COGNITIVE BEHAVIORAL THERAPY FOR TRAUMATIC BEREAVEMENT IN CHILDREN TREATMENT MANUAL

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TABLE OF CONTENTS

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INTRODUCTION

Until the 1990's, the fields of thanatology (bereavement) and traumatology developed independently, with little communication about the intersection of these disciplines. Efforts in the late 1990's led to greater recognition that many children experience bereavement combined with posttraumatic stress disorder (PTSD) or other trauma-related conditions. This typically happens when children lose a loved one to unexpected, violent or particularly gory deaths, or when children are exposed to graphic details such as blood, mutilated or missing body parts, or being the first person to discover the body of the loved one. Examples include death due to interpersonal violence (community, domestic or school settings), motor vehicle or other accidents, suicide of a family member or peer, natural disasters, or acts of terrorism. However, in some instances, children can develop PTSD in the absence of objective "trauma" causing the death of the loved one.

DEFINITION OF CHILDHOOD TRAUMATIC BEREAVEMENT

Because of inconsistency of terminology used by various authors, and because the adult

condition "Complicated Grief" was formerly called "traumatic grief," and described a somewhat different condition than what authors writing about children were describing, there has been some confusion and disagreement about the definition of childhood traumatic bereavement (also called traumatic grief or traumatic loss). We define different types of bereavement here for greater clarity in this treatment manual, recognizing that there is not universal agreement about these definitions.

Uncomplicated bereavement refers to the normal process of grieving for the loss of an important relationship. This condition resembles the diagnosis of Major Depressive Disorder (MDD) in several regards, and MDD is typically not diagnosed in the first 2 months after the death of a loved one, unless the bereaved person has 1) "guilt about things other than actions taken or not taken by the survivor at the time of death; 2) thoughts of death other than the survivor feeling that he or she would be better off dead or should have died with the deceased person; 3) premorbid preoccupation with worthlessness; 4) marked psychomotor retardation;
5) prolonged or marked functional impairment, and 6) hallucinatory experiences other than thinking that he or she hears the voice of, or transiently sees the image of, the deceased person" (APA, 2000, p 741). Although early writings suggested that there were standard "stages" of grieving as described by Kubler-Ross and others, more recent authors have contested this (Simpson, 1997). There is also great variability in how long it takes people to complete "normal" grieving.

Complicated grief refers to bereavement accompanied by symptoms of separation distress and trauma (Prigerson et al,1995; 1997), and in reference to adults, this term has in the past been used interchangeably with the terms "traumatic bereavement" or "traumatic grief" (Prigerson et al., 1997). Complicated bereavement in adults typically occurs following a death which would

not be objectively considered to be "traumatic" (i.e., not resulting from an unanticipated, horrifying event), and requires that the person experience a) extreme levels of three of the four "separation distress" symptoms (intrusive thoughts about the deceased; yearning for the deceased, searching for the deceased, and excessive loneliness since the death), as well as b) extreme levels of four of the eight "traumatic distress" symptoms (purposelessness about the future; numbness, detachment or absence of emotional responsiveness; difficulty believing or acknowledging the death; feeling that life is empty or meaningless; feeling that part of oneself has died; shattered world view; assuming symptoms of harmful behaviors of the deceased person; excessive irritability, bitterness or anger related to the death) (Prigerson & Jacobs, 2001). Additionally, these symptoms must have lasted at least 6 months (Criterion C) and lead to significant functional impairment (Criterion D). Complicated grief is measured by the Inventory of Complicated Grief (ICG), and is associated with increased risk of psychiatric comorbidity and physical illness in adults.

The term **traumatic bereavement** (TB) has been used somewhat differently in the child literature, and typically refers to a condition in which both grief and trauma issues are present. In most descriptions of this condition, the PTSD symptoms of intrusive traumatic reminders (whether true or imagined) and avoidance encroach upon and interfere with the child's bereavement symptoms in a manner that precludes resolution of either the PTSD or grief (Layne, Saltzman, Savjak & Pynoos, 1998; Nader, 1997a; Pynoos, 1992; Rando, 1996). One team of investigators has developed a measure of TB which consists of 20 items; factor analysis indicates three independent factors of this scale including positive reminiscing, intrusion of PTSD on grieving process, and existential loss.. This measure, the Grief Screening Scale (Layne, Steinberg, Savjak & Pynoos, 1999; 1998), has shown strong psychometric properties and may be used by clinicians to

follow the clinical course of TB during treatment. It is included in Appendix 1 of this manual. PTSD symptoms should also be independently evaluated, using instruments and/or interview techniques described in detail elsewhere (AACAP, 1998). In order to facilitate therapists in measuring PTSD symptoms, the child and adolescent versions of the UCLA PTSD Index for DSM-IV (Pynoos et al., 1998) are included in Appendix 1 of this manual. Either of these instruments may be used to follow the course of PTSD symptoms during treatment. Because of developmental variations in the way PTSD presents in children of different ages (AACAP, 1998), younger children in particular may not meet DSM-IV-TR diagnostic criteria for PTSD, yet may have many psychological characteristics associated with this disorder. It thus may be more difficult to identify TB in younger children.

WHY DISTINGUISH TB FROM OTHER FORMS OF BEREAVEMENT?

Uncomplicated bereavement in childhood, even when it involves the loss of a parent, does not appear to place children at increased risk for ongoing mental illness, provided they have adequate parenting after the death (Harrington & Harrison, 1999). However, the presence of childhood PTSD places children at risk for developing other serious psychiatric conditions, including depression, substance abuse, and borderline personality disorder, which may last for years, into adulthood and beyond (AACAP, 1998). Additionally, there is evidence that children with PTSD have abnormal psychobiological functioning, smaller brains and lower IQS than children without this disorder, and that the degree of impairment is directly related to the amount of time that has passed since the traumatic event occurred (DeBellis et al., 1999a; 1999b). Thus, it is critical that children who are developing or who have PTSD, receive the best possible treatment to resolve these symptoms as early in the course of the disorder as possible . As discussed above, some children with TB do not meet diagnostic criteria for a diagnosis of PTSD.

However, we believe that children who have TB may be at heightened risk of developing PTSD if their trauma-related issues are not addressed in treatment. On the other hand, addressing the traumatic aspects of TB without resolving bereavement issues will not adequately address the needs of these children, and may make them more vulnerable to relapsing trauma symptoms. Children with TB therefore need treatment which addresses both the trauma/ PTSD symptoms and the bereavement issues that they are experiencing. We have developed this treatment model, individual child and parent cognitive behavioral therapy for traumatic bereavement (CBT-TB) in order to address these needs. We chose to adapt trauma-focused CBT for use in this population, because of all the interventions which have been scientifically evaluated for treating childhood PTSD, CBT has the most support (Cohen et al., 2000). Like all specific treatment models, empirical evaluation will be needed to determine whether CBT-TB is effective and/or superior to other treatments in decreasing symptoms and improving adaptive functioning in children with TB.

THE IMPORTANCE OF DEVELOPMENTAL LEVEL

Cognitive, social, and emotional development have a crucial influence on a child's ability to negotiate grief (Christ, 2000; Geiss et al., 1998; Nagy, 1948). In fact, Piaget's cognitive theory of development is most often used when conceptualizing the child's understanding of death. For this reason, we include a brief review of children's concept of death and **normal bereavement** reactions at different developmental stages. Therapists should be knowledgeable about these concepts in order to appropriately adapt CBT-TB for children of varying developmental levels.

Very young children, age 4 and younger, are unable to comprehend the permanence of death. They are likely to continue asking, "When will daddy be home?" Their response to grief may be very intense but brief. They are most aware of any alterations in their daily care and routines. It is common to see difficulties with eating, sleeping, bed wetting, and insecurity at this

stage. Interventions at this stage should consist of brief interactions with frequent repetition. These children need consistency, comfort, and physical closeness, and if these are provided will usually not require specialized therapeutic interventions.

"Magical thinking" marks a 5 to 8 year old's cognitions. These children may feel guilt because they mistakenly believe that they caused the death. For example, they might believe that because they were mad at their parent, they made them die. These children will perhaps be most likely to develop multiple cognitive distortions. These children will be concerned with how and why, with repetitive questioning. They tend to play out aspects of the death or funeral that they have experienced or imagine. Nightmares, sleeping and eating problems may arise, along with violent play and attempts to take on the role of the person who died. At this age, children are able to express feelings and memories. Drawing and symbolic play are excellent methods of encouraging such expression. It should be noted that many 6-8 year olds can also engage in directive feeling expression (as described below).

Eight to 11 year olds enter the realm of concrete operations and are interested in facts and information. Because their ability to understand concepts is increasing (such as the permanence of death), they become more able to experience the feelings associated with those thoughts. Unfortunately, they are not adept at appropriate expression of such emotion and can be easily overwhelmed. They will want to know as much as they can about the death and may become angry if they believe information is being kept from them. Problems in school, withdrawal from friends, acting out, and eating and sleeping problems are all possible. In addition, suicidal ideation may appear but is usually a wish to join the deceased rather than a true wish to end one's life. Nevertheless, suicidal ideation should always be carefully screened by a competent clinician. Symbolic play continues to be helpful for these children but adults need to be prepared

to give age-appropriate information and to praise the child for their ability to question and discuss the death. Talking is extremely important to this age group. In addition, because their understanding of death and mourning has increased but they may remain confused about what to do with such information, these children may need professional and parent assistance in creating concrete ways of mourning or memorializing their loved ones.

Formal operational thought begins by age 11 when these children are able to use formal problem solving and abstract thinking. Children ages 11-18 begin to truly conceptualize death and work at making sense of such concepts. They can become egocentric as they focus on the tasks of separation and identity development. A permanent separation, as in the case of death, may interfere with that process. These children may become depressed, very angry, noncompliant, and rejecting of former values held by themselves or by their parents. It is important to allow adolescents to take some control. This can be encouraged through active listening and by not attempting to take the grief away or fix the problem for them. They are quite aware that this is not possible. Christ (2000) found some interesting differences between early and late adolescents in this regard. Specifically, she noted that 12-14 year olds were more isolative. They were less likely to reach out to friends for support and struggled to control any expression of emotion. These children in particular might benefit from directive feeling expression exercises, as described below. Older adolescents (15-18 year olds) on the other hand were more likely to share their experience with people outside of the family and were able to express intense emotions.

This treatment manual was developed for children and adolescents 7-16 years of age. The SAMHSA National Child Traumatic Stress network and Traumatic Bereavement Task Force are in the process of revising a group treatment manual for adolescents with TB (Layne et al., 1999),

and with Dr. Alicia Leiberman of UCSF, are developing a manual for preschool children with TB.

THE IMPORTANCE OF CULTURE IN TREATING CHILDHOOD TB

Although studies have shown that PTSD occurs across diverse cultures, cultural factors can affect how this disorder is manifested (Ahmad & Mohamad, 1996; DiNicola,1996; Jenkins& Bell, 1994). For example, some Latino children may manifest PTSD symptoms as *susto* ("fright" or "soul loss"), an illness which is attributed to a frightening event that causes the soul to leave the body, resulting in somatic symptoms, sleep and appetite disturbances, sadness, poor self-esteem and impaired functioning (APA, 2000). American Indians may develop *ghost sickness*, a preoccupation with death and the deceased resulting in bad dreams, feeling of danger, fear, hopelessness, and symptoms of panic (APA, 2000). Additionally, different cultural and religious groups have their own traditions and rituals for addressing death and bereavement. Because children live in a family and community, which likely influence both the way they manifest distress and access support, it is essential that therapists treating childhood TB understand the broader context of the child's family and cultural/religious community (Cohen, Deblinger, Mannarino & DeArrellano, 2000). The therapist should discuss these issues directly with the parent/caretaker, and in some cases with the child as well. This will facilitate the therapist in applying the CBT-TB interventions in a manner which respects and benefits from the child's culture and religion.

PHASE-ORIENTED TREATMENT

Many authors, as well as our clinical experience, suggest that when trauma and bereavement symptoms are both present, it is advisable, and often essential, to address and at least

partially resolve the trauma issues before the bereavement issues can be successfully processed (Nader, 1997; Rando, 1996; Layne et al., 1999). This may be particularly true for certain traumatic reminders or obsessions, for example, when the child is fixated on the most horrifying aspects of the dead body, or does not have accurate information on how the person died and imagines repeatedly about "worst case" scenarios. Often in such children, even positive memories of the deceased (an important aspect of negotiating the bereavement process) segue into traumatic reminders, i.e., the child can't think of the deceased without remembering the terrifying details of the death. Additionally, children who have avoidance symptoms may be so detached from their feelings that they are unable to experience their grief. For these reasons, some trauma-focused interventions are typically utilized in the beginning phase of CBT-TB, with bereavement issues being addressed later in treatment. However, individual children progress at their own pace, and on their own path. Some children will resolve most or all trauma symptoms before moving on to bereavement issues, but many children will need to intersperse bereavement and trauma work, according to which issues are most problematic at different times. Thus, the trauma and bereavement phases of treatment may be interwoven as clinically indicated.

External factors may also influence the phasing of treatment. For example, investigation, media attention or litigation related to the deceased's death, an intervening traumatic event or familial death (even if by natural causes), may retrigger traumatic reminders, excessive avoidance, anger, or other PTSD symptoms which had previously dissipated. Returning to trauma-focused interventions may be warranted in such situations.

THE IMPORTANCE OF THERAPIST AND FAMILY CREATIVITY

This manual suggests several specific techniques which may be useful in implementing the

CBT-TB interventions. However, therapists are encouraged to use their own creativity, instincts and clinical experience in developing individualized methods and techniques. CBT is an interactive, collaborative form of treatment, and child and parent input should also be encouraged with regard to specific therapeutic activities. We welcome children's and parent's ideas for how to practice or clarify these CBT principles during therapy. For example, if a child prefers to write a song or create a collage instead of writing a book for the gradual exposure (GE) component, this should be encouraged. The therapist should find creative ways to implement the telling of details and repeated graduated exposure in this situation. Thus, while all of the CBT principles should be included in the child's treatment, the specific manner in which these are implemented is highly flexible.

OPTIMIZING ADAPTIVE FUNCTIONING

The term "secondary adversity" is used to describe additional difficulties that arise as a result of an identified primary problem. In order to optimize adaptive functioning (the ability to optimally function in one's family, with peers and at school, in a state of physical and emotional health), it is important to prevent or minimize secondary adversities. In the context of a traumatic loss, these difficulties may include any psychological, financial, legal, medical, or other situation, that arise either as a result of the traumatic death, or secondary to the child's or parent's TB reactions.

Few people are informed about or prepared for the complexities of legal and administrative actions that need to be completed following a death. These are further complicated in cases of traumatic death when the remains are not located or identified for a prolonged period of time, as in the case of the 2001 terrorist attacks on the U.S.; or when release of official records of victims' names is delayed, as was the case in the1994 crash of USAir Flight 427 in Pittsburgh (Stubenbort

et al., 2001). Locating financial records, gaining access to the deceased's financial assets, settling the deceased's estate, accessing insurance benefits, etc, are all potentially difficult tasks under the best of circumstances; TB may impair the surviving parent's ability to complete these tasks in a timely manner, which may negatively impact on the family's financial situation. In some cases, the family may have lost their home (for example, in a fire or explosion), means of transportation (in a motor vehicle accident), or ability to pay for essentials such as food, electricity, mortgage, et.. It is imperative that surviving parents/caretakers be provided with information and resources to address these needs, and in some cases the therapist may be the most readily available source of such information. For this reason, therapists treating children with TB should familiarize themselves with resources such as state Victims Compensation services, the American Red Cross (which provides emergency food, shelter and clothing for survivors of fires or disaster situations), free or reduced fee legal aid services, Aid for Dependent Children (food stamps, etc.), and other social service agencies whose mission is to address these needs. In some cases the therapist will need to advocate for the child in non-therapeutic settings (for example, assisting school personnel in recognizing traumatic behaviors in the child which may be impairing his or her ability to function in school). These interventions are not formally included in the CBT-TB

treatment components, but may be as important to the child's recovery as any other interventions the therapist may provide.

Children with preexisting psychiatric or medical conditions may experience exacerbations of these difficulties following a traumatic death. In order to prevent secondary adversities related to these conditions (such as school failure, violent or aggressive behaviors, etc.) therapists should be experienced at diagnosing the full spectrum of child psychiatric disorders, and be knowledge-

able about appropriate treatments and/or referral resources, and address these comorbid conditions in a timely manner.

Finally, it is important to recognize the special needs of children who have lost both parents, or a single parent who was the child's sole caretaker. These children have experienced not only trauma and loss of parent(s), but also are likely to be displaced from their home, school, peers, and/or community as a result of going to live with relatives or in foster homes. Since these children are deprived of the parental support and stability which normally assists children in adapting to such changes, they have even greater challenges to overcome. Assuring placement with a competent caretaker, and preferably a relative or family friend with whom the child has comfort, and who knew the deceased parent(s), should be the first priority. The new caretaker also faces significant challenges, both practical (financial, arranging legal custody, dealing with new schools, pediatricians, adjusting family routines to accommodate a child raised with different routines) and emotional (adjusting to being the caretaker for a traumatized and bereaved child). Therapists may assist the new family by helping to establish optimal communication between the child and new caretaker (for example, facilitating flexibility in the child and caretaker in adjusting to each others' rules, expectations, etc.). Although this is presented in the section on Parenting Skills, these issues may need to be addressed throughout the course of CBT-TB treatment.

As noted above, the individual child and parent treatment components are provided in parallel, with 1-2 joint family sessions following the trauma-focused component and 1-2 joint sessions near the end of treatment. For clarity, the child and parent interventions are described in separate sections. We have typically had one therapist treat each child-parent dyad, and have found that this facilitates treatment of both the child and parent. (For example, when the child or

parent expresses concern about the other's reaction to specific therapeutic interventions, the therapist is knowledgeable and credible regarding that reaction, and therefore optimally able to provide appropriate reassurance.) Typically, the child and parent are each seen for 30-45 minutes in each treatment session.

If more than one child in the family is being treated for TB using this protocol, we typically see each child individually for 30-45 minutes, and then see the parent individually for 45 minutes. Although much of the information given to the parent will be similar for both children, the parent session may need to be extended to 60 minutes in order to give appropriate attention to each child's individual situation. Also, in the case of multiple siblings receiving treatment, we typically have provided separate joint child-parent sessions for each child.

CHILD TREATMENT

TRAUMA-FOCUSED INTERVENTIONS

Trauma-focused CBT interventions include components of Stress Inoculation Therapy (SIT), Gradual Exposure (GE) and Cognitive Processing (CP). In order to assist therapists in implementing the treatment model, we have organized this manual by treatment session. Thus, specific elements of each of these components are described as they are typically provided in treatment. However, this order is flexible and may be adapted to each child's and parent's individual needs.

SESSION 1: ORIENTATION TO CHILD CBT-TB TREATMENT; STRESS INOCULATION THERAPY

It is important for the therapist to spend some time in the initial treatment session orienting the child to the CBT-TB model. This consists of explaining to the child the reason that the child is coming to treatment and what treatment may consist of. The following should be addressed:

- Someone very important to the child has died.
- The nature of death was traumatic.
- The nature of the trauma was intentional (i.e., a group of terrorists planned and purposely carried out acts meant to hurt or kill many innocent people).
- When such a terrible thing happens, people usually have a lot of strong feelings and the natural tendency is to not want to talk about it.
- Through working with a lot of children who have had such experiences we have learned that talking about these feelings is the best thing to do.

It may be helpful if the therapist begins by telling the child a bit about him/herself and then gives the child the opportunity to ask questions and share some personal information. Following this the therapist may introduce the nature of CBT-TB treatment in this manner:

> "I know how hard it is to talk about painful things, especially to someone who you don't know all that well. Let's begin by talking about why you are here. What is your idea about why you are coming here?" (Let the child answer).

The therapist may then confirm or explain the purpose of treatment as follows:

> "You are here because someone whom you cared about very much

has died, and that person died in a very terrible way. Even worse, that person died because some other people wanted to kill people in the United States. It would really help me to know, at least a little bit, about what has happened to you and your family. Can you tell me something about the person you love who died? Who was the person? What was his (or her) name? What was he (or she) like?" (Allow the child to respond to each question. The child may be reticent to talk. Give the child time and encouragement to respond.)

"During therapy, we are going to have a lot of time to talk about the person who died and the feelings you are having about what happened. I'm sure that you are having a lot of strong feelings. After working with lots of kids who have lost someone they love, we have learned that the more kids talk about this stuff, the better they feel and the easier it is to talk. Sometimes it is easiest to begin by just talking about feelings, any kind of feelings at all."

At this point, the therapist typically proceeds to introduce feeling identification (described below under Stress Inoculation Therapy).

Stress Inoculation Therapy (Sit)

Stress Inoculation Therapy refers to a variety of interventions which protect children from the negative effects of stress, and encourage the use of optimal coping skills. The SIT techniques used in CBT-TB include feeling identification, relaxation (deep breathing and progressive muscle relaxation), thought stopping, cognitive coping, and enhancement of sense of safety. We typically

start CBT-TB treatment by introducing SIT techniques because many children benefit from mastering these skills prior to embarking on the gradual exposure and cognitive processing components of CBT.

Feeling identification involves assisting children in accurately identifying their feelings. For children exposed to terrorist attacks, the fact that someone intentionally set out to injure or kill the child's loved one may lead to intense feelings of anger, fear, hatred or wanting to get even (revenge). It is important that the therapist state that many children may have these feelings and that all feelings are okay to feel because feelings are not actions and therefore are not by themselves harmful. This involves practicing the skill of feeling identification. The therapist should begin by asking children to write down all the different feelings they can think of in 3 minutes (younger children may only be able to think of 5-10 feeling words, whereas adolescents will typically identify more feelings than they can write in 3 minutes). This exercise helps the therapist to estimate how adept the child is at identifying different feelings. Through the use of commercially available games such as Emotional Bingo (Western Psychological Services, 1998), the Mad, Sad, Glad Game (Peak Potential, Inc., 199), or the Stamp Game (for older children and teens) (Black, 1984), the therapist should then have the child practice identifying feelings that occur in diverse situations (getting an "A" on a test, someone teasing you at school, etc.), and identifying situations in which the child would experience a specific feeling (for example "tell me a time you felt embarrassed"). Another useful feeling identification intervention is the "Color Your Life" technique (O'Conner, 1985). The therapist asks the child to pair different colors with specific feelings, and then the child is asked to elaborate on each feeling. This technique facilitates the ability to access a variety of cognitions and feelings and it is also fun for children because they are able to draw. In addition to appropriate identification and expression of thoughts

and feelings, the therapist may find this technique helpful in identifying salient treatment foci. These games/ activities should be continued until the child is able to accurately identify a variety of feelings in the appropriate situations.

SESSION 2: SIT (CONTINUED)

Relaxation techniques are helpful in reducing the physiologic manifestation of stress and PTSD, such as increased adrenergic tone (higher resting heartbeat and faster heart rate in response to stress), increased startle response, hypervigilance, agitation, difficulty sleeping, restlessness and irritability, and anger/rage reactions. These manifestations may be especially problematic when the child experiences traumatic reminders, and may occur during gradual exposure (GE) exercises. For this reason, we teach and practice relaxation techniques prior to starting the GE sessions in this protocol, and utilize these techniques in the middle of GE if hyperarousal symptoms become problematic.

Deep breathing ("belly breathing") is a technique borrowed from meditation/yoga, which has been found to decrease a number of stress-related symptoms in adults (Kabat-Zinn, 1990). The therapist instructs the child to close his or her eyes, and to breathe in deeply so that the lower abdomen protrudes during inhalation, and recedes during exhalation. (This is the opposite of chest breathing, where the chest expands and the abdomen is pulled in during inhalation.) Younger children may be assisted in mastering this by lying on the floor and putting a small book or stuffed animal on their lower abdomen; when they can make this object rise during inhaling, they are doing belly breathing correctly. Once the child has mastered this, the therapist instructs the child to slowly count to 5 while breathing in through the nose, and then to slowly exhale through the mouth during another 5 count period. (Many children will breathe in slowly but exhale quickly

unless specifically instructed in this manner).

Perhaps the most difficult element of this breathing technique is that of directed attention, which younger children may not be able to understand or master. The relaxation effect is thought to come at least in part from "quieting" one's thoughts and consistently refocusing on breathing rather than being distracted either by external objects/events or internal thoughts or feelings. By directing one's attention to the act of breathing alone, one simultaneously experiences profound relaxation (loss of tension) and focused awareness. The therapist should instruct the older child or adolescent to be aware of any thoughts he or she is having during the breathing exercise, and as soon he or she is aware of such a thought, to redirect his or her attention back to the moving in and out of air through the body. The goal is not to judge, reject or focus on the thought, but to learn to simply redirect one's focus to the act of breathing. Some children are not able to do this, but if instructed to just pay attention to counting to five during each inhalation and exhalation, they will derive similar benefits from the deep breathing exercises. Children can use this deep breathing technique at times when they feel themselves being overwhelmed with physical or emotional stress, as long as it is not a situation where they have to be paying attention to

something external (for example, during an exam or if caught in a fire, attention needs to be focused on these challenges, rather than inwardly).

Progressive muscle relaxation is another SIT technique which can be particularly helpful to children who have difficulty falling asleep, or who are having many somatic symptoms. With younger children we use the analogies of a piece of spaghetti before it is cooked (stiff) versus after it is cooked (wiggly), or a tin soldier (stiff and tense) versus Raggedy Ann (loose and floppy). The therapist should explain that when people's muscles are not relaxed, we feel tight and tense

and sore, but when we relax those muscles, it helps us to feel easy and loose. Some children can relax their muscles simply by trying to "be like a piece of wet spaghetti" or "sit like Raggedy Ann." However, others will need specific instructions on how to progressively relax different muscle groups. This is best practiced in a lying down position; children may either lie down in the therapy room or practice at home. The child should be instructed to first tense (in order to accurately feel where these muscles are), and then to relax, one set of muscles at a time, starting with the toes, then the foot, then the ankle, etc., all the way up to the head, until every body part has been progressively relaxed. Through practice, children can learn to fall asleep or to relax specific aching body parts using this technique. However, even when nothing hurts and it is not bedtime, progressive relaxation may be helpful to children with TB, because the selective attention given to relaxing typically precludes focusing on thoughts about the trauma or death at those particular times. In fact, instructing children to use these techniques when they have intrusive recollections of the trauma/death at home may help to reverse the physiologic hyperarousal symptoms that typically accompany such thoughts, because tension and relaxation are incompatible.

Thought stopping is a SIT technique which can short circuit the vicious cycle which typically occurs in TB (where a reminder of the loved one leads to thoughts of the traumatic nature of the death, which leads to cognitive distortions, which leads to more upsetting thoughts and more cognitive distortions, etc.). It is also a very powerful tool in preparing the child for cognitive processing (CP) interventions, because it teaches children that they *can have control over their thoughts*. Thought stopping basically works through interruption, that is, it is method of interrupting the child's attention on the traumatic thought, and refocusing the child's attention on a non-traumatic replacement thought. In some ways, thought stopping is the opposite of GE (where

we try to focus the child's attention *on* rather than *away from* the trauma/death itself). It may therefore seem contradictory to use both of these interventions in the same treatment model. However, children are instructed to use thought stopping at times when they need to be focused on things going on around them, such as at school, when playing sports or interacting with friends. They use GE techniques in therapy. This teaches children first and foremost, that they have control over their own thoughts – not just *which* thoughts they choose to focus on, but also *when* they focus on which thoughts. For children initially overwhelmed by intrusive reminders of trauma and loss, as well as distorted thoughts of their own responsibility or thoughts which

exaggerate or catastrophize the reality of the situation (for example, "I will never be happy again"), simply learning this principle can be enormously helpful.

Thought stopping is accomplished by interrupting an unwanted thought, either verbally (saying "go away" or "snap out of it" to the thought) and/or physically (by wearing a rubber band around one's wrist and snapping it when one wants to stop a thought). The next step is to replace that unwanted thought with a welcomed one. Some children prepare for thought stopping by having a positive thought or mental image ready – such as thinking about a special happy event, place or experience (birthday, Christmas, amusement park, etc.). This may be complicated for children with TB, as most of their pleasant memories may involve the deceased loved one, and thinking these thoughts may re-trigger traumatic/loss thoughts. It may be more helpful for such children to simply visualize a "perfect moment" (for example, hitting a game-winning home run; being elected class president) to use for thought replacement. (This is the technique used in Lamaze childbirth). This mental picture can be drawn and taken home as a prompt to use in thought stopping at home. Also, the more detailed description the child can give of this image

(example: sights, sounds, smells, tastes about this "perfect moment"), the more this image can distract from the intrusive thought. Teaching children thought stopping techniques helps to prepare them for the likelihood that they will experience ongoing reminders or negative intrusive thoughts about the trauma/ death, both during the course of therapy and after therapy has ended. It is also helpful for children to have mastered these techniques before starting gradual exposure (GE), so that children feel confident that if they start to feel overwhelmed while directly talking about the trauma/death, they will be able to stop or control these thoughts.

For children having intrusive thoughts about revenge or rescue fantasies related to the traumatic death, it may be helpful to replace these thoughts with more constructive thoughts of how to take "corrective action" or how to stay safe in the future. These more helpful thoughts will be identified during the upcoming CP exercises; once these "correction action" thoughts have been specified in therapy, the therapist may encourage the child to use these thoughts as replacement thoughts rather than using "perfect moment" thoughts during future thought stopping procedures.

Cognitive coping skills are closely related but not identical to cognitive processing (CP) interventions. While CP requires the child to logically dismantle inaccurate or unhelpful thoughts as discussed below, cognitive coping refers to what has been termed "learned optimism" (Seligman, 1990). Simply put, this consists of practicing the skill of focusing on the positive instead of the negative aspects of any given situation. One could easily argue that there is nothing positive to be found about a traumatic event that has caused a child to lose a parent or other loved one. However, many children have come through the traumatic loss of a loved one to find themselves stronger, more compassionate toward others, more thankful for the remaining family members they have, more aware of the generosity of strangers and more appreciative of the

outpouring of sympathy and assistance that they experienced. Children may benefit from recognizing (and focusing attention on) the fact that, despite great adversity, they *are* coping, and are often coping quite well. Cognitive coping interventions consist of helping the child recognize the ways in which he or she is coping well, and to remind the child to verbalize these, particularly when they are feeling discouraged. This is also called "positive self-talk." Examples of cognitive coping statements are as follows:

- I can get through this.
- Things are hard now, but they will get better.
- I still have a family and they will help me.
- Lots of people care about me and my family.
- Some things have changed, but lots of things are the same as they were before this happened (ex: I still do well in school, I still have friends, I'm still good at math).

Although some children are more optimistic in their outlook than others, optimism can be learned and practiced so that it becomes more a part of the child's life. Encouraging children to practice positive self-statements may enhance their ability to cope with adverse life events long after therapy has ended.

Enhancing the Child's Sense of Safety

Some children may be in a single parent living arrangement for the first time, or may have lost a sibling, grandparent, or other relative who was an integral part of the child's family. Others may have been in a single parent environment and have lost their only known parent. Furthermore, some children may have lost both parents and are now living with a relative, or another caretaking environment. In all of these situations, the child may be feeling a loss of safety and

may be experiencing a decreased sense of trust. It is important to help the child express these emotions as well as to recognize the supports in the environment that can enhance the child's sense of safety *right now.*

Before addressing safety issues with the child, the therapist should first have asked the parent the nature and degree of social support available to the child at this time. There are special considerations related to children's losses following the September 11th terrorist attacks which the therapist should ask the parent about in the first treatment session. If the person who was lost to the child was one of the rescue workers, is the police, fire or EMT department providing a specific support for the family? What kinds of messages is the child hearing about the deceased as well as surviving rescue workers? For example, does the child consider the deceased a hero, or does the child no longer consider rescue workers helpful or capable of providing safety? For children who lost a loved one who was not a rescue worker, rescue workers may seem ineffectual, contributing to a sense of insecurity in the child.

After assessing the nature of the social supports for the child, the therapist may begin addressing safety with the child in this manner:

> Sometimes, when bad things happen around us, to people that we love, we start to worry that bad things are going to keep on happening. Sometimes it just seems like the world isn't a safe place. Have you been having any of these worries or feelings? (If the child responds affirmatively, continue.) When you are feeling this way, what can you do or say to yourself that might help you feel safe? Let's make a list. What do you count to keep you safe? Who can kids count on to keep them safe when their parents aren't around, like at school or

when they are outside playing (grandparents, teachers, police officers, etc.)? Who is keeping our country safe (president, armed forces, FBI, etc.)?

Psychoeducation may be introduced at this point in therapy if the child expresses clear misinformation or distortions regarding safety. For example, it may be helpful to point out to the child who doubts the ability of rescue workers to provide safety, that these workers rescued/ helped save thousands of people who escaped from the World Trade Center, even though others could not be saved. Furthermore, the FDNY added hundreds of new firefighters to the Department soon after September 11th in order to assure that there would be enough rescue workers to keep people safe in the future. (If appropriate, the therapist may point out that the efficacy of these rescuers and other citizens was proven after the November 12th airline crash in Rockaway, when all but six people on the ground were rescued from fires, etc.)

Many supports are being put in place for the children of fallen police officers and firefighters (personal communication from FDNY to Robin Goodman, Ph.D., November, 2001), such that fellow rescue workers function as an extended family for the children and spouses of fallen comrades. Children in this situation should be encouraged to identify people in this extended support network who are available to comfort them and keep them safe. As noted in the parent treatment section, parents who take steps to enhance their own sense of security and safety will most likely be able to enhance this sense of safety in their own children.

SESSION 3: THE COGNITIVE TRIANGLE

Many children and parents do not realize that they can choose and change their own thoughts, and that doing so can change their feelings and behaviors. This idea is the basis of the

"cognitive triangle," depicted in Figure 1.

Figure 1: The Cognitive Triangle

Educating children about the connections between thoughts, feelings, and behaviors is an essential element of cognitive processing (CP). The first step in this process is to practice **feeling identification**, which has been introduced in Session 1. The therapist may begin Session 3 by reviewing and practicing feeling identification with the child.

The next step in explaining the cognitive triangle is to help the child **recognize the distinction and relationship between feelings and thoughts**. This may have already occurred during feeling identification exercises, if the child mistakenly identified a thought instead of a feeling during these activities (for example, when asked, "How would you feel if a girl in your class never talks to you?", the child answered, "I would think she hated me.") If this occurs during feeling identification activities, the therapist should point out to the child that he or she just named a thought, or idea, rather than a feeling, and ask the child what she would be feeling in that situation (for example, sad, angry, rejected, unloved).

In order to teach the child how to distinguish between thoughts and feelings, the therapist

should explain to the child the following:

> "Most people assume that thoughts come from inside of us, of their own accord, and we have no control over what feelings we have or when we feel them. However, this isn't really accurate. Most of the time, we have feelings in response to the thoughts we are thinking at that time. Sometimes we get used to having certain thoughts so often that we aren't even aware that we are having them. These are called 'automatic thoughts' because we have them automatically out of habit, and just assume that everyone else would have the same thoughts as us at those times. But we often have thoughts that are inaccurate, or not helpful, and this leads to feelings that hurt us rather than help us. Let me give you some examples." The therapist can then give examples such as the following (these should be tailored to each individual child's interests, age and gender, so that the child is easily able to relate to them): "Say, there's a girl in your class, and she never talks to you. When you walk by her, she looks down or looks the other way. If your thought in this situation is, 'that girl hates me,' it might make you feel sad or angry. But let's suppose that, instead of thinking 'she hates me,' your thought is, 'gee, she must be really shy.' How would that make you feel?" (Then allow the child to answer. Typical responses might be, "I wouldn't feel so sad," "I would feel sorry for her," etc.)

. Once the child understands this concept, the therapist should present a series of scenarios to the child in which the child has to **identify both a thought, and a feeling that results from that thought**. If the child names a feeling first, the therapist should ask, "What thought did you have that made you have that feeling?" Sample scenarios and appropriate responses include the following:

1) Your mother blames you for something your little brother did.

   Thought: She's not being fair. Feeling: hurt, mad

2) Your teacher announces there will be a pop quiz today.

   Thought: Math isn't my best subject. I'm gonna get an "F." Feeling: scared, worried , mad at teacher.

3) You get invited to a dance by a boy you really like, who you thought didn't like you.

   Thought: He does like me!! Feeling: excited, happy

The next step is to encourage the child to learn how to **generate alternative thoughts that are more accurate, or more helpful**, in order to feel differently. For example:

1) Your mother blames you for something your little brother did.

   More Accurate Thought: Mom won't be mad at me once she knows the truth.

New Feeling: Hopeful

2) Your teacher announces there will be a pop quiz today.

   More Helpful Thought: I've done all my homework, I should do okay.

New Feeling: Calm, reassured

3) You get invited to a dance by a boy you really like, who you thought didn't like you. You don't need to change the first thought you had–it was accurate, helpful,

and made you feel good!

The final step in explaining the cognitive triangle is to help the child recognize the relationship between thoughts, feelings and behaviors, as well as the relationship between our behaviors and how other people act in response to us. (This is the same approach used in teaching children Problem Solving skills, and may promote healthier coping in children with TB as well.) The relationship between thoughts, feelings, behaviors, and results (how other people respond) can be demonstrated using the above examples, or others that are more applicable to an individual child.

Your mother blames you for something your little brother did.

Scenario A: Thought: She's not being fair.

Feeling: Mad

Behavior: You say "I hate you!" and run to your room.

Result: Mom punishes you.

Scenario B: Thought: Mom won't be mad once she knows the truth.

Feeling: Hopeful

Behavior: You calmly explain to your mother that you didn't do it.

Result: Mom apologizes for blaming you unfairly.

Therapists should practice this with the child by discussing several different scenarios in which the child can **change his or her feelings and behaviors by thinking differently**. If possible, these scenarios should be from the child's real life. However, unless the child spontaneously gives as an example his or her thoughts and feelings related to the trauma/death, exploration and revision of these cognitions should be done in conjunction with GE techniques later in

treatment (i.e., once the child's trauma/death cognitions have been identified through the GE procedures). Frequently, children will have been told repeatedly that the trauma/death was not their fault, that they should try to stop thinking about it, etc. Children are sensitive to these adult expectations, and particularly after losing a loved one, are often anxious to please caring adults. This may lead to reticence to discuss their true thoughts, and particularly their most horrifying or "unacceptable" thoughts. Thus, when asked in therapy about their trauma/death related thoughts prior to GE, children may minimize or avoid revealing these cognitions. Once GE techniques have desensitized the child regarding directly discussing the trauma/death, the therapist is more likely to hear the child's true cognitions in this regard.

SESSIONS 4-6: GRADUAL EXPOSURE (GE)

GE has been utilized in the treatment of sexually abused children (Deblinger and Heflin, 1996; Cohen & Mannarino, 1993), children exposed to community violence (Pynoos & Nader, 1988), disasters (Goenjian et al., 1997), and single episode traumatic events (March et al., 1998). The goal of GE is to unpair thoughts, reminders, or discussions of the traumatic death of the loved one, from overwhelming negative emotions such as terror, horror, extreme helplessness, or rage. Over the course of several sessions, the child is encouraged to describe more and more details of what happened before, during and after the loved one's death, as well as the child's thoughts and feelings during these times. Therapists may encourage the child to "put yourself back there in your mind," and remember all the details "just like it was happening now." Many children will not be able to tolerate doing this until they have spent one or more sessions describing these events, thoughts and feelings from their present perspective.

Prior to starting GE sessions (typically introduced around session 4), the therapist should introduce the child (and parent, as will be discussed below) to the theoretical basis of this intervention. Children and parents may be understandably concerned about directly discussing the specific events surrounding the traumatic death of their loved one; PTSD-based avoidance may play a factor in this reticence, or it may simply be due to the discomfort which is commonly experienced in discussing these sad and painful events. We have described the reason for using GE as follows (Deblinger & Heflin, 1996).

> "It is very hard to talk about painful things, and often children and parents try to avoid doing this. In fact, they say things like "let sleeping dogs lie," and wonder if it is a good thing to bring back memories of sad things. We tell kids and parents that if they had been able to put those memories behind them, children would not be having any problems, and they would not be coming here to therapy in the first place. It's like when you fall off a bicycle and skin your knee on the sidewalk, and all that dirt and germs get into the wound. You have two choices about what to do with that wound. You can leave it alone, not wash it off or put any medicine on it, and hope that it gets better all by itself. Sometimes that works fine. But other times, if you do that it will get infected. Infections don't usually get better by leaving them alone; they get worse and worse. Your other choice is to wash the wound out real carefully, getting all the dirt and germs out of there. That stings, it hurts at first, but then the pain goes away, and it doesn't get infected,

> and can heal quickly. In the end, once an infection starts, it hurts a lot less to clean it out than to let it get worse and worse. GE is like cleaning out the wound. It might be a little painful at first, but it hurts less and less as we go on, and then the wound can heal. Just like when you clean out a wound, if you rub too hard or too fast, it will hurt a lot more than if you go more carefully. We try to go at just the right pace in GE, so that it never hurts more than a little bit. You can let us know at any point if we are going too fast for you, and we will slow down."

Once the child understands the theory of GE (i.e., talking a little bit at a time about the upsetting aspects of the trauma/death so that it is less and less painful/frightening/overwhelming over time), the therapist should begin the GE intervention. This process is most typically accomplished by having the child **create a book** which tells the child's story about the traumatic death. Children will often write very little, perhaps just one sentence, the first time they attempt this. For example, one child wrote "My father hit my mother and she died." In such situations, the therapist may ask the child to verbally describe what he or she was doing at the time this incident occurred, and to describe what happened next, and after that, and so on. Once the child has verbally described these events, the therapist suggests that the child now write them down as he or she just described them. While it is essential to also encourage the child to recall, describe and write down the thoughts and feelings he or she experienced during these events, it is usually more productive to have the child first describe his or her perception of **the facts about the trauma/death**, and after these have been written, to return to the beginning and ask about thoughts and feelings. This is because interrupting the child in the flow of his or her narrative may make it

harder for the child to keep focused on the narrative, and may also encourage avoidance of describing further details of what occurred. For children who have difficulties with writing or spelling, the therapist may act as the "secretary" and write as the child dictates the narrative.

For children who have difficulty writing their own book, it may be helpful to use fill-in-the-blank books in the Creative Healing Book Series (Alexander, 1993) such as It's My Life, All My Dreams, It Happened in Autumn, and When I Remember. These allow the child to read about another child's experience with trauma/loss and creates a structured format for the child to write about their own experience.

Writing the entire descriptive narrative of what happened may take more than one treatment session, depending on how difficult it is for the child to recall, describe and write these details, how much detail the child recalls and is willing to provide, and how long a time period is covered in the child's description. For example, following the 2001 terrorist attacks on New York City and Washington, DC, it took several days to determine with certainty that a loved one was killed. The child's narrative may include the events that transpired in all of that intervening time, or may skip directly from learning of the disaster to learning of the loved one's death. After the child has completed each segment of writing (whether in one session or over the course of several sessions), having the child read what he or she has written thus far is helpful in both desensitizing the child to verbalizing the details of the trauma and death, and in re-focusing the child to write the next segment of the description. If the child is reticent to read what he or she has written, the therapist may read it out loud to the child, which also exposes the child to a retelling of the trauma/death. Over **several repetitions**, the goal is for the child to experience progressively less extreme emotional reactions and physiological reactivity. If the child continues to experience a high degree of reactivity, relaxation techniques can be utilized during the session (as

described above).

In some situations, the child may not know exactly how the deceased died. This may lead to the child imagining horrifying scenes of the loved one suffering prior to death. In this case, it is important for the child to verbalize and write these imagined traumatic reminders in the book. Methods for neutralizing the intense negative emotions that accompany these traumatic reminders will be discussed below.

Once the child has completed his or her description of what happened during the trauma/ death, the therapist should ask the child to read it from the beginning, and ask the child to add **thoughts** and **feelings** he or she was having during the events described in the narrative. Worden (1996) suggests facilitating this by having the child draw a picture of what the weather was like outside on the day of the funeral (or traumatic event/death), and then asking the child to draw what the weather was like inside the child (the "weather inside") on that day. It is not unusual for the child to also recall additional narrative details during this part of the process, and he or she should be encouraged to add these at the appropriate parts of the book. Initially, the goal is to have the child simply describe all of his or her recalled thoughts and feelings; exploring and challenging these should be put off until they have been recorded in the book.

At some point in the writing of this book, the therapist should ask the child to describe the **worst moment, worst memory, and/or worst part of the trauma/death**, and include this in the book. The child should be encouraged to describe this in as much detail as possible, including drawing a picture of this memory. While doing this, many children reexperience some degree of fear, revulsion, sadness or anger. The therapist should encourage the child to write these feelings, and to describe the physical sensations that accompany these feelings. However, if the child seems overwhelmed by these feelings, it is helpful for the therapist to remind the child that these

are only feelings, and that they are related to something that has happened in the past, not something that is occurring in the present. The use of puppets to describe these events may be helpful with younger children in providing initial distance between the description and overwhelming feelings (Worden, 1996). The therapist should transcribe into the book what the child enacts through the puppets, and in subsequent readings the child should be encouraged to read and discuss these events, thoughts, and feelings more directly. Relaxation techniques may be helpful at these junctures, and thought stopping may be used (as described above) to remind the child that he or she has control over his or her thoughts. Children may also benefit form a brief (less than 5 minutes) distraction task (talking about something unrelated to the trauma/death, such as what they did at school that day) at these points. In our experience, children are typically able to describe the "worst moment" without overwhelming negative emotions, provided they have spent adequate time earlier in the session (or in previous sessions) gradually describing, and becoming desensitized to, less horrifying aspects of the trauma/death. When done correctly, the therapist **gradually exposes** the child, in carefully calibrated increments, to **increasingly traumatic aspects of the trauma/death**, so that each step is only slightly more difficult than the one before. This is not always easy to accomplish, because the therapist may not know what aspect of the event was most difficult for the child, and only learns this when the child gets to that part in the narrative.

When the death of a loved one occurs as a result of acts such as terrorism or murder, children may experience a variety of thoughts and feelings related to the intentionality behind the act. Feelings of anger, helplessness, and/or thoughts of revenge are not uncommon, and indeed, are to be expected. However, when these thoughts and feelings become intrusive and repetitive, i.e., become trauma reminders, they should be addressed and resolved through direct discussion,

therapeutic enacting, and moving towards more constructive manifestations.

It is important for the therapist to encourage the child to talk about any thoughts and feelings that may be related to the intentionality of the terrorist attacks. It may be helpful during the GE component to encourage the child to explicitly describe these thoughts and feelings, and to include these in the GE book. These may include rescue fantasies as well as revenge fantasies. The therapist may want to use a prompt such as: "If you had special powers, and could have made things turn out differently, what would you have said or done to change what happened?" The child should be encouraged to include these thoughts in the GE book as well. The therapist can then point out to the child that these thoughts are normal, and indicate how much the child wishes the events had not happened the way they did. The therapist should then assist the child in recognizing that no one can change the past because the past is over. However, we all have the ability to change some things in the present and the future by our own actions. Most of all, we can change our own thoughts, feelings, and behaviors, as discussed with the child during the previous session (Cognitive Triangle). The therapist should ask the child what he or she could do right now to make things "come out better" in the present or future. The therapist should then encourage the child to think about specific ways to achieve symbolic corrective action in the present and future.

Older children can sometimes achieve resolution by engaging in some benevolent or symbolic activity that gives them a sense of power and closure, such as the twelve year old boy who gave up his lunch money in order to buy a video game that allowed him to repeatedly shoot down airplanes before they were able to crash into buildings. Other children may volunteer to help others (food kitchens for homeless, etc.) or become more involved in religious or community activities in order to "do good" for others. The therapist can encourage youngsters to think along

these lines: “We can’t change what happened, but we can sometimes do things that are good in response to the bad things other people have done. Sometimes that can just help us begin to feel better, too. Can you think of something that could make you feel better right now?”

Finally, the therapist should encourage the child to write a corrective story that can be placed the end of the child’s GE book. The therapist may prompt the child to include a page entitled “I would like the story to turn out like this in the future” or “My happy ending.” For example, some children will hope to grow up to become a rescue worker, or to work for world peace or religious tolerance, as ways to prevent such terrible events from happening again.

While some therapists believe that acting out aggressive rescue or revenge fantasies (for example, flying to the top of the WTC and carrying victims to safety, or killing the terrorists before they crashed the plane) leads to resolution of underlying feelings, we have found that in many cases aggressive reenactment may serve as “practice” to become a victimizer (Ryan, 1989). We therefore believe that aggressive behaviors should be addressed behaviorally outside of therapy, and while expression of these aggressive urges is acceptable in treatment sessions, therapists should actively intervene to resolve these. For example, the therapist may point out to the child that such actions reflect what he or she wishes could have happened, and to help the child move towards more constructive thoughts/fantasies/actions through which to make the world safer in the future.

Once the child has written the full narrative of his or her memories of what happened, and the associated thoughts and feelings, cognitive processing techniques are employed to explore and correct cognitive distortions and errors as described in the following section. (In many cases, CP techniques may be introduced prior to Session 7 and used in conjunction with GE interventions.) At the end of each GE session, the therapist should be sure to **praise** the child for his or her efforts,

and to reward the child with either a material reinforcer (food, stickers) or with a brief enjoyable activity (for example, playing game unrelated to trauma/death).

SESSION 7: COGNITIVE PROCESSING (CP)

Cognitive processing refers to a variety of interventions which encourage the child to explore his or her thoughts about the trauma/death, and to challenge and correct cognitions which are either inaccurate or unhelpful. **Inaccurate cognitions** are thoughts that are either absolutely false (for example, "It's my fault my father got killed in the WTC. He usually doesn't work on Tuesdays, but he worked September 11th so he could take me to my first day of school on Thursday."), or are so unrealistic as to approach impossibility (for example,"I should have known an airplane was going to crash into the World Trade Center, and called my mother to warn her to get out.") **Unhelpful cognitions** may also be inaccurate (such as the preceding two examples), or may be unhelpful despite being accurate (for example, "people who get burned in a fire are in terrible agony") or possibly accurate (for example, "my mother must have been terrified when she was trapped in the WTC before it collapsed and killed her").

Inaccurate cognitions sometimes represent rescue or hero fantasies (wishing to have saved the deceased, including through the use of magical or super powers), and may arise in part from overidentification with real-life rescuers or heros (firemen, police, etc.) depicted in the media. In other situations, inaccurate cognitions may represent the child's attempts to gain control over the uncontrollable. This is a common response to post-trauma fears that the world is out of control,

unpredictable and dangerous. However, gaining a sense of control at the cost of blaming oneself for uncontrollable or unpredictable events is rarely helpful in promoting optimal adjustment. The

therapist may find it helpful to explain the concept of "accident" or unfortunate coincidence to the child, i.e., that some things happen accidentally, or unluckily (i.e., the loved one being at the wrong place at the wrong time when terrorists attacked).

Accurate but unhelpful cognitions may be seen by the child or parent as "facing reality" or "accepting the truth," i.e., something that is necessary to truly deal with the situation at hand. In fact, focusing on the most horrifying (unhelpful) realities or possible realities of the trauma/death is a choice, not a necessity, and doing so may impair the child's ability to optimally cope with the trauma and loss.

After the child's trauma/death cognitions have been identified through the use of GE, and the child has mastered the concepts of the cognitive triangle and how revising one's thoughts can change one's feelings and behaviors (typically the latter occurs earlier in treatment than GE), the therapist should begin to directly explore and correct the child's cognitive errors (inaccurate or unhelpful thoughts). One way to do this is to re-read the child's GE book in this session, with a focus on all of the thoughts the child expressed in the book. As each thought is verbalized in the book, the therapist should explore with the child whether this thought was accurate and helpful. For example, one child wrote, "I should have warned my mother to get out of the WTC before it collapsed." The following dialogue illustrates how to use CP to address this inaccurate cognition.

Therapist: Can you see any thoughts in this sentence that are not accurate or helpful?

Child: I guess I should have warned her to get out.

Therapist: Why is that inaccurate?

Child: I don't know. I think I should have warned her, but I don't know if that's true.

Therapist: Did you know the WTC was going to collapse? How could you have known? The loudspeaker told people they should go back to their offices. If the people in

charge of the building didn't know it would collapse, how would you know?

Child: I don't know, I just should have, I guess.

Therapist: Help me understand this. Are you saying there were signs, or warnings, or something obvious that you should have seen to indicate it was going to collapse and you just ignored it? Is that what you mean?

Child: No, no, nothing like that. I mean, it looked scary when I saw it on TV later, but I was in school then and I didn't even see it until after it happened.

Therapist: So as far as you know, there were no obvious signs that this would happen, that you should have seen and warned your mother about this.

Child: No, but I still should have known, I mean, she was my mother, we were really close, I should have known she was in danger.

Therapist: So just because you were her daughter, you should have been able to predict the future danger to her?

Child: Well, not predict the future. But I wish I knew.

Therapist: I understand that. I wish we all had known it was going to collapse. But nothing like that ever happened before, even the architects and engineers who build skyscrapers were surprised that happened. So unless you were a mind reader or a psychic or something, there was no way you could have known this was going to happen, right?

Child: No, I guess not. I just wish I could have known.

The above illustrate the **progressive logical questioning technique** used in CP to explore and correct inaccurate thoughts about self-blame in relation to the trauma/death. In contrast is an example of a trauma/death cognition which was true (or possibly true) but unhelpful. This child,

whose mother died in an airline disaster, was "fixated" on the idea that her mother felt horrible, sustained pain and terror during the crash. Although GE techniques had helped her become less overwhelmed emotionally when she described these thoughts, she could not think about her mother without returning to these "awful" thoughts. Since there was no way for anyone to know for sure what her mother experienced prior to her death, the therapist and father agreed that it was just as "true"--and certainly more helpful--for the child to believe that although her mother may have suffered that she also experienced some other things. The therapist utilized **reverse role play** CP interventions to process this traumatic thought into a more helpful one.

Therapist: So every time you try to picture your mother, it is back in the airplane, not somewhere nice?

Child: Yes. I just know she suffered so much, and I wish I could have made her feel better before she died.

Therapist: So you don't think that she was killed instantly, before she knew the plane was in trouble? You think there was some time, a few minutes before the plane crashed, when your mother knew the plane was going to crash and she was going to die?

Child: They (media and airline officials) told my Dad that there was less than five minutes before it crashed, when they knew there was trouble.

Therapist: And what do you suppose your mother would think about at a time like that?

Child: She would be scared, if it were me I would be too scared to think.

Therapist: Well, that's a good idea. Let's pretend that it *was* you, that you are in a plane that's about to crash, and you are a grown up mom with a little girl who you love more than anything in the whole world, and you won't get to see her to tell her all

the things you want to say to her... Can you pretend that for a few minutes?

Child (teary): Okay, I'm trying.

Therapist: And let's pretend that we can freeze those minutes, just long enough for you to write a letter to your daughter, okay?

Child: Okay

Therapist: Okay, lets write that letter. Remember, you are the mother, and you're writing your most important thoughts to your daughter. What would you say to her?

Child: (Writes) Dear sweetheart, I just want you to know that I love you forever and ever.

Therapist: Well, I agree that that's the most important thing a mom would want to say to her child. Would you also want to say how proud you are of her, what a great daughter she was, how happy she made you?

Child: (Adds to letter.) I am so lucky I got to have you for my child. You are a very good daughter and a very wonderful student.

Therapist: Would you want her to worry about you, or could you say anything to help her not worry?

Child: (Adds to letter.) Please do not worry about me. I am not afraid because I am going to be with Jesus very soon. (Child and therapist discuss the child's comforting religious beliefs about death).

Therapist: You know what? I believe that when your mother realized the plane was going down, she may have been scared but she was also very focused on thinking about you and your Dad, and she probably prayed that you would somehow know the things she wanted to tell you. Can you see your mom closing her eyes, not

because she was in pain or scared, but because she was concentrating so hard, praying so hard for you and your Dad to be okay and know these things she wanted to tell you? Close your eyes and try to picture her this way.

Child (teary): I can see her that way.

Therapist: Tell me what she is praying.

Child: She is praying that I know how much she loves me and that she wants me to be good and that she is with Jesus.

Therapist: How does that thought make you feel?

Child: It makes me feel sad, but it also makes me feel like maybe she didn't suffer so much.

Therapist: Because she had you, and she was thinking about you, and praying for you, she didn't suffer nearly as much when the plane crashed. And that feels better than thinking about her suffering so much. So the next time you think of your mother suffering and being afraid, what thought can you have that is more accurate and more helpful?

Child: I can think of her praying for me and my Dad in the plane and I can think of her with Jesus.

Many children with TB struggle with cognitive distortions about the meaning and consequences of death resulting in body disfigurement, dismemberment or fragmentation of body parts (including failure to ever make a positive identification of the loved one's remains, as will be the case for most victims of the September 11th terrorist attacks). For example, some children believe that damaged, destroyed or missing bodies continue to hurt even after death, or that loved

ones whose remains are no longer intact become "haunted" or cannot go to Heaven. Layne et al. (1999) have described a "body reconstruction" technique which has been used with success in group therapy settings for adolescents in war zones (Layne et al., 2001). This technique encourages the child to "put the body back together" for the loved one, through mental imagery and/or pictorial methods. Specifically, the child is encouraged to start by drawing a picture which depicts the body or body parts of the deceased that were present at the time of death or viewing. The child then adds onto this picture, either by drawing additional body parts, cutting and pasting additional body parts taken from magazine pictures, or mentally imagining these missing body parts being put back together to enable the body to be made whole again. When no remains are discovered (or even when the body is present but disfigured), this may take the form of placing a photograph of the deceased (preferably a full length picture taken when the deceased was in good health) in a prominent and easily visible place outside the coffin (R. Pynoos, personal communication, 9/01). This technique allows the child's last visual memory to be one of happier times, and has been used for many years in hospice settings. Other children may need to "fix up" or repair the damaged body in their minds by writing, acting out, or imagining scenes whereby the body is taken to the hospital and sewn up, etc. Through these techniques, the child can thus be left with a mental image of the deceased as once again having an intact (albeit no longer living) body. In some cases where no body remains are identified, we have found it helpful to provide the child with a copy of the official death certificate as a concrete confirmation of the physical reality of the loved one's death. It may be helpful to directly ask the child, "What would make your mother's death more real for you?" and then, if possible, following through on the child's suggestion (for example, going to view the site of the destroyed World Trade Center, talking to other people who lost loved ones on the same floor of the WTC, etc.). Of course, it is also important to educate the

child that, whatever happens after death, the state of one's corpse does not affect this. Some children may believe this information most if it is explained to them by a member of the clergy rather than a parent or therapist. Parents should be encouraged to ask their clergy for assistance in this way when this appears to be an issue for specific children.

In addition to self-blame for the traumatic event, intrusive horrifying thoughts about the agony and suffering experienced by the loved one prior to death, and misconceptions or frightening thoughts about death accompanied by disfigurement, other inaccurate or unhelpful cognitions which commonly occur in children with TB include the following:

- I should have been able to save the life of my loved one.
- My loved one was stupid for being where the traumatic event happened (blaming the victim).
- My family will never be normal again.
- It is my responsibility to become "the man of the house" now that my dad is dead.
- My family will never be okay again.
- I will never get back to normal/never be happy again.
- I should have done something to prevent my loved one from being where this occurred.

Once such distortions are identified (and new ones may develop or be verbalized for the first time at any point in therapy), CP techniques should be employed to explore and correct these, and to practice and reinforce more accurate and helpful thoughts.

JOINT CHILD-PARENT SESSIONS

INTRODUCTION

The CBT-TB model includes two sets of joint sessions in which the child and parent meet together to read the child's GE and bereavement books, and to enhance the child's comfort in talking directly with the parent about the traumatic experience, the death of the loved one, and any other issues the child or parent want to address. These joint sessions typically occur at session 8 (at the end of the trauma-focused phase) and 14-15 (near the end of treatment). The therapist and family should decide together whether one or two joint sessions are optimal at each point.

For one-hour sessions, the joint sessions are typically divided so that the therapist first meets with the child for 15 minutes, then with the parent for 15 minutes, and finally, with the child and parent together for 30 minutes. The therapist should be flexible in adjusting this division of time to each individual family's needs.

Prior to having each set of joint sessions, the child should have worked on the book to be read together (GE or bereavement book), be comfortable reading it aloud and discussing it in therapy with the therapist, and willing to share it with the parent. The parent should have heard the therapist read the complete book in parent therapy sessions at least two or three times, be able to emotionally tolerate reading the book (i.e., without sobbing or using extreme avoidant coping mechanisms), and be able to make supportive verbalizations when practicing responses during parent therapy sessions. The therapist should role play this with the parent to be sure the parent's responses are supportive and appropriate.

SESSION 8: CHILD-PARENT TRAUMA-FOCUSED SESSION

On the day of the trauma-focused joint session (typically Session 8), when meeting with

the child individually, the therapist should have the child read the GE book out loud and suggest that the child is ready to share it with the parent. (The therapist should have already mentioned at the previous GE sessions that this might occur.) The therapist should then suggest that the child write a "quiz" for the parent, comprised of 5-10 questions the child will ask the parent. These questions may pertain to PTSD symptoms in general, to aspects of the specific trauma that the child is unsure about, specifics contained in the child's own book, relaxation techniques or CP principles (for example, "What are the three parts of the cognitive triangle and how are they related?"), the parent's feelings or thoughts about the deceased or the trauma, or any other questions about the trauma/death the child may have. The therapist should have the child discuss these questions in this individual setting, and assist the child on formulating clear questions.

During the individual session with the parent (15 minutes before the joint session), the therapist should once more read the child's book to the parent, and ascertain that the parent is prepared to hear the child read the book directly to the parent. The therapist should then go over the child's "quiz" with the parent, and assist the parent in generating optimal ways of responding. The parent may also have questions for the child, and the therapist should help the parent phrase these in appropriate ways.

During the joint GE session, the child should read the GE book he or she has written to the parent and therapist. At the conclusion, the parent and therapist should praise the child for his or her courage in writing this book and being able to read it to the parent. The child should then give the parent the "quiz," taking time to discuss each answer to the satisfaction of both parent and child. If the parent has also prepared questions for the child, these should be asked after the child has completed his or her "quiz" of the parent. The therapist's role in this interchange should be to allow the child and parent to communicate directly with each other, with as little intervention as

needed from the therapist. If either the child or parent has difficulty, or if either expresses an inaccurate or unhelpful cognition which the other does not challenge, the therapist should intervene (if judged clinically appropriate), so that this does not go unquestioned. The therapist should also praise both the parent and child for completing the GE component of treatment with such success.

At the end of the first joint session, the therapist, parent and child should decide whether there should be another the following week. Often the child and parent have enjoyed this session so much that they will be enthusiastic about having another. If there was awkwardness or difficulty in communication, they may be less positive about the idea, but in this situation, the therapist should actively encourage another joint session in order to improve the parent's and child's comfort with talking about these subjects.

BEREAVEMENT-FOCUSED INTERVENTIONS

Bereavement issues addressed in CBT-TB were selected based on child treatment studies of children experiencing parental loss due to cancer (Christ, 2000; Siegel et al., 1996a, 1996b) as well as writings by leading authorities in the bereavement and traumatic bereavement fields (Eth & Pynoos, 1985; Wolfelt, 1991; Fitzgerald, 1992, 1995; Webb, 1993; Rando, 1993; 1996; Worden, 1996; Goldman, 1996, 2000; Nader, 1997; Black, 2000) and our own experience in treating bereaved children in inpatient, outpatient and hospice settings. These include mourning the loss; recognizing and resolving ambivalent feelings about the deceased; identifying and preserving positive memories of the deceased; redefining the relationship with the deceased as one of memory, and recommitting to present relationships. Each of these will be addressed in detail below.

SESSIONS 9-10: INTRODUCTION TO BEREAVEMENT; MOURNING THE LOSS

Even after they have dealt with the traumatic aspects of the event, it may be hard for many children to talk about death. To some extent, this is modeled by adults, who often "do not know what to say" when someone dies, and as a result, may say nothing at all, or avoid the topic entirely. It may be helpful for these children to start the bereavement portion of therapy by **reading a developmentally appropriate book about death**. Such books provide a model for the child to talk openly about death, and many also educate the child about some aspects of death and bereavement. Examples of this type of book are Goodbye Mousie (Harris, 2001), I Miss You: A First Look at Death (Thomas, 2000, for younger children), and What on Earth Do You Do When Someone Dies? (Romain, 1999, for preteens and adolescents). We have found that children respond well to reading out loud in therapy, books written about situations like theirs, as this gradually introduces them to talking about their own situation, without requiring them to immediately talk about themselves. In this sense, reading such books is a form of gradual exposure to death and bereavement.

The therapist may next ask the child to draw a picture of what the child thinks happens when someone dies (Stubenbort et al., 2001). While some misconceptions about death may have been addressed in the trauma-focused interventions above (body reconstruction), the child may still have many confusing ideas about death. The therapist should correct these in a manner that is consistent with the family's cultural and religious beliefs (as discussed in the Parent Treatment section). The therapist may then ask the child to list different feelings that kids or grownups might have when someone they love dies. Thus, in three steps (reading a book about death,

asking the child about his or her beliefs about what happens after death, and listing feelings that people may have following the death of a loved one), the child has gradually been able to tolerate talking about death in the abstract. The next step is to encourage the child to talk directly about his or her own bereavement, which is addressed in the following sections.

Mourning the Loss

Mourning the loss includes mourning both the loss of the relationship with the deceased in the present (including all the fun, comforting loving aspects of that relationship), and the loss of things that might have been in the future, but now will never be. These will be addressed separately in this discussion, but in therapy, they are often intermingled.

Mourning the loss of the relationship the child had with the loved one requires the child to remember, identify and name the things the deceased and the child did with and for each other, which will no longer occur. These may include everything from basic caregiving (tasks which theoretically could be performed by a variety of other caretakers) to the most unique aspects of the relationship. Even mundane tasks such as cooking or cleaning, may have been special to the child because of the unique way that the deceased involved the child in their doing (for example, mother may have had the children each perform special tasks in baking cookies–one measured, one poured, one stirred–which made baking cookies more than a mere food preparation task). The therapist should encourage the child to describe these **special aspects of the relationship, which are now lost**. It may be helpful for some children to write a separate **bereavement book** (i.e., not the same book that they wrote earlier about the trauma). The child may also write the feelings that he or she previously experienced while sharing those activities or interactions with the deceased. The child can then write how he or she feels now, knowing that those activities will not be shared with the deceased again, except in memory. This is expected to prompt sadness, which

is part of the normal grieving process. The therapist should educate the child that almost everyone feels this great sadness when they have lost a loved one, and that it is a natural result of having loved the deceased so much. It may be helpful for some children to know that other family members are also sad and missing the things they used to share with the deceased; however, children who feel overly protective of remaining family members may not benefit from hearing about their grieving.

In addition to losing the past relationship with the deceased, children have also **lost things that might have been in the future**, which can now never be shared with the deceased. Important rites of passage -- confirmation, high school graduation, weddings, birth of one's first child -- are times usually shared with family and other loved ones. The absence of a parent or other loved one at such events is a significant loss to many children. Less celebrated but nonetheless meaningful events occur throughout the course of children's growing up years – being in a school play, participating in sports competitions, getting school or extracurricular prizes – these are all events at which children hope to have their parents and other loved ones present. Recognizing, naming, and grieving these losses is also important for many children, and should be included in the child's bereavement book, along with the feelings that accompany the naming of these losses.

Preparing for the loved ones' absence at these events is one manner in which children can come to realize that in the future there may be many be reminders of the loss. **Anticipating "loss reminders"** (Layne et al., 1999) in advance, and developing positive coping responses to address them, is something children can start to practice while still in therapy. It is hoped that this preparation will make them less vulnerable to being overwhelmed when such reminders occur in the future. One method for doing this is for children to think of ways in which these events may

be made special despite the absence of the loved one. Some children "dedicate" their special events to the deceased in some manner, either publicly or privately. (For example, one young man announced that his Bar Mitzvah was "in honor of my sister, who is still with me in spirit;" some adolescents run a big race or play an important game "for my dad"). Others will invite someone special to these events in lieu of the deceased (the deceased's best friend, etc.). A teenaged girl whose father died months before her high school graduation wrote in her bereave ment book, "I will be happy because I will remind myself of how proud my Dad would be of me if he could be there."

Grieving these losses will not be accomplished in a single treatment session, or indeed for many children, even in the course of 16 weeks of therapy. The goal is not to complete the grieving process, but to model for children that it is okay to feel great sadness when they have experienced a great loss, to give them an opportunity to express these sad feelings in a setting where they do not have to worry about others' vulnerability, and to encourage them to believe that their pain will diminish over time.

SESSION 11: RESOLVING AMBIVALENT FEELINGS ABOUT THE DECEASED

It is often difficult to acknowledge imperfections in a loved one who has died. This may be even more true if the death occurred in a sudden, unexpected, traumatic manner, which sometimes leads to the child or others seeing the deceased as a martyr or hero. However, there is often "unfinished business" in the relationship between the child and the deceased, i.e., unresolved conflicts, words said or unsaid that are now regretted by the child.

This may be most apparent in situations where the deceased was in fact somewhat

responsible for his or her own death (for example, a death caused by suicide, drug overdose, a "drug deal gone bad," or an accident in which the loved one was driving while intoxicated). In these situations, the child has to deal with the **stigma** associated with these activities in addition to trauma and bereavement issues. In fact, one of the main differences we have seen between children who lost a loved one to a highly publicized disaster (airline attack, bombing, terrorist attack) and those who lost their loved one due to interpersonal violence, accidents or suicide, is this issue of stigma. In the former case, the deceased are seen as innocent victims, if not heroes, and there is typically an outpouring of public attention, emotional support, and often public and/or government financial assistance. These children are often rightfully proud of their fallen loved one, and this positive aspect is often helpful in resolving the trauma/death issues. However, these positive aspects are rarely present for the second group of children, whose loved one died in less "heroic" circumstances. In these situations, there may be strong extended family support, but in the broader community, there may be insinuations or innuendos rather than support. Even children whose parents were murdered by strangers are often faced with questions about whether the deceased was somehow partly responsible for his or her own demise (for example, they may hear adults or peers say, "You have to wonder what she was doing in that neighborhood so late at night.") If these issues have not been addressed in the trauma-focused portion of therapy, they may arise when discussing "unfinished business" in the relationship with the deceased.

Regardless of the type of trauma that led to the loved one's death, almost all children have occasional conflicts with their siblings or parents, and these may have been unresolved at the time of the death. Adolescents in particular might have gone through weeks or months of thoughtless, rude or rebellious interactions with the loved one, and not have resolved these conflicts prior to the death. This typically leads to guilt feelings in the surviving child, but may also leave the child

with unresolved resentment or anger, which remains unspoken due to family or social expectations to" not speak ill of the dead," etc. The therapist should give the child an opportunity to discuss these issues and feelings, and normalize them by pointing out that all children have these interactions and feelings about their parents/siblings at times, but typically these are eventually discussed and worked out over time. The therapist can then suggest that while the premature death of the loved one prevented that from happening in person, the child can still have a "conversation" with the deceased, in which these issues and feelings can be laid to rest. If the family's religious beliefs (discussed below in the Parent Treatment section) are consistent with this, the child may choose to have such a **mental conversation** with the deceased's soul or spirit of the deceased in this regard. Other children will be more comfortable with the **reverse role play** method, as described above. Another technique is having the child **write a letter to the deceased**, saying all the things the child wishes he or she could have said before the person died (Stubenbort et al., 2001). Whichever method is used, the goal is to have the child say the things he or she wishes had been said before the death, and to imagine and verbally describe what the deceased would have wanted to say to the child, in order to resolve their unfinished business. Care should be taken to not confuse the child into thinking the parent is alive somewhere (one usually sends letters to living people at distant locations). It may be helpful to put the letter in a balloon to send up into the sky (towards heaven), or to bury the letter in the ground for children who seem confused in this way (Worden, 1996).

With regard to imagining a "healing" conversation to resolve problems with the deceased, some parents and therapists may feel uncomfortable encouraging the child to believe something about the deceased that would be "out of character," and may be concerned that this intervention would encourage unhealthy idealization of the deceased. The goal is not to alter the reality (or the

child's perception) of what the deceased was like in life, but to allow the child to believe that despite these problems, the deceased loved the child and at the end, would have wanted the best for the child. For example, the child whose father died of a drug overdose would be encouraged to believe that the father would want to say something like the following: "I was wrong for using drugs and I am sorry; I used drugs because of my own weakness and sickness, not because of anything about you; you were a great kid, and my biggest regret is that I missed out on being a better parent; you are strong and you will not end up like me; I love you and want you to be happy, etc." Other parents may be idealizing the deceased themselves, and may have difficulty accepting that the child had negative feelings about the loved one. The therapist should address this with parents as described below, in order to allow the child to resolve these issues in an optimal manner. It is thus important for the therapist to discuss this intervention with the parent/caretaker prior to introducing it in child sessions, not only to respect the parent's wishes in this regard, but also because the parent may have important insights about the deceased which can facilitate the therapist in this process. Finally, in the joint sessions (child and parent together), it will be important for the parent to reinforce the child's belief that the deceased would have hoped to work these issues out before he or she died.

SESSION 12: PRESERVING POSITIVE MEMORIES OF THE DECEASED

Once the child has begun the process of mourning the deceased and what has been lost from the future, and has addressed unfinished business with the deceased, she or he may be able to focus on positive aspects of the relationship shared with the loved one. Recording and preserving these positive memories in a concrete manner is bound to produce some sad and painful feelings, but in many cases it also allows children to reexperience the joy and happiness they shared with the

loved one. It is very important for children to realize that they still have the capacity – and permission – to be happy. Some children prefer to preserve these memories in their bereavement book, while others may want to make a separate **memory book**, which consists of pictures, keepsakes (tickets to movies or sporting events, etc..), photographs, hand drawn pictures, and/or poems or other writings about the loved one. Some authors have alternatively suggested the use of a "memory box" (Worden, 1996) in which the child puts memorabilia to be saved in a special place. A few children have also put together videotapes or slide shows of their loved one. Some children have asked other family members and friends to contribute to their memory book, while others prefer to write the book alone. One child lamented that all of the family pictures had been lost in the house fire that killed her sibling. She decided to ask her sister's friends and various other family members to contribute their favorite pictures of her sister and their family to her book. Many of the sister's friends wrote stories for this book, which included loving and funny stories the sister had told her friends about the child over the years. This was enormously meaningful to the child, who through this activity realized how important she had been to her sister. Recent advances in computer imaging make it even more convenient to reproduce borrowed or faded pictures. Children greatly enjoy this activity, and often reconnect with other family members and friends in the process of making these books. Here are some ideas that children have written, drawn, or included photographs about in their memory books with regard to the deceased:

- His favorite clothes
- Funniest habit
- Hobbies
- The best time we ever had together

- Favorite things that he gave me
- The nicest thing she ever did for me
- His favorite expressions/jokes

Children are encouraged to share this book with their parent/caretaker during the joint sessions, and to continue adding to it after therapy is over.

In some cases, children may have difficulty remembering activities or events shared with the deceased, and the surviving parent may not have been present for these occasions. It may be helpful to ask others to provide memories in these situations (for example, if the deceased parent attended the child's sporting events and the surviving parent did not, the child might ask the team coach or other team members what they remembered about the deceased parent's involvement, etc.). Younger children will typically have more difficulty recalling positive memories due to developmental considerations. Such children may benefit form looking at photographs of themselves with the deceased, writing stories about these photographs, drawing pictures of themselves with the deceased, and asking the surviving parent, older siblings, grandparents, etc. to assist in recalling happy times together with the deceased.

Many children will benefit from holding a **memorial service** for the deceased, even if there has already been a formal service. This allows children to orchestrate their own special tribute to the deceased. These can be held in the therapy session, at home, at the cemetery or wherever children choose, and should include the people, symbols and words children wish to use to memorialize the loved one. The therapist should assist parents in supporting children to hold such services.

SESSION 13: REDEFINING THE RELATIONSHIP; COMMITTING TO PRESENT RELATIONSHIPS

Throughout these bereavement exercises, the therapist has encouraged the child to have mental "conversations" with the deceased, imagining what the loved one would say or would have wanted to say to the child if given the opportunity. Many children continue to have these mental interactions with their loved one long after the trauma/death. Although this is normal, it is hoped that over time, the child will begin to **accept that the relationship with the loved one is not an interactive one in the present but rather a relationship of memory** (Wolfelt, 1991). Some children may feel guilty, as if they are betraying the loved one, when they gradually adjust to a present and future without the loved one. But this is what the child needs to do in order to reinvest in present relationships.

One intervention we have used in group and individual settings, is the use of a balloon drawing (Stubenbort et al., 2001) in which the child is given a drawing of two balloons, one floating away in the air, and one anchored on the ground. The floating balloon represents things the child has lost, while the anchored balloon symbolizes all that the child still has, including memories of the deceased. The child is asked to fill each balloon with words that describe what he or she has lost, and what he or she still has. This allows the child to concretely recognize that, while memories of the deceased remain, the interactive relationship is gone.

Recommitting to present relationships is an important step in enhancing the child's adaptive functioning. It is normal after the death of a loved one, to withdraw somewhat from one's usual activities and relationships for a time. Following a traumatic loss, the development of PTSD symptoms may contribute to the child isolating him or herself to an extreme or unhealthy

degree. This social isolation may prevent the child from accessing natural support systems such as friends, teachers, the parents of friends, clergy and members of one's religious congregation, etc., who could be available to the child if the child were only available to them.

Even uncomplicated bereavement can interfere with the reciprocal nature of healthy relationships. The child's focus is on the loss and, in the case of traumatic grief, much of their psychic energy is consumed with intense reminders and attempts to avoid them. However, once the child has begun to accept the death and begins to turn back to the task of living, an important aspect of healing is that of reconnecting with other important individuals in their life. The energy that had been unavailable is now freed up to reinvest in and cultivate existing and new relationships (Rando, 1993; Worden, 1996). Cognitive coping (learned optimism) can help the child to refocus on what he has as opposed to what he has lost. The therapist should ask the child to create a list of significant people in his life, and then ask the child to identify (for each person) positive qualities, characteristics, or ways in which the person contributes to the child's life.
Younger children can be directed to draw pictures of such significant people and the therapist can write the positive aspects for the child.

Therapists must be aware of obstacles to this important task of reinvesting. In addition to feelings of betrayal, children may also be wary of strong attachments for fear of additional losses. It is helpful for the child to understand how their desire to protect themselves from pain and loss also prevents them from receiving companionship and love. This can be illustrated to the child visually by having them draw themselves inside of a wall, and then having them draw the pain (sad face), hurt (broken heart), and other negative feelings outside of the wall. Allow the child to discuss how good it feels to be able to keep that pain away. After they have completed this, the therapist can demonstrate (by drawing) how love (heart, people hugging, etc.) and other positive

feelings and experiences are also unable to get through the wall. This could then lead to a discussion about choosing to let the wall down a little at a time to allow for the possibility of positive relationships.

SESSION 14: MAKING MEANING OF TRAUMATIC LOSS

This final phase of the child's therapy addresses an issue that is salient to both trauma and bereavement: finding meaning in life after tragedy or loss. Jacobs (1999) believes that TB includes an existential component characterized by the feeling that life is meaningless and empty, and that one will never be able to escape the void left by the death of the loved one. Terr (1991) expands on this experience by comparing a traumatized child to that of a depressed child: "The feeling of futurelessness of the traumatized child is quite different from that of the depressed youngster. For the traumatized, the future is a landscape filled with crags, pits and monsters. For the depressed, the future is a bleak, featureless landscape stretched out into infinity." The child with TB may experience a combination of these features of emptiness, and may need assistance in making meaning for him or herself out of the experience of traumatic grief. The type of meaning which we refer to could be likened to finding the "silver lining" in a negative situation. By doing so, it enables the person to integrate what was a traumatic experience in to his or her existing identity and world view, to refocus on the positive, and to begin to once again be future, rather than past, oriented.

In order to assist the child in "making meaning," the therapist may ask a series of questions:

- If you met another child whose parent died like yours did, what would you want to tell them about what you have learned?

- What would you want them to know that might help them?
- If they thought therapy would be too hard, what would you say to them?
- What do you think about yourself now that you've gone through this?

The answers to these questions should be used to develop a summary of the child's advise to others which would reflect the child's experience of progression through treatment and the process of recovery. One child, for example, wrote, "I would want to say I know what you feel like, it hurts really bad...you want to pretend it didn't happen, but you really can't... You have to talk about it and then it will get better. I know no one can take away the love my mom felt for me. I think she is proud of me for getting through this." In addition, because these types of questions require reflection, it underscores to the child that he moved beyond the TB by answering these questions from a position of having been "through" something rather than being "in" it. Further, putting the child in a position of authority provides a level of mastery and allows him to experience the rewards which come with the belief that he is helping another child. The child is thus contributing and comforting in a way that he could imagine might have been helpful to him in the beginning of his grief.

Another valuable way in which to assist children in making meaning is to find a "corrective activity." Corrective activities are positive behaviors child can engage in that are somehow related to the death of their loved one, perhaps lessons they have learned from the person's death. For example, a child whose father died of a drug overdose may choose to speak to other students about the dangers of drug use. A child who lost a parent in the attack on the Word Trade Center may choose to visit the fire department to thank the firefighters for trying to rescue her parent. That child could instead choose to write a letter to the firefighters or draw a picture for them.

Again, these activities provide opportunities for mastery, the experience of helping others, and making meaning out of tragedy.

In a similar manner, parents can turn their most difficult experience into something positive, by engaging in activities which help others to cope when faced with similar tragedies. An example of this is the USAir Flight 427 Support League, which was established by surviving loved ones of victims of that airline crash. This league has traveled around the United States to provide assistance and support to family members of other airline crash victims, and has had a major impact on how airlines address the needs of these survivors (Stubenbort et al., 2001).

Finally, the therapist should prepare for treatment termination by teaching the child "The Three Ps:" predict, plan, permission. This includes:

- **Predict** to the child that he or she will have times of sadness and grief throughout various points in life. These may be triggered by loss reminders (or trauma reminders).
- **Plan** for how to optimally cope with these times. This plan may include talking to parent or other significant person, using a specific relaxation technique, visiting a memorial site, looking at bereavement book, or any other activity that will bring the child comfort.
- Give **permission** to the child to have these feelings at any point in life, and have the child give permission to other family members, to have these feelings and to express these feelings without construing them as a sign of pathology. Parents also need to learn and practice The 3 Ps and to reinforce them in their children.

SESSIONS 15-16: JOINT CHILD-PARENT BEREAVEMENT-FOCUSED SESSIONS; TREATMENT REVIEW AND CLOSURE

As the end of therapy approaches (around session 13), the therapist should assess how the child and parent are progressing in the bereavement sessions. If they are each tolerating this phase of treatment adequately, the therapist should suggest the possibility of having one to two more joint sessions toward the end of treatment. This should be presented as an opportunity to share the child's bereavement book, and to acknowledge the gains both child and parent have made in treatment. It is important that these be planned ahead of time so that there will be time for one to two joint sessions and the final treatment session can still be utilized for individual wrap-up meetings.

Preparation for the bereavement joint sessions should parallel that or the GE sessions, i.e., the 15 minute individual child and parent sessions preceding the joint sessions should consist of reading the child's book and preparing questions for the child and parent to ask each other. The parent should also practice appropriate responses. The joint sessions should consist of the child reading the book, the parent praising the child's ability to do this, and the child and parent asking each other questions and discussing each others' responses. Additional issues to be addressed in joint sessions might include discussion of how the roles in the family have changed since the death of the loved one; how to assign new tasks or agree on new rules in response to these changes; having the child conduct the memorial service for the deceased in the joint session (if this is the child's preference); and openly discussing how the parent, child, and other families are coping with their own and each other's grief. The 3 Ps (predict, plan, give permission) discussed in the child's bereavement sessions, should also be addressed together with the parent and child prior to treatment termination. Finally, the parent should praise the child for all of the effort and

commitment put into therapy, and for all of the progress the child has made. The therapist should praise the child and parent in this regard during the joint session.

The final session (session 16) should be spent in part discussing the joint session experience, including thoughts and feelings the parent and child, respectively, experienced during these interactions. Additionally, the child's and parent's progress in therapy should be reviewed and acknowledged by the therapist, with appropriate praise given to each other. If the therapist believes that either needs ongoing therapy, this should be discussed with appropriate referrals and arrangements made prior to treatment termination.

PARENT TREATMENT[1]

Most parents of children with TB will have their own trauma and bereavement issues, as they will have known/been related to the deceased. (Exceptions include if a child has lost both parents or a single parent who was the sole caretaker, and has been placed in a non-relative foster home; or if a child has lost a close friend/peer whom the parent did not know well.) It should be emphasized that this CBT-TB model is **child-focused**; while some of the parent's symptoms and difficulties may be addressed in this process, parents who are experiencing severe PTSD or other

[1]For the sake of brevity, the term "parent" will be used throughout this manual to refer to the primary caretaker with whom the child is currently living. It is recognized that this will not always be a biological parent, nor the parent with whom the child had been living prior to the trauma/death.

psychiatric symptoms may need referral to individual treatment (psychotherapy and possibly pharmacotherapy) to adequately resolve these. This is especially important if the parent's symptoms are significantly impairing his or her emotional availability or judgement to the point that the therapist believes it is interfering with adequate parenting practices. The therapist should address these concerns directly with the parent in a supportive and non-judgmental manner.

The parent interventions parallel those for the child, so that the parent is aware of the content covered in each child session, and is optimally prepared to reinforce/discuss this material with the child between treatment sessions. Several studies of sexually abused children have demonstrated the benefit of actively involving parents in the treatment process (Deblinger, Lippmann & Steer, 1996), and that enhancing parental support of the child (Cohen & Mannarino, 1998; 2000) and helping the parent resolve her own emotional distress (Cohen & Mannarino, 1996a) predicts better child outcome. Although the only published study examining treatment of TB in adolescents was a group format that did not include a parental component (Layne et al., 2001), we believe that adding a parental component will enhance the effectiveness of TB-focused CBT interventions, particularly for pre-teen and younger adolescent children, as has been shown to be the case for sexually abused children. We hope to empirically evaluate this question in the future.

In order to parallel the child sessions, the parent interventions are presented in this manual in the same order as the child interventions. The therapist should be flexible in adjusting this sequence in order to parallel each individual child's treatment, as well as to address parental issues that arise during the course of therapy. It is helpful to start each parent session by asking how the child and parent have been doing since the last treatment session, and to address any specific concerns at that time.

TRAUMA-FOCUSED INTERVENTIONS

SESSION 1: ORIENTATION TO CBT-TB; GATHERING INFORMATION; PARENTING SKILL BUILDING

It is important for the therapist to spend a few minutes in the initial session orienting the parent to the CBT-TB model. This consists of explaining the philosophy of using this approach, and should include the following elements:

- the child has experienced both trauma and loss, and is having significant PTSD symptoms related to this experience
- clinical experience as well as research suggests that these PTSD symptoms need to be addressed in addition to the bereavement issues
- briefly review the PTSD symptoms the child is experiencing based on the clinical assessment that has been completed prior to treatment initiation
- talking directly about the trauma/loss is important in resolving these difficulties
- this will be done in a gradual, supportive manner so that the child will be able to tolerate the discomfort associated with such discussion
- the therapist will work in collaboration with the parent throughout treatment, and the therapist welcomes the parent's suggestions at any time
- although bereavement is universal, people of different religions and cultures have different ways of addressing this; the therapist is eager to learn from the child and parent the traditions and rituals of their culture, religion and family, and will remain respectful of these in the treatment process

At this point, the therapist should ask the parent about family, religious and cultural

traditions regarding death, and how the parent and child are coping with the loved one's death thus far. The therapist should also ascertain social supports available to the child and family as this will be addressed with the child in Session 2.

Parenting Skill Building

In the face of traumatic loss, even the most competent parent may experience difficulty in implementing optimal parenting practices. This is unfortunate, because maintaining normal routines and consistency in rules and expectations in the face of stress promotes adaptive functioning in children as well as adults. For parents who did not have optimal parenting skills prior to the trauma/death, gaining these skills may be even more crucial in optimizing the child's outcome. This is particularly true because some children's PTSD symptoms take the form of aggression, angry outbursts, and other negative behaviors (AACAP, 1998). Additionally, many parents will not be able to focus attention on trauma or bereavement issues until their children's behavioral problems have been addressed and resolved to some degree. For this reason, we begin the parent sessions with the parent skill building module. The parenting skills included in CBT-TB are basic and easy to learn, but nevertheless have been found to have a great impact on parenting abilities and behavior problems in parents of children experiencing stressors such as sexual abuse (Deblinger et al., 1996; Cohen & Mannarino, 1996a). These skills include the use of praise, active ignoring, effective time out procedures, and contingency reinforcement schedules (behavior charts).

Praise. Most people thrive upon praise, or positive attention. Most parents believe that they praise their children frequently and consistently, but in fact many parents are more likely to criticize children for negative behaviors than to praise them for positive ones. The therapist should start by asking the parent what his or her child does right, or well, or what the parent is most

proud of the child for doing. Once these behaviors have been identified, the therapist should ask the parent how often he or she verbally praises the child for these behaviors. Upon reflection the parent may realize that these positive behaviors are taken for granted, and therefore not often noticed or singled out for verbal comment. The therapist should instruct the parent to **focus on actively praising the child** for positive behaviors in the coming week, and note the effect of this praise on the child's mood and subsequent behavior.

As part of this instruction, the therapist should specify how to effectively give praise. This includes the following:

- Praise a specific behavior (for example, say "I like how you took out the garbage the first time I asked") rather than providing global praise (for example, "you're a great kid"). This will allow the child to more readily identify which behavior you are pleased with. Since children crave praise, the better they understand how to get it, the more you will see of the positive behaviors.
- Provide praise as soon as possible after the behavior has occurred.
- Be consistent. Praise the behavior each time it occurs (at least at first).
- Do not qualify your praise. For example, do not say "I'm so glad you took out the garbage when I asked. Why can't you listen like that more often?" This turns the intended praise into a criticism of the child.
- Provide praise with the same level of intensity that you would provide criticism. Many parents praise faintly ("nice job"), but criticize loudly, with great emotional intensity ("How could you DO a thing like this!!!") If a child is trying to get

intense focused attention from the parent and can only get it through negative behaviors, the negative behaviors will continue.

Having parents role play with the therapist various scenarios where the parent praises the child may help the therapist to identify any errors the parent may be making in praising attempts, and allow the therapist to correct these in the session.

Some parents may have difficulty identifying any praiseworthy behavior in the child. As noted above, childhood PTSD is sometimes manifested by irritable mood and angry outbursts (APA, 2000), and parents may understandably be focused on these behaviors. The therapist should encourage such parents to "catch your child being good," or at least catch times when the child is exhibiting no overtly negative behaviors, and praise that (for example, "it's so nice to sit here with you watching TV so peacefully"). When children respond to such comments with sullen responses ("just leave me alone"), the parent has the perfect opportunity to practice active ignoring, as described below.

Active Ignoring. Active ignoring refers to the parent consciously making a decision to not react to certain negative behaviors the child exhibits. This is based on the idea that children want focused, emotionally intense attention from their parents and others, and they will continue to exhibit behaviors that get this type of attention, *even if the attention takes a negative form* (like yelling at the child). Without realizing it, parents often attend and respond more to misbehavior than to good behavior in their children. Thus, they are inadvertently reinforcing (rewarding through attention) the very negative behaviors they want to discourage. In order to reinforce desired behaviors, the parent must learn to praise these good behaviors, and ignore most negative ones. Of course the parent cannot and should not ignore overtly dangerous behaviors, but should punish them appropriately as discussed below. Examples of behaviors which parents often

respond negatively to, which should usually be ignored include the following:

- Defiant or angry verbalizations directed at the parent
- Making nasty faces, rolling eyes, smirking at parent
- Mocking, taunting, mimicking the parent

The therapist should point out to the parent that such behaviors, while unpleasant, are not harmful and are most often the child's effort to "get the parent's goat," i.e., to provoke a negative response. If the negative response is not forthcoming, the behaviors often stop. The parent should practice walking away calmly, without commenting on such behaviors, and busy herself or himself with another activity, in another part of the room or in a different room from the child. The therapist may predict to the parent that this may result in the child trying harder to get a reaction, by engaging in even more provocative behaviors. If the child escalates in his or her provocations, the parent may need to use a time out, but above all, the parent should maintain a calm, dispassionate, controlled demeanor, to avoid giving the child the reinforcing attention he or she is seeking. Equally important, the next moment the child is behaving well, the parent should give positive attention (praise) for this behavior. An added benefit of active ignoring is that the parent saves herself from emotional distress by remaining calm and unflustered despite the child's inconsequential negative behaviors.

Time out. The purposes of the time out procedure are to interrupt the child's negative behaviors and thus allow him or her to regain emotional and behavioral control; and to deprive the child of positive attention. Ideally, the parent should explain time out to the child before the first time it is used, stating that if the child cannot obey the parent's request to stop a particular behavior, the parent will place the child in time out. Time out should occur in the quietest, least

stimulating room available, and should only last one minute for every year of age (for example, a 7 year old should have a 7 minute time out). The timer should start when the child has stopped screaming, banging on the walls, etc. in the time out room. The parent should calmly ask the child to stop the undesired behavior, specifying exactly what the parent wants the child to stop (for example, "Please stop kicking the door," rather than "BEHAVE!") If the behavior continues, the parent may remind the child once that he or she will go to time out if the behavior does not stop. If the child does not stop, the parent should escort the child to the designated time out room, without any further comment, and with a calm, dispassionate demeanor. The door should be closed, and the parent should refrain from responding to the child's verbalizations or further negative behaviors. A timer may be helpful for the parent to keep track of the 5-10 minutes. Once the time has elapsed, the parent should retrieve the child from time out and proceed with normal activities. If the child is now acting in an appropriate manner, the parent should interact positively with the child, giving positive attention and refraining from showing annoyance or anger about the previous behavior problems. Thus, the child learns that good behavior leads to positive parental attention whereas bad behavior leads to time out (no attention). Parents who are able to implement this consistently often see rapid behavioral improvements in their children, and feel more competent about their own parenting skills because they are not losing control, yelling, hitting, or engaging in other angry parenting responses. More persistent behavioral problems may be addressed through the use of contingency reinforcement programs, which are briefly described below.

Contingency Reinforcement Programs. Contingency reinforcement programs (behavior charts) are useful for decreasing unwanted behaviors and/or for increasing desired behaviors in many children. This intervention is described in great detail elsewhere (Bloomquist,

1996) and therapists are referred there for specific instructions. Briefly, behavior charts should adhere to the following guidelines:

- Select only one behavior at a time to target for change.
- Discuss with the child exactly how to earn a star on the chart (for example, every day that you do not hit your sister, you will get a star at bedtime)
- Involve the child in decisions about what the reward will be (for example, I will go to a movie alone with mom on Sunday if I have gotten 5 stars between Monday and Saturday)
- Add up stars and give rewards at least weekly
- Give stars and rewards consistently

If the child is exhibiting significant behavioral problems, the therapist should attempt to assess whether these are manifestations of the child's TB, or were present before the trauma/death. If the therapist is finding that the behavior problems are becoming the main focus of treatment, referral for ancillary treatment to address those problems may be advisable. In fact, the parent may have brought the child for treatment because of these behavior problems rather than to address TB issues, and if the therapist fails to address these in some manner, the parent will likely be dissatisfied and less likely to attend or comply with other aspects of the treatment.

When children are troubled by thoughts and feelings related to the intentionally caused traumatic loss of a loved one, they often express this through behavior problems such as aggressiveness or risk taking. Given the dangerous nature of such behaviors, it is important that the

parent use the parenting skills outlined above (praise, active ignoring, and time out) to interrupt and manage such negative behaviors. The parent should be told that the issue of intentionality also be addressed directly with the child during treatment.

SESSION 2: STRESS INOCULATION THERAPY (SIT)

We include SIT interventions for parents following traumatic bereavement both so that they can practice and reinforce these skills in their children, and because they also typically need techniques for managing high levels of stress. In addition to the techniques described below, therapists may find additional helpful strategies for teaching stress management to parents in The Relaxation and Stress Reduction Workbook (Davis, Eshelman & McKay, 1988) as well as in a variety of other books, websites, etc. Finally, the SIT techniques described here are often helpful for both parents and children to use during the gradual exposure and cognitive processing treatment components.

Deep breathing and progressive muscle relaxation techniques may be taught to the parent in the identical manner used with the child as described above. Some parents may be interested in using deep breathing as a form of **meditation**, which is the practice of uncritically focusing one's attention on a single thing. While the object of attention can be anything one chooses, it is often easiest to focus on one's own breathing. One reason why this practice is so helpful for reducing stress is that it is impossible to truly focus on more than one thing at a time; if the parent is focusing on his or her own breathing, he or she will not be able to focus on trauma/death related thoughts or emotions (sadness, fear, anger, etc.) at that moment. Other benefits of meditation are that one learns that not all thoughts that come into one's head need to be attended to; that thoughts and feelings are not permanent but come and go frequently; and that

most of the things we feel stress about are not happening right now but rather are related to the past or the future. These realizations can be very helpful when the parent is starting to feel overwhelmed in his or her attempts to deal with the trauma/death or with the challenges of daily living.

Although there are many methods and instructions for meditating, the easiest is the following: "Find a comfortable position, begin deep breathing (as described above in the child section), and attempt to focus only on your breathing. When other thoughts or feelings interrupt your focus, or your mind starts to drift to other things, bring your focus back to your breathing. Do this as many times as necessary, and do not judge yourself for not being able to perfectly maintain your focus; this is normal. The benefits of meditation accrue from the effort of refocusing your attention, not from being perfect at maintaining it. Do this for 10 minutes a day to start, and try to work up to 30 or 45 minutes a day." Some parents may want to spend 5 minutes in the session attempting this, and the therapist should encourage this, as enhancing stress management in the parent may have a very positive impact on the parent's availability to and support of the child.

Thought stopping. In addition to the techniques described in the child treatment section, therapists may want to suggest the use of **paradoxical intention**. This involves requiring the parent to think about the upsetting thought for a predetermined amount of time, after which he or she must use thought stopping to stop thinking about it. Paradoxically, trying one's hardest to think about something makes it easier to stop thinking about it. For example, if the parent is fixated on worries about the child before going to bed at night, the therapist may instruct the parent that she can worry about those things in the morning only, not at night. At night she must use thought stopping to interrupt those thoughts and to replace them with "perfect moment" thoughts.

Each morning, the parent should set a timer for 3 minutes, and then think of nothing but these worries, as intensely as she can for those 3 minutes. When the timer goes off, she can no longer think about those worries for the rest of the day. Some parents will report that their mind wandered during the 3 minutes, and that such focused worry was difficult to sustain all at once (probably for the same reason that it is hard to stay focused on one's breathing without distraction). Other parents will report that giving themselves "permission" to worry lessened their need to do so. Typically, paradoxical intention should be replaced by CP techniques to reframe inaccurate or unhelpful thoughts as therapy progresses.

Cognitive coping can be used to challenge pessimistic thoughts that either arose following the trauma/death, or those that the parent held previously but which have become stronger since the loss. Such pessimistic thoughts may include the following

- I can only be happy if I am in a romantic relationship
- There is only one true love for everyone, and I lost him/her
- Being strong means I should never feel upset/unhappy/angry
- Good parents always know the right thing to say to their children
- It's horrible when things go wrong in life
- Some problems have to be avoided because they are just too hard to handle.

Coping statements to challenge these might include the following:

- Lots of things can make me happy; I will try to do one fun thing for myself each day
- It is too soon for me to think of loving someone else, but someday it may be possible
- Being strong means doing what you have to do, and I am doing that

- I am a good parent; I do lots of good things for my child, including bringing her to therapy even though it is painful
- Things going wrong is just a part of life; facing challenges can make you stronger
- I am facing the hardest thing that has ever happened to me, and that takes a lot of courage

The therapist can encourage and reinforce these cognitive coping statements by telling the parent true observations the therapist has made about the parent. For example, the therapist might tell the parent that she (the therapist) admires the parent's strength in the face of adversity; that the parent is doing a great job of keeping a positive attitude and modeling this for her child, etc.; hearing this type of genuine comment from the therapist may have a very significant impact on how the parent views herself and/or her child.

Enhancing the Parent's Sense of Safety

In situations of parental or other familial death, children often exhibit increased feelings of fear, vulnerability, and mistrust; the surviving parent is also often feeling fearful, unsafe and distrustful. It is important for the parent to communicate a general sense of safety to the child and to provide an environment of emotional support. In order to enable the parent to do this, the therapist needs to optimize the parent's own sense of safety.

The therapist should begin by asking whether the parent has been experiencing a decreased sense of safety and trust since the trauma. If a parent is reporting a general decrease in safety and trust, the therapist should provide the parent with tools to recognize and correct cognitive distortions and misinformation. For example, for the parent who reports that, since the terrorist

attacks, the world will never again feel safe, the therapist may say something in this manner:

> "I hear you saying that it feels like you will never be able to move on since the terrorist attacks, but I wonder how the people living in Northern Ireland, or Israel, manage to carry on amidst the constant fighting and terrorist attacks. Clearly, many people are choosing to stay there. There must be something positive that keeps them there. If we asked them, I wonder what they would say. What do you think they would say?" (Allow the parent to answer. If the parent does not respond, the therapist may suggest the following.)
>
> "I have heard some people in these situations say things like 'this is my home, my country, and I will not let these few evil people chase me away or frighten me into not living a full life.' Others have said, 'Our way of life/religious freedom/etc. is worth fighting for, and even worth dying to preserve. We have to give a message to terrorists that they cannot take away our freedom or way of life, by standing up to them even when we are afraid.' "

The therapist may then ask the parent to identify actions or information which could restore some of their sense of trust and the will to begin building a new life. Parents should be encouraged to pursue practical ways to feel safer, including seeking information, attending support groups in their churches or neighborhoods, etc. where "courageous" behaviors are rewarded by others.

If the parent is evidencing unrealistic fears and worries about ongoing terrorism or

hopelessness, the therapist may use cognitive interventions to address these issues. Although these are described in greater detail in the section on Cognitive Processing below, the following example is how these may be used to enhance the parent's sense of safety.

Therapist: I understand that it is hard to stop thinking about the terrorist events and you are worried that these kinds of activities are going to continue to happen. Can you tell me more specifically what it is that you are worried about?

Parent: I worry that they are going to drop bombs all over the United States and that millions of people are going to be killed. I especially worry that New York is going to be their primary target and I will lose the rest of my family.

Therapist: Now, given the fact that the United States is on extreme alert, and our knowledge that these terrorists do not have the sophisticated weapons that we have, how likely do you think it is that, even if the terrorists have planned this, that they would be able to carry it out?

Parent: Well, they were able to carry out the Twin Towers attack! Although, I guess we weren't on alert at that point. I don't know...I still worry about the ones that I love.

Therapist: Of course you do, and you will always be concerned about the safety of your loved ones. That is the nature of love, and parenting. But, your sense of general safety is my concern right now, and I think that it is very important that you regain a sense of safety and confidence, for yourself and your children. So, tell me this, on a scale of 1 to 10, with ten being the most likely, how likely do you think it is that the terrorists will be able to carry through with another bombing of New York?

The therapist may then use psychoeducation about the safety precautions being taken (National Guard guarding waterways, INS scrutinizing immigrants and foreign visitors closely; heightened airline security; fighter jets guarding the airways of the east coast and NYC/Washington in particular; recent military victories in Afghanistan giving terrorists reason to fear revenge if they try to attack again, etc.).

The therapist should ask the parent to make a specific plan for how to feel safer, and how to convey a greater sense of safety to the child. These might include the following:

- Watching news channels which make me feel safer and not watching those which sensationalize every small development (such as insignificant amounts of anthrax found in offices, etc.).
- Join a community volunteer organization working with less fortunate people (homeless, AIDS patients, etc.) who live with chronic risks.
- Seek information regarding safety steps being taken in parent's own community; contact authorities regarding parent's own ideas about improving security measures.
- Verbally reassure the child about the safety measures being taken to enhance security.

Enhancing Parental Social Support

The therapist should begin by assessing current emotional and social support available in the parent's environment. It is important to help the parent to identify current needs and to recognize those areas over which the parent has some control. The therapist should prompt the parent to talk about the persons or organizations that can be counted on to provide help. It may be helpful to make a list of specific needs such as child care, finances, or employment, who or which

organizations may be accessed to get these needs met, where this person/organization can be reached, etc. The parent may also want to list whether any resources have been contacted, what the response has been, and which needs remain. The therapist should work with the parent to identify potential barriers to accessing available support. In some cases, barriers will arise from parental factors (e.g., a sense of helplessness, inability to make needs known). In other cases, barriers will be the result of systemic problems (e.g., charities being overwhelmed or poorly organized; poor dissemination of information). In either case, the therapist should assess the parent's needs and advocate (or find an advocate who can assist) to get these needs met.

SESSION 3: THE COGNITIVE TRIANGLE

During this session, the therapist should **introduce the cognitive triangle to the parent**. This may be done in the same manner that was used for the child, or using an example such as the following.

> "Suppose you go to a movie and you see two women you know only slightly. They look your way from across the lobby but continue to talk to each other without coming over to say hello to you. Let's take a look at what your thoughts might be and how that might affect your feelings and behavior. Say your thought is "they are gossiping about me." How would that make you feel? (Parent answers "embarrassed," "angry," "hurt.") If you felt embarrassed, what would you do? What would your behavior be in this situation? (Parent answers "walk away," "glare at them," "leave the theater," etc.) Now what if, instead of thinking they are gossiping about

you, your thought is, "they must not have seen me." How would you feel then? (Parent answers, "neutral," "curious about what they are discussing," etc.) Now if you felt nothing, or curious, what might your behavior be? (Parent answers, "I might go over and say hello to them;" "I would just go in and see the show," etc.). So you see, the objective reality of what happened in those two scenarios was exactly the same, but changing the thought made a big difference in your feelings and behavior in that situation."

The therapist should then show the parent the cognitive triangle.

Thoughts

Feelings

Behaviors

The therapist should ask the parent to identify several examples of upsetting events, thoughts or feelings recently experienced by the parent. For each of these, the therapist should assist the parent in accurately distinguishing between thoughts and feelings, identifying negative thoughts which are contributing to difficult feelings, and replacing these thoughts with different thoughts that may lead to less upsetting feelings and more productive behaviors. These activities may introduce elements of cognitive processing (CP) described in Session 7 below, but as with the child's session, thoughts and feelings specific to the trauma/death do not need to be examined at this point unless the parent brings these up. If this occurs, the therapist should utilize the appropriate CP techniques to explore and correct cognitive distortions at this point in therapy. These techniques can be reviewed again in Session 7.

SESSIONS 4-6: GRADUAL EXPOSURE (GE)

To begin the GE component, the therapist may again inquire directly about the bereavement customs of the child's family, religious congregation, and/or cultural group, and how the child has responded to these thus far (for example, how was the death explained to the child, was a funeral or memorial service held, did the child attend, how did he or she react to this, how have relatives and friends responded to the trauma/loss, how has it affected the composition and functioning of the nuclear family unit, how has the greater community responded, has there been supportive or non-supportive media coverage, etc.). These questions are in fact a form of gradual exposure for the parent, in that without asking specifically about the traumatic event, the therapist is encouraging the parent to discuss some aspects of the trauma/death.

The therapist should then **directly explain the GE procedure**, using similar analogies (cleaning out the wound) to that used with the child (pages 31-32). The parent may wish to discuss concerns about this procedure, and the therapist should encourage such discussion. It may be helpful to predict that the child may not enjoy this part of therapy, may resist attending, and may even transiently show more symptoms during this phase of treatment. The therapist should ask the parent to tell her/him if this happens, so that therapy can be adjusted to the child's comfort level. It is our experience that almost all children can tolerate GE if it is correctly calibrated and the child is given the appropriate support from the therapist and parent. The parent

should be reassured in this regard, and also told that the GE intervention will not start until the child has gained some comfort with the therapist and the therapeutic process.

Finally, the therapist should explain that in addition to resolving the child's PTSD

symptoms and enabling the child to adequately grieve, another goal of GE is to allow the child to become more comfortable in discussing his or her thoughts and feelings *with the parent*, even when they are upsetting. The therapist should explain that this is important, because the parent should be the person the child can come to with any problems or worries, whether about the trauma/death or anything else. Showing the child through joint sessions that the parent is able to tolerate discussing even the most upsetting subjects (trauma/death), and that the parent responds to the child in a supportive and helpful manner, will encourage the child to talk to the parent about any problems that arise in the future. Most parents are eager to accomplish this goal, and support the GE procedures when they are explained in this manner.

Once the child embarks on the GE component, it is usually helpful to share with the parent the information the child is writing in the GE book. Particularly with adolescents, this should only be done after the therapist discusses with the child if this is acceptable. Some children may object on the grounds that they do not want to upset the parent with reminders of the trauma/death. It is important for the child to learn that the parent can tolerate this. If the child is concerned about this, the therapist should reassure the child that the parent is discussing similar things in his or her own sessions, and that the parent wants to be able to share the child's experiences, thoughts and feelings. The therapist can offer that, if the parent starts to get overly upset, the therapist will stop reading the book to the parent, but at the same time reassure the child that the parent will be able to handle reading the child's book.

In other cases, the child may be afraid that the parent will be mad at the child for things he or she has written (for example, if the child expressed anger at the deceased for being where the trauma occurred or anger at the surviving parent for whatever reason). The child should in this case be reassured that the parent wants to understand what the child is going through, and the

therapist does not believe the parent will be upset or angry at any of the child's thoughts or feelings. The therapist must then be prepared to address the child's concerns with the parent, and to resolve these issues so that the parent can remain supportive of the child and therapy.

To prepare the parent for hearing and seeing the child's GE book, the therapist should ask the parent to **describe the parent's own experience of the trauma/death**, in whatever manner he or she is able. The therapist may begin by asking how the parent heard about what happened – where was the parent, who told her the news, what was her first reaction, how did the child find out about what happened, what was the child's response, etc. Having the parent talk through the sequence of events, his or her thoughts and feelings, etc., may be very difficult, and adequate time should be available during the parent session to allow the parent to complete this narrative without interruption. It is important that the parent also have adequate time to regain his or her composure before the end of this session, as it is usually not helpful for the parent to return to the waiting room in tears (many children will believe that such parental distress is related in some manner to things the child did or said in therapy).

The parent should then be reminded that the child is also describing this experience in therapy, in the form of a book, which the therapist will share with the parent as it is being written. If the child has already started the GE book, the therapist may then **share the child's GE book with the parent**. It is important for the therapist to **praise the child's ability** to the parent, and to overtly **praise the parent** for encouraging the child to attend therapy and share memories, thoughts and feelings about the trauma/death, even though it is painful.

As the child continues in the GE sessions, the parallel parent session should be devoted largely to the parent reading the child's book, and discussing the parent's reactions to this. As with the child, at each subsequent GE session, the therapist should re-read the book out loud to the

parent from beginning to end. This provides ongoing GE for the parent, with the goal of desensitizing the parent to hearing about the trauma/death, and improving the parent's ability to tolerate hearing the child's description of this. The culmination of the GE component is the GE joint session, which is held at the end of the GE sessions. This is described in the Trauma-Focused Joint Session section above.

Some parents may "correct" the child's book (for example, noting that the child described events out of sequence or had some other detail wrong). The therapist should explain that unless these details are directly relevant to the child's functioning or otherwise having a clear negative impact, the parent should not "correct" the book with the child. Occasionally the child has heard, remembered, or interpreted details of death incorrectly and an informational question-answer period (i.e., the parent can say, "You can ask me anything") in a joint session may be necessary to clarify these questions. This is particularly helpful for those children who vehemently debate the accuracy of their information and this stance will ultimately effect the outcome of their GE book. The point is not to describe the exact objective reality of the trauma, but to get the child to describe and become desensitized to his most upsetting, intrusive memories and images of the trauma.

SESSION 7: COGNITIVE PROCESSING (CP)

In a parallel manner to the child sessions, during the GE sessions the therapist may have identified cognitive errors (inaccurate or unhelpful thoughts) that the parent has regarding the traumatic event and/or death of the loved one. The parent may also have developed cognitive distortions about the child's or parent's response to the trauma/death. Common parental errors in this regard include the following:

- My child will never be happy again
- Our family is destroyed
- My child's childhood is ruined
- I can't handle anything anymore

The therapist should ask the parent to **examine her own thoughts for both their accuracy and helpfulness**. For example, with regard to the thought, "My child will never be happy again," most children will have moments of normal mood or happiness, even when suffering from PTSD or grieving the loss of a loved one. The therapist may have personally witnessed a moment or two when the child was smiling, cheerful, or interacting normally with others. The therapist can point this out to the parent, and ask whether there have been any other moments, however fleeting, in which the child has seemed less sad. Once the parent is able to acknowledge that the child has experienced such moments, the therapist can point out that this has occurred even early in the bereavement process, when nearly all children are sad. The therapist can next point out that "never" is a long time, that the child has already made a lot of progress, and will continue to improve over time. Modifying this thought to a more realistic assessment (for example, "My child is often sad now but this is normal; even now she has moments of happiness and as time passes she will continue to get better"), will help the parent to feel more hopeful. This may also help the parent to be more capable of offering encouragement to the child, when the child is making similar distorted comments about himself. For many parents, the belief that their child can never again be happy is connected to concerns about not having two parents ("a boy needs a father"). Therapists should share with the parent that while it is true that the child will miss their deceased parent deeply, research has shown that if a child has at least <u>one</u> person with whom they have a positive attachment, they do well. Emphasizing the benefits of having one loving parent

rather than focusing on the loss is a helpful way to reframe for the parent.

The therapist should then discuss with the parent some examples the child gave in his or her parallel session, of some distorted thoughts the child had, and how CP techniques were used in the session to replace these distortions with more accurate and helpful thoughts. The parent should then be asked to come up with some examples of how he or she has been thinking about the traumatic event and/or the death of the loved one, and to use the cognitive triangle to understand the impact of those thoughts on the parent's feelings and behaviors. The therapist can then model using CP techniques to **have the parent challenge her own inaccurate or unhelpful thoughts**, and have the parent practice this. Finally, the therapist may give the parent some examples of things the child might say in the future, which represent cognitive distortions, and have the parent **practice how to effectively challenge the child's cognitive distortions** and help the child generate more accurate and helpful cognitions in this regard.

SESSION 8: JOINT CHILD-PARENT TRAUMA FOCUSED SESSION

This session is described on pages 47-49.

BEREAVEMENT-FOCUSED INTERVENTIONS

SESSIONS 9-10: INTRODUCTION TO BEREAVEMENT; MOURNING THE LOSS

In addressing bereavement issues with the parent it is important for the therapist to understand the parent's family, religious and cultural beliefs with regard to death and grieving. Some of these issues were touched on in the GE parent component. As the bereavement phase of

the child's treatment begins, the therapist should discuss these issues again with the parent. In some instances, the parent may be struggling with conflicts between what his or her family/ religion/culture dictates to be "normal;" or "appropriate" grieving, and what he or she is actually thinking, feeling or doing. For example, parents may feel negatively judged or rejected by their religious community if they no longer have faith in God; or a parent who begins to date again after a few months may feel that family and friends are angry about this "disrespect" for the deceased. Providing a non-judgmental, accepting setting for the parent to discuss these issues may be of great benefit, both for the parent and child.

It is also important for the therapist to ascertain the parent's perception of the child's understanding of death. Often parents are upset or confused because children are showing very *little* emotion about the death of the loved one. This may be due to shock, developmental limitations in the child's ability to comprehend the permanence of death, PTSD avoidance, or attempts by the child to shield the parent from knowing how upset the child is. Certain circumstances may also make it difficult for the child to truly believe that the loved one is dead, or to know how to act. For example, for many days following the terrorist attacks on New York and Washington in September 2001, thousands of people in New York were shown on television posting pictures and descriptions of their loved ones, obviously holding out hope that people were still alive beneath the wreckage. Children who saw this in the media or in person, might well be confused, and may believe even months later, that their loved one is still alive. Even observing first hand how the adults' hope turned gradually to grief, may not have convinced such children that the "final" truth was known. In general, the younger the child, the more likely these kind of circumstances are to be confusing. The parent may thus need considerable help in understanding the child's concept of death, and assistance in providing age-appropriate explanations of death to

the child. If the parent prefers that the therapist provide these explanations, the therapist and parent should discuss and agree ahead of time, on what precisely the therapist will be telling the child, so that this will be consonant with the parent's belief system. This will also assure that information provided to the child by the therapist and parent will be similar, and not cause confusion in the child.

As noted above, although the focus of CBT-TB is on addressing the child's trauma- and bereavement-focused issues, it is likely that the parent will also address his or her own trauma and bereavement issues to some extent in this treatment. It is expected that as the parent hears about the child's grieving process during therapy, this will trigger the expression of some of the parent's own grieving. We believe that assisting the parent in resolving personal emotional distress is likely to positively impact on the child's response to treatment, as we have found this to be the case with sexually abused children (Cohen & Mannarino, 1996b). Thus, the therapist should encourage this parental expression of feelings related to the death of the loved one, and assist the parent in addressing and, to some extent, resolving personal bereavement issues. As the parent becomes more comfortable with discussing these feelings (including ambivalent feelings about the deceased if these are present), this will model for the child that it is okay to talk about death, the deceased loved one, and even to express negative feelings about loved ones. This culminates in the joint sessions at the end of therapy, which are discussed below. Typically, the parent's personal bereavement issues have some commonalities with the child's issues, but there are also differences due to the different relationship the parent had with the deceased, as well as the fact that the parent is an adult. Child-focused parental bereavement interventions are described in the following section. Regardless of the parent's own bereavement issues, the therapist should emphasize the importance of the parent expressing his or her own feelings to the child in an

appropriate manner (i.e., the parent not necessarily tell the child everything he or she discusses with the therapist).

Mourning the Loss

The therapist should discuss with the parent what the child is writing in the bereavement book with regard to things the child has lost. It is expected that this will prompt feelings of great sadness, just as it did for the child. In addition to grieving the parent's own loss, the parent will be grieving the losses the child has to bear. The therapist should normalize these feelings, and characterize them as feelings a good parent who loves her or his child would feel. It may be helpful to frame this for the parent in the following manner:

> "Of course it fills you with sadness to hear about your child's sadness. It's hard for any loving parent to see her child experience pain. But as a therapist, I am relieved that your child can experience this pain. So many children build a wall around their feelings, and are afraid to feel anything at all in this situation. There is less pain, but these children will have trouble feeling other feelings, too – happiness, pride, enthusiasm, and other good feelings. Feeling sadness and pain is unfortunately a necessary step on the way to healing, and I am grateful that your child is brave enough to let herself feel."

With regard to lost things that might have been in the future, the parent may be able to suggest ways in which the child can optimally deal with these loss reminders in the future. The parent can try to anticipate some of these and recognize the importance of making these future events "special" for the child. For example, a parent who missed school plays or sporting events in

the past because the deceased parent attended them all, might plan to attend these events regularly in the future in order to minimize the feelings of loss the child may experience. Inviting other friends or relatives to these events may be another way to keep these events special for the child even in the absence of the deceased.

SESSION 11: RESOLVING AMBIVALENT FEELINGS ABOUT THE DECEASED

As noted in the child treatment section, the therapist should discuss with the parent any ambivalent feelings the child is expressing toward the deceased, and help the parent understand the child's perspective in this regard. Some parents may be feeling similar ambivalence toward the deceased loved one, but any lack of consonance between the child's and parent's feelings needs to be addressed by the therapist. This may happen in either direction, i.e., the parent may feel ambivalence while the child does not, or vice versa.

The therapist should help the parent understand that the child did not have the same relationship with the deceased that the parent did. Thus, it is not surprising that they may have different feelings about the deceased. The therapist should explore with the parent whether the child or parent is idealizing (or devaluing) the deceased. .If this is occurring**,** CP interventions may be helpful in restoring a more realistic view of the deceased. However, since it is not clear that idealizing a deceased loved one is necessarily harmful, caution should be used in correcting children's or parents' overly positive views of deceased loved ones. The best approach may be to encourage the parent to accept the child's view of the deceased as being valid for the child, and to focus on ways to help the child resolve "unfinished business" with the deceased regardless of whether the parent share an identical view of the deceased.

The parent should also receive support in resolving guilt and other personal "unfinished business" with the deceased. Few relationships are without ups and downs. It is therefore not surprising that many bereaved parents had a less than perfect relationship with the deceased , and are filled with guilt over the things that they did or did not do with or for the deceased, sometimes over the course of many years prior to the trauma/death. For example, a husband who had an extramarital affair, a wife who was uninterested in marital intimacy, a sister who stopped speaking to her sibling 5 years ago over an argument that was unresolved – all of these parents may feel overwhelmed with guilt and self-blame following the wife's, husband's or brother's unanticipated death. This may be magnified if the deceased died in a manner that made him or her into a hero (for example, the New York City rescue workers in the 2001 terrorist attack). The therapist should encourage the parent to **reflect accurately on the totality of the deceased**, not just the manner in which he or she died. While there may be legitimate regrets, there are usually some valid reasons for the parent's previous feelings and/or behavior towards the deceased; it is important for the parent not to lose sight of this in the height of emotions following the traumatic loss. It is also likely that, in addition to the regretted action, the parent contributed many positive things to the relationship, which are being overlooked or minimized in the parent's current mind. Finally, it may be helpful to remind the parent that "hindsight is 20/20;" few people are blessed with the ability to see things with perfect clarity while they are happening. The parent should thus be encouraged to be a bit more generous in her self-assessment. Use of the best friend role play may be helpful in this regard.

The **best friend role play** is a method by which the parent is encouraged to be more realistic and fair in his or her self-assessment. The therapist should instruct the parent to pretend that he or she is the parent's best friend. The therapist plays the role of the parent and says to the "best

friend" the disparaging, guilt-ridden things the parent has been saying about him or herself. For example, the therapist says to the "best friend," "I was the worst husband ever. I wouldn't let Jane take that job she wanted, and now I feel terrible. She died unfulfilled because of my selfishness." The therapist then asks the "best friend" what he would say to that friend to make him feel better or see things more clearly. Through this role play, the parent often is more supportive of the "best friend" than he has been to himself. Once the parent has corrected the attributions in the role play (for example, "You didn't do it out of selfishness, she told me that she didn't really want to work, she just wanted the extra money. You were trying to keep her from getting too stressed out."), the therapist should encourage the parent to be his own best friend, i.e., use these same methods of challenging his own distorted cognitions that he would use with a best friend (Deblinger & Heflin, 1996).

SESSION 12: PRESERVING POSITIVE MEMORIES OF THE DECEASED

The parent should be encouraged to assist the child in recalling and preserving positive memories of the deceased. This may be difficult if the parent's own relationship with the deceased was problematic; in this situation, the therapist should help the parent understand why positive memories are important for the child's healing to proceed. As discussed in the child section above, the therapist should explain to the parent that allowing the child to attribute **benevolent intent** (i.e., he or she meant well and wanted good for the child) to the deceased is important even if there were negative aspects of the deceased's treatment of the child. Benevolent intent does not erase any negative acts of omission or commission that occurred in the relationship between the child and parent. In fact, allowing the child to attribute benevolent intent to the deceased may enable to the child to more accurately recognize the negative as well as positive aspects to the relationship with

the deceased (because the child feels less guilt about thinking badly of the deceased).

The parent who had a good relationship with the deceased may be able to add many fond memories of the child's interactions with the deceased to the child's book, including things that occurred when the child was a baby or which the child has forgotten. The parent who is able to assist the child in this way (for example, looking through old scrapbooks or photo albums with the child or discussing past happy events where the deceased was present) models for the child that it is good to have happy memories and okay to have happy as well as sad feelings about these memories. It also shows the child that the parent can emotionally tolerate talking about the deceased, and that this does not always have to cause sadness.

SESSION 13: REDEFINING THE RELATIONSHIP, COMMITTING TO PRESENT RELATIONSHIPS

The child may need the parent's "permission" to let go of the relationship with the deceased as an interactive one, i.e., the child may fear that this would be disloyal to the deceased, and may need the parent to dispute this idea. This may be difficult for the parent who has not yet negotiated this transition herself or himself. The therapist should help the parent understand that until the child can do this, he or she will not be able to reinvest in present relationships, including the ability to feel close to the surviving parent.

The therapist should explain that the child's ability to refocus on present and future relationships is crucial not only to bereavement, but to the child's overall development as well. Most parents will want to assist their child and do whatever it takes to help; therefore, understanding the importance of this task will enable them to move beyond their grief in order to "do what's right" for their children. Therapists should explain to the parent that one of the major differences

between the parent's and child's recovery has to do with the child's developmental stage. Specifically, the child is still a "work in progress," whereas the adult is assumed to be a full-formed, full-functioning being. A crucial task of development has to do with the formation of identity. As social beings, children's identity development to a large degree hinges on their relationships with others, particularly significant others such as parents. It is through interactions with these significant persons that children learn who they are. Therefore, if a child's interactions continue to be with a person who is no longer living, that primary relationship is one of the past. That is not to say that the deceased is no longer an important part of the child's life or an important aspect of who they are. However, in order for the child to continue to develop, they must have an interactions with significant others who are a part of the living world and who will live, change, and grow along with the child. These significant adults will provide "anchors" for the child to the world of the present and future, rather than allowing him or her to become stuck in the past. Providing such an anchor for their child will ensure that their child will truly be able to incorporate the positive aspects of the deceased parent into their developing identity, promote a loving relationship with the surviving parent, and enhance the likelihood that they will be able to form positive, healthy relationships in the future (i.e.,friends, teachers, a future spouse). It is helpful to assist the parent in focusing on what he or she desires for the child's future. When asked, most parents will report that one of the things they most want for their child is to have a loving wife or husband. Helping the parent to focus on their child's future may circumvent some of the resistance to viewing the relationship with the deceased as one in the present.

Once the parent has accepted the importance of this task and worked through such resistance, at least as it applies to the child, the therapist can review specific ways in which the parent can encourage redefining the relationship and investing in present ones. For example, the

parent should be instructed to "tune in" to the language they use when they talk about the deceased. Do they refer to them in the present or past tense? Parents and others should be encouraged to use past tense whenever possible (i.e., "daddy worked at the bakery" versus daddy works at the bakery"). Parents do not necessarily need to correct the child's language but should use their own language as a powerful way of modeling that the family is moving into the present. Encouraging any steps towards maintaining or developing relationships is also important. Just as parents will be using praise to increase other positive behaviors, their praise of appropriate social behaviors can be effective as well. Parents should praise the child for wanting to spend time with grandparents or friends. Simply stating "that sounds like a fun thing to do " or "I'm glad you're doing that, I want you to have fun with your friend" helps to relieve the child of any guilt or reluctance they might be experiencing. Some children feel guilty about leaving the surviving parent, and may need to hear directly that the parent is okay spending some time alone. Parents can model this for children by spending time with their own friends or other relatives. Afterwards, it may be helpful for the parent to initiate a discussion about thoughts and feelings during their time spent with others.

SESSION 14: CONCERNS ABOUT ABILITY TO RAISE CHILDREN ALONE

This discussion relates to situations in which the deceased is one of the child's parents. Although some bereaved parents may have had the primary responsibility for child rearing activities prior to the trauma/death, others will be assuming these responsibilities for the first time. In either case, parents often feel overwhelmed with the idea that they are alone in making all the decisions about the child's health, education, financial future, etc., which in the past had been shared to a varying extent with the deceased parent. As the seriousness of this responsibility

becomes clear, parents may feel a variety of emotions: fear or anxiety about being able to make the right decisions, anger or resentment towards the deceased for leaving this burden on them, and/or sadness about not having the deceased parent to lean on, share decision-making with, and share the joy of watching the child grow up together. These feelings may be complicated by the deceased parent's previous decisions (for example, to not get life insurance, to not save for college; to insist on the child attending private school which the child is now accustomed to but the surviving parent will no longer be able to pay for, discouraging the surviving parent from developing a career, etc.). Allowing the parent to openly express these feelings may assist in their resolution. Cognitive distortions and misinformation can also be challenged and corrected in this process (for example, " I don't know how to pay the bills; my husband did all of that" can be addressed through pointing out that paying bills is mostly a matter of being organized, that the mother has been organizing many things in the household for years, and that she can learn to do this as well). As noted above, one of the therapist's most important interventions may be providing the parent with appropriate information about legal, financial, medical and other assistance programs. Finally, the therapist may point out that the parent *is* raising the children alone at the moment, and doing it well despite great adversity.

SESSIONS 15-16: PARENT BEREAVEMENT SESSIONS; TREATMENT REVIEW AND CLOSURE

As the end of therapy approaches (around session 13), the therapist should assess how the child and parent are progressing in the bereavement sessions. If they are each tolerating this phase of treatment adequately, the therapist should suggest the possibility of having one to two more joint sessions toward the end of treatment. This should be presented as an opportunity to share the

child's bereavement book, and to acknowledge the gains both child and parent have made in treatment. It is important that these be planned ahead of time so that there will be time for one to two joint sessions and the final treatment session can still be utilized for individual wrap-up meetings.

Preparation for the bereavement joint sessions should parallel that of the GE joint session, i.e., the 15 minute individual child and parent sessions preceding the joint sessions should consist of reading the child's book and preparing questions for the child and parent to ask each other. The parent should also practice appropriate responses. The joint sessions should consist of the child reading the book, the parent praising the child's ability to do this, and the child and parent asking each other questions and discussing each others' responses. Additional issues to be addressed in joint sessions might include discussion of how the roles in the family have changed since the death of the loved one; how to assign new tasks or agree on new rules in response to these changes; having the child conduct the memorial service for the deceased in the joint session (if this is the child's preference); and openly discussing how the parent, child, and other families are coping with their own and each other's grief. The 3 Ps (predict, plan, give permission) discussed in the child's bereavement sessions, should also be addressed together with the parent and child prior to treatment termination. Finally, the parent should praise the child for all of the effort and commitment put into therapy, and for all of the progress the child has made. The therapist should praise the child and parent in this regard during the joint session.

The final session (session 16) should be spent in part discussing the joint session experience, including thoughts and feelings the parent and child, respectively, experienced during these interactions. Additionally, the child's and parent's progress in therapy should be reviewed and

acknowledged by the therapist, with appropriate praise given to each other. If the therapist believes that either needs ongoing therapy, this should be discussed with appropriate referrals and arrangements made prior to treatment termination.

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APPENDIX A: INSTRUMENTS

a. Grief Screening Scale
b. UCLA PTSD Index for DSM-IV (Child Version)
c. UCLA PTSD Index for DSM-IV (Adolescent Version)
d. UCLA PTSD Index for DSM-IV (Parent Report)

APPENDIX B: WEBSITES FOR THERAPISTS AND PARENTS

1. www.ncptsd.org
   The National Center for PTSD has many helpful fact sheets including:

   - Terrorism and children
   - Effects of traumatic stress in a disaster situation
   - Self-care and self-help following disasters
   - Mental health intervention for disasters (for therapists)

2. www.aacap.org
   American Academy of Child and Adolescent Psychiatry has fact sheets for parents in English, Spanish, German and French, including:

   - Helping children after a disaster
   - Posttraumatic Stress Disorder
   - Teen suicide
   - Grief

3. www.mentalhealth.org
   Center for Mental Health Services (SAMHSA) has fact sheets in English and Spanish for parents and therapists including:

   - How to help children after a disaster
   - After a disaster: What teens can do
   - After a disaster: A guide for parents and teachers
   - Crisis counseling guide for children and families in disasters (for school personnel and parents)
   - Self-care tips for dealing with stress