, a 36-item test pool, the Grief Facilitation Inventory (GFI; Kaplow & Layne, 2012), was developed to assess a range of caregiver behaviors theorized to reduce or contribute to distress in youth. Items for the GFI were based on the extant childhood bereavement literature, clinical experience, and feedback from providers in a trauma- and grief-focused outpatient psychology clinic. The original test construction process involved the creation of parallel child-observational report and caregiver self-report versions of the GFI.

The GFI is comprised of a range of bereavement-specific caregiver behaviors. Positive behaviors theorized to reduce post-bereavement distress include: verbal and non-verbal communication with the child about the deceased person (e.g. *my caregiver talks with me about _*), memorializing the deceased person (e.g. *does things with me to help me remember _*), and activities aimed at establishing stability and family cohesion (e.g. *does most things the same way we used to before my _ died*). Possible negative behaviors theorized to evoke or exacerbate maladaptive grief reactions include avoidance (e.g. *my caregiver tries not to mention my _'s name or his/her death*) and emotional suppression (e.g. *my caregiver tries hard not to show how upset he/she is about my _'s death*).

To our knowledge, the GFI is the first measure of caregiver engagement in behaviors theorized to influence grief reactions in bereaved children, thus hypotheses are primarily exploratory. We hypothesized that: (1) applying an exploratory factor analysis (EFA) to the child-report GFI item pool would generate multiple factors; (2) parenting practices theorized to be helpful (e.g. warmth) versus unhelpful (e.g. avoidance) would respectively aggregate into different factors; (3) the factor structure of the caregiver-report GFI items would align with the factor structure of the child-report GFI items, and parallel child- and caregiver-report factors would be correlated. Last, (4) the factors would

differentially correlate with indicators of child adjustment: Helpful factor scores would correlate inversely, and unhelpful factor scores would correlate positively, with measures of child distress.

Method

Participants and procedure

Participants came from two child and adolescent outpatient clinics. Sample 1 was drawn from an outpatient clinic for trauma-exposed and/or bereaved youth housed in a large academic medical center. Youth who reported experiencing a death were included in the current study ($n = 237$); youth who denied bereavement ($n = 61$) were excluded from the sample. A proportion of Sample 1 youth ($n = 184$) also had a caregiver complete the caregiver-report version of the GFI. Sample 2 included 197 bereaved youth referred to a community-based grief support center that provides individual and group counseling for bereaved children and families. The combined sample included 432 children and adolescents (60% female), aged 6–18 years old ($M_{age} = 12.76$, $SD = 2.79$), 46% identified as Hispanic/Latinx; 23% White; 13% Black; and 13% Mixed/Biracial. Detailed descriptive statistics for each sample are reported in the [Supplemental Materials \(Appendix A\)](#). At both clinics, youth completed a standard battery of self-report measures prior to treatment that included those reported in this study. Trained clinicians read all measures to participants. Youth received \$50 for their participation. All procedures were approved by senior author's institutional review board.

Measures

Grief Facilitation Inventory (GFI):The GFI has 36 items rated on a 5-point frequency scale (0 = *not at all*, 1 = *a little*, 2 = *sometimes*, 3 = *a lot*, and 4 = *all the time*), designed to evaluate the frequency of caregiver grief facilitation behaviors during the past month. Child-observational report and caregiver self-report versions of the GFI contain parallel items (e.g., “my caregiver talks with me about my ___” vs. “I talk with my child about his/her loved one”).

Persistent Complex Bereavement Disorder (PCBD) Checklist:The PCBD Checklist (Kaplow et al., 2018; Layne et al., 2014) has 39 child self-report items that measure maladaptive grief symptoms. PCBD is a provisional disorder listed in the appendix of DSM-5 as a condition for further study. Items are on a 5-point scale from 0 (*not at all*) to 4 (*all the time*). The PCBD

Checklist has shown strong evidence of convergent, discriminant, and discriminant-groups validity as well as developmental appropriateness and clinical utility, in clinic-referred bereaved youth (Hill et al., 2020; Kaplow et al., 2018). To permit more nuanced examination of links between the GFI and children's maladaptive grief reactions, the PCBD was scored to align with multidimensional grief theory by averaging items within each of the three grief domains: Distress ($k = 15$ items; $\alpha = 0.91$), Existential/Identity Distress ($k = 7$, $\alpha = 0.85$), and Circumstance-Related Distress ($k = 10$, $\alpha = 0.85$).

The UCLA Posttraumatic Stress Disorder (PTSD) Reaction Index:The UCLAPTSD Reaction Index for DSM-5 (RI-5; Kaplow et al., 2020) is a 31-item child self-report measure that assesses symptoms of PTSD experienced in the past month in relation to an identified index trauma. Items are rated using a 5-point scale ranging from 0 (*never happens*) to 4 (*most of the time*). A total symptom score was created based on a sum of all items ($\alpha = 0.95$). RI-5 items have shown good internal consistency and convergent validity in relation to other measures of PTSD and depressive symptoms (Kaplow et al., 2019).

Short Mood and Feelings Questionnaire (SMFQ):The SMFQ (Angold et al., 1995) is a 13-item child self-report measure of depressive symptoms experienced during the past 2 weeks. Youth rate each item on a 3-point scale consisting of 0 (*not true*), 1 (*sometimes true*), and 2 (*true*). A total symptom score was created based on a sum of all items ($\alpha = 0.89$). SMFQ items have shown good internal consistency, diagnostic accuracy, and criterion-referenced validity in relation to other measures of depressive symptoms (Thapar & McGuffin, 1998).

Results

There were few missing data on the child GFI, with 6% of youth ($n = 25$) missing data on 5 or fewer items and 94% of youth ($n = 407$) with complete data. Of the 184 caregivers from Sample 1, 86% ($n = 158$) had complete data and 11% ($n = 20$) were missing data on 5 or fewer items, with the remaining 3% ($n = 6$) completing at least half of the GFI items.

Preliminary analysis of the child self-report GFI item properties resulted in removing two skewed items endorsed by less than 5% of the sample. Visual inspection of the scree plot produced via EFA of the 34 remaining child-report GFI items identified four factors for further analysis. The four-factor solution had an Eigenvalue of 1.43, acceptable model fit, $\chi^2(431) = 866.29$, CFI = 0.970, RMSEA = 0.049 (0.044,

0.054), and theoretically meaningful factors. Therefore, we retained the four-factor solution. We removed items with primary loadings <0.30 one at a time and reran analyses, resulting in the removal of three items. Next, we removed items that cross-loaded and shared conceptual overlap with two or more factors one at a time and reran analyses, resulting in the further removal of seven items, which minimized item redundancy and multicollinearity. One additional item (GFI26: “My caregiver lets me know that he/she isn’t really the best person to talk to about my ___’s death”) significantly loaded onto two factors (primary loading of 0.55 on factor 4, secondary loading of 0.32 on factor 1), however, the difference between the primary and secondary loadings was greater than .15 and, in terms of conceptual meaningfulness, this item aligned well with the other items that loaded onto factor 4 and was conceptually distinct from factor 1. Therefore, we retained this item. The final four-factor EFA solution with 24 items showed excellent model fit, $\chi^2(186)=391.11$, CFI = 0.982, RMSEA = 0.050 (0.043, 0.057). We inspected the content of each of the factors and labeled them via consensus among the authors. Table 1 presents the final Pattern Matrix and factor descriptions. The item-factor correlations and communalities are reported in the Supplemental Materials (Appendix B). Items aggregated into three helpful caregiver behaviors and one unhelpful caregiver behavior. Internal consistencies were: 0.91 for *Ongoing Connection* (7 items); 0.78 for *Existential Continuity and Support* (8 items); 0.84 for *Caregiver Grief Expression* (4 items); and 0.62 for *Grief Inhibition/Avoidance* (5 items). For *Grief Inhibition/Avoidance*, given the few number of items used and the lower alpha coefficient, corrected item-total correlations (ITC) were also used to assess internal consistency, which were all in the acceptable range (r_s 0.34 to 0.46; Nunnally & Bernstein, 1994).

Ongoing Connection items include helping keep the deceased person’s memory alive, encouraging behaviors that help the child feel closer to the deceased person, and highlighting positive things the child and the deceased person have in common (e.g. *does things with me to help me remember my ___*). *Existential Continuity and Support* items include behaviors theorized to promote continuity of the child’s routines and reassure a positive future (e.g. *lets me know that I can still have a good life even though my ___ has died*). *Caregiver Grief Expression* items involve caregivers sharing their own grief reactions with their child (e.g. *tells me how he/she is feeling about my ___’s death*). *Grief Inhibition/Avoidance*

items measure caregiver behaviors theorized efforts to either *inhibit* (e.g. *tells me not to talk about how my ___ died with people outside of my family*) or *avoid* the child’s grief reactions (e.g. *tries not to mention his/her death*).

We then used CFA to evaluate caregiver self-report GFI items corresponding to the EFA-derived child self-report GFI items. The CFA model showed acceptable fit, $[\chi^2(249)=530.087$, CFI = 0.96, TLI = 0.96, RMSEA = 0.078 (0.069, 0.088)], with standardized factor loadings ranging from 0.65–0.98 for *Ongoing Connection*, 0.38–0.84 for *Existential Continuity and Support*, 0.70–0.97 for *Caregiver Grief Expression*, and 0.43–0.68 for *Grief Inhibition/Avoidance* (see Supplemental Materials, Appendix C, for all factor loadings and R^2 values). Internal consistencies were: 0.90 for *Ongoing Connection*; 0.80 for *Existential Continuity and Support*; 0.87 for *Grief Expression*; and 0.62 for *Grief Inhibition/Avoidance* (ITCs ranged from 0.30 to 0.47).

Descriptive statistics and bivariate correlations are reported in the Supplemental Materials (Appendix D). Among the child-report GFI factors, substantial inter-factor correlations occurred among *Ongoing Connection*, *Existential Continuity and Support*, and *Caregiver Grief Expression* ($r_s=0.44$ –0.67). Child-reported *Grief Inhibition/Avoidance* was also positively correlated with *Caregiver Grief Expression* ($r=0.19$) and *Existential Continuity and Support* ($r=0.10$), though to a lesser degree. *Grief Inhibition/Avoidance* was not significantly correlated with *Ongoing Connection*. Among the caregiver-report GFI factors, significant inter-factor correlations occurred among *Ongoing Connection*, *Existential Continuity and Support*, and *Caregiver Grief Expression* ($r_s=0.46$ –0.70). Caregiver-reported *Grief Inhibition/Avoidance* was not significantly correlated with any of the other caregiver-reported factors. Parallel child- and caregiver-report factors were also significantly positively correlated ($r_s=0.22$ –0.39).

A series of linear regression models examined the unique associations between the four GFI factors (as predictors) and child symptoms (as criterion variables), while accounting for child demographic characteristics and circumstances related to the loss. All regression models examining child-report GFI factors were significant (see Table 2). Greater child-reported *Grief Inhibition/Avoidance* was associated with higher maladaptive grief symptoms across all three domains and higher PTS and depressive symptoms, after accounting for child demographics and bereavement-related variables. Further, contrary to our hypothesis, child-report of *Ongoing Connection* was associated positively with

Table 1. EFA factor loadings of child-report Grief Facilitation Inventory items.

Item	Item description	Ongoing connection	Existential continuity/support	Caregiver grief expression	Grief inhibition/avoidance
GFI10	(tells me about my good things my _ used to say or do)	0.96	−0.02	−0.03	0.00
GFI11	(shares good memories with me about things that my _ did with me)	0.91	0.01	0.00	−0.06
GFI13	(does things like help keep my _'s memory alive)	0.66	0.08	0.14	0.03
GFI34	(tells me about good things I have in common with my _)	0.62	0.19	0.02	−0.03
GFI4	(does things with me to help me remember my _)	0.60	−0.02	0.25	0.01
GFI21	(helps or encourages me to do things that help me feel closer to my _)	0.57	0.18	0.15	0.03
GFI12	(shares comforting spiritual beliefs with me about my _)	0.54	0.19	0.05	−0.01
GFI27	(reminds me of all of the people in my life who care about me)	0.00	0.72	0.04	−0.07
GFI16	(encourages me to keep doing the things I liked to do before my _ died)	0.03	0.63	0.11	0.06
GFI29	(lets me know there will always be someone around to take care of me)	0.16	0.63	−0.07	−0.08
GFI36	(lets me know that I can still have a good life even though my _ has died)	0.27	0.62	−0.08	0.06
GFI17	(encourages me to talk with him/her about parts of my _'s death that upset me or are hard to think about)	0.06	0.50	0.24	0.07
GFI22	(does most things the same way we used to before my _ died)	−0.21	0.49	0.00	0.03
GFI30	(gives me hugs and kisses, cuddles me, tickles me, or wrestles with me in a loving or caring way)	−0.01	0.48	0.14	−0.15
GFI31	(tells me everything that I want to know about what caused _ to die)	0.20	0.37	0.13	−0.06
GFI3	(shares his/her thoughts with me about _'s death)	0.00	0.00	0.91	0.03
GFI2	(tells me how he/she is feeling about my _'s death)	0.04	0.06	0.85	0.00
GFI6	(cries about my _ in front of me)	0.02	−0.05	0.67	0.04
GFI1	(talks with me about my _)	0.27	0.03	0.56	−0.13
GFI14	(tries not to mention my _'s name or his/her death)	−0.06	0.19	−0.14	0.72
GFI35	(starts to act uncomfortable or strangely when the topic of my _'s death comes up)	−0.05	−0.04	0.23	0.69
GFI26	(lets me know that he/she isn't really the best person to talk to about my _'s death)	0.32	−0.26	−0.01	0.55
GFI20	(tells me not to talk about how my _ died with people outside of my family)	0.29	0.01	0.06	0.52
GFI28	(tells me about some of things my _ did that weren't so good)	0.13	0.05	0.08	0.45

Bolded values represent factor loadings >0.32.

maladaptive separation distress and existential identity distress.

In contrast, linear regression models examining caregiver-report GFI factors indicated that after controlling for covariates, caregiver-reported GFI scores were not significantly associated with child maladaptive separation distress ($\beta_s = -0.15$ – 0.16 , $p = .173$ – $.936$), existential identity distress ($\beta_s = -0.07$ – 0.14 , $p = .292$ – $.749$), circumstance-related distress ($\beta_s = -0.08$ – 0.11 , $p = .222$ – $.605$), PTSS ($\beta_s = -0.17$ – 0.06 , $p = .411$ – $.759$), or depressive symptoms ($\beta_s = -0.10$ – $.06$, $p = .403$ – $.757$).

Discussion

EFA results from the current study demonstrated that (1) parenting behaviors in the context of bereavement were multifactorial; (2) theorized helpful vs. unhelpful parenting behaviors aggregated in coherent ways; (3) factor structure of the caregiver-report GFI items aligned with the factor structure of child-report GFI items; and (4) child-reported GFI dimensions (but not caregiver-reported GFI dimensions) differentially related to measures of child adjustment. Both child-

and caregiver-report forms had acceptable internal consistency, providing preliminary evidence that the GFI factors are internally coherent. Further, preliminary evidence for criterion-referenced validity of the child-report GFI was supported by findings demonstrating significant associations between certain child-reported GFI factors and child symptoms of distress.

Results of our multiple regression models offer insights regarding which grief-facilitating behaviors may be more robust predictors of psychological distress among bereaved youth. Consistent with hypotheses that unhelpful caregiver behaviors would correlate positively with child distress, after controlling for youth demographics, bereavement-related variables, and other GFI factors, child-reported *Grief Inhibition/Avoidance* was uniquely associated with greater maladaptive grief symptoms. Although the items for this factor were exploratory, and additional measurement work is needed to improve the internal consistency of this subscale, results suggest caregivers' avoidance of their own grief or their child's grief as perceived by the child may be detrimental to youth in the aftermath of loss. Avoiding or suppressing grief is

Table 2. Multiple regression results: Regressing five types of childpost-bereavement distress on child-reported GFI scores after controlling for demographic and bereavement-related variables.

Predictors	Separation distress		Existential identity distress		Circumstance-related distress		Posttraumatic stress symptoms		Depressive symptoms	
	B (SE)	β	B (SE)	β	B (SE)	β	B (SE)	β	B (SE)	β
Female	0.16 (0.09)	0.09	0.22* (0.10)	0.11	0.16 (0.09)	0.09	6.39** (2.00)	0.17	2.51*** (0.69)	0.19
Age	0.01 (0.02)	0.02	0.02 (0.02)	0.05	-0.02 (0.02)	-0.07	0.54 (0.36)	0.08	0.49*** (0.12)	0.22
Black	0.54*** (0.14)	0.21	0.32 (0.16)	0.11	0.33* (0.14)	0.13	9.21** (3.14)	0.18	1.86 (1.10)	0.10
Latinx	0.38*** (0.10)	0.20	0.35** (0.12)	0.17	0.41*** (0.10)	0.23	4.26 (2.27)	0.12	1.67* (0.79)	0.13
Time since death	-0.05* (0.02)	-0.13	-0.05* (0.02)	-0.12	-0.04* (0.02)	-0.11	-0.40 (0.44)	-0.05	-0.04 (0.15)	-0.01
Long-term illness	-0.19 (0.13)	-0.10	-0.14 (0.15)	-0.07	-0.34** (0.13)	-0.19	-2.92 (2.91)	-0.08	-0.33 (1.02)	-0.03
Short-term illness	-0.29 (0.16)	-0.12	-0.22 (0.18)	-0.08	-0.25 (0.15)	-0.11	-1.79 (3.39)	-0.04	0.81 (1.18)	0.05
Homicide	-0.10 (0.16)	-0.04	-0.18 (0.18)	-0.06	-0.05 (0.16)	-0.02	-2.00 (3.57)	-0.04	-1.17 (1.24)	-0.06
Suicide	-0.22 (0.17)	-0.08	-0.14 (0.19)	-0.05	0.12 (0.17)	0.04	-0.39 (3.75)	-0.01	-0.59 (1.30)	-0.03
Ongoing connection	0.03*** (0.01)	0.28	0.03*** (0.01)	0.23	0.01 (0.01)	0.11	0.07 (0.21)	0.03	0.03 (0.07)	0.04
Exist. cont. and support	-0.01 (0.01)	-0.07	-0.01 (0.01)	-0.09	0.01 (0.01)	0.08	0.12 (0.18)	0.05	-0.03 (0.06)	-0.03
Grief expression	0.02 (0.01)	0.11	0.03 (0.02)	0.12	0.02 (0.01)	0.10	0.08 (0.32)	0.02	0.09 (0.11)	0.06
Inhibit/avoid	0.42*** (0.07)	0.31	0.48*** (0.07)	0.33	0.40*** (0.06)	0.31	7.97*** (1.43)	0.31	2.19*** (0.50)	0.24
R ²	0.34		0.28		0.33		0.19		0.18	
Adjusted R ²	0.31		0.25		0.30		0.16		0.15	
F-statistic	12.04*** (df = 13; 304)		8.98*** (df = 13; 304)		11.31*** (df = 13; 304)		5.37*** (df = 13; 294)		5.16*** (df = 13; 304)	

Note: White youth are the reference group for race/ethnicity. Accidental death is the reference group for cause of death.

* $p < .05$, ** $p < .01$, and *** $p < .001$

theorized to hinder adaptive grieving processes (Shear, 2012), and treatments for grieving children often involve open expression regarding the death of their loved one (Kaplow et al., 2019). Unfortunately, avoiding discussions regarding grief is common for many bereaved families, often because surviving caregivers are unsure of how to discuss the topic or have concerns about openly discussing their grief with their children (Kaplow et al., 2012). Findings from this study suggest that such avoidance may exacerbate youths' grief-related symptoms.

It is also possible that caregivers' grief avoidance reflects their own maladaptive grief reactions, which may present a barrier to facilitating adaptive grief reactions in their bereaved child. Child-reported *Grief Inhibition/Avoidance* was also the only GFI factor significantly associated with more severe child PTS and depressive symptoms. These findings are consistent with previous studies which demonstrate that avoidant coping is related to higher levels of maladaptive grief, PTSD, depression, and anxiety among youth who have experienced trauma and/or loss (Dodd et al., 2020; Kaplow et al., 2014).

Maintaining an ongoing relationship to the deceased person or "continuing bonds" is viewed as a normative and healthy facet of the grieving process (Kaplow et al., 2019); however, there is a great deal of heterogeneity regarding the extent to which continuing bonds helps or hinders adaptive grief (Normand et al., 1996; Stroebe et al., 2005). In the present study and contrary to hypotheses, youths' perception that their caregivers encouraged *Ongoing Connection* with the deceased person was associated with higher levels of separation distress and existential identity distress after accounting for contextual factors including circumstances of the death, child demographics, and other GFI factors. Although the cross-sectional nature of the study design hinders the clarification of potential causal pathways, it may be that youth who are already experiencing higher grief-related distress actively seek out opportunities to engage in *Ongoing Connection* activities with the surviving caregiver in an effort to alleviate their distress. Alternatively, encouraging bereaved youth to reminisce about the deceased person and encouraging the child to remain connected to the deceased person may exacerbate grief-related distress by perpetuating ruminative thinking about the loss (Ho et al., 2013). Wardecker et al. (2017) found that positive reminiscing between the surviving caregiver and child that occurred within the first 3–4 months of the death was associated with higher levels of distress in the child, indicating the

timing of these “ongoing connection” activities and/or positive reminiscing may be an important moderator to explore in future studies.

A notable study strength is the use of a relatively large database of bereaved youth and the multi-informant design. However, this study was cross-sectional, thus precluding causal or temporal inferences. The samples in this study consisted of treatment-seeking youth, which limits the generalizability of these findings to bereaved youth not seeking counseling or psychological services. In addition, the current sample was drawn from the United States; thus, there may be important cultural differences in parenting behaviors concerning children’s post-bereavement distress and their expressions of grief. It is worth noting that although the Cronbach’s alpha for one of the GFI factors, *Grief Inhibition/Avoidance*, was in the acceptable range for exploratory measures (e.g. 0.60–0.70; Nunnally & Bernstein, 1994), future research should work to develop additional items that may strengthen our ability to reliably assess caregivers’ tendencies to avoid or inhibit child grief, including a wider range of explicitly avoidant behaviors (e.g. not taking child to the cemetery, taking away photos of the deceased, removing the deceased person’s possessions from the home).

Although the current study examined several maladaptive outcomes (maladaptive grief, PTS, depressive symptoms), further research should examine links between caregiver grief-facilitation behaviors and positive youth outcomes to better understand how these behaviors may relate to adaptive grief reactions in bereaved youth. Future research should also examine caregiver grief facilitation cross-culturally. In addition, longitudinal research is needed to test prediction over time, assist with disentangling potential bidirectional causes, and help map out the clinical course of child adjustment including different adjustment trajectories. Longitudinal designs or multiple cohort designs will also allow for tests of potential moderators. Future research examining caregiver grief facilitation should consider the role of fit between caregiver’s and children’s grief experiences and preferences. For example, the impact of caregiver grief facilitation on child psychological distress may vary depending upon the child’s own coping strategies and degree of expressiveness. Future research should also consider how caregiver grief facilitation may have differential impacts on children at different points in time (e.g. Wardecker et al., 2017). Thus, both “goodness of fit” between caregiver and child grief processes and coping strategies, as well as longitudinal examination of grief facilitation over time, may contribute to a more

nuanced understanding of children’s post-bereavement distress.

Although child observational-reports of caregiver grief facilitation was associated with children’s psychological distress, caregiver self-reported grief facilitation was not. The findings that (a) compared to theorized positive parenting behaviors, theorized negative parenting behaviors are differentially more strongly related to indicators of child mental distress; and (b) child-reported parenting behaviors are differentially more strongly related to the child’s distress and well-being, are both consistent with findings within the broader parenting literature (e.g. Barber, 2002) and may offer fruitful avenues for future research. If confirmed by future longitudinal research, the GFI may serve as a useful clinical tool for examining the child’s caregiving environment and helping to identify specific caregiver behaviors that may play a role in the child’s ability to cope with the death of a loved one.

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