

NCTSN

The National Child
Traumatic Stress Network

The Courage to Remember

CHILDHOOD TRAUMATIC GRIEF VIDEO
COMPANION CURRICULUM GUIDE



From the NCTSN Childhood Traumatic Grief Working Group,
Educational Materials Subcommittee

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National Child Traumatic Stress Network
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Educational Materials Subcommittee

Robin F. Goodman, PhD
National Child Traumatic Stress Network

Judith Cohen, MD
Center for Traumatic Stress in Children and Adolescents
Allegheny General Hospital

Matthew D. Kliethermes, PhD
The Greater St. Louis Child Traumatic Stress Program

Julie Kaplow, PhD
New Jersey Medical School

Carrie Epstein, MSW
Safe Horizon

Christopher Layne, PhD
Brigham Young University

Robert Franks, PhD
National Center for Child Traumatic Stress, Duke University

Amy Blalock, BA
National Center for Child Traumatic Stress, Duke University

Lt. Christine Guthrie, MPH
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

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INTRODUCTION

ABOUT THIS GUIDE

Children who have experienced the traumatic death of a person significant in their lives may have reactions and symptoms that we are beginning to understand are distinct from the grief following nontraumatic death. We believe that children who have experienced traumatic grief and who are troubled by overwhelming traumatic memories can be identified and helped to cope with traumatic reactions and ultimately remember the person who died in a healthy, meaningful way.

The material presented in *The Courage to Remember* video and this companion guide represents the results of significant advances in the field of childhood traumatic grief and the unique collaboration of researchers and clinicians in academic and community settings throughout the country. We developed the video and guide using extensive expert involvement and commentary. Although the focus of these training materials is on individual work with school-age children and teens, additional information and resources are provided regarding work with young children and groups. The materials provide specific guidelines and options for interventions to

- educate care providers about childhood traumatic grief,
- introduce others to principles of treatment that have been identified as helpful in treating the condition, and
- offer practitioners an opportunity to enhance their treatment skills.

We hope to improve awareness about childhood traumatic grief as well as increase the ability of clinicians to respond in the most effective way possible.

ABOUT THE NATIONAL CHILD TRAUMATIC STRESS NETWORK

This project is the result of a collaboration within the National Child Traumatic Stress Network (NCTSN), which comprises 54 research and treatment centers from around the United States. The Network is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, US Department of Health and Human Services. The mission of the NCTSN is to raise the standard of care and improve access to services for traumatized children, their families, and communities throughout the United States. *The Courage to Remember* videotape and guide serve to further the mission of the Network by increasing the availability of care for children and expanding public and professional awareness of the specific condition of childhood traumatic grief.

ACKNOWLEDGMENTS

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And special thanks go to the families who courageously shared their stories.

WHO SHOULD BE TRAINED?

This Childhood Traumatic Grief guide was developed as a companion to the training video *The Courage to Remember*. The video is an advanced training tool and assumes that you are familiar with the concepts of trauma and bereavement and with general mental health principles.

This training is intended for all professionals and trainees working with children, especially school-age children and adolescents. Readers and viewers with a background in medicine (e.g., psychiatrists, nurses), mental health (e.g., clinical and school psychologists, social workers), and bereavement (e.g., pastoral and bereavement counselors) may find the information especially relevant. Professionals specializing in bereavement can benefit from the focus on differentiating childhood traumatic grief reactions from other types of grief reactions. Professionals in other fields may be unaware of the extent to which trauma and grief are part of a child's life. Equipped with further knowledge, you will be better able to identify problems related to childhood traumatic grief and help children and families get appropriate care.

HOW SHOULD THIS TRAINING BE USED?

It may be helpful to first view the introductory video, *It's OK to Remember*, which provides basic background information on childhood traumatic grief. The training video, *The Courage to Remember*, is the companion to this curriculum guide. As a training package, the two videos and the guide can be used in a variety of ways:

- If you are a clinician using them on your own, we hope you will find the concepts and techniques helpful in your everyday practice with children.
- If you are a trainer, a minimum total of three hours for the training is suggested; one hour for viewing the videos (each is approximately 30 minutes in length) and two hours for training and a discussion of the concepts presented in the videos and described more fully in the guide. This could be completed in one day or over two to three course sessions. Ideally the videos should not be shown back-to-back. Use the materials in whatever way best suits your program needs.
- If you are an administrator at your institution, we hope you will support the goals of this training program and encourage participation by your staff and faculty.
- You are also directed to the *Information for Parents on Childhood Traumatic Grief* found at the end of the guide, which provides suitable information that can be used as a handout for parents. Additional background information and handouts for medical and mental health professionals, educators and the media on Childhood Traumatic Grief are available at the NCTSN website, NCTSN.org.
- We invite you to explore other resources and information on topics related to childhood traumatic stress available at NCTSN.org.

The Courage to Remember video and guide are by no means exhaustive presentations of childhood traumatic grief. Depending on your level of training, prior experience, and background, additional training is strongly recommended. For example, it may be helpful to pursue specific training in cognitive behavioral techniques or work with bereaved children to become more familiar with the concepts presented here. You may also want to read more about Posttraumatic Stress Disorder (PTSD), trauma, grief, and the research being done in these areas by utilizing the resource and reference section at the end of the guide. Additional supervision and consultation is urged as practitioners develop their expertise. Both when beginning to treat children with childhood traumatic grief and even once trained, it is extremely helpful to discuss issues, share experiences, and get support for your work from colleagues and supervisors.

Specific references for professionals, parents, and children can be found at the end of the guide. Specific organization and Internet resources for further training information can be found at the end of the guide.

The video and guide cover issues related to the diagnosis and treatment of childhood traumatic grief in the same sequence. This guide provides more in-depth explanations, step-by-step instructions, additional resources, and quoted excerpts from professionals and family members seen in the videos to identify main concepts. A variety of different icons have been used throughout the guide to help you more easily find the information you need. Icons will be used to highlight the following:

GLOSSARY OF ICONS



DEFINITION

Important issues or terms are defined.



MAIN CONCEPT

Main concepts about childhood traumatic grief or treatment are identified within the text.



CASE EXAMPLE

Case examples and quotes are used to illustrate certain concepts.



CHILD

The treatment being described is conducted in individual child, parent, and joint parent and child sessions. We are aware that the treatment may be conducted with a primary caregiver who is not a parent, but for ease of presentation we are using the term “parent” generically to describe the child’s significant adult caregiver(s). The treatment components described here can be adapted to other situations and for children of different ages, such as a group of adolescents.



PARENT



CHILD PARENT JOINT

The treatment being described is conducted in individual child, parent, and joint parent and child sessions. We are aware that the treatment may be conducted with a primary caregiver who is not a parent, but for ease of presentation we are using the term “parent” generically to describe the child’s significant adult caregiver(s). The treatment components described here can be adapted to other situations and for children of different ages, such as a group of adolescents.



TREATMENT COMPONENT

Different treatment components and suggested tools to use with clients will be described.



ACTIVITY

Specific activities used in the treatment sessions are described.



HANDOUT

Different handouts are referred to and provided (1) as background information for parents and professionals and (2) for use in sessions or for homework.



REFERENCE

At times you will be referred to additional references that can be found at the end of the guide.



RESOURCE

At times you will be referred to additional resources that can be found at the end of the guide.

WHAT SHOULD YOU LEARN OR TAKE AWAY FROM THIS TRAINING?

Childhood traumatic grief is a condition that children may develop after the death of a significant person under circumstances that have been traumatic for the child.

We are beginning to understand how to identify this condition. In childhood traumatic grief, a child has reactions and symptoms similar to those found in children with PTSD. These reactions make it difficult for the child to follow the usual path of bereavement and reminiscence about the deceased person in a positive and meaningful way.

There are promising treatments that have been shown to be most helpful for children with childhood traumatic grief. Treatment can be done with individuals and with groups of children of different ages, and it should address both trauma and grief symptoms. Treatment initially involves treating the trauma aspects of the condition and then moving on to help the child deal with bereavement issues and master specific tasks.

The intervention described in this program draws from a variety of existing approaches. The treatment includes teaching the child skills for managing stress, helping the child to create a story about the death, and finally supporting the child while engaging in specific activities related to bereavement. The goal of the treatment is to enable the child to remember and cope with previously troubling thoughts and feelings about the death and go on to have more positive and comforting memories about the person.

OVERVIEW OF CHILDHOOD TRAUMATIC GRIEF

WHAT IS CHILDHOOD TRAUMATIC GRIEF?



CASE
EXAMPLE

After being broadsided, the car was spinning out of control. When it stopped, eight-year-old Devon, who was buckled up in the back seat and pinned in the car, yelled for his mother to wake up. He heard the sirens, then watched the paramedics drag his mother onto the street and saw blood running down her face. Later, whenever he rode in a car, he refused to put on his seat belt because he wanted to get out as fast as possible in case of an accident.



CASE
EXAMPLE

Twelve-year-old Anna's brother drowned in the neighbor's pool. She had a fight with him right before he left, teasing the five-year-old about not being able to swim. Later she frequently had nightmares in which she couldn't breathe, so she stayed up most of the night. In school, she was exhausted, sleepy, and couldn't concentrate. Her grades plummeted, but she said she didn't care and deserved whatever punishment she got.

Childhood traumatic grief is a condition in which children who lose loved ones under very unexpected, frightening, terrifying, traumatic circumstances develop symptoms of posttraumatic stress and other trauma symptoms that interfere with their ability to progress through typical grief tasks, because they are stuck on the traumatic aspects of the death. —Judith Cohen



DEFINITION

Childhood traumatic grief can develop following the death of a significant person when the death has been perceived by the child as traumatic. The hallmarks of the condition are reactions related to (1) trauma, a situation that is sudden and terrifying and that results in death and may have also been life threatening for the child, and (2) grief, feelings of intense sadness and distress from missing the person who died and the changes that have resulted. The distinguishing feature of childhood traumatic grief is that trauma symptoms interfere with the child's ability to navigate the typical bereavement process. In other words, a child's preoccupation and inability to relinquish a focus on death leaves little or no room for other more helpful thoughts about the person who died, leaves little emotional energy for adjusting to change, and compromises the child's ability to function in school or with friends. According to our current understanding, childhood traumatic grief is distinct from uncomplicated bereavement and conditions such as PTSD, yet it shares features of both. The definition, characteristics, and assessment of childhood traumatic grief are still evolving and likely vary due to such things as the type of death, age and cognitive ability of the child, culture and beliefs, and family situation.



MAIN
CONCEPT

The child's perception, not just the cause of death, plays a key role in determining the development of symptoms. Not every child develops traumatic grief after a death that happened in a particularly dramatic or threatening manner, such as death from a homicide, war, or motor vehicle accident. In some cases, childhood traumatic grief can result from a death that most would consider expected or normal, such as death from illness or natural causes. There may be isolated traumatic moments that can be lodged in the child's memory, such as seeing a parent in profuse pain, that provoke the child's reaction. Childhood traumatic grief can affect children's development, relationships, achievement, and later effectiveness in life if not treated or otherwise resolved.

Children lose their developmental momentum that they had been pursuing. They need support to regain that developmental momentum, and without the support it often happens that children really stop gaining these skills that are appropriate for their age, and that has long-term repercussions. —Alicia Lieberman

The traumatic aspects of the death and the child's relationship to the person that died are entwined in such a way that thoughts or reminders of the trauma and overwhelming painful grief about the person who died are linked together. The child's traumatic reaction can stem from the sudden and horrific nature of the death with or without the child's life also being in danger. The grief reaction stems from the sadness of missing the person and all that has changed. The child contends with the complex mix of trauma and grief. Hence, in providing treatment the clinician must address both.



CASE
EXAMPLE

A child survivor of a car crash in which her mother was killed may be confronted with reminders of the smell of rubber and gasoline, the fear of being trapped in the car, the sight of blood and a mother's lifeless body, and a caretaker whose absence is felt every waking moment.

CULTURAL AND INDIVIDUAL VARIATIONS

Communication, expression and behavior following trauma and death can vary according to one's race, ethnicity, culture, and religion. It is important to be fully aware of these variations in order to accurately identify those reactions outside the norm of what is accepted and that prevent the child from participating fully in productive activities. For example, intense displays of emotion may be more common in some cultures than in others, and spiritual beliefs about an afterlife may influence a child's reactions and expressions. In some cultures it may be common practice to refrain from using the name of the deceased for a certain period of time, hence, what may be interpreted as avoidance in one setting is respectful and necessary in another. Either through naturally occurring common practices or due to unfortunate war or devastation,

children in different countries may also have more or less exposure to death throughout their life, which can influence their response. Regarding intervention, you must be sensitive to instances when certain treatment principles may be contrary to what is accepted practice in the child's particular family. For those times when a practitioner is unfamiliar with a family's practices and beliefs it is essential to seek consultation or consider additional referral.

OVERLAP OF CHILDHOOD TRAUMATIC GRIEF, POSTTRAUMATIC STRESS DISORDER, AND TRAUMA REACTIONS

The typical traumatic stress symptoms that children might experience with childhood traumatic grief include things like intrusive thoughts or recurring images associated with the death of their loved one. It could be the child becoming very constricted emotionally, becoming numb as a way of not dealing with all the pain associated with the tragic circumstances of their loved ones death. The child who has childhood traumatic grief doesn't have to have all those symptoms, just some of them. —Anthony Mannarino

There is overlap in the reactions and symptoms of uncomplicated bereavement, PTSD, and childhood traumatic grief. Children may show different signs of childhood traumatic grief at different ages. However, difficulties specific to childhood traumatic grief that can occur across developmental stages include those listed below. Although the following reactions and symptoms are consistent with characteristics of PTSD, they are notable as indicators of childhood traumatic grief because of the direct reference to the traumatic death. A helpful way of understanding the following reactions is to view them as indicating a child's distress, communicating to others that the child is not letting go of thoughts, feelings, and behaviors related to the images, details, circumstances, and actions surrounding the death.

- ***Intrusive memories and preoccupations about things that happened before, during, and after the death:*** These can appear through nightmares, guilt, or self-blame about how the person died, or recurrent or intrusive thoughts about the horrifying manner of death. Thoughts may also focus on wished-for protective or rescue interventions, such as regret for not doing something that would have changed the outcome.



CASE
EXAMPLE

A seven-year-old boy keeps thinking he should have done CPR to save the life of his three-year-old sister who was caught in the crossfire of a drive-by shooting.

- **Avoidance and a fear of strong feelings:** This can be expressed by withdrawal or by the child avoiding reminders of the person, the way the person died, or the event that led to the death. In attempting to keep strong unpleasant feelings related to the death at bay, the child may also try to dampen all feelings, which results in what adults would understand as “numbing.”



A 14-year-old girl could not go to any fast-food restaurant after her father was accidentally shot to death in one while they were getting milkshakes.

- **Physical or emotional symptoms of increased arousal:** These can include irritability, anger, trouble sleeping, decreased concentration, a drop in grades, stomachaches, headaches, increased vigilance, and fears about safety for oneself or others. The reaction can generalize and occur in a context that resembles, but is different than, the original situation.



A four-year-old girl started crying and screaming “stop shooting my mommy” when she heard the fireworks at the park on the Fourth of July.

- **Re-enactment:** In re-enacting aspects of the events that are perceived to have led to the death, there is an attempt to intervene, manage feelings of helplessness, and undo what has been done and identify ways to prevent the tragedy and death.



A six-year-old bereaved survivor of a motor vehicle crash repeatedly drew and cut out replicas of the car and steering wheel. He built an oversized speedometer so the driver of the other car would notice he was driving too fast. The boy went on to make a car with extra protection that was strong enough to withstand any crash.

HOW IS CHILDHOOD TRAUMATIC GRIEF RELATED TO OTHER TRAUMA REACTIONS?

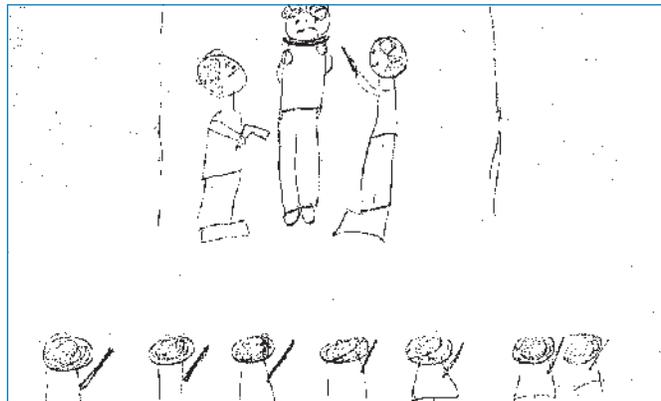
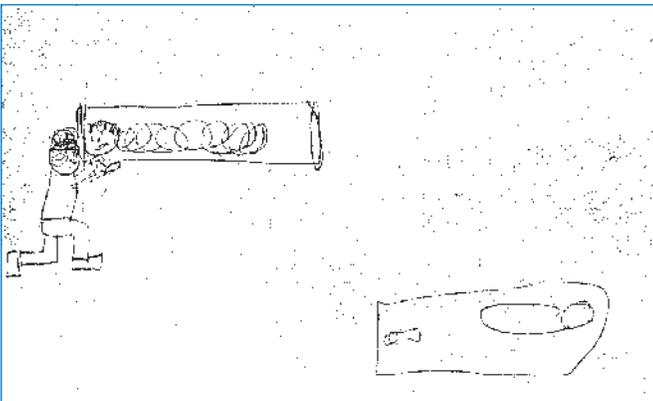


Traumatic events can involve an actual death, other loss, serious injury, or threat to the child’s own life or well-being. These events could include natural or man-made disasters, violence, war, or accidents. A child may be traumatized by direct exposure, witnessing the event, or hearing about another person’s experience. For some children, the response can have a profound effect on how they view themselves and the world. They may develop changes in their behavior (externalizing problems) or emotional functioning (internalizing problems). Left untreated, the severe trauma-related reactions can lead to more serious and chronic difficulties and, in some cases, coalesce into PTSD. PTSD is diagnosed when the child has specific symptoms that continue for a month or more following exposure to a traumatic event. The symptoms fall into the three categories of **re-experiencing**, **hyperarousal**, and **avoidance**.

When children with childhood traumatic grief show reactions and symptoms characteristic of PTSD, the reactions and symptoms are directly related to the death and interfere with the child's day-to-day functioning and bereavement work. Children may present with other symptoms not necessarily associated with PTSD but related to bereavement and traumatic death. These may include guilt, yearning, anger, and rescue and revenge fantasies.



Eleven-year-old Lisa witnessed her mother's murder. In an interview with a therapist five days after her mom was fatally shot and stabbed by her estranged boyfriend, Lisa revealed her feelings about revenge when describing a dream: "In my dream I had the same knife he used to stab my mother and the same gun that he shot her with. Then I went up to him and said 'Do you remember this, now you can feel it' And I stabbed him right where he stabbed my mother. Then I said, 'I guess you remember this too,' and then I shot him."



Lisa's Drawings

It was hard for Lisa to talk about her mother, who she dearly loved, without feeling as if she was back in that room. In the days and weeks after the murder, when she had that feeling, she would focus on her mother being killed. But as she stood at the door, frozen in place, one suspects she worried about herself as well as about her mother being killed.



In childhood traumatic grief, the interaction of traumatic and grief symptoms is such that any thoughts or reminders, even happy ones, about the person who died can lead to frightening thoughts, images, or memories of how the person died.



Kevin, the 17-year-old brother of 15-year-old Briana, was killed in an avalanche. His body was never found. She was haunted by feelings of guilt for not demanding he stay at the lodge. She was so distraught that she isolated herself from friends. On further questioning, it became clear that Briana and Kevin had many of the same friends. So when Briana was with them, she was reminded of the good times they used to have together. But this quickly led to her thinking about Kevin suffocating and it being her fault.

Three types of reminders may trigger unpleasant and distressing reactions:

- 1. Trauma reminders:** places, situations, people, sights, smells, or sounds reminiscent of things associated with the actual death. These may include the street corner where a fatal accident occurred, the bedroom where a parent died, or the sound of an airplane reminding a child of a mother who died in a crash.
- 2. Loss reminders:** people, places, objects, situations, thoughts, or memories that are reminders of particular aspects of the person who died — for example, photo albums, an empty chair at the dinner table, or a new coach who has replaced a parent who previously headed a child’s sports team.
- 3. Change reminders:** situations, people, places, or things reminding the child of changes in his or her life resulting from the death — for example, moving to a new house or having to walk home with a babysitter rather than an older sibling who died.

Reminders can certainly provoke sadness or thoughts about the deceased. However, in childhood traumatic grief, these reminders may lead to the child re-experiencing the traumatic events that led to the death. The terror associated with these memories results in increased arousal symptoms. The child then attempts to handle the distressing re-experiencing and symptoms with avoidance or numbing, often characterized as a deadening of emotions in older children and a fear of feelings in younger children. Because traumatic aspects of the death are so upsetting, the child tries to avoid all reminders of the trauma, loss, or resulting changes so as not to stir up unpleasant thoughts or feelings.

For example, a younger child may be afraid to sleep alone at night because of nightmares about a tragic shooting, whereas an older child may avoid flying in a plane because it brings up painful memories about a father who died in a plane crash. One of the most common reminders of the trauma, loss, and change is the person’s own family. Looking across at each other, knowing each has experienced the same death even if having individual reactions, can be upsetting.



HOW DOES CHILDHOOD TRAUMATIC GRIEF DIFFER FROM UNCOMPLICATED GRIEF?

Any death can be difficult for a child, and certain reactions are more likely than others. *Uncomplicated bereavement* is the intense sadness and longing for the deceased that children typically feel after the loss of a loved one. *Complicated bereavement* has been described in adults as bereavement complicated by separation distress and traumatic symptoms related to the loss of the security-enhancing relationship with the deceased. This has not been clearly defined as a condition for children.

Uncomplicated or typical grief reactions in children vary according to age, developmental level, previous life experiences, culture, beliefs, emotional health prior to the death, and the family and social environment. Over time, a child is relieved of extreme sadness and is able to engage in accepted mourning rituals, and, when appropriate, remember good times and have positive feelings about the person who died. However, while grieving, a child typically may have:

- **Emotional reactions:** feeling sad, angry, anxious, numb, lonely, guilty, powerless, shamed, insecure, and remorseful.
- **Changes in behavior:** lack of interest and participation in usual activities, diminished self-care, unpredictable or odd behavior, angry or aggressive behaviors, increased risk taking, irritability and conflict with others, impulsivity, regression to earlier behaviors, changes in sleep behaviors (increased or decreased), difficulty sleeping or sleeping alone, changes in appetite (increase or decrease in weight), and changes in physical health.
- **Difficulty with interpersonal interactions:** withdrawal, social isolation, peer difficulties, clinging, irritability, difficulty sharing memories, difficulty participating in group or athletic activities, and general lack of interest in others.
- **Changes in thinking:** constant thoughts and memories about the loved one, persistent thoughts about the death, disbelief about the death and the finality of the death, constant or intrusive thoughts about death, preoccupation with one's own or a loved one's physical health and safety, difficulty making decisions, confusion, impaired memory and concentration, lowered self-esteem and self-confidence, disillusionment, thinking that the death was one's fault, and survivor guilt.
- **Altered perceptions:** believing the deceased is still present, feeling the person's presence nearby, seeing the person's face in a crowd, smelling the person's perfume, hearing the person's voice, and experiencing vivid dreams about the person.
- **Physical reactions:** susceptibility to illness, loss of energy, fatigue, difficulty or changes in eating, physical complaints, and changes in physiological arousal (for example, increased heart rate, respiration, and startle response).
- **Changes in academic functioning:** poor school performance, difficulty studying or concentrating, and potential school failure.

In nontraumatic bereavement, kids may be sad, or upset, or feel lonely, but they are able to continue on with activities and eventually maybe enjoy life again and be re-engaged with people and situations. The child with traumatic grief is kind of stuck, so a child may not want to be around a cousin who is the same age as a sister who died because it's too upsetting, or a boy may not want to play baseball anymore because he can't bear the thought of looking in the stands and his father not being there, and he falls apart. So these things segue into the awful reminders, and the child then avoids every reminder, even a positive one. —Robin Goodman



Throughout their lives, children continue to adjust to the loss and develop new ways of coping. Over time, it is helpful for children to relate to their loss by engaging in, and mastering, certain bereavement tasks. The following chart presents the outcome of common bereavement tasks and how childhood traumatic grief interferes with completion of these tasks.

Completion of Bereavement Tasks for Children with Uncomplicated Grief and Indicators of Difficulty for Children with Childhood Traumatic Grief	
<i>In uncomplicated bereavement typically children will:</i>	<i>Childhood traumatic grief interferes with bereavement due to:</i>
Accept the reality and permanence of death	Difficulty with accepting or unwillingness to accept that the person has died due to associations of the death with the traumatic circumstance
Experience and cope with difficult emotional reactions	Intense, distressing feelings that are triggered by reminders leading to avoidance or lack of feelings
Adjust to changes in their lives and changes in their identity that result from the death	Changes that lead to unpleasant reminders of the way the person died, possible overidentification with the person who died, feeling overly responsible
Develop new relationships or deepen existing ones	Feelings such as guilt, anger, and revenge interfering with the formation of new relationships

<i>In uncomplicated bereavement typically children will:</i>	<i>Childhood traumatic grief interferes with bereavement due to:</i>
Maintain a continuing, healthy attachment to the deceased person through remembrance activities	Difficulty or avoidance of positive memories because they are linked to horrible images and upsetting thoughts and feelings
Find some meaning in the death and learn about life or oneself	Inability or resistance to moving past the terrifying, unpleasant aspects of the death, negative feelings about self related to the death or person
Continue through the normal developmental stages	Emotional reactions and resulting behavior, e.g., withdrawal, anger, and distrust, interfering with the ability to engage in positive, age-appropriate activities and relationships



In uncomplicated bereavement, children may feel sad when remembering the deceased person but are generally able to have positive memories of the person and continue with necessary life activities. It is important to keep in mind that bereaved children are at risk for other types of mental health problems such as depression, anxiety, and substance abuse either alone or in conjunction with childhood traumatic grief. In childhood traumatic grief specifically, the terrifying and frightening aspects of the death are so prominent that they get in the way of adjusting to life in ways that are deemed helpful for the bereaved. Because positive memories of the person who died lead directly to frightening reminders of the death, without help, the child never reaches the point of finding comfort in memories, calling up better times, or participating in what are culturally customary mourning practices. The child may also have been unable to participate or benefit from various rituals used to ease grief, for example, avoiding a funeral or being unable to cry for many months. In childhood traumatic grief, the traumatic reactions make it difficult for the child to

- reminisce or enjoy positive memories of the deceased person when that is deemed comforting in the child’s culture,
- cope with the many life changes that occur as a result of the death, and
- continue with normal development in ways that are expected and necessary.

WHO SUFFERS FROM CHILDHOOD TRAUMATIC GRIEF?



Children can develop childhood traumatic grief when they experience the death of a significant person, such as a parent, a sibling, or a close friend. Children of all ages, even a young preschooler, can have a traumatic reaction to a death, especially of a primary caregiver. It is estimated that five percent of all children in the United States experience the death of a parent before the age of 15, and children under the age of three are often present when a sibling or parent dies in a traumatic circumstance, making young children particularly vulnerable and in need of attention.

However, not all children who have experienced a death develop childhood traumatic grief. In fact, many recover and do well over time. Although it is true that the majority of children who experience a death do not develop childhood traumatic grief, the number of children who do struggle with childhood traumatic grief is quite significant. For example, up to 70 percent of children in inner city communities have seen someone shot or stabbed. Even if only five percent of these children develop childhood traumatic grief, this translates into thousands of children developing this condition each year. Although all children witnessing a homicide are likely affected in some way, some are better able to tolerate the experience, whereas others are deeply impacted and cannot continue on as well as before the death.

HOW IS CHILDHOOD TRAUMATIC GRIEF RECOGNIZED?



Children's symptoms and presentation may vary according to factors related to their age, stage of development, culture, religious beliefs, social supports, and family functioning. However, the most common signs of childhood traumatic grief that can occur across the different developmental stages include **intrusive memories** (e.g., nightmares) and **increased arousal** (e.g., irritability or difficulty sleeping), both of which can lead to **avoidance and numbing** to manage the distress. Not all children will meet criteria for a diagnosis of PTSD. A child may have other difficulties more typically seen following an uncomplicated death, such as depression or anxiety.



Children may exhibit problems at home, in school, or with friends that are not readily understood as related to the death or usual trauma-related symptoms. For example, avoidance may be recognized by its consequences, such as poor concentration and failing grades, resistance to engaging in previously enjoyed activities, or refusal to participate in events or activities related to remembering the person who died. The point in a child's life at which the death occurred is a factor in adjustment. Children's reactions to trauma and death can have a varied impact on their later

development. For example, when a toddler experiences the death of a parent, attachment behaviors may be affected, and a death that occurs in adolescence may impact a teen's later interpersonal relationships.

A child may present with symptoms not readily appreciated as indicating childhood traumatic grief. For example, a pediatrician may see a child for recurrent stomachaches or poor compliance with management of a chronic illness. The relationship between the physical symptoms and the avoidance of childhood traumatic grief reminders may become apparent upon further inquiry. As another example, a bereavement counselor may find that the intensity of a child's anger has not remitted over time and has interfered with the child's ability to work through his or her grief-related feelings.

Symptoms of childhood traumatic grief may become apparent in the first months after a death. However, childhood traumatic grief can also be unrecognized or not apparent until many years later, when a traumatic or stressful time triggers childhood traumatic grief symptoms. Because childhood traumatic grief reactions can interfere with ongoing development, problems may arise at significant stages of life. A mother's remarriage, a decade after a father's death, may trigger memories of the car crash that killed the father and result in intense, upset feelings, distress, and avoidance of activities related to the marriage. A missed opportunity to visit a grandparent who dies of natural causes may stimulate an intense longing and guilt over a sibling who committed suicide.

Childhood traumatic grief can pose developmental challenges. Children who idealize a parent who died may adhere to unrealistic expectations of others in future intimate relationships. Similarly, when a significant person dies during a stormy phase of a relationship, the conflicted feelings and guilt can infuse later relationships. A child's ability to fully understand death, coupled with a shocking death, can lead to inaccurate beliefs and fear.



When Jamal was seven, he was with his 39-year-old father, who died suddenly of a heart attack. At 16, Jamal had an anxiety attack when he had chest pain from bronchitis. He thought he was going to die.



MAIN
CONCEPT

Risk Factors for Childhood Traumatic Grief

Although it is not always possible to predict who will develop childhood traumatic grief, there are a number of factors that put children at greater risk for developing problems following a traumatic death. You should be alert to children who have experienced the following:

- **Previous traumas:** Children who have experienced a previous trauma (e.g., abuse or a natural disaster) can be more vulnerable to experiencing a more intense reaction to a new trauma or traumatic loss. The circumstances of the current death may cause the person to remember and react to a previous trauma, and dealing with both can make the current reactions more intense or severe.
- **Prior mental health problems:** Children with a history of mental health problems may be vulnerable to having those difficulties exacerbated by the traumatic death and the accompanying stress reactions. The prior mental health problems can also make it more difficult for a child to manage the current situation. Bereaved children are also at risk for depression and anxiety, hence it is important to thoroughly assess and differentiate a child's response.
- **Impaired functioning of parents and family:** The ability of children's primary caregivers to manage their own reactions to a traumatic death has a direct effect on how a child is able to cope with his or her own reactions. In a culture where memorialization is encouraged, a caregiver's avoidance of talking about the person who died can make the child reluctant to communicate about the death and hence interfere with the child's adjustment.
- **Poor/lack of social support:** If a child is feeling unsafe, abandoned, sad, and angry following a traumatic death, a good social support network can provide comfort and reassurance. It is more difficult to seek and engage in new supportive relationships than to find support in relationships already in place.
- **Secondary adversities:** The death of a significant person often results in many life changes. The changes that result from the death, such as remarriage, loss of health or employment benefits, and changes in financial circumstances, housing, or school can cause tremendous stress for the child and family. Other related activities, such as custody and criminal proceedings, also contribute to the child's stress reactions.



CASE
EXAMPLE

Jonathon lived with his single-parent mother. He did not get along well with his father and rarely saw him. After his mother died in a homicide, his father obtained custody and the boy moved to a new city. On top of witnessing his mother's death, he now had to deal with a new school, loss of his friends and church support, and the adjustment to living with a father he barely knew, a stepmother, and stepsiblings.

HOW IS CHILDHOOD TRAUMATIC GRIEF TREATED?

PRINCIPLES AND OVERVIEW OF TREATMENT

In childhood traumatic grief, difficulties stem from exposure to a death that was experienced as terrifying, and in some instances the child felt his own life was in danger, as well. The threatening and traumatic reaction interferes with, and impairs, the child's ability to cope with the death and engage in meaningful and necessary bereavement-related activities. When preoccupied and overwhelmed by trauma-related distress, the child avoids or is unable to enjoy positive memories, develop relationships, and fully participate in life. Due to this complex interaction of trauma reactions and symptoms of usual bereavement, it is necessary to treat both the trauma and grief responses in a sequential fashion.

Sometimes when we talk to parents, they are resistant to the idea of children recounting the details of the trauma. In fact sometimes, quite honestly, therapists are resistant to having children recount the details of the trauma. The primary reason for that is that parents and therapists alike don't want children to be exposed to more pain and more difficulty. Parents often feel "my child has been through enough and if we put them through more, it's just going to be too much." Kids might experience some pain associated with detailing what happened to their loved one, but if they experience a little pain and anxiety associated with doing that now, that is going to save the child from a deeper, more disturbing problem later on because it wasn't addressed when it could have been. —Anthony Mannarino

WHAT ARE THE KEY COMPONENTS OF CHILDHOOD TRAUMATIC GRIEF TREATMENT?



The treatment described in detail here is for use with individual school-aged children. Initially the focus of treatment is on the traumatic nature of the death. The child first learns ways to cope with the frightening thoughts, images, feelings, and arousal associated with the traumatic experience. It is crucial to carry out the components of childhood traumatic grief treatment in a progressive fashion in order to help the child learn and build skills enhancing self-efficacy. Once the traumatic aspects recede, the practitioner is better able to help the child integrate what was learned with a less trauma-focused world view and help the child actively engage in remembering the person who died. The child is then also better able look at the current and enduring aspects of bereavement.



CASE
EXAMPLE

Fifteen-year-old Thomas was home watching television when his father jumped to his death outside their apartment window. The family was unaware that he had stopped taking his medication for his schizophrenia. Thomas was afraid to go to sleep at night due to the recurring images he saw of his father on the ground. During the day, he was feeling the urge to jump out the window himself. He learned ways to manage the impulses, talk about the suicide, and stop blaming himself for not making his father take his medication and saving him. When baseball tryouts came and went, he drew pictures about feeling lonely if he played without his father watching. Gradually he was able to think of how he could still feel encouraged by his father and enjoy going to games with the rest of his family.



MAIN
CONCEPT

Researchers and practitioners in the fields of trauma and bereavement have collaborated, piloting their work and sharing their experiences to develop the current childhood traumatic grief interventions. The childhood traumatic grief intervention components being described are based on the common practice of supportive bereavement counseling utilizing both directed activities and nondirected play interventions and cognitive behavioral therapy (CBT)–oriented treatment that has been



traditionally used to address problems related to trauma as well as anxiety and depression. Cognitive behavioral techniques have been adapted to teach skills to manage specific thoughts and behavioral distress reactions the child is having in situations that generate unhelpful and unpleasant feelings. Gradual exposure through creation of a story is based on the CBT technique that encourages the child to speak directly about the traumatic circumstances related to the death — what was heard, seen, and most troubling — and to develop helpful strategies, rather than avoidance, for dealing with traumatic memories. Once the child’s trauma-related reactions recede, the child can engage in activities enabling access to comforting memories and adjust to a life that is now different. Thus, following the sharing of

the child’s experience, treatment focuses on reconnecting the child to significant memories about the person who died, their relationship, and plans for the future.

INDIVIDUALIZED TREATMENT



MAIN
CONCEPT

Children and parents come to treatment with their own strengths, experiences, and expectations. Bereaved individuals may be in pain but should be supported to find and use the internal and external resources that have been most helpful at other times in their life. All treatment should be based on a strong, caring relationship, guided by the principle of collaboration between client and practitioner in a way that communicates a belief in the individual’s own abilities.



MAIN
CONCEPT

The treatment being described should not be followed in a cookbook fashion. You should be flexible and creative in adapting the techniques to fit a particular client in a particular treatment setting. Different strategies can be modified according to a child's and family's culture, beliefs, customs, preferences, and styles. There are a number of variations that can be used in teaching the various skills, and you should adapt them to the child's age and preference. For example, play rather than direct discussion may be more appropriate when working with young children, and anticipation of future mourning rituals should be integrated into the work. Clinical judgment and expertise should determine the overall format, structure, and pace of treatment for specific childhood traumatic grief issues and any other mental health problems.

Although the training video focuses on treating children and their parents in an individual format, very similar treatment interventions have been utilized when working with groups and with older adolescents. For example, trauma- and grief-focused groups were used to help Bosnian youth recover from childhood traumatic grief following the war in their country. This group treatment was also piloted for children who developed childhood traumatic grief in response to urban violence in Los Angeles. Following the description of the components and activities used with individual school-age children, you will find guidelines for adapting the treatment for use with groups. Additionally, treatment guidelines have been developed for preschoolers whose parents have died; these focus on issues of attachment and safety. Introductory guidance when working with young children and groups is provided later in the curriculum.



RESOURCE

For further information and treatment manuals for work with toddlers, adolescents, and groups you are directed to the following resources:

- Lieberman, A. F., Compton, N. C., Van Horn, P. & Ghosh Ippen, C. (2003) *Losing a parent to death in the early years: Guidelines for the treatment of traumatic bereavement in infancy and early childhood*. Washington, DC: Zero to Three Press.
- Cohen et al. (2001) *Cognitive behavioral therapy for traumatic bereavement in children: Treatment manual*, available by contacting the National Resource Center for Child Traumatic Stress at (919) 682-1552 or nationalresourcecenter@duke.edu.
- Cohen et al. (2001) *Cognitive behavioral therapy for traumatic bereavement in children: Group treatment manual*, available by contacting the National Resource Center for Child Traumatic Stress at (919) 682-1552 or nationalresourcecenter@duke.edu.
- Saltzman, W. R., Layne, C. M., Pynoos, R. S. (2003) *Trauma/grief-focused intervention for adolescents*, available by contacting wsaltzman@sbcglobal.net.

WHAT ROLE DO PARENTS HAVE IN THE TREATMENT?

It is important to recognize the tremendous impact parents have on their child's development, behavior, and coping with both trauma and grief. Parents should be enlisted to help their children with traumatic grief. A parent's own reactions and



symptoms can interfere with the child's progress, hence the better the parent is doing the better the child will do.

Parents naturally wish to protect their children. However, parents do best when helped to be honest and open with their children and express their emotions appropriately. Children must be taught about particular practices for ritualizing the person or customs dictating how and when the deceased are honored. In most Western cultures, when a parent avoids or denies the death or

the child's difficulties, the children may conclude that being sad or remembering the person who died is not acceptable. The child may feel that memories are forbidden or feel the need to protect the parent, believing the parent will fall apart if the person who died is talked about.



At bedtime, three months after his father died, seven-year-old Ben asked his mother to read a book. It was one of his favorites that his father always used to read to him. Ben joined in, laughed, and imitated the different characters as his father had done many times. Although a pleasant reminder for Ben, Mom struggled to finish and quietly cried for hours once alone in her own bed.



It is crucial to include parents in the childhood traumatic grief treatment. When working with young children, treatment with the parent focuses on enhancing the parent-child attachment in addition to supporting and encouraging positive parenting and the parent's processing of her own traumatic grief reactions. With children school-age and older, the objective in working with parents is to

- understand the specific family and cultural beliefs,
- inform them about expected adult and child reactions and course of bereavement,
- help them process their own trauma and grief reactions,
- maintain good parenting practices while bereaved,
- learn ways to help the child with his or her trauma and grief reactions, and
- help the child continue with developmentally appropriate tasks.



CASE
EXAMPLE

Twelve-year-old Anna survived an earthquake that killed several of her family members, including her mother and grandmother. She appeared detached, with a fixed and incongruous smile. Anna began to talk about her earthquake experiences. On the day of the earthquake, her grandmother had come to their house to help her mother bake a cake for Anna's birthday. Suddenly "the earth shook" and the house collapsed on top of them. Anna and her grandmother held on to each other under the collapsed building for two days. She remembered her grandmother's constant prayers to God to save her grandchild. In recounting this, Anna said, "God, why didn't you take me away with them? Is it because I am not good enough? You made me live and suffer and remember everything. God, I love my mother even though I was teasing her when the earthquake happened, telling her that I loved grandmother more than her." She had difficulty falling asleep, nightmares about the earthquake, recurrent stomachaches, and difficulty paying attention in class. She was ambivalent about her father's plan to remarry and saw herself as an obstacle to his finding a new wife. She confided in the therapist that she felt obliged to keep smiling for the benefit of her father.



HANDOUT

Information for Parents on Childhood Traumatic Grief can be found in the Appendices on page 72.

Parents and children may have had different levels of exposure to the circumstances of the death and have experienced different levels of danger. Parents and children might not both have been present at the scene of the death, they may have heard or seen different details on the news, and may have learned of the death through different means. They will also likely have had different relationships with the person who died (e.g., spouse, sibling, or parent). Therefore their reactions and progress through treatment can be different. There are times when parents' reactions and symptoms warrant different or more intensive individual treatment. Parents should be referred for additional treatment either as an adjunct to the childhood traumatic grief parent-child treatment being described here or once the parent-child treatment is completed.

It's very important to understand the specific religious beliefs, culture, and customs that families use in dealing with bereavement, because these may be very important when you hear about the stories of what happened before or after the death, because you want to make sure that your own specific beliefs or ideas are not imposed on the child and the family. —Robin Goodman



For both the trauma- and bereavement-focused work, it is essential to be aware of, and sensitive to, the family's personal and cultural beliefs and practices. This is helpful for integrating personal beliefs into the treatment, knowing the origin and accuracy of a child's beliefs, and planning for current and future bereavement-related rituals and events. Certain topics or explanations for events may be common practice in a particular culture, advocated by a family, and accepted by a particular child. Thus there should be normalization for what is typical in a given cultural setting.

STRUCTURE OF TREATMENT

The training video and the following sections in the printed guide outline the general structure, format, and treatment components of childhood traumatic grief treatment as it is conducted with individual children school-age and older. This treatment has typically been provided in 12-to-16 sessions each for the child and parent, with joint sessions held at appropriate times. However, the length of time for the childhood traumatic grief intervention can vary with the age of the child, severity of the problem, and type of setting, thus requiring additional sessions. The individual treatment is structured according to the following guidelines:

- The child and parent are seen individually in their own sessions to allow for freedom of expression. The work done in the child and parent sessions is complementary. Having the parent in companion treatment allows the parent to facilitate training and reinforcement of the child's newly learned skills, promote understanding of issues, and increase communication between the child and the parent. The child is engaged in specific skill-building, trauma, and memorializing activities. The caregiver may be taught the same skills as the child, taught how to help the child with new skills, and taught how to manage problem behavior.
- At specified times, joint caregiver and child sessions are conducted. Following careful preliminary planning, the child and caregiver engage in a shared activity related to the story of the death and remembering the person who died.
- In most situations it is suggested that the same therapist treat the child and parent. In certain situations it may be preferable to have different therapists for the child(ren) and parent(s) — for example, when there are different levels of exposure and intensity in the reactions, or when a parent is hesitant to bring up personally significant issues to a therapist who is also treating the child. Regardless of the number of therapists involved in the treatment, the case should be conceptualized as a family case rather than as separate child and adult cases. The individual child and parent sessions can be held consecutively on the same or different days. When there is more than one child in treatment, the same therapist works with each child in his own session but conducts only one parent session where issues for all children are discussed. Children can start treatment at the same time or the most symptomatic child may begin first.

WHAT ARE THE KEY COMPONENTS OF CHILDHOOD TRAUMATIC GRIEF TREATMENT?

TREATMENT SEQUENCE

In doing the treatment, we often start with educating the child about the kind of treatment and the reasons it's important to focus on the trauma. So the first job is to really help children feel more in control of those upsetting reactions, and you do that by teaching them ways to manage their stress. —Robin Goodman

The following trauma- and grief-focused treatment components represent techniques that NCTSN professionals have found to be most effective in helping children overcome their trauma and grief reactions and symptoms. The intervention is based on a particular sequence; it is important to address trauma-focused issues first before moving on to grief-focused issues. When working on the trauma issues, keep in mind it may be necessary to address details of the death as well as a child's sense of his life being in danger prior to moving on to grief issues. The content and activities are being presented as they would be used in individual treatment with the child, with the parent, and in joint sessions.

Summary of Treatment Component Sequence and Goals	
<i>Trauma-Focused Phase Components</i>	<i>Goals</i>
1. Psychoeducation	Will acquire knowledge about trauma and understand the cause of personal trauma reactions
2. Affect expression	Will be able to recognize and identify a variety of feelings
3. Stress management skills	Will have a repertoire of portable relaxation and cognitive skills to use when feeling distress related to the traumatic death
4. Cognitive affect regulation	Will understand the relationship of thoughts, feelings, and behaviors and have ways to manage affect and automatic reactions

Trauma-Focused Phase Components	Goals
5. Trauma narrative	Will be able to tell the story of the traumatic death experience and gradually tolerate the more difficult, most distressing elements
6. Cognitive processing	Will be able to recognize and correct thoughts and beliefs that are not helpful and inaccurate
Grief-Focused Phase Components	Goals
7. Communicating about death	Will understand, and be able to talk about, death in an age-appropriate manner
8. Mourning the loss	Will recognize and communicate the things that are no longer the same and what will be missed about the person.
9. Addressing ambivalent feelings about the deceased	Will acknowledge, communicate, and accept any ambivalent feelings about the deceased
10. Preserving positive memories	Will acknowledge and engage in an activity that focuses on positive memories, and when necessary participate in a memorial ritual
11. Redefining the relationship	Will be able to differentiate between activities done with the deceased and aspects of the relationship that can be committed to memory
12. Committing to new relationships	Will be able to engage in new relationships, understanding that they are different but necessary
13. Making meaning	Will find some meaning in the experience through self-learning and/or activity aimed at using the experience in a positive way
14. Evolution of grief and termination	Will understand the ongoing and changing nature of grief; will be aware of and plan for future times that are potentially difficult

TREATMENT
COMPONENT

1. PSYCHOEDUCATION

The trauma-focused portion of treatment begins with psychoeducation about trauma and the trauma response. Educating the child and parent about the common reactions to trauma and their causes provides a useful language and background for understanding what they are experiencing. It can also be a relief to have words to describe such confusing and distressing reactions.



CHILD

Childhood traumatic grief reactions and symptoms can be very disturbing, feel unlike anything else, and leave the child feeling quite different than before and different from others. Therefore, when providing education to children it can be useful to reassure them that they are not “going crazy.” Many children will experience significant relief just from having an “expert” explain that there is a rational reason for their difficulties, that their symptoms are a “normal response to an abnormal event” or “understandable if you thought your life was in danger.” You can also explain that when something very frightening happens, our brains remember things in different ways than they do for ordinary events, and these memories keep getting played back to us like replaying a video over and over again.



CHILD

It may be helpful to provide children and parents with explanations for the various symptoms associated with childhood traumatic grief. **Re-experiencing** symptoms can be described as the mind’s continued efforts to make sense of what happened or achieve a different outcome. **Avoidance** can be described as something we do



PARENT

automatically in an effort to avoid the emotional pain associated with the trauma; the mental equivalent of jerking your hand away from a hot stove. When feeling threatened, an aroused state is understandable. Even though the original danger is no longer present, later **hyperarousal** symptoms can be explained as the person’s body and mind going “overboard” in making efforts to avoid any further potential danger. Although adaptive in some situations, such reactions can become problematic when they start to interfere with the child’s everyday functioning. It is also important to identify specific people, places, or things that remind the child of the trauma, as they are likely to elicit or exacerbate symptoms.



PARENT

It is important that parents understand that children who experience a traumatic event often experience a significant increase in behavioral difficulties. One useful way for explaining this issue is the idea of shaking up a beehive. Honeybees are typically docile, but if someone shakes up their beehive they are likely to sting anything that gets in their way. A traumatic event can “shake up” a child’s world in a similar manner resulting in more active and aggressive behavior.



HANDOUT

Information for Parents on Childhood Traumatic Grief can be found in the Appendices on page 72.

TREATMENT
COMPONENT

2. AFFECT EXPRESSION



CHILD

Helping children with affect expression is an important next step in the treatment. The goal is to have children identify or label a variety of feelings, pleasant ones as well as those that make them uncomfortable or that they perceive to be bad. It is important to explain that children should pay attention to their feelings and that feelings are not good or bad. Certain feelings are more likely associated with the



trauma (e.g., helplessness), others to bereavement (e.g., sadness), and others to everyday activities (e.g., annoyed). It is important for children to know the difference between feelings and behaviors. All feelings are okay (e.g., feeling angry), but some behaviors (e.g., aggressive behaviors) are not acceptable.



ACTIVITY

There are a number of therapeutic games and creative activities that can be used to help children with this component. Children can add facial expression to an outline of a face, decorate two sides of a mask to show outside feelings visible to others and more private inside feelings, or pick songs that portray different emotions. There are various games that also can be purchased that focus on feelings identification. Once identified, it is important to also discuss what situations accompany and cause different feelings and talk, draw, play, or act out ways of coping with different feelings. A handout of different feeling faces can be useful in helping children learn to identify various feelings.



RESOURCE

See the resource list at the end of the guide for suggested games for purchase.



HANDOUT

A **Feeling Faces** sheet can be found in the Appendices on page 57.



PARENT

In addition to learning about their own emotions, it is essential that parents understand the importance of the child being able to express his or her emotions. The goal is to engage parents as partners in helping the child and support their role as coaches for the child's newly learned skills. When unaware of the benefit of or meaning of a child's expression of emotion, the parent may unknowingly discourage or even punish the child. Parents should be accepting of the child's full range of emotions but maintain discipline if the child engages in inappropriate behaviors.

Parents may also need to be taught appropriate ways to express their own emotions. In particular, parents need to be coached to avoid exhibiting intense feelings of distress in front of the child. It may be appropriate to explore the parents' own feelings related to the traumatic death at this time and suggest ways to monitor and modulate their emotions and model appropriate expression (e.g., "It's sad that Dad isn't here to help make a snowman").



3. STRESS MANAGEMENT SKILLS

TREATMENT COMPONENT



CHILD



PARENT

Following feelings identification and regulation, it is important to teach stress-management skills. These skills are used as the child confronts previously avoided or uncomfortable thoughts and feelings experienced during and outside the sessions. Stress-management skills are used to help children and parents manage unpleasant physiological trauma reactions and symptoms, feel more in control, and cope effectively with traumatic reminders. It is important to help children identify ways they can soothe themselves when experiencing unpleasant or difficult feelings. Children are encouraged to think about things they use or do that already help them; for example, they can bring in CDs of songs that help them relax and feel happy, talk about sports, or dance to relieve stress.



ACTIVITY

Some specific relaxation techniques that can be taught include:

- **Focused “belly breathing”:** This involves teaching the child to focus on breathing rather than on anxiety symptoms. Children are taught to use diaphragmatic breathing, slowly inhaling through the nose and exhaling through the mouth to a count of three-to-five seconds. They can be helped by placing a cup or stuffed animal on their stomach and instructed to make it go up and down. Older children can imagine a balloon inside their stomach getting bigger and smaller with each breath.
- **Progressive muscle relaxation:** This involves alternating between tensing and relaxing muscle groups and focusing on the different sensations associated with tension and relaxation. Young children are often able to relax their bodies by pretending to be a “stiff piece of spaghetti” that becomes a “wet noodle” or a “tin soldier” who changes into a “Raggedy Ann doll.”



HANDOUT

Progressive Muscle Relaxation scripts can be found in the Appendices on page 58.



ACTIVITY

Imagery techniques: These can be thought of as “controlled daydreaming” in which the child is taught to intentionally recreate the mental image of a safe or relaxing place in their mind.



HANDOUT

A **Learning to Relax Through Imagery** script can be found in the Appendices on page 63.



ACTIVITY

Other stress-management strategies include thought-stopping techniques such as envisioning a stop sign. Alternatively, the child could first draw a picture of the two different scenes, one distressing and one that is pleasant. The child is then instructed to visualize them on separate TV channels and instructed to replace a traumatic thought with a more pleasant one by changing them on the imaginary TV. Older children may prefer other relaxation strategies such as listening to their favorite music.



ACTIVITY

The child can also be taught to use positive self-talk to combat negative thoughts that generate self-defeating or negative thoughts or unpleasant feelings. The following are examples of positive self-statements.

Negative: “I’m never going to be able to handle this.”

Positive: “I miss my mom, but I’m strong enough to deal with it.”

Negative: “Sometimes I was bad. Maybe that’s why Dad died.”

Positive: “I loved my dad. It’s not my fault that he died.”

Negative: “I’ll never be happy again.”

Positive: “A sad thing happened, but one day I’ll feel better.”



CHILD

These skills are generally taught to both the parent and the child in the clinician’s office, and the child is encouraged to practice them at home. The parent is instructed to assist the child in practicing the strategies. Parents may also personally benefit from using these strategies.



PARENT

It may be necessary to explain the rationale for these techniques, as children and parents may think they are simplistic or initially feel self-conscious. It may be useful to use the analogy of a life preserver. Relaxation techniques are like a life preserver; they help the child and parent to “stay afloat” until symptoms begin to diminish over the course of treatment. When someone who can’t swim falls into the water and is drowning, it’s not the right time to teach him how to swim. Instead, it is better to throw him a life preserver in order to keep him afloat until pulled out of the water.



TREATMENT COMPONENT

4. COGNITIVE AFFECT REGULATION

Improving a child’s ability to manage distressing affect is the focus of the next strategy. This is also referred to as **cognitive affect regulation**, the goal being for the child to use productive, age-appropriate responses to distress. The child is taught ways to express and cope with distressing emotions, for example, counting to 10 when angry, giving himself a “time out,” or doing some physical exercise when upset.



CHILD

In order to help parents and children manage affect more effectively, it can be helpful to explain the relationship among thoughts, feelings, and behaviors using the visual metaphor of a triangle, referred to as the **Cognitive Triangle**. The source of some distress may be the child's appraisal of danger, reactions to feeling threatened, and attempts to be safe. It is important to explain how situations trigger certain distressing and automatic thoughts, feelings, and behavior. This concept can be described in the following manner:



PARENT



ACTIVITY

"Today we are going to talk about thoughts, feelings, and behaviors. In particular, we're going to talk about how our thoughts can affect the way we feel and then how the way we think and feel can affect the way we behave. Thoughts are the things we say to ourselves in our own head where nobody else can hear them. When our



thoughts make us feel good, it can affect our behavior; we may want to smile or laugh. When our thoughts make us feel bad, it can affect our behavior too; we may want to cry, scream and shout, or hit somebody. It is helpful to understand how thoughts, feelings, and behaviors are related and especially important to figure out what thoughts make us feel bad and how to help ourselves. A lot of times, people can learn how to change what they think. They can choose to think about things more positively and do things that can make them feel better." (Paraphrased from Deblinger, D. & Heflin, A. H. (1996). *Treating sexually abused children and their nonoffending parents: A cognitive behavioral approach*. Thousand Oaks: SAGE Publications, Inc.)

their nonoffending parents: A cognitive behavioral approach. Thousand Oaks: SAGE Publications, Inc.)



HANDOUT

A **Cognitive Triangle** illustration can be found in the Appendices on page 64.



ACTIVITY

Metaphors and illustrations of children in different situations can be a helpful aid to the discussion. It is important to use examples to help children understand that changing one's *thoughts* can lead to *feeling* better and using more adaptive or productive *behavior*. The following examples can be helpful:

1. In the cafeteria, a table of girls ignores a girl, and she thinks, "They don't like me" (thought). This makes her feel hurt and lonely (feelings), and she cries in the bathroom (behavior). Alternatively she could say, "There are other girls who treat me better" (new thought). She is then confident and hopeful (new feelings) and goes to sit with the other table of girls (new behavior).



HANDOUT

Thinking, feeling, behaving **Cafeteria** illustration can be found in the Appendices on page 65.

2. A boy realizes he has a math test in three days and thinks, “I don’t know this stuff very well, I’m going to flunk” (thought), which makes him feel fidgety and hopeless (feelings), so he doesn’t study (behavior). If he replaces it with “I still have plenty of time to learn this and do well” (new thought), he will be optimistic and determined (new feeling) and study extra hard (new behavior).



HANDOUT

Thinking, feeling, behaving **Test** illustration can be found in the Appendices on page 66.

There are a variety of ways to introduce and teach these different skills and techniques, and they can be modified for children at different ages. Some or all of the techniques are also used according to the format of the treatment and the age of the child (individual/group, toddler/teen).

It is necessary to establish these skills in preparation for the next phase of treatment. Collectively, these first steps help children feel more confident about managing upsetting thoughts and feelings. Having learned coping strategies, the child will be less fearful of being overwhelmed or flooded by unpleasant emotions when creating the trauma narrative.



TREATMENT COMPONENT

5. TRAUMA NARRATIVE

Most therapists who treat children already use many of the techniques that have been presented. However, one part of this treatment may not be as familiar to some therapists, because it involves encouraging children to directly recall and discuss their most frightening memories. Learning which reminders are significant for the child allows the therapist to prepare the child for managing unpleasant times, places, and reactions. It is especially important to be mindful of any cultural taboos against such work.



DEFINITION

A trauma narrative is the re-creation or retracing of the child’s experience of someone’s traumatic death, told in their own words, pictures, and even songs. By creating the story, the child is carefully exposed to the traumatic elements of the death and gradually becomes able to tolerate the more painful and disturbing aspects of the experience. A child’s sharing of the trauma narrative with a parent increases their mutual support.

“The trauma narrative is typically developed gradually over several sessions. We will often start by having the child describe something about him or herself; this helps children feel more comfortable in telling their story or writing their book. Then we have the child focus on what life was like before the traumatic event that took the loved one away. As the child comes closer to talking about the traumatic loss through talking about less threatening aspects, he or she is more able to engage in the process of gradually talking about more and more upsetting aspects of the traumatic death itself.” —Judith Cohen

when Kelsey was being born, Lauren helped with everything. It was the same with this. We all went to Lanarus to pick out a dress for Kelsey to be buried in. It had sparklies + a bow. She would've loved it, I got one too.



A child with childhood traumatic grief typically avoids reminders of details associated with the death, because they cause overwhelming and upsetting thoughts and feelings. By confronting such feelings in a safe and controlled environment, while also using the stress-reducing strategies and coping skills previously learned, the child is better able to tolerate trauma-related thoughts and feelings about the death.

Children (and adults) are often resistant to the idea of creating a trauma narrative. It is typically distressing for people to remember traumatic events in detail. Therefore, it is often necessary to provide a rationale. Creating a trauma narrative can be compared to removing a splinter from your finger. The splinter likely hurts, but people resist taking the splinter out with a needle or tweezers because they think it will hurt too much. However, if the splinter is left in, the finger could become infected, the person could get sick, and it will be more difficult to treat. Therefore, it's better to remove the splinter as soon as possible, knowing that a small amount of pain early prevents more problems and promotes healing. Then it is discussed that creating a trauma narrative is like pulling out the splinter. Even though it is a little painful, it is the best way for the person to heal from his or her traumatic experience.

The trauma narrative should focus as much as possible on various sensory details (i.e., sights, sounds, smells, tastes, and tactile sensations) that the child associates with the traumatic death. It is important to expose the child to the details as he has remembered them, because they often serve as powerful reminders of the trauma and triggers for symptoms.



Building the trauma narrative takes time and should be done over a number of sessions. It should begin gradually with a conversation about less threatening details about the traumatic death and the person who died. When discussing the actual death the first time through, it may be helpful to focus on a factual account (e.g., who, what, when, where, how) of the traumatic event, without asking about the child's thoughts and feelings about the detail. When developing the factual account, it is not important that the narrative be perfectly accurate, but major discrepancies should be addressed.

After the factual account has been created, the clinician should then go back through the narrative with the client and ask questions about how the child felt, and what he was thinking about during certain aspects of the traumatic event. It is important to be careful to monitor the child's distress while creating the trauma narrative and help the child use the skills he learned prior to making the trauma narrative in order to handle any distress that occurs while making the narrative. The goal is to have the child's distress decrease over time, with continued exposure to the trauma narrative.



The child develops the trauma narrative jointly with the therapist through a series of carefully guided questions. The initial trauma narrative may be brief, but it provides anchor points that can be used in discussion to help the child elaborate on the details. There are a variety of ways a child can create a trauma narrative. In addition to writing, some children may prefer to document their story in other ways, such as by writing a play, composing a song, play acting, or making a video. The child can be guided to create the trauma narrative by engaging in a conversation or asking questions such as the following:

Background for the Trauma Narrative

- Tell me a bit about yourself and about school.
- What you like to do in your free time; do you have any favorite hobbies?
- What kinds of things did you and your dad do together?

Beginning the Trauma Narrative

- It would be helpful for me to hear what it was like the day your mom died.
- Do you remember anything specific about the weather that day?
- What is the first thing you remember about your mom's death?
- I would like to know more about what it was like when you first found out your dad had cancer.
- All stories have a beginning; how does the story about your grandma's death start?

Creating the Factual Account

- I wanted to hear what you saw from the backseat of the car.
- Who was in the car when the accident happened?
- What happened after he pulled out the gun?
- Was it nighttime when that happened?
- What did he say next?

Incorporating Sensory Detail

- What did your brother's hospital room look like?
- Could you smell the flowers at the funeral?
- What sort of sounds did you hear during the accident?

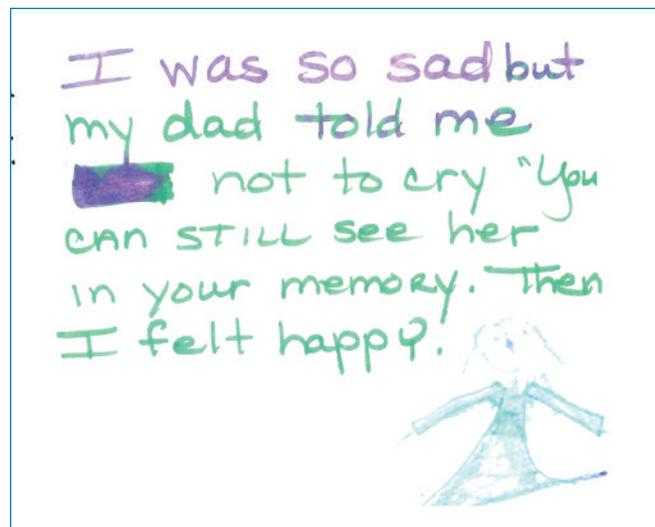
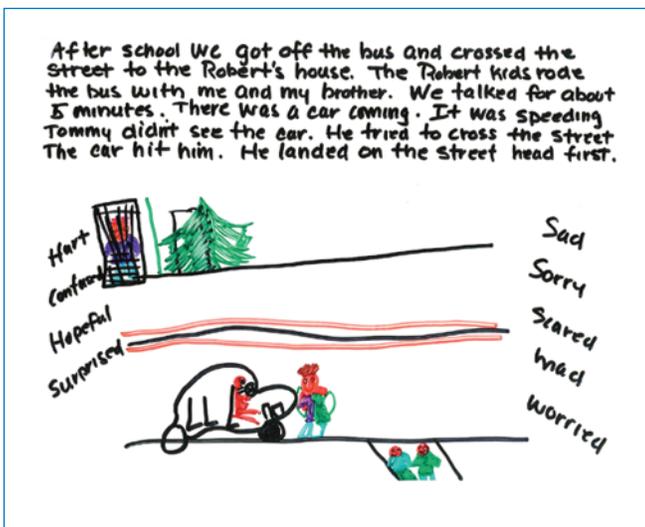
Incorporating the Child's Thoughts and Feelings

- What did you think when he told you to shut up?
- I would like to know more about what it felt like to be trapped under the tree.
- How did you feel when you found out he had cancer?
- What did you think when the guy with the gun told your grandma to lay down?
- Wow, I think that would have made a lot of people feel really scared. How did you feel?



RESOURCE

Sample excerpts from trauma narratives can be found in the Appendices on page 67.





CHILD

In addition to creating the trauma narrative with the child, the therapist talks to the child about sharing the trauma narrative with the parent. The child is told the importance of being able to communicate openly and honestly and share thoughts about the death and the deceased. The therapist will be reading the trauma narrative to the parent without the child at first, prior to their joint meeting. In addition, the therapist prepares the child for a joint session by talking about parts to focus on and obtaining any particular questions the child would like the parent to ask.



PARENT

The parent should be prepared for the joint session with the child in which the trauma narrative is presented. This provides an opportunity for the parent to appreciate the child's unique experience. While the child is creating the trauma narrative, the therapist shares what the child is creating as it is being developed. This allows the parent to respond in private to the trauma narrative and plan for an appropriate response in the presence of the child.

CHILD
PARENT
JOINT

Once completed by the child, ideally the trauma narrative is then shared with the parent, again according to carefully guided steps to prepare both child and parent for the details that will be presented and any possible emotions. Reading the story together and talking about it in a structured way helps the parent and child effectively communicate about the upsetting circumstances of the death.



ACTIVITY

Some of preliminary work that should be done before the joint session includes the following:

- Having the child practice reading the narrative aloud to the clinician.
- Discussing and addressing any concerns that the child may have about sharing the trauma narrative with her parents (e.g., “What if they get angry?”).
- Discussing and addressing any concerns that the parent may have about listening to the child's trauma narrative (e.g., “What if I get really upset?” “What do I say to her?”).
- Explaining, to the parents the rationale for having the child share the trauma narrative with them (e.g., “Your child looks to you for support, and you can be a role model for how to cope and talk about the death.”)
- Preparing parents to be supportive, attentive listeners.
- Gradually exposing the parents to aspects of the trauma narrative prior to having the child share it with them to help desensitize the parent to the content of the trauma narrative.
- Training the parent to talk about the death and the person who died, express appropriate emotions, and model effective coping when listening to the TN.

What was helpful to Hannah in treatment was the story that she got to tell about her grandmother's death. Because until then, I don't think she was able to express what she envisioned her grandmother's death was all about. She heard us discuss it, we discussed it with her in our terms, but I don't think she understood exactly, she wasn't able to express exactly what she thought, and the story gave her an opportunity to understand what grandmommy might have been looking like while she was dying in bed. Hannah had a vision in her head as to what this all looked like that no one else shared, so for her to be able to draw this and talk to somebody about this was very very helpful. I think it gave her more permission to remember her without feeling so much pain because one of her pictures was a great picture, at the end of the story where she's smiling on the ground, and she sees grandmommy up in the clouds with a big smile, an angel smiling down on her. I think she felt safer. —Parent

TREATMENT
COMPONENT

6. COGNITIVE PROCESSING

As the trauma narrative is being created, the therapist is able to identify thoughts and beliefs about the traumatic event that are inaccurate or not helpful. These are often tied to feelings of responsibility for the death and related feelings of helplessness. It is extremely difficult for the child or parent to feel he could have done something to prevent the death and especially complex if there is any way the child or parent could have changed the outcome.



CHILD

Once the narrative is completed, cognitive processing is the final component of the trauma-related portion of the treatment and is used to modify and correct these thoughts and beliefs.



ACTIVITY

The following are example questions for the child that may be helpful in eliciting distortions:

- Why did this happen?
- Was it anyone's fault?
- Could something have been done to prevent it?
- Has this event changed you?
- Has this event changed what you think about other people? The world?
- Some kids think they should have done something different. Do you?
- Some kids think someone else should have done something different. Do you?
- Some kids think they made it happen. Do you ever feel that way?
- What do you think your life will be like in the future?

- Why do things like that happen to people?
- Why did that person do what he or she did?



ACTIVITY

Unhelpful beliefs may be totally false, such as thinking “my brother died because I was bad.” Unrealistic thoughts such as “I should have stopped the bad man from hurting my mom” are also unproductive and harmful. Other thoughts may be accurate but unhelpful, for example, when a child thinks “people who are burned in a fire are in terrible agony.” When attempting to handle feelings of helplessness, children may feel a need or begin to take on excessive responsibility. Ways to tolerate and address such feelings can also be addressed. After a child’s specific trauma-related cognitions and beliefs have been identified, the therapist and the child begin to evaluate and correct them. This can be accomplished through the use of such techniques as the following:

- **Progressive logical questioning:** For example, “So you’re saying that you should have stopped that guy from shooting your mom? How big was that guy? And how big are you? So he probably weighed about 200 pounds and you weigh about 60 pounds? Is there really any way that a 60-pound kid could stop a 200-pound guy from doing something like that?”
- **Best-friend role-plays:** For example, “What would you tell your best friend if he told you that he believed that he should have stopped the guy from shooting his mom?”
- **Therapist-child role reversal:** For example, “I’m going to pretend to be you, and I want you to pretend to be a therapist. I’m going to tell you some things that you’ve told me you think about. I want you to say what you think a therapist would say about those things.”
- **Corrective mantras:** These may be more suitable for younger children who are less able to engage in cognitive processing. The therapist may provide them with corrective “mantras” such as “I did everything I could to help my mom.” The child practices repeating the mantra when he finds himself thinking about the traumatic event.



PARENT

Cognitive processing should also be done with the parent regarding his or her own thoughts.



CASE EXAMPLE

A mother thinks she should not have fought with her husband before he shot himself. When asked what the fight was about, she explained that she told him that she did not like the way he coped with losing his job. His getting drunk every night did not solve anything and made things worse. She told him to see a therapist because he seemed depressed. She says “I should have just left him alone and he wouldn’t have killed himself.” The therapist reframed this, saying that the wife recognized his depression and that alcohol was making the depression worse. She saw he needed help and offered him support, doing everything she could have done to help him. The therapist helps her to see that he was not in his right mind when he was depressed and drunk. He killed himself for these reasons, not because she suggested he get help.

HOW ARE GRIEF-RELATED ISSUES HANDLED IN THE TREATMENT PROCESS?

Following the trauma-specific treatment, the therapist helps the child with mastery of bereavement tasks. Many of the techniques used in bereavement therapy and supportive counseling are similar to what is done in this phase of the treatment. Techniques often associated with CBT are also incorporated into the grief-related activities. The strategies or tools used in this phase of the treatment are tailored to the usual bereavement tasks.



TREATMENT
COMPONENT

7. COMMUNICATING ABOUT DEATH



CHILD

When the trauma symptoms recede as a result of the prior trauma-focused sessions, the child is better able to address issues related to death. However, the child may still be hesitant to talk about the death of a loved one due to societal taboos surrounding the topic of death and/or the parent's own discomfort in talking about death. The practitioner should know of any prohibitions against talking about those who die and know any culturally specific terminology that is used when guiding the discussion.

Many adults feel uncomfortable talking about death due to their own confusion and/or grief and may therefore send subtle (or not so subtle) messages to children about remaining silent. Consequently, it is helpful to begin this phase by having the child openly communicate about death in session with the therapist. The goal is to educate the child about death, have the child become comfortable talking about death, and have the child ask questions to develop a clear understanding of death. The activities below can encourage more open discussion. After talking about death in general, the child will be more prepared to talk directly about his or her own bereavement.



ACTIVITY

Engaging in communication about death can be accomplished any number of ways, such as playing a specific grief board game (e.g., The Good Bye Game) or creatively restructuring a child's favorite game with personally prepared bereavement-related questions. Reading age-appropriate story books with the child and discussing the information is also useful. The child is also encouraged to draw a picture of what he or she believes "death" looks like. This can offer an opportunity for the therapist to correct any cognitive distortions or fears about death that the child may have. In addition, the child can list feelings that most people have after a loved one dies. This also helps to normalize the child's experience of loss.



RESOURCE



REFERENCE

See the resource and reference sections at the end of the guide for suggested grief-related games and books on page 81.



A seven-year-old child and her therapist are reading a book about death and come across a particular sentence: “Every living thing dies. Once it dies it can never come back to life again.” About two minutes later, several pages after this section, the little girl says, “I didn’t know that.” When the therapist asks what she means, the girl says, “I didn’t know that you couldn’t come back alive again.” This highlights the value of communication about death and how direct discussion helps identify and correct cognitive distortions.



Younger children may be preoccupied with more concrete questions or concerns regarding the physical body of the deceased person. For example, a six-year-old child asked how her deceased father would be able to go to the bathroom if he could not get out of the coffin. These questions might be brought to light only if the child is given the opportunity to voice his or her concerns, again emphasizing the need for open communication regarding the death.



This is a good time to assess the parent’s ability to talk about death in general as well as his or her own loss. It may be necessary to revisit and stress the importance of talking about the loss, particularly if the parent seems hesitant to do so. In addition, it is important for the therapist to have a good understanding of the parent’s religious



and cultural beliefs surrounding death and grieving to ensure that the therapist does not inadvertently give the child any conflicting information. Finally, the therapist should ascertain the parent’s own perception of the child’s understanding of death. Parents may be confused or upset about the fact that a child is not showing strong emotions about the death. However, parents may be more empathic toward the child if they understand that the child’s nonemotional response may be due to developmental limitations with regard to the child’s ability to comprehend the permanence of death.

The child may also be attempting to shield the parent from the child’s own sadness, which may be an important area to explore with the child and parent together.

TREATMENT
COMPONENT

8. MOURNING THE LOSS

Mourning the loss encourages and supports the child in acknowledging what has been lost by the person's death.



CHILD

It's important for the child, in order to accept the magnitude of the loss, to be able to name these things that they've lost. —Judith Cohen



ACTIVITY

The process may begin with an activity focusing on the characteristics of the person who died. This can be done by writing a new “bereavement book” or even drawing pictures, guiding the child with prompts or questions similar to the process used for creating the trauma narrative. As the child becomes more comfortable talking about the person, she is encouraged to list or describe things she will miss sharing with the person in the future. These can include things that the deceased person and the child did for each other, including basic caregiving activities as well as unique aspects of the relationship. This is a good time to talk about anticipating “loss reminders,” particularly if the activities that the child used to do with the deceased are now triggering posttraumatic reactions. Next, using the letters of the person's first name, the child creates an anagram, attaching a characteristic of the person to each letter. The child is encouraged to identify which characteristics he or she will miss the most. By helping children talk about the deceased, rather than avoid the topic, the child and therapist will be better able to anticipate painful situations that may arise and prepare accordingly.



PARENT

The therapist should discuss with the parent what the child has been writing and/or talking about with regard to the things the child has lost. This will likely precipitate feelings of great sadness for the parent given that the parent will be grieving his or her own losses in addition to the child's losses. These feelings should be normalized by the therapist. In addition, the therapist should help the parent to generate ways in which the child may optimally be able to deal with loss reminders in the future (e.g., the parent may wish to attend all of the child's football games that the child's deceased father used to attend).

The therapist can also point out the ways in which the parent's own grief responses may be contributing to the child's bereavement process. For example, if the parent makes every effort to avoid the topic of the deceased person, it is likely that the child will hold in his or her emotions. On the other hand, if the parent becomes overtly distraught at the mention of the deceased person's name, the child may also choose to avoid talking about the deceased in an effort to protect the parent. The therapist should help the parent to support the child's expression of emotion, while at the same time find ways of helping the parent to receive the support that he or she needs.

TREATMENT
COMPONENT

9. ADDRESSING AMBIVALENT FEELINGS ABOUT THE DECEASED



CHILD

Another bereavement task involves acknowledging and accepting any ambivalent feelings about the deceased. As with most relationships, the child has likely experienced some unpleasant aspects, even if the majority of interactions with the deceased were positive. However, if the relationship was highly ambivalent prior to the death, or if the death occurred in a way that is stigmatizing, such as suicide, the child's feelings of grief can be even more difficult to express.

In particular, the child may feel guilty about having negative feelings such as shame or anger toward the deceased, and may think it means he or she didn't really love the deceased person. Or, particularly in the case of a suicide, the child may blame himself or herself for the death in some way (e.g., "If I had only behaved better, Mom wouldn't have wanted to kill herself"). This may lead to feelings of abandonment as well as concerns regarding the deceased person's true feelings toward the child. Therefore, an important role of the therapist is to help the child to understand that it is normal to have both positive and negative feelings toward the deceased by encouraging expression of all feelings about the person.

There might have been some aspects of the relationship that weren't always that positive. For example, you might have a child who loved her dad who died in tragic circumstances, but perhaps the dad never spent any time with her. —Anthony Mannarino



ACTIVITY

One useful technique in this process is having the child write a letter to the deceased, in which he describes a range of feelings. The child also writes a letter that the deceased would write back if he could. This can help the child to express feelings that he or she may not have verbalized and also provide a sense of closure for the child.

CASE
EXAMPLE

The father of a 14-year-old girl died of a drug overdose. She was angry about how his lifestyle created such heartache for her mother, and she was ashamed of how he died. She expressed these feelings in her imaginary letter to her father. In the letter she composed as a response from him, he revealed that he was sorry for the pain he had caused and that he could never forgive himself for having his illness interfere with his ability to show her how much he truly loved her.



PARENT

In many cases, the parent may idealize the deceased person, which may preclude the child from fully expressing any negative feelings about the deceased. Therefore, it is important for the therapist to help the parent understand the child's perspective and address any dissonance between the parent's and child's respective beliefs about the deceased person. However, given that the idealization of the deceased person is not necessarily harmful, caution should be used in correcting the child's or the parent's overly positive view of the deceased. Instead, the best approach is to encourage the parent to validate the child's perspective and to focus on ways of helping the child to resolve any "unfinished business" with the deceased.

TREATMENT
COMPONENT

10. PRESERVING POSITIVE MEMORIES

This task is often a necessary prerequisite for helping children to give themselves permission to engage in new relationships. Different exercises are used to help children preserve positive feelings and memories of the deceased person.



CHILD

In order to successfully grieve the loss of a loved one, it's important for the child to convert the relationship from one of interaction to a relationship that is based on memory, not current interaction. —Judith Cohen



ACTIVITY

Some positive memory activities include making a scrapbook or a memory box filled with reminders of the deceased person. Children are encouraged to ask other family members to assist them with these activities in an effort to facilitate open communication regarding the loss. Other techniques may include recreating a memorial service or another ritual, particularly if the child was unable to attend the actual funeral. For situations in which no remains of the deceased were found, body reconstructive techniques can be particularly helpful to foster a complete positive memory of the physical person.



PARENT

The parent should be encouraged to help the child recall and preserve positive memories of the deceased person. This may be difficult if the parent's own relationship with the deceased was conflicted. However, the therapist should help the parent understand why positive memories are important for the child's healing process. If a parent has died, and the remaining parent remarries, the child may fear how previous memories will be maintained.

CHILD
PARENT
JOINT

The parent may wish to add sections to the child's bereavement book that focus on positive aspects of the child's relationship with the deceased that the child may have forgotten or omitted. This activity can help the child to understand that it is OK to have both happy and sad memories about the deceased person. It also shows that the parent can tolerate thinking and talking about the deceased, and that this does not have to lead to sad feelings.

TREATMENT
COMPONENT

11. REDEFINING THE RELATIONSHIP

This bereavement task is designed to help children accept that the relationship with the deceased has changed from one of interaction to one of memory.



CHILD

One technique that is often used to exemplify this change is a drawing of two balloons — one that is anchored to the ground and the other that is floating toward the sky.



ACTIVITY

The child identifies things that she has lost in the relationship, such as going to baseball games together, and writes them in the floating balloon. The child also identifies things that remain in the relationship with the deceased, such as memories of fun times spent with the deceased and writes them in the balloon on the ground. This helps children to understand that although some aspects of the relationship have changed, their positive memories can serve as the foundation for a new and different relationship with the person who died.



PARENT

The child will likely need the parent’s “permission” to let go of the interactive relationship with the deceased, given that many children feel guilty or disloyal in doing so. The parent may need assistance in understanding the importance of this task and working through any resistance that he or she may have. The therapist can review specific ways in which the parent can help the child to redefine his or her relationship with the deceased. For example, parents may wish to be more cognizant of the language they use to talk about the deceased (e.g., referring to the person in the past as opposed to the present).

TREATMENT
COMPONENT

12. COMMITTING TO NEW RELATIONSHIPS

The goal of this task is to have the child identify and discuss what has changed in his or her life since the death and the difference between a real previous relationship and a new relationship with the person in one’s memory, and then engage in new relationships. Following the death of a loved one, children may be reluctant to engage in new relationships. They may feel that they are being disloyal to the deceased loved one if they form new relationships or that no other person will ever be able to make up for the loss of the loved one. It is important to help the child realize that if he or she forms new relationships it does not mean he or she loves the new person more than the person who died. Also, the child may need assistance coming to the realization that, although new relationships will be different than the relationships with the deceased, it is not a competition, and the new relationships can be satisfying.



CHILD

One way to help a child develop new relationships is to begin by identifying, in a list, the things that he or she used to do with the deceased person. Next the child writes in names of people who could fill those roles left empty by the deceased.



ACTIVITY



PARENT

This may be a particularly difficult task for parents if they are struggling with their own ability to move forward and develop new relationships. The therapist may need to spend some time discussing the parents' own concerns/fears in this regard. The therapist may also need to provide psychoeducation regarding the importance of parental modeling of the development of new relationships and a strong future orientation. Parents should not only be encouraged to maintain and develop important relationships for themselves, but they should also be encouraged to praise their children for developing new relationships. This can help to relieve any guilt that the child may have for spending time with other people or leaving the parent by himself or herself.



TREATMENT COMPONENT

13. MAKING MEANING OF THE DEATH



CHILD

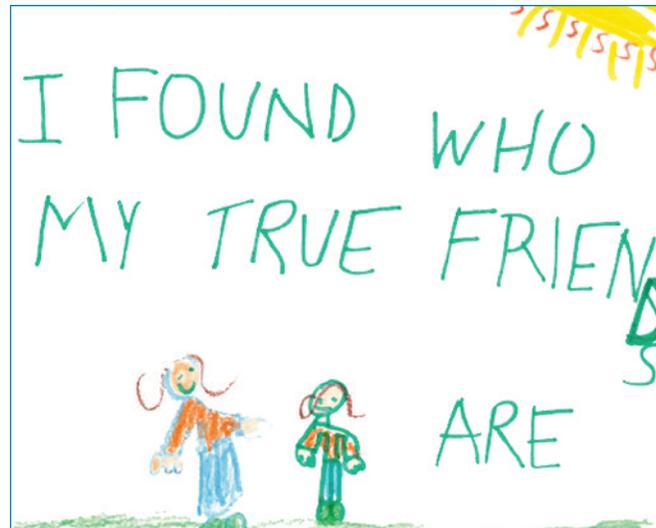
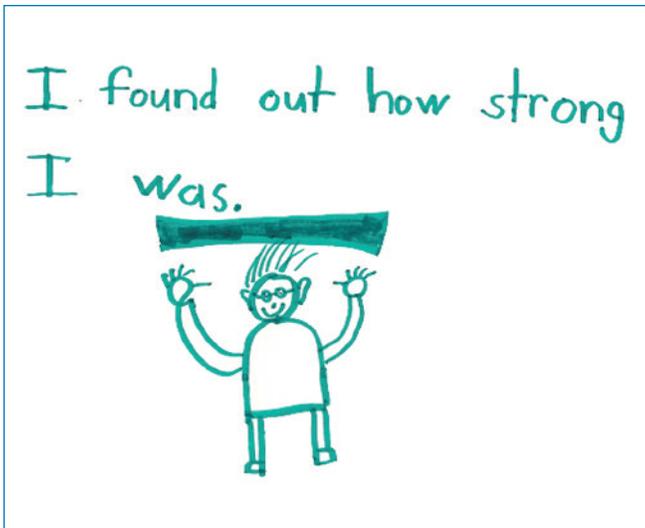
Making meaning of the death is a bereavement task that encourages children to view their traumatic experience as one that, while difficult and painful, has helped them to grow or become stronger in some way. If the child felt helpless due to fearing for his life as well, e.g., having survived a hurricane in which a younger sister died, engaging in an activity to make the world a better or safer place is constructive.

You want to help children develop some meaning about the death. It's not to turn it into a positive experience, but you want them to realize they may have learned things about themselves, about other people, or may learn that there's a way to help other kids that are in this same situation. —Robin Goodman



ACTIVITY

Some specific techniques involve asking children to talk about what they have learned about themselves or the world around them as a result of the death. Some children may have learned they are stronger than they thought, while others may have learned they have many people to count on for help. Some children find meaning in their loss by helping other children who are going through similar situations, perhaps by being a mentor or volunteer or helping to prevent the type of traumatic loss that they experienced by joining a group like Students Against Drunk Driving. These activities can often help children to find meaning in the face of tragedy. Children are encouraged to look at what was learned from the death, at how the experience can help the child help others.



The parent can help the child by pointing out ways in which the child has changed for the better or grown in some way since the loss. The parent can also offer suggestions for ways in which the child may be able to help others as a result of his or her painful experience.



14. THE NATURAL EVOLUTION OF GRIEF AND TERMINATION

One of the most important things we can do for children and parents in preparing them for the termination of treatment, and for coping with future trauma change and loss reminders, is to review with them the 'three P's.' —Judith Cohen



It is important to help the child and family with the three P's of grief. Children and families can be helped to **predict** difficult times in the future. For example, if the child's father usually accompanied her to her basketball games, it may be difficult for the child to return to those games without him. Accordingly, the family should **prepare** for future trauma and loss reminders. The therapist can help the family to strategize about ways of making those reminders or difficult times easier to deal with. It is also necessary to give **permission** to oneself — both the child and family — to have different feelings about the trauma and death as time goes by.



When talking with the parent about the evolution of grief, it is best to keep the perspective of the entire family in mind. Parents should be helped to develop an understanding of the family members as individuals and the family as a whole. This should be done by exploring and addressing various issues as they relate to the specific death as well as to current family life and future experiences. In particular,

attention should be paid to the impact of the following issues on the individuals and on the family:

- individuals' different trauma and loss reminders
- individuals' different experiences of the death and previous traumatic losses
- individual differences in the course of trauma and grief
- individuals' different roles in the family
- developmental differences among all the individuals
- cultural differences
- generational differences
- the different stages in the family's life
- the functioning of the family system

The parents should encourage mutual respect and support among the family members for their own grief issues and develop a family focused plan for managing future grief and trauma related reminders and activities.



ACTIVITY

One helpful activity is to create a perpetual calendar (with months and dates but no specific year). The child and/or parent identify times and dates of the year that will be more difficult, looking for patterns such as a time of year that is more stressful. Dates that will recur such as the deceased's birthday are indicated with one symbol or color and occasions that are one-time events, such as a first day of school, can be indicated with another symbol or color. The individual is helped to make plans for coping with the stressful time and feelings, such as using good self-care, or creating new alternative rituals. This exercise also emphasizes to the family that difficult times will happen in the future, not just in the coming year, and helps them learn ways to process and brainstorm ways to cope with those hard times.

CHILD
PARENT
JOINT

Termination requires its own specific attention. It is important to address the ways in which terminating treatment with the therapist (whom can be called upon again) is different from a relationship that ends because of a death. For children and parents, this can be a good opportunity to talk about different kinds of losses and generate ways of coping with those difficult experiences. This is also a good time to review all of the progress that both the child and the parent have made, and for the therapist to offer praise for their tremendous effort. It is important for the therapist to remind the parent and child that difficult times may arise again, particularly during life transitions, and that therapy is always an option in the future, even if only used as a booster session. In addition, if the clinician believes the child or parent continues to have troubling symptoms or difficulty with usual activities, additional treatment may be warranted. It may be helpful to recommend additional trauma- or grief-focused treatment or a different type of treatment.

TREATMENT OF CHILDHOOD TRAUMATIC GRIEF WITH YOUNG CHILDREN AND GROUPS

HOW IS CHILDHOOD TRAUMATIC GRIEF IN YOUNG CHILDREN TREATED?



Working with infants, toddlers, and preschoolers with childhood traumatic grief following the death of a parent requires a specialized approach. Young children depend completely on the parents for their sense of security and well-being, and the parent's death shatters their age-appropriate expectations that the parent will be reliably available for care and protection. Children in the birth-through-five age range also have difficulty grasping the finality of death. An attachment-oriented intervention should be used for treating childhood traumatic grief in this age range. This approach focuses on

- reestablishing and strengthening the quality of the relationship between the young child and his new or existing primary caregiver,
- maintaining predictable daily routines, and
- providing opportunities that enable the child to learn that dead the parent will not return.

This treatment also encourages children to resolve their traumatic memories of the parent's death through the use of therapeutic play interventions and to memorialize the parent in age-appropriate ways with the help of the new or surviving caregiver.



Detailed instruction on work with toddlers and young children can be obtained at: Lieberman, A. F., Compton, N. C., Van Horn, P. & Ghosh Ippen, C. (2003) *Losing a parent to death in the early years: Guidelines for the treatment of traumatic bereavement in infancy and early childhood*. Washington, DC: Zero to Three Press.



WHY AND HOW IS CHILDHOOD TRAUMATIC GRIEF TREATED IN GROUPS?

Both individual and group-based treatment address the trauma and grief-related aspects of childhood traumatic grief. However, a group-based treatment may be especially appropriate for adolescents. In addition to being cost effective, trauma- and grief-focused groups are beneficial in a number of specific ways. For example, groups provide and encourage

- normalization and validation of emotions,
- direct member-to-member feedback and interaction,
- exposure to other members' experiences,
- opportunities to offer positive and constructive feedback,
- peer support, and
- mutual understanding between members.



Group work can result in a member feeling less isolated or estranged, and it can impact issues related to the adolescents' emerging self-concepts, feelings of shame and guilt, and the desire for revenge. For example, group therapy allows members to give constructive and positive feedback, which can assist in increasing group cohesion and treatment effectiveness. Member-to-member interactions can be a highly influential tool for challenging and replacing maladaptive beliefs, such as pessimistic expectations and cognitive distortions. Group treatment also makes use of the *helper-therapy principle*, wherein the chance to help others with a similar problem serves as a catalyst for personal change. That is, helping others allows members to help themselves by strengthening their self-concept, self-esteem, self-confidence, and interpersonal skills.

Group work enriches members' capacities to give and receive support and to speak authentically and genuinely about their experiences. When others talk about their feelings in similar situations, feelings are validated. They develop and practice social skills to help them select with whom, when, and how much of their experience to disclose. These skills help them to be self-protective, maintain closeness to selected others, and recruit support from others when confronting distressing reminders and difficulties. The supportive transactions that follow can greatly help members to challenge and change their pessimistic beliefs that no one cares, that no one can understand what they have been through, that others will reject them if they shared their feelings and experiences, or that no one can really help them deal with the serious problems they face.



The skill set of a well-trained group therapist will overlap with, but are independent from, the skill set of a competent individual therapist. Importantly, the interaction of group members serves as the most direct mechanism of change; the group itself serves as the primary vehicle of change, and the group leaders serve as the indirect agents of change. Hence, skilled group leaders provide a therapeutic structure and facilitate interactive processes.

The goals of group-based and individual-based childhood traumatic grief treatment are similar. These include

- reducing the frequency, intensity, and degree of interference associated with childhood traumatic grief reactions, including trauma-related symptoms, depressive reactions, and grief reactions;
- enhancing effective coping and positive adaptation in relation to distressing reminders and grief-related adversities;
- enhancing the ability of youth to access high-quality social support from others; and
- reducing trauma-related developmental derailment and encouraging engagement in normal developmental tasks.

As with individual treatment, one focus of the group-based treatment is on the **traumatic experiences**.



ACTIVITY

Intervention tasks consist of psychoeducation to normalize and validate posttraumatic distress reactions, and therapeutic exposure via construction of a trauma narrative, the goal being to reduce reactivity and psychic numbing and to increase tolerance to trauma related material.

A second therapeutic focus is on **trauma and loss reminders**, the goal being to normalize, validate, and promote effective coping with distressing reminders



ACTIVITY

Intervention strategies include identifying the nature and frequency of reminders of trauma and loss, linking reminders with distress symptoms, and identifying maladaptive coping responses. Additional strategies include using reminders to explore the personal meaning of traumatic events, acquiring thought/emotional regulation and support-seeking skills to cope with reminders, and facilitating pro-active modification of the physical environment to remove unhelpful and unnecessary distressing reminders.

A third focus is on **posttraumatic adversities** and involves identifying and ameliorating the effects of the reactions in the wake of traumatic events and losses.



ACTIVITY

Intervention strategies focus on the seven major areas in which disruption is likely to occur: school performance, peer relationships, family relationships, living conditions, health problems, economic prospects, and neighborhood/community environment. Additional areas are more grief-related and focus on acceptance, adaptation, and coping with life changes and losses and training in communication skills to enhance support-seeking. As appropriate, direct intervention is also carried out at the family, community, and/or national levels to reduce or remove unnecessary adversities.

An additional therapeutic focus is **bereavement and the interplay of trauma and grief**. In particular, intrusive distressing traumatic images, emotional numbing, and cognitive/behavioral avoidance associated with traumatic death may interfere with normal grief reactions, including reminiscing and establishing a memory-based psychological relationship with the deceased.



Intervention tasks include identifying grief reactions, psychoeducation about the nature and course of bereavement, and working on bereavement tasks related to one's past, present, and future relationship with the deceased.

The last therapeutic focus is on **resuming developmental progression** and involves efforts to ameliorate the adverse developmental impact of the on the child.



Intervention includes identifying missed developmental opportunities and difficulties with functioning in major areas of adolescent development, including independence from parents, the capacity for intimate relationships, moral development, ambition and motivation for educational and occupational achievement, and citizenship.

Additional tasks in group treatment include initiating developmental progression in adversely affected life domains, identifying and replacing maladaptive basic beliefs with more adaptive core beliefs, and promoting prosocial efforts with peers, at home, at school, and in the community and neighborhood. Adolescents are especially prone



to interpret many of their distress reactions as regressive or “childlike,” indications that they are “going crazy,” or signs that they are weak, defective, or different from their peers. Adolescents should be helped to understand their reactions are expected, adaptive in the face of danger, often similar to those of adults, and capable of being changed for the better.

Because parents are integral to a teen's life and to the teen's progress in treatment, parents are included in very specific ways in group-based treatment. In conjunction with the group treatment sessions described below, parents should be brought in for a minimum of two sessions. One session with parents should be devoted to providing an overview of the treatment, psychoeducation about childhood traumatic grief, and background about the interventions. In a second session, the focus is on helping parents understand their child's needs with respect to support and helping parents develop skills to provide such support, e.g., listening and giving appropriate feedback to the teen. Parents may be brought in at other times as needed and during specific modules in order to have teens share their experience and talk about specific reminders that are difficult for them and about ways parents can be helpful to them.

CONDUCTING GROUP-BASED TREATMENT FOR CHILDHOOD TRAUMATIC GRIEF

The group-based treatment is organized into four different modules that focus on the five different aspects of childhood traumatic grief. The different activities used throughout a group-based intervention include those previously described for individual treatment: *psychoeducation, skills building, and process-oriented activities.*

Potential group members should have an individual pregroup interview. Members need not have been exposed to the same traumatic death. However, it is strongly recommended that the magnitude of the trauma be similar for all members. In addition to a general assessment for appropriateness, the interviewer should work with the teen to select the portion of the traumatic death experience that is suitable for discussion in the group. It is often useful to focus on the individual's subjective experience rather than the potentially gruesome details of the death. The leader may find that there are other portions of the experience that are better processed in an additional individual treatment session.



CASE
EXAMPLE

The therapist should introduce the group by explaining the special nature of the group. For example: "This group is designed to help you become more aware of your trauma and grief reactions. As you share more as a group about the difficulties you experience, you give the gift of telling your fellow group members that they are not alone. It takes courage to share this kind of personal information. Working together will also help you be more aware, not only of ways in which other people can support you so that you can deal better with your problems and feel better, but also of ways in which you can support other people. So, you'll be practicing the skills of both giving support and receiving support. In the group everyone is on a level playing field."



MAIN
CONCEPT

The four basic treatment modules are described briefly below. The approximate number of sessions for each is identified. However, keep in mind that the length of time varies due to such things as number of members in the group and the nature of issues that arise during the group. As with all treatments, leaders should be flexible in adjusting the activities and number of sessions to meet the needs of the group.

Module 1: Up to six sessions. In the beginning of treatment, the goal is to develop group cohesion and a positive group identity. Psychoeducation about childhood traumatic grief is used. Interventions are also aimed at developing adaptive coping skills (e.g., cognitive coping, affect management, and developing a plan to cope with trauma reminders before, during, and following their occurrence). Social support and support-seeking skills are also important to develop in this beginning stage, in order to lay a strong foundation for the later trauma- and grief-focused work.

Module 2: Up to six sessions. The traumatic event is identified and a trauma narrative is developed and processed. In the pregroup interview, the therapist begins working to identify aspects of the traumatic death that will be appropriate for using in the group. In doing the trauma narrative, special attention is given to identifying and processing the worst traumatic moments in order to increase tolerance and to enhance regulation of intense negative emotions. When group participants have a common experience, it may be possible to develop a groupwide trauma narrative followed by individual trauma narratives.

Cognitive restructuring techniques help establish a frame of personal meaning that places the trauma in perspective and increases perceptions of realistic control and life continuity. The number of sessions can vary with the number of group members, hence length of time to sufficiently develop the trauma narratives and any complexities related to the traumas will also vary.

Module 3: Up to eight sessions. The group then undertakes grief-related work. Once again, psychoeducation is used about loss reminders, grief tasks are addressed, and the core emotions of grief, especially anger and guilt, are discussed. Additional tasks are reconstituting a nontraumatic mental image of the deceased to facilitate reminiscing, processing conflicted feelings relating to the deceased, acquiring social skills needed to communicate appropriately about the loss, and renegotiating one's relationship with the deceased.

Module 4: Up to four sessions. The last portion of treatment should focus on resuming and engaging in developmentally appropriate tasks and activities. Issues relate to how the traumatic death affected the course of the child's life are addressed; these can be positive or negative. Treatment should identify missed developmental opportunities, support the resumption of compromised developmental activities, facilitate an active future orientation, and challenge and change maladaptive belief systems. Secondary adversities that impact the here and now are looked at with an eye toward problem solving and a focus on the future. As with all childhood traumatic grief interventions, termination issues are addressed in the last session(s), with an emphasis on the difference between ending treatment and relationships that end in death.



RESOURCE

For further information and treatment manuals for work with adolescents and groups you are directed to the following resources:

- Cohen et al. (2001) Cognitive behavioral therapy for traumatic bereavement in children: Group treatment manual, available by contacting the National Resource Center for Child Traumatic Stress at (919) 682-1552 or nationalresourcecenter@duke.edu.
- Saltzman, W. R., Layne, C. M., Pynoos, R. S. (2003) Trauma/grief-focused intervention for adolescents, available by contacting wsaltzman@sbcglobal.net.

CONCLUDING THOUGHTS

RECOGNIZE, RESPOND, REMEMBER

For clinicians who are unfamiliar with childhood traumatic grief, it would be important to recognize that childhood traumatic grief includes traumatic stress symptoms and that these symptoms interfere with the child's ability to go through the normal steps of the bereavement process. —Anthony Mannarino

Things to look for include children who do not talk about their lost loved one, who avoid reminders such as going to the grave site, who do not want to remember or memorialize the person who died, and children who are very avoidant of talking about not only the death and the cause of death but also the loved one. —Judith Cohen

Professionals should be able to recognize the signs of childhood traumatic grief, respond so as to help a child and family obtain the appropriate treatment, and help the child and family understand that “it’s OK to remember.”

The child and family can be relieved when they themselves and others come to **recognize** the difficulty they are having. Once in treatment, they can learn appropriate ways to **respond** and handle their distress and can go on to **remember** the person who died in a positive and meaningful way.

As practitioners, I think it’s very important that we respond to childhood traumatic grief, because it’s something that children do not outgrow, and if we don’t respond, it’s quite likely that they’re going to continue to have the traumatic stress symptoms, and these children won’t be able to go through the normal grieving process. —Anthony Mannarino

Using *The Courage to Remember* video and curriculum is the first step in developing your skills at helping children with childhood traumatic grief. Although presented as a specific structured intervention, treatment should always be adapted to the individual child's family and situation. Further training and supervision is recommended. This work is challenging and rewarding. You should be mindful of your own experiences and reactions to trauma and bereavement as it informs your work, and seek out your own support if necessary.

We need to know that children always remember; the question is how they remember. For this reason, it's very important to help a child translate visceral memories of fear and anger into cognitive memories so that the child can be helped to develop coping mechanisms for feelings that are overwhelming in order to help them become modulated and under control. —Alicia Lieberman

One of the best things you can do for these children is help them realize it's OK to remember the way the person died as well as who the person was. —Robin Goodman



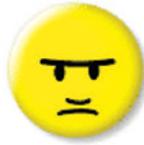
APPENDICES

HANDOUTS, RESOURCES, REFERENCES

Feeling Faces



CONFIDENT



MEAN



CONFUSED



SHOCKED



DISAPPOINTED



LONELY



FRUSTRATED



CALM



HAPPY



SCARED



SAD



GUILTY



WORRIED



SURPRISED



ANGRY

Images from DesignStop.Com

PROGRESSIVE MUSCLE RELAXATION SCRIPTS

The following scripts are taken from Ollendick, T. H., & Cerny, J. (1981). *Clinical Behavior Therapy with Children*. New York: Plenum Press.

PMR Script 1

Suggested for children ages 9 and older. (Ollendick, 1978)

Head and Arms

Make a fist with your left hand. Squeeze it hard. Feel the tightness in your hand and arm as you squeeze. Now let your hand go and relax. See how much better your hand and arm feel when they are relaxed. Once again, make a fist with your left hand and squeeze hard. Good. Now relax and let your hand go. (Repeat the process with the right hand and arm.)

Arms and Shoulders

Stretch your arms out in front of you. Raise them high up over your head. Way back. Feel the pull in your shoulders. Stretch higher. Now just let your arms drop back to your side. OK, let's stretch again. Stretch your arms out in front of you. Raise them over your head. Pull them back, way back. Pull hard. Now let them drop quickly. Good. Notice how your shoulders feel more relaxed. This time let's have a great big stretch. Try to touch the ceiling. Stretch your arms way out in front of you. Raise them way up high over your head. Push them way back. Notice the tension and pull in your arms and shoulders. Hold tight now. Great. Let them drop very quickly and feel how good it is to be relaxed. It feels good and warm and lazy.

Shoulders and Neck

Try to pull your shoulders up to your ears and push your head down into your shoulders. Hold it tight. Okay, now relax and feel the warmth. Again, pull your shoulders up to your ears and push your head down into your shoulders. Do it tightly. Okay, you can relax now. Bring your head out and let your shoulders relax. Notice how much better it feels to be relaxed than to be all tight. One more time now. Push your head down and your shoulders way up to your ears. Hold it. Feel the tenseness in your neck and shoulders. Okay. You can relax now and feel comfortable. You feel good.

Jaw

Put your teeth together real hard. Let your neck muscles help you. Now relax. Just let your jaw hang loose. Notice how good it feels just to let your jaw drop. Okay, bite down again hard. That's good. Now relax again. Just let your jaw drop. It feels so good just to let go. Okay, one more time. Bite down. Hard as you can. Harder. Oh, you're really working hard. Good. Now relax. Try to relax your whole body. Let yourself go as loose as you can.

Face and Nose

Wrinkle up your nose. Make as many wrinkles in your nose as you can. Scrunch your nose up real hard. Good. Now you can relax your nose. Now wrinkle up your nose again. Wrinkle it up hard. Hold it just as tight as you can. Okay. You can relax your face. Notice that when you scrunch up your nose that your cheeks and your mouth and your forehead all help you and they get tight, too. So when you relax your nose, your whole face is relaxed too, and that feels good. Now make lots of wrinkles on your forehead. Hold it tight, now. Okay, you can let go. Now you can just relax. Let your face go smooth. No wrinkles anywhere. Your face feels nice and smooth and relaxed.

Stomach

Now tighten up your stomach muscles real tight. Make your stomach real hard. Don't move. You can relax now. Let your stomach go soft. Let it be as relaxed as you can. That feels so much better. Okay, again, tighten your stomach real hard. Good. You can relax now. Kind of settle down, get comfortable and relax. Notice the difference between a tight stomach and a relaxed one. That's how we want to feel. Nice and loose and relaxed. Okay. Once more. Tighten up. Tighten hard. Good. Now you can relax completely. You can feel nice and relaxed.

This time try to pull your stomach in. Try to squeeze it against your backbone. Try to be as skinny as you can. Now relax. You don't have to be skinny now. Just relax and feel your stomach being warm and loose. Okay, squeeze in your stomach again. Make it touch your backbone. Get it real small and tight. Get as skinny as you can. Hold tight now. You can relax now. Settle back and let your stomach come back out where it belongs. You can feel really good now. You've done fine.

Legs and Feet

Push your toes down on the floor real hard. You'll probably need your legs to help you push. Push down, spread your toes apart. Now relax your feet. Let your toes go loose and feel how nice that is. It feels good to be relaxed. Okay. Now push your toes down. Let your leg muscles help you push your feet down. Push your feet. Hard. Okay. Relax your feet, relax your legs, relax your toes. It feels so good to be relaxed. No tenseness anywhere. You feel kind of warm and tingly.

Conclusion

Stay as relaxed as you can. Let your whole body go limp and feel all your muscles relaxed. In a few minutes I will ask you to open your eyes and that will be the end of the session. Today is a good day. You've worked hard in here and it feels good to work hard. Shake your arms. Now shake your legs. Move your head around. Slowly open your eyes. Very good. You've done a good job. You're going to be a super relaxer.

PMR Script 2

Suggested for children ages 5 through 8 years old. (Koeppen, 1974)

Hands and Arms

Pretend you have a whole lemon in your left hand. Now squeeze it hard. Try to squeeze all the juice out. Feel the tightness in your hand and arm as you squeeze. Now drop the lemon. Notice how your muscles feel when they are relaxed. Take another lemon and squeeze it. Try to squeeze this one harder than you did the first one. That's right. Real hard. Now drop your lemon and relax. See how much better your hand and arm feel when they are relaxed. Once again, take a lemon in your left hand and squeeze all the juice out. Don't leave a single drop. Squeeze hard. Good. Now relax and let the lemon fall from your hand. (Repeat on right side.)

Arms and Shoulders

Pretend you are a furry, lazy cat. You want to stretch. Stretch your arms out in front of you. Raise them up high over your head. Way back. Feel the pull in your shoulders. Stretch higher. Now just let your arms drop back to your side. Okay, kitten, let's stretch again. Stretch your arms out in front of you. Raise them over your head. Pull them back, way back. Pull hard. Now let them drop. Good. Notice how your shoulders feel more relaxed. This time let's have a great big stretch. Try to touch the ceiling. Stretch your arms way out in front of you. Raise them way up high over your head. Push them way, way back. Notice the tension and pull in your arms and shoulders. Hold tight, now. Great. Let them drop very quickly and feel how good it is to be relaxed. It feels good and warm and lazy.

Shoulders and Neck

Now pretend you are a turtle. You're sitting out on a rock by a nice, peaceful pond, just relaxing in the warm sun. It feels nice and warm and safe here. Oh-oh! You sense danger. Pull your head into your house. Try to pull your shoulders up to your ears and push your head down into your shoulders. Hold in tight. It is not easy to be a turtle in a shell. The danger is past now. You can come out into the warm sunshine, and once again, you can relax and feel the warm sunshine. Watch out now! More danger. Hurry, pull your head back into your house and hold it tight. You have to be closed in tight to protect yourself. Okay, you can relax now. Bring your head out and let your shoulders relax. Notice how much better it feels to be relaxed than to be all tight. One more time, now. Danger! Pull your head in. Push your shoulders way up to your ears and hold tight. Don't let even a tiny piece of your head show outside your shell. Hold it. Feel the tenseness in your neck and shoulders. OK. You can come out now. It's safe again. Relax and feel comfortable in your safety. There's no more danger. Nothing to worry about. Nothing to be afraid of. You feel good.

Jaw

You have a giant jawbreaker bubble gum in your mouth. It's very hard to chew. Bite down on it. Hard! Let your neck muscles help you. Now relax. Just let your jaw hang loose. Notice how good it feels just to let your jaw drop. OK, let's tackle that jawbreaker again. Bite down. Hard! Try to squeeze it out between your teeth. That's good. You're really tearing that gum up. Now relax again. Just let your jaw drop off your face. It feels so good just to let go and not have to fight that bubble gum. OK, one more time. We're really going to tear it up this time. Bite down. Hard as you can. Harder. Oh, you're really working hard. Good. Now relax. Try to relax your whole body. You've beaten the bubble gum. Let yourself go as loose as you can.

Face and Nose

Here comes a pesky old fly. He has landed on your nose. Try to get him off without using your hands. That's right, wrinkle up your nose. Make as many wrinkles in your nose as you can. Scrunch your nose up real hard. Good. You've chased him away. Now you can relax your nose. Oops, here he comes again. Right back in the middle of your nose. Wrinkle up your nose again. Shoo him off. Wrinkle it up hard. Hold it just as tight as you can. OK, he flew away. You can relax your face. Notice that when you scrunch up your nose that your cheeks and your mouth and your forehead and your eyes all help you, and they get tight too. So when you relax your nose, your whole face relaxes too, and that feels good. Oh-oh, this time that old fly has come back, but this time he's on your forehead. Make lots of wrinkles. Try to catch him between all those wrinkles. Hold it tight, now. OK, you can let go. He's gone for good. Now you can just relax. Let your face go smooth, no wrinkles anywhere. Your face feels nice and smooth and relaxed.

Stomach

Hey! Here comes a cute baby elephant. But he's not watching where he's going. He doesn't see you lying there in the grass, and he's about to step on your stomach. Don't move. You don't have time to get out of the way. Just get ready for him. Make your stomach very hard. Tighten up your stomach muscles real tight. Hold it. It looks like he is going the other way. You can relax now. Let your stomach go soft. Let it be as relaxed as you can. That feels so much better. Oops, he's coming this way again. Get ready. Tighten up your stomach. Real hard. If he steps on you when your stomach is hard it won't hurt. Make your stomach into a rock. OK, he's moving away again. You can relax now. Kind of settle down, get comfortable, and relax. Notice the difference between a tight stomach and a relaxed one. That's how we want to feel — nice and loose and relaxed. You won't believe this, but this time he's really coming your way and no turning around. He's headed straight for you. Tighten up. Tighten hard. Here he comes. This is really it. You've got to hold on tight. He's stepping on you. He's stepped over you. Now he's gone for good. You can relax completely. You're safe. Everything is okay, and you can feel nice and relaxed.

This time imagine that you want to squeeze through a narrow fence and the boards have splinters on them. You'll have to make yourself very skinny if you're going to make it through. Suck your stomach in. Try to squeeze it up against your backbone. Try to lie as skinny as you can. You've got to get through. Now relax. You don't have to be skinny now. Just relax and feel your stomach being warm and loose. OK, let's try to get through that fence now. Squeeze up your stomach. Make it touch your backbone. Get it real tight. Get as skinny as you can. Hold tight, now. You've got to squeeze through. You got through that skinny little fence and no splinters. You can relax now. Settle back and let your stomach come back out where it belongs. You can feel really good now. You've done fine.

Legs and Feet

Now pretend you are standing barefoot in a big fat mud puddle. Squish your toes down deep into the mud. Try to get your feet down to the bottom of the mud puddle. You'll probably need your legs to help you push. Push down, spread your toes apart, and feel the mud squish up between your toes. Now step out of the mud puddle. Relax your feet. Let your toes go loose and feel how nice that is. It feels good to be relaxed. Back into the mud puddle. Squish your toes down. Let your leg muscles help push your feet down. Push your feet. Hard. Try to squeeze that mud puddle dry. OK. Come back out now. Relax your feet, relax your legs, relax your toes. It feels so good to be relaxed. No tenseness anywhere; you feel kind of warm and tingly.

Conclusion

Stay as relaxed as you can. Let your whole body go limp and feel all your muscles relaxed. In a few minutes I will ask you to open your eyes, and that will be the end of this session. As you go through the day, remember how good it feels to be relaxed. Sometimes you have to make yourself tighter before you can be relaxed, just as we did in these exercises. Practice these exercises every day to get more and more relaxed. A good time to practice is at night after you have gone to bed and the lights are out and you won't be disturbed. It will help you get to sleep. Then when you are a really good relaxer, you can help yourself relax at school. Just remember the elephant, or the jaw breaker, or the mud puddle, and you can do your exercises and nobody will know. Today is a good day. You've worked hard in here, and it feels good to work hard. Very slowly now, open your eyes and wiggle your muscles around a little. Very good. You've done a good job. You're going to be a super relaxer.

LEARNING TO RELAX THROUGH IMAGERY

Here is an exercise that can help you to relax when you are feeling tense or nervous. It's kind of like day dreaming, but it's something that you can do, on purpose, to help make yourself feel more relaxed. Once you have learned this exercise, you can use it almost any time that you want to.

To get started: Get comfortable. Relax as much as you can. Take some deep breaths and close your eyes.

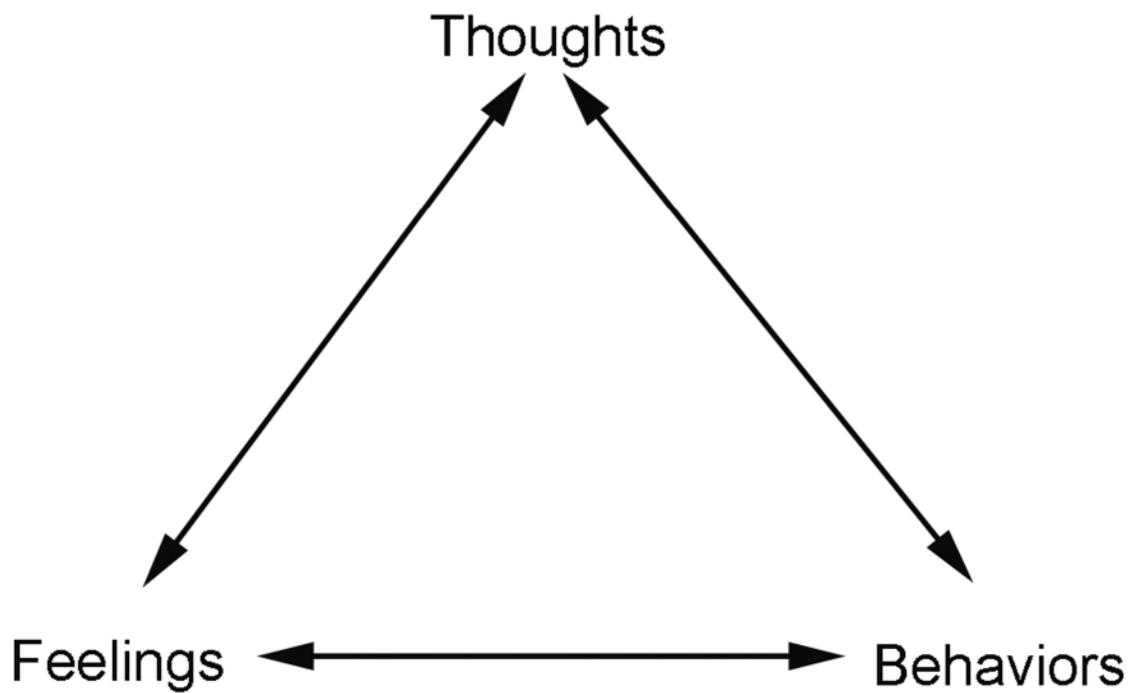
In your head, imagine that you are some place very beautiful and peaceful. It should be a place that makes you feel happy and safe. It may be somewhere that you've been before, or it may be a place that you've never been to except in your dreams. It could be in a forest where you can smell the trees and hear the birds singing. It could be on a warm beach where you can hear the ocean and feel the warm sand. You pick the place.

When you have picked your special place, think about all of the things that you might see there. What would you smell? Can you hear anything? Is there anything there that you can touch? Taste? Are you alone, or is somebody with you?

Keep taking deep breaths and relax your whole body. In your special place you can feel relaxed, calm, and safe. It is your place...a place where nobody can bother you. What are you doing in this place? Are you resting, sitting, or walking around? How do you feel? This is your place...your safe place.

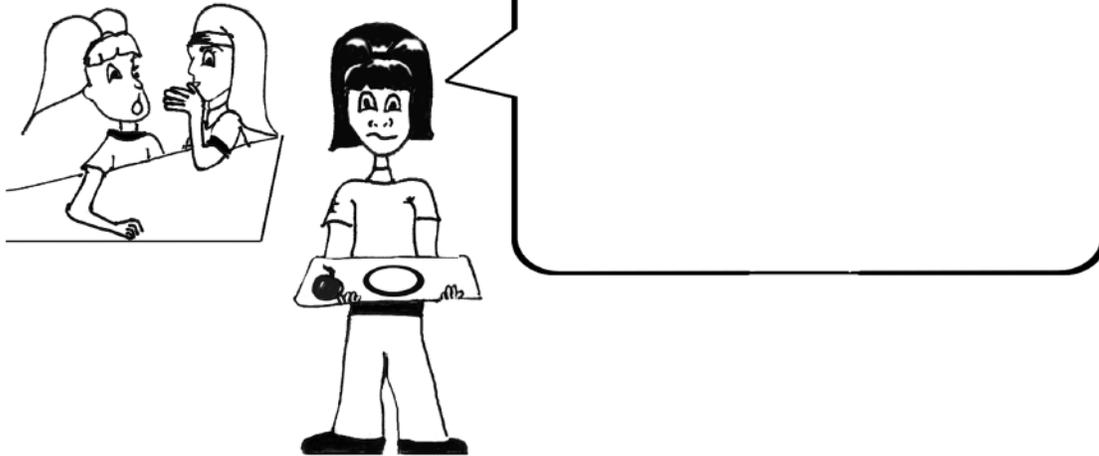
Now that you have picked your special place, whenever you need a break you can go there and help yourself to relax. It will be there in your imagination whenever you want it. It is a place for you to relax and feel better.

Cognitive Triangle



Cafeteria

Write what the person is THINKING.



Thoughts

Feelings

Behaviors

A large, empty rectangular box intended for writing or drawing about the person's feelings.

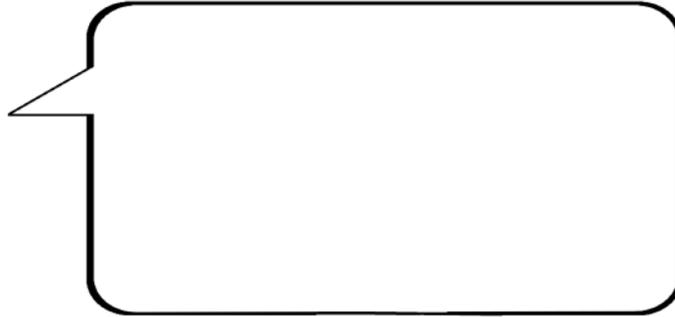
Write or draw how the person FEELS.

A large, empty rectangular box intended for writing or drawing about the person's behaviors.

Write or draw how the person BEHAVES.

Test

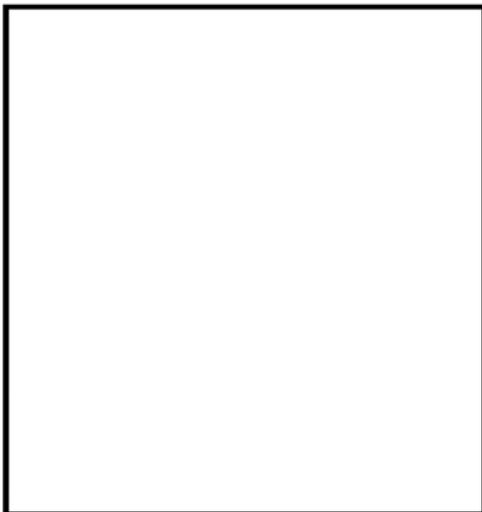
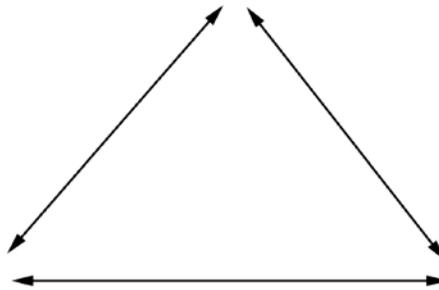
Write what the person is THINKING.



Thoughts

Feelings

Behaviors



Write or draw how the person FEELS.



Write or draw how the person BEHAVES.

SAMPLE TRAUMA NARRATIVE BY SCHOOL-AGE CHILD*

I am Lauren. I am seven-and-a-half years old. My sister Kelsey died on September 27, 2000. She was five-and-a-half. My family and I had fun together. We played Uno. On Tuesday September 26, 2000, the day before my sister died, we played games and we had fun. We played lots of things together. We used to play Play-Doh. But the Play-Doh got hard. On Tuesday September 27 we were playing on the sunporch. On September 27 I went to the bathroom. Meanwhile, my sister Kelsey was playing on the sunporch. When I was going to the bathroom, I didn't hear any noises. Meanwhile, my sister was playing on the sunporch. I was playing my Gameboy while I was going to the bathroom. When I went to the sunporch, Kelsey wasn't there. I thought she ran away, because when my mom yelled at her she moved into the bathroom! I looked around the house for her. I looked around the house but she wasn't there.

Then I looked in the basement and she wasn't there, so I looked out the window. I saw her and I thought "oh oh!" I felt very sad. I saw the window hanging and she was on the ground. She wasn't bleeding. That's what I don't get. I went outside to see if she was OK. I was staring at her. Her eyes were closed. I was feeling very sad and a little scared because it looked like she might be dead. Then I went to go get my dad. He was in the living room watching TV. I said, "Daddy, Kelsey's down on the ground." He just got up and he was running fast. We went outside. I was underneath the sunporch. My dad was lying on the ground holding Kelsey's head. She was trying to move her arm. She was moaning. I felt sad. I think my dad felt sad too. My neighbors called the ambulance. Josie asked me how she old she was and I said "five."

They wouldn't let me ride in the ambulance. I was mad. My dad rode in the ambulance with Kelsey. I rode with Josie's mom to Children's Hospital. I thought my sister was dead. We got to Children's Hospital. They took her to the operating room. I'm not sure. I went to the cafeteria and got an ice cream sandwich. Then I went up to the playroom with Darcie and Debbie and played with the pool table. I forgot all about it. We went down to the waiting room. We took up a whole room. My mom was there. I saw her before too. She cried a lot. I felt sad. I went to be with Mom and Dad. They hugged me. They squeezed me pretty hard. We were waiting for the news on Kelsey. The doctor came in and said "she has another chance." I thought she might stay alive.

Two doctors came and shook their head and we knew. We asked to see her — now! Everyone was crying. Daddy was so upset he threw a chair, well almost. Then they took Mom and Dad back to Kelsey. They cried. Daddy left the room to talk to me. Mommy stayed with Kelsey. It was hard for Mommy because Kelsey had a breathing tube. Kelsey was wrapped in a blanket so Mommy could hold her. Daddy told me Kelsey died. We walked down the hall and sat on the floor.

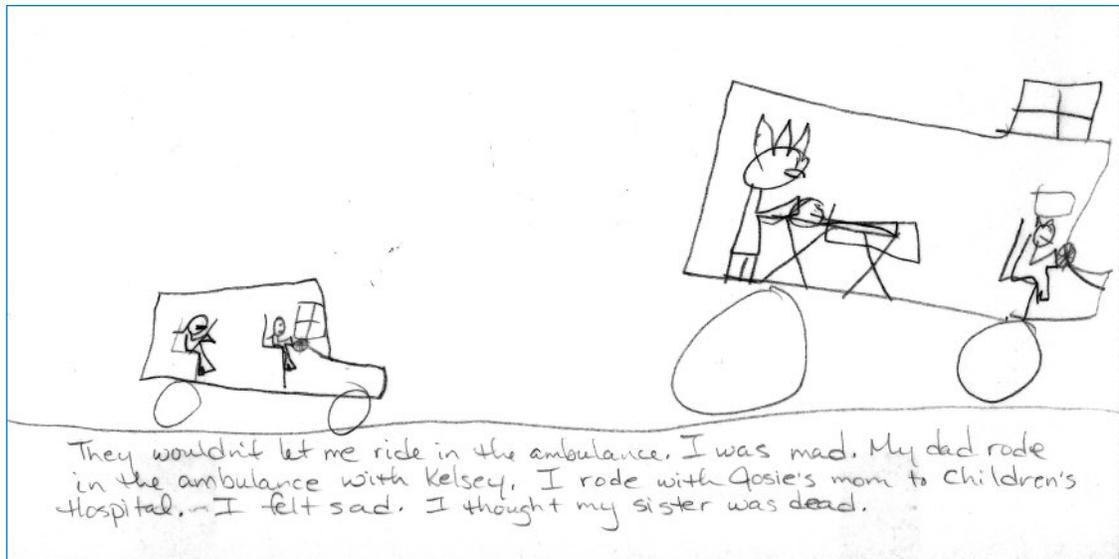
The doctor came in. I forget what he said. My mom and dad were squeezing me. The doctor said she died. I felt **very** sad. My mom and dad were crying. I never saw Kelsey, but my mom got to hold her. That really stinks. I feel **mad** that I didn't see her or hold her or hug her or kiss her or even get to say good bye to her. My mom and dad stayed and my Aunt Kathy and Gramma took me to Erica's house. I was very sad.

Daddy went to hold Kelsey and Mommy went to be with me. We sat together. Mommy went back to hold Kelsey. I went home with Aunt Kathy. I went to my friend Erica's house. When I woke up there were people around. Daddy carried me home. The people at the hospital were very nice. They gave me a Koala bear.

I stayed home from school. People came over to visit. Daddy called the coroner's office to find out when Kelsey would be sent to the funeral home. Kelsey broke her head, some ribs, and maybe her neck. It broke our hearts. I remember that!

When Kelsey was being born, I helped with everything. It was the same with this. We all went to Lazarus to pick out a dress for Kelsey to be buried in. It had sparklies and a bow. She would've loved it. I got one too. Shelby and I put most of Kelsey's shoes in a bag. We went to see Mr. Zalewski (Walt) at the funeral home. We went to pick the casket. They had all different kinds, but just one for children. We picked out the funeral cards. We made all the arrangements for the funeral. Friday night was a private family viewing. We went in by ourselves first. We went in and said hi and cried. We wanted to see her. She looked like herself but like she was asleep. I touched her arm. She was very cold. Ice cold. Then the family came in. We stood up by the casket and people came up to see Kelsey and to support us. There were lots of hugs and kisses. We put flowers and notes and pictures and a Barbie in her casket. I put a picture or note in. Saturday we had a viewing for everyone. There were so many people. We were there from two to four. Then the family went to eat. We stayed and ate downstairs. I went with Grandma for awhile. Seven to nine was another viewing. Sunday were viewings again. JJ brought Lauren a maroon bear. Kelsey got a white one. Mommy and I went to Kelsey and sang "You are My Sunshine" and "I Love You a Bushel and a Peck." Me and my friends sold penny candy for \$1. We got about \$20, and I bought mass cards for Kelsey.

Monday was the funeral. It was at 10 a.m. We went to the funeral home and said our final goodbyes to Kelsey. We rode in a limo to the church. The priest blessed us. Father Joe was crying. We can't remember what he said. We rode in the limo to the cemetery. The cemetery was really big. There were a lot of people waiting in line to come to her grave. I remember seeing her being buried. After the funeral we had a wake. It was a party for our family and friends to show their support. I remember getting presents and getting chips, pretzels, and Pepsi. People were talking and crying. I wore my daddy's jacket. After the wake, we went to Grandma's house. I didn't go back to school until the end of the week. The kids were hugging me. They made cards



for us. I didn't want to go back. My teachers knew. I didn't like that. It was my personal business. One day we were watching a movie about whales. It made me think about Kelsey. I was crying and my parents had to come pick me up. It's hard to get over.

About one week later, we went to pick out the headstone. They had all different shapes and sizes. I picked out the marble piece and it was multicolored. The plaque was Aztec blue. "Gone so young from our loving hearts..." It was at the cemetery about a month later.

I went to school and soon. Mom and Dad went back to work. People sent cards and money every day. The church took up a collection for us. Looking back on everything, my life has changed a lot without Kelsey here. It's changed me. I appreciate life more and try to do well in school. I miss her in my life. I miss her sleeping with me. I miss hugging her. I'm sad because my mom and dad cry. If I had a friend who had a brother or sister die, I would tell them to go see a therapist and they will help you a lot and make you feel at home. It's hard to talk about, but it made me feel better to talk about it. We learned a lot here. It makes you a lot better about your loss. I knew I'll always miss Kelsey, but I'll always remember her in my heart.

The End

**NOTE: The original trauma narrative included illustrations as shown in It's OK to Remember.*

SAMPLE TRAUMA NARRATIVE BY TEEN

Chapter 1: Who I Am

Hi. My name is Crystal. I am 13 years old and go to school in Pittsburgh. I like to play sports such as basketball. I have one brother who is 15 years old. I like to listen to music but most of all I like to hang out with my friends. I live with my mom during the year and my dad during the summer. My brother lives with his mom.

Chapter 2: Our Relationship

Harold was my mother's boyfriend. I knew him about three years. At first I got to know him because he was friends with my mother. Then he became her boyfriend, and a little bit after that we decided to move into his house because it was a much bigger place. When we moved I also had to switch schools. It was a tough experience at first but then I grew to like my new school. Harold always made me laugh. We would always tease each other and wrestle. Sometimes he would take me out to dinner and we would just hang out. He was like another father to me since I didn't see my real dad so much.

Chapter 3: Leading Up to the Day

A couple months before he died, Harold started working for another guy. Since he worked as a plumber he got a good paycheck most of the time. The new boss hadn't paid him for awhile and Harold was getting pretty upset. After work on Fridays my mom and Harold would go out for a drink. Sometimes they would fight a lot over stupid stuff and sometimes they got in bad fights. After he realized he hadn't gotten paid in a while he started getting angrier and would drink more. The fights would get worse and caused me and Harold not to hang out as much since he was angry and drunk a lot. About two weeks before he died he lost his job.

Chapter 4: The Big Day

The day Harold died was a pretty normal day. I got up and in the shower and headed off to school as I normally did. After school I found a note on the table telling me that my mom and Harold had gone out. I went upstairs to study and talk to my friends. I was having a great conversation with one of my best friends when I heard them pull up. It seemed to me that they were laughing and joking. But later I realized they were arguing about something. Harold called up to me to get off the phone so he could call the cops. I didn't think anything of it because he would do that sometimes when he was drunk. Throughout the evening they kept fighting about little things, nothing to lose your relationship over. Later on I went to downstairs to get something to drink before bed and my mom and I heard a loud bang. We didn't know what it was so we didn't think anything of it. As I was laying in bed I heard a loud and terrible scream. I got curious so I opened my bedroom door. I saw red flashing lights and I didn't know what to think so I laid back down. My mom came in with a police officer behind her and took me outside. The police had just told my mom that Harold had killed himself and she was screaming and crying. I didn't know what to think. I wasn't feeling

anything because I was in shock. I didn't know what to think or feel. A detective had come and asked my mom questions about what had happened. My grandma came and so did Harold's mom and one of his grown-up daughters. I felt really bad for my mom because when Harold's mom and his daughter pulled up his daughter got out of the car and was screaming "what did you do to my father?!" His mom was praying and I got out of the police car and gave her a hug. After a lot of commotion had gone on, my mom, Grandma, and I went back to my grandma's house and tried to sleep.

Chapter 5: The After Days

Harold committing suicide wasn't all bad. My mom has gotten involved in her church a lot more and has stopped drinking. She has also been spending more time with me. I have changed in ways too. I don't take things for granted anymore. I appreciate things in new ways, because you never really know how much something means to you until it's gone. I have thought a lot about the way Harold died. Sometimes it makes me upset because how could someone do such a foolish thing? It's selfish, I think when you commit suicide because you're not thinking about the people that love you. If Harold wasn't drunk I don't believe he would have done that. He was drunk at the time and when you're drunk you're not in your right mind. I don't think he killed himself purposely to hurt my mom. I knew he loved her and would never want her to go through that kind of pain. If he had done it on purpose then he really wasn't the person I thought he was. I think he is 100 percent responsible for what he did because he chose to get drunk and he chose to let himself get upset and everything. My mom tried to help him not drink. I don't really think anyone could have stopped him from doing what he did. My mom once tried to get him to go to therapy or something. He said he would but I guess he didn't. If this happened to another child I would tell them that everything happens for a reason. Don't always think about the negative about the situation. It may help you get stronger like it has with me.

INFORMATION FOR PARENTS ON CHILDHOOD TRAUMATIC GRIEF

Introduction

This guide to childhood traumatic grief for parents builds on the “In-Depth General Information Guide to Childhood Traumatic Grief” and “Brief Information on Childhood Traumatic Grief,” which can be found at NCTSN.org. Those publications should be read in conjunction with the information here as they provide essential background for understanding the difference between uncomplicated bereavement following a death, childhood traumatic grief, and other reactions to trauma.

Not every child who experiences a death will develop childhood traumatic grief. Many children will experience an appropriate grieving response and in time, with adequate support, adjust to the loss of the loved one. In some cases, however, children may have enduring difficulties that interfere with their ability to function and remember the person who died in positive ways.

The information presented here provides an overview of childhood traumatic grief, its general signs and symptoms, and some suggestions on what parents can do to help their child. Using this guide can be a first step for parents to help them understand their child’s experience of intense grief following a death of a loved one that the child experienced as being especially difficult or traumatic. If you are a concerned parent or guardian and after reading this guide you think that your child is demonstrating the symptoms of childhood traumatic grief, we recommend that you seek further help.

What Is Childhood Traumatic Grief?

When someone special dies, it can be a very sad and painful experience for the child. When the death occurs as a result of a traumatic event, or when the child experiences the death as traumatic, the child may show signs of both trauma and grief. Childhood traumatic grief is explained more fully in the “In-Depth General Information Guide to Childhood Traumatic Grief,” but the following basic facts hold true:

- Childhood traumatic grief is an intense grief response that can occur following the death of a loved one.
- Childhood traumatic grief is different from and can interfere with the normal bereavement process following the death of a loved one.
- Not all children who have been exposed to deaths they perceive to be shocking will develop childhood traumatic grief.
- Childhood traumatic grief may appear differently in different children.

- Parents, caregivers, and important adults can help children cope with childhood traumatic grief.
- Help is available to parents and children who are experiencing childhood traumatic grief.

Childhood traumatic grief is a condition that some children develop after the death of a close friend or family member. Children with childhood traumatic grief experience the cause of that death as horrifying or terrifying, whether the death was sudden and unexpected (due to homicide, suicide, motor vehicle accident, natural disaster, war, terrorism, or other causes) or due to natural causes (such as cancer or a heart attack). Even if to you, as the adult, the manner of death does not seem to be sudden, shocking, or frightening, the child may perceive the death in this way and can be at risk of developing childhood traumatic grief.

When a child is struggling with childhood traumatic grief, the child's trauma reactions interfere with his or her ability to go through a normal bereavement process. Because of the interaction of traumatic and grief reactions, any thoughts, even happy ones, of the deceased person can lead to frightening memories of how the person died. Because these thoughts can be so upsetting, the child often may try to avoid all reminders of the loss so as not to stir up upsetting thoughts or feelings. A younger child may be afraid to sleep alone at night because of nightmares about a shooting that she witnessed, while an older child may avoid playing on the school baseball team his father used to coach because it brings up painful thoughts about how his father died in a terrible car accident. In this way, the child can get "stuck" on the traumatic aspects of the death and cannot proceed through the normal bereavement process.

How Is Childhood Traumatic Grief Different from Normal Grief?

In both normal grief (also called *uncomplicated bereavement*) and childhood traumatic grief, children often feel very sad and may have sleep problems, a loss of appetite, and a decreased interest in family and friends. They may also develop increased complaints of physical discomfort (such as headaches or stomachaches), or they may regress and return to behaviors they had previously outgrown (such as bed wetting, thumb sucking, or clinging to parents). They may also be irritable, do risky things, be withdrawn, have trouble concentrating, and think often about death.

Children experiencing normal grief usually want to talk about the person who died, do things to remember the person, and perhaps find comfort in thinking about the person. Over time they also are able to complete the following "tasks" of normal bereavement:

- Accept the reality and permanence of the death
- Experience and cope with the range of feelings about the person who died, such as sadness, anger, guilt, and appreciation

- Adjust to changes in their lives and identity that result from the death
- Develop new relationships or deepen existing relationships with friends and family
- Invest in new relationships and life-affirming activities
- Maintain a continuing, appropriate attachment to the person who died through such activities as reminiscing, remembering, and memorialization
- Make some meaning of the death that can include coming to an understanding of why the person died
- Continue through the normal developmental stages of childhood and adolescence

For children experiencing childhood traumatic grief, thinking or talking about the person who died often leads to thoughts of the traumatic manner of death. For this reason, these children often try to avoid thinking or talking about the person who died and avoid facing the frightening feelings associated with these reminders. This prevents them from completing the tasks of normal bereavement mentioned above.

What Are Some Common Signs that a Child Is Struggling with Traumatic Grief?

Not all children who experience a traumatic death will develop childhood traumatic grief. Some children will be able to grieve the loss without complications. A small number of grieving children may develop some reactions or symptoms that can become difficult and perhaps interfere with their daily functioning. Signs that a child is having difficulty coping with the death may be noticeable in the first month or two or may not be apparent until one or more years later. Some of these signs include the following:

- ***Intrusive memories about the death:*** These can be expressed by nightmares, guilt or self blame about how the person died, or recurrent or disturbing thoughts about the terrible way someone died.
- ***Avoidance and numbing:*** These can be expressed by withdrawal, acting as if not upset, or avoiding reminders of the person, the way he or she died, or the things that led to the death.
- ***Physical or emotional symptoms of increased arousal:*** Children may show this by their irritability, anger, trouble sleeping, decreased concentration, drop in grades, stomachaches, headaches, increased vigilance, and/or fears about safety for oneself or others.

What Additional Challenges Can Increase the Risk of Childhood Traumatic Grief? (Secondary Adversities)

Children who must face additional difficult experiences as a result of the death or are already facing stressful life circumstances are at risk for developing traumatic grief. For example, after a father's death, a child who has to move must contend with both the death of her parent as well as changes in her social network, and a child who is witness to the murder of a family member must deal with legal procedures and unpleasant questions from peers.

What Can Parents Do to Help Children and Teenagers?

Parents can play a very important role in helping children and adolescents affected by childhood traumatic grief. Children may be struggling with finding ways to understand and cope with their reactions to a traumatic loss. Here are some suggestions about ways that parents can help support children:

- Be aware of the common reactions of children to death described above.
- Remember that not all children will develop childhood traumatic grief, and those that do may demonstrate a range of symptoms depending on their developmental level, personality, and prior history of traumatic experiences.
- Provide children of all ages with opportunities to talk about their worries and concerns. Children at different ages may need different types of support. Younger children may need more attention, patience, understanding, and a few extra hugs. Older children may need reassurance that it is normal to experience a range of reactions and that there are adults in their lives to help them through difficult times. Some children, especially older children, may not want to talk about their experiences and feelings or may shut adults out.
- Understand that anger or regressive behavior may be a part of a child or adolescent's reaction to a traumatic loss.
- Recognize that children of all ages carefully observe how the adults in their lives are reacting and will often take their cues from the adults around them. Children will find comfort by observing how adults manage difficult reactions and model effective ways of coping.
- Be prepared to revisit the loss with children as they become older and acquire new information, develop new questions, and have new experiences.
- Seek support from friends and family to help manage your own grief.
- Reach out for professional help if you're concerned that a child's reactions are affecting his or her daily life.

Additional help is available through the National Child Traumatic Stress Network at (310) 235-2633 and (919) 682-1552 or at NCTSN.org.

REFERENCE AND RESOURCE LIST

Mental health professionals are encouraged to consult the following professional articles and resources to gain an understanding of childhood traumatic grief. Background information sheets about the condition, based on these materials, as well as assistance locating an appropriate mental health professional with expertise in Childhood Traumatic Grief is available from the National Child Traumatic Stress Network at (310)235-2633 or (919) 682-1552 or at NCTSN.org.

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Books for Children and Teens on Trauma and Bereavement

- Agee, J. (1957) *A Death in the Family*. New York: Bantam. (ages 13 and up)
- Aliki (1979) *The Two of Them*. New York: Greenwillow Books. (ages 3–8)
- Buscaglia, L. (1982) *The Fall of Freddie the Leaf: A Story of Life for All Ages*. Thorofare, NJ: Slack, Inc. (all ages)
- Canfield, J. Hansen, M. V., Kirberger, K, (Eds.) (1997) *Chicken Soup for the Teenage Soul: 101 Stories of Life, Love and Learning*. Deerfield Beach, FL: Health Communications, Inc. (ages 12 and up)
- de Paola, T. A. (1973) *Nana Upstairs and Nana Downstairs*. New York: Putnam. (ages 4–8)
- Gray, A. (1999) (Ed.) *Stories for a Teen's Heart Sisters*, OR: Multnomah Publishers. (ages 13 and up)
- Grollman, E. (1993) *Straight Talk About Death for Teenagers: How to Cope With Losing Someone You Love* Boston: Beacon Press. (ages 13 and up)
- Gunther, J. (1949) *Death Be Not Proud: A Memoir*. New York: Harper. (ages 13 and up)
- Harris, R. H. (2001) *Goodbye Mousie*. New York: Margaret K. McElderry Books. (ages 4–8)
- Holmes, M. M., Mudlaff, S. J. (2000) *A Terrible Thing Happened: A Story for Children Who Have Witnessed Violence or Trauma*. Washington, DC: Magination. (ages 4–8)
- Kremnetz, J. (1988) *How it Feels When a Parent Dies*. New York: Knopf. (all ages)
- Mellonie, B. and Ingen, R. (1983) *Lifetimes: A Beautiful Way to Explain Death to Children*. New York: Bantam. (ages 3–8)
- O'Toole, D. (1998) *Aarvy Aardvark Finds Hope : A Read Aloud Story for People of All Ages About Loving and Losing, Friendship and Loss*. Burnsville, NC: Celo Press. (all ages)
- Paterson, K. (1977). *Bridge to Terabithia*. New York: Crowell. (ages 12 and up)
- Porterfield, K. M. (1996) *Straight Talk about Post-Traumatic Stress Disorder: Coping with the Aftermath of Trauma*. New York: Facts on File. (ages 13 and up)
- Romain, T. (1999) *What on Earth Do You Do When Someone Dies? Minneapolis: Free Spirit*. (ages 9 and up)
- Smith, D. B. (1973) *A Taste of Blackberries* New York: Crowell. (ages 9–12)
- Thomas, P. (2001) *Miss You: A First Look at Death*. Hauppauge, NY: Barrons. (ages 4–8)
- Varley, S. (1984). *Badger's Parting Gifts*. New York: Lothrop. (ages 5–8)
- Viorst, J. (1971) *The Tenth Good Thing about Barney*. New York: Atheneum. (ages 4–7)
- White, E. B. (1952) *Charlotte's Web*. New York: Harper. (ages 4–8)

Suggested Treatment Books and Supplies

Creative Therapy Associates: <http://www.ctherapy.com/> (*How Are You Feeling Today* posters and supplies)

The Goodbye Game, M & B Distributors PH: 1(204) 728-3758

The Grief Game, Jessica Kingsley Publishers, 116 Pentonville RD, London N1 9JB, www.jkp.com

Black, C (1984) *The Stamp Game: A game of feelings*. Denver: MAC Printing and Publications.

O'Conner, K (1983) The Color-Your-Life technique. In C. E. Schaefer & K. J. O'Conner (Eds.) *handbook of play therapy* (pp. 251-258). New York: Wiley.

WPS-11 Emotional Bingo for Children (6–12). Available @ www.slosson.com/item98761.ctlg

Manuals

Cohen et al. (2001) *Cognitive behavioral therapy for traumatic bereavement in children: Treatment manual*, available by contacting the National Resource Center for Child Traumatic Stress at (919) 682-1552 or nationalresourcecenter@duke.edu.

Cohen et al. (2001) *Cognitive behavioral therapy for traumatic bereavement in children: Group treatment manual*, available by contacting the National Resource Center for Child Traumatic Stress at (919) 682-1552 or nationalresourcecenter@duke.edu.

Lieberman, A. F., Compton, N. C., Van Horn, P. & Ghosh Ippen, C. (2003) *Losing a parent to death in the early years: Guidelines for the treatment of traumatic bereavement in infancy and early childhood*. Washington, DC: Zero to Three Press.

Saltzman, W. R., Layne, C. M., Pynoos, R. S. (2003) *Trauma/grief-focused intervention for adolescents*, available by contacting wsaltzman@sbcglobal.net.

Training

Contact the National Child Traumatic Stress Network at (310) 235-2633 or (919) 682-1552 or www.NCTSN.org

Websites

National Center for PTSD, *Managing Grief after Disaster*. www.ncptsd.org/facts/disasters/fs_grief_disaster.html

National Child Traumatic Stress Network: NCTSN.org