Chapter Seven

Grief and Youth in Crisis

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Introduction

This chapter addresses the issues of traumatic, complex, and disoriented grief in

children and adolescents in crisis. This includes children and adolescents who are

victims of abandonment, domestic violence, natural disaster, and other emergency

situations. Often these children and adolescents are in transitional living arrangements

and are facing unknown and uncertain futures. Facing and enduring such a crisis as a

child or adolescent can be a traumatic and emotionally overwhelming experience. Often

the primary focus is on practical concerns such as living arrangements, legal issues, and

securing and maintaining physical safety. In addition to physical needs, there is a realm

of emotional, social, and cognitive grief responses to trauma and crisis that must be

attended to. Information related to the assessment and intervention of traumatic grief and

loss issues that may underlie the prominent challenges that these children, adolescents,

and families confront will be provided.

Overview of Grief and Loss

Grief and loss come into the lives of children and adolescents in many forms and with

more frequency than adults realize. There are the obvious crises such as the death of a

parent, sibling, friend, or other family member. Children and adolescents who are

victims of abandonment, intrafamilial (domestic) violence, interpersonal violence,

community violence, serious accident, and other emergency situations may experience

indescribable ensuing grief and loss. The crisis event may take the form of a natural disaster such as a hurricane, flood, wildfire, avalanche, or earthquake. It may occur through a technological, or human-made, disaster such as a shipwreck, plane crash, building collapse, toxic spill, or nuclear reactor leak. There are times when these crises may overlap, producing a complex crisis event that may cause multiple and varied losses. Disasters invariably involve extreme danger, suddenness, a magnified sense of helplessness, tend to happen to many people simultaneously, and cause significant degrees of loss (Miller, 1998). The crisis might be violent in nature and may occur in the home, school, neighborhood, or community. Less obvious crises that may elicit grief responses in children and adolescents include the impact of exposure to media coverage of catastrophic events such as 9/11, the devastations of the Iraq war, or the impact of Hurricanes Katrina and Ike.

Grief and loss experienced in childhood and adolescence "constitutes a risk factor for concurrent and sometimes chronic distress" (Currier, Holland, & Neimeyer, 2007, p. 253). Children and adolescents exposed to trauma and crisis events may exhibit impairments in academic, peer and family functioning. Recently acquired developmental growth and achievements are particularly vulnerable to disruption in the wake of a crisis. Reactions to trauma may appear immediately after a traumatic event or weeks, or even months later. Crisis events can shatter hopes, destroy confidence, and cast children and adolescents into despair that could last a lifetime.

During the aftermath of a crisis, traumatic reminders may contribute to intense psychological and physiological reactivity, which can provoke and maintain distress

(Saltzman, Steinberg, Layne, Aisenberg, & Pynoos, 2001). Chronic distress may take the form of physical, emotional, social, and cognitive grief responses, as outlined in Table 1.

TABLE 1: Types of Grief Responses

Physical	Emotional	Social	Cognitive
Trouble eating	Dazed	Feeling different from peers	Decline in school performance
Sleep disturbances	Numbed	Perception of peers being intolerant of their grief	Paranormal (hallucinatory) experiences
Headaches	Shocked	Social isolation	Preoccupation
Stomachaches	Afraid	Isolation from family	Thoughts of own death
Joint pain	Frustrated	Risk-taking behavior	Sense of presence of the deceased
Muscle pain and tension	Depressed	Increased sense of maturity	Realization of the permanency of death
Being ill more often	Alone	Experience of unkind remarks from peers	Disbelief
Lump in throat	Anxious	Avoidance of reminders	Confusion
Tightness in chest	Guilty	Antisocial	Distraction
Aching arms	Uncomfortable when happy	Withdrawal from normal activities	Difficulty with concentration
Muscle weakness	Sad	Change in peer group	Intrusive thoughts
Dry mouth	Irritable	Self-destructive behavior	Lowered self-esteem
Lack of energy	Vulnerable		Memory problems
Eating disturbances	Angry		
	Aggressive		

Crisis Responses in Children

Children's grief responses can be extremely varied as children are themselves. Often following a disaster, adults notice how extraordinarily quiet some children are in comparison to the level of distress evidenced in adults, and make the mistaken assumption about how well they appear to be coping. The inhibition of children's normal

spontaneous activity is typically an indicator of enormous underlying stress (Miller, 1998). Other children may express their distress with excessive crying, clinging, and regressive behavior. They may cry out or act out to inform the adults around them that they are in pain (Schuurman, 2008). Additionally, children intuit and absorb the distress of the adults around them, which increases their level of fear, uncertainty, and distrust.

The pre-school tasks of sharing and cooperation with other children may be impacted by a child's withdrawal, emotional constriction, and problems with impulse control (Pynoos, Steinberg, & Goenjian, 1996). Traumatic or reenactment play may limit and disturb the typical fantasy play of a pre-school child, which may lead the child to being labeled "deviant" by other children, parents, and teachers (Pynoos et al., 1996). Pre-school children are typically able to organize narrative material into a beginning, middle, and end. This is a crucial developmental task that allows for competency in reading, writing, and communication skills. Exposure to trauma or a crisis event may interfere with this developmental task, resulting in a more chaotic narrative construction (Pynoos et al., 1996). This may also lead to the child's inability to cognitively and emotionally process the trauma or crisis event in a healthy and resilient manner. Additionally, school-age children exposed to trauma or crisis events may have difficulty developing appropriate emotional regulation which is necessary and critical to functioning with family, peers, and within school settings (Pynoos et al., 1996).

School-age children may increase attachment behaviors, becoming clingy toward parents or caretakers, due to worries about the safety of family members and of their own safety. Childhood is a time for transitioning to more involvement with peers and development of friendships. A trauma or crisis event may jeopardize this necessary

transition, adding frustration to the child-parent relationship, and creating embarrassment and shame for the child (Pynoos et al., 1996). In contrast, some children may strive to accelerate autonomy and pursue activities beyond their developmental capabilities, becoming estranged from parents in the process.

Crisis Responses in Adolescents

Adolescent grief responses do not necessarily parallel the grieving of adults. Notably, adolescent grief may involve mourning that comes and goes, and the overall process may extend over a long period (Hogan & DeSantis, 1992). Adolescent grieving is paradoxically both continuous and intermittent (Balk & Corr, 1996). The experience of a crisis can cause traumatic distress which may take the form of avoidant behavior in adolescents. They may restrict their normal daily activities as a way to avoid confronting reminders that strongly evoke traumatic images and reactions (Saltzman et al., 2001).

The major task of adolescence is identity formation with themes of separation and connectedness having primacy. Identity tends to shift away from parents and family, although attachment to parents is still vital, and move toward forming identity among peers (Noppe & Noppe, 2004). They get to practice who they are and who they might become. This is an important period for the formation of self-esteem, determination of self-efficacy, absorption of others' perceptions, and acquisition of the ability to manage life demands and unexpected change (Steese, Dollette, Phillips, Hossfeld, Matthews, & Taormina, 2006). Adolescents perceive themselves as members of the peer culture and view their peers, popular culture, and themselves as the support system that offers feedback and definition about who they are and who they are developing into. Crisis and

"traumatic experiences may skew expectations about the world and the safety and security of interpersonal life. Such expectations map onto a schema of risk, danger, injury, loss, safety, security, protection and intervention, which once organized, may be incorporated into the developing personality" (Saltzman et al., 2001, p. 45). Traumatic experiences and crises can upset or complicate, but most certainly have an impact on, identity formation, which may already be unstable (O'Brien & Goodenow, 1991). Adolescents have not developed the social or emotional maturity to fully incorporate and process bereavement into a coherent world view (Rowling, 2002).

Adolescents tend to seek out one another when they have experienced a trauma or crisis event and may feel most comfortable talking with other teens who have experienced the same crisis. Yet simultaneously, they can feel different from and misunderstood by their peers (Ringler & Hayden, 2000). They may feel discomfort talking with parents or other adults about their feelings, often disappointed in parents' reactions (O'Brien & Goodenow, 1991). Many adolescents expect more support from parents and other adults than they actually receive. Parents are unsure how to react to their adolescent. The disenfranchised nature of adolescent grief is a phenomenon "that is shaped fundamentally by grieving rules of parents, other adults, and peers, all of whom create the grieving norms of an adolescent's world" (Rowling, 2002, p. 276). Adolescents are often perceived as resilient and not seriously affected by the trauma, especially if it is a crisis event experienced by the entire family or community (Ringler & Hayden, 2000). The adolescent's perception of lack of parental or adult support makes it difficult to find people they can trust with whom to talk about their traumatic grief.

Adolescents can experience multiple emotions that exist separately, coexist, or alternate (Webb, 2002). These bereavement reactions may include a sense of bravado, denial, anger and rage, shock, numbness, fear of one's own death, nightmares, insomnia, loneliness, survivor guilt, school problems, great sadness, substance abuse, and suicidal ideation (Rheingold, Smith, Ruggiero, Saunders, Kilpatrick, & Resnick, 2004; Ringler & Hayden, 2000). Adolescents are typically reluctant to show strong emotions, making it difficult to assess the nature and depth of their emotional pain. Their natural and expected narcissism can make them difficult to reach (Goodman, 2002).

Adolescents are often invested in projecting an image of independence and control over their lives, not wanting to need adults. They may delay or repress their grieving in order to keep up this appearance. Adolescents can look like adults in physique, body development, and attire yet still struggle with the emotional immaturity of their age (Noppe & Noppe, 2004). The adults in their lives may react to this pseudo-sophistication with unrealistic expectations for emotional control. These adolescents may look like they are doing well, but may in fact be postponing their grief reactions which can re-emerge later in adulthood (Kandt, 1994). Typically, adolescents endure an overwhelming sense of being forever changed by their experience of grief with a sense of never being the same again. This "changed self" does not reflect their previous carefree, invulnerable self and instead, is more fearful and reflective (Lattanzi-Licht, 1996).

Disoriented Grief

Children and adolescents who experience a crisis that leaves them devoid of home, family, pets, and a life that they were familiar with may exhibit symptoms of

disoriented grief (Malone, Pomeroy, & Jones, 2009). This type of grief may be in response to a natural disaster such as a hurricane, flood, wildfire, avalanche, or earthquake. It may be induced due to a technological, or human-made, disaster such as a shipwreck, plane crash, building collapse, toxic spill, or nuclear reactor leak. It may also be a reaction to placement in foster care. Disoriented grief is characterized by a paralyzing effect, a pervasive feeling of uncertainty and fear, a perceived lack of motivation, and an enduring sense of living in survival mode. Disoriented grief is composed of categories to include displacement, destruction, death, and distress.

Displacement encompasses the loss of family members, loss of friends, loss of pets, loss of an adolescent's job, and a loss of identity. Being displaced means leaving behind all that was familiar. Loss of identity involves a sense of isolation, not knowing where one belongs, and a feeling for children and adolescents that they do not fit into their current location.

Destruction includes the physical loss of a home or house, the loss of material belongings, and the loss of a child's or adolescent's neighborhood. Children and adolescents may experience the death of family members, the death of their friends, and/or the death of their pets. They may also exhibit or express fear of their own death.

Distress entails the witnessing of events that children and adolescent should never in the ordinary scope of life be exposed to. This also includes a loss of hope about the future and about life in general, and a loss of time, particularly for children and adolescents who have missed school due to a crisis. There can also be stigma and blaming attached to the crisis that the child or adolescent endured.

These components of disoriented grief lead to a paralyzing effect that makes it difficult for children and adolescents to move forward in their lives beyond the crisis experience. They are often left with a pervasive feeling of uncertainty and fear, unsure of what the future holds for them and about whom they can trust. Teachers and mental health professionals frequently perceive a lack of motivation on the parts of these children and adolescents whose main purpose is an enduring sense of living in survival mode.

Assessment Methods with Children and Adolescents

Assessment needs to occur directly with children and adolescents in addition to interviewing parents/caretakers in order to obtain a thorough evaluation of traumatic grief reactions. To accurately and thoroughly assess traumatic grief in children and adolescents, practitioners must take into account the wide range of potential responses in the aftermath of a crisis, especially after a sudden or violent loss (Crenshaw, 2008). To fully understand the extent and impact of the crisis event, a thorough assessment can be divided into three categories: *assessment of the situation*, *tasks of the assessment*, and *treatment goals* (Goodman, 2002).

Assessment of the Situation (Goodman, 2002; Webb, 2002)

- Personal thoughts and beliefs about the crisis

- Family's thoughts and beliefs about the crisis

- Relationship with any person(s) involved in the crisis or loss event

- Memories of the crisis event

- Relationship with any survivors

- Current emotional state and functioning

- Personality traits

- Family, social environment, and social supports

- Adaptation to life changes resulting from the crisis

Tasks of the Assessment (Christ, 1999; Goodman, 2002; Liotta, 1996)

- Assessing symptoms, thoughts, and feelings related to the crisis

- Normalizing the grieving process

- Allowing nonverbal and verbal content to be revealed at the child's or adolescent's own pace

- Encouraging trust

- Respecting all expressed emotions

- Aiding adjustment to changed family relationships

- Supporting mastery of events and emotions

- Promoting continued age appropriate development, reengagement, and reinvestment in activities and peers

Treatment Goals (Goodman, 2002; Goodman, Williams, Agell, & Gant, 1998)

- Establish a trusting relationship

- Express feelings in a safe environment

- Explore memories of the crisis

- Understand and adjust to life that has changed

Further assessment involves a comprehensive evaluation that addresses a tripartite etiology of the trauma or crisis event, which should include (1) a clear delineation of the objective features and a thorough description of the child's or adolescent's subjective experience of the trauma or crisis event; (2) a determination of the type and frequency of traumatic reminders to include both external and internal cues; and (3) a detailed accounting of current secondary stressors that the child or adolescent may be facing, as well as potential adversities or ongoing hardships (Pynoos et al., 1996). The practitioner needs to gather precise information regarding the specific objective features of the trauma or crisis event to include (Pynoos et al., 1996):

1. Extent of exposure to direct life threat

2. Any injury to self, including extent of physical pain endured

3. Witnessing of mutilating injury or grotesque death, especially to family members or friends

4. Any perpetrating of violent acts against others, especially to family members or friends

5. Hearing unanswered screams for help and cries of distress

6. Smelling noxious odors

7. Being trapped or without assistance

8. Proximity to violent threat and violence

9. Unexpectedness and duration of the trauma or crisis event

10. Extent of violent force and use of a weapon or injurious object

11. Number and nature of threats during any violent episode

12. Witnessing of atrocities, to include torture, rape, and murder

13. Witnessing of dead bodies, especially family members or friends

14. The relationship to the assailant and other victims

15. Use of physical coercion

16. Violation of the physical integrity of the child or adolescent

17. Degree of brutality or malevolence

All of these factors contribute to the onset and persistence of traumatic grief and loss in children and adolescents (Pynoos et al., 1996).

Interventions with Children and Adolescents

It is imperative that grief and loss interventions for children and adolescents who have experienced a trauma or crisis event meet developmental and age appropriate needs. Conflicts and issues that are specific to the developmental tasks and transitions of early, middle, and late adolescent development are important to consider (Balk, 2008). Since the "symptomatology is like a blanket covering the mourning" (Rando, 1993, p. 587), the impact of the trauma or crisis event must be addressed prior to grief and loss issues. The goal of interventions for grief and loss responses related to trauma and crisis is to ameliorate chronic distress symptoms, enhance coping and adaptive behaviors, increase family support, and help children and adolescents resume activities that promote normal developmental growth and progression (Saltzman et al., 2001).

Psychoeducation about Grief and Loss

Trauma or crisis intervention must incorporate a psychoeducation component regarding age-appropriate reactions to trauma, grief, and loss. This is essential in order to assist children and adolescents in identifying the physical, emotional, social, and

cognitive symptoms they may be experiencing related to the trauma, crisis event, or loss. This benefits them by reducing their perceptions about their reactions or responses as wrong, abnormal, bizarre, or related to personal shortcomings or faults (Saltzman et al., 2001). This also involves teaching children and adolescents the vocabulary for communicating about trauma, grief, and loss.

Symptom Management and Reduction

The following are some symptom management and reduction techniques that practitioners can utilize with children and adolescents during individual, group, or family therapy sessions. Symptom management and reduction can be taught to children and adolescents as a skill set to be used at any time, and is an extremely important component of trauma or crisis intervention and use in ongoing therapy. These may include (Saltzman et al., 2001):

- Relaxation techniques to include graduated muscle tensing and relaxing, and creating safe-place imagery.
- Thought stopping as a cognitive strategy designed to increase the ability to monitor disturbing or dysfunctional thoughts and replace them with more calming and adaptive thoughts.
- Self-talk to counter against negative and distorted thinking and to replace with positive and rational thinking.
- Breathing retraining as a method of taking deep and focused breaths as a calming technique. This also increases the child's or adolescent's awareness of when they stop breathing as a maladaptive method to reduce upsetting feelings.

- Interpersonal skills training to increase knowledge and awareness of interaction with others.

- Grounding techniques to be used during sessions when child or adolescent is overwhelmed or not able to stay in the moment:
    - Focusing on bodily sensations
    - Listening to practitioner's voice
    - Touch on the hand

Group Therapy

Group therapy is an intervention that can work well for both children and adolescents. Many participants in bereavement support groups report more freedom in expressing feelings, that they are more in control of their lives, and are more confident, happy, and able to connect to others (Tedeschi, 1996). The ideal developmentally appropriate group teaches symptom management and reduction, increases coping strategies, identifies and minimizes risk factors, and identifies and maximizes protective factors. Risk factors may include the experience of previous losses or crises, isolation, few friends or close relationships, problematic relationships with friends or family, substance use or abuse, low self-esteem, and poor school performance (Balk, 1996). Protective factors may include good relationships with friends and family, a sense of connection to the school community, involvement in extracurricular activities, a healthy level of self-esteem, good school grades, and parental involvement.

Group therapy goals may include creating a sense of safety, identifying and embracing the emotions of grief, commemorating or remembering the trauma or crisis

event, acknowledging ambivalence, and recovering and preserving positive memories and thoughts about one-self and others that may have been lost during the crisis event (Schuurman, 2008). Group therapy allows children and adolescents the knowledge that there are others who care and understand their feelings, thoughts, and behavior. The group practitioner needs to incorporate the following tasks (Heegaard, 1990):

- Teach basic concepts about death, loss, and grief

- Help children and adolescents recognize, accept, and express feelings

- Provide opportunities for taking and risks and problem solving

- Encourage open communication and opportunities to learn from each group member

- Give support and encouragement

- Discover unhealthy misconceptions

Each of these tasks can be addressed through group activities, sharing times, and the dynamics of the group process (Dane, 2002). Additionally, the use of games and communication exercises may help children and adolescents express feelings and thoughts about the trauma, crisis event, or loss.

Group therapy for children can offer experiences that provide them with emotional connection and safety. It can alleviate the sense of loneliness that many children report following a trauma, crisis event, or loss. Children may also receive validation for who they are, what they feel, and what they experience (Schuurman, 2008). Groups provide a setting for children to learn how to express and share emotions they may feel overloaded with, ranging from anger and self-pity to relief and panic (Schuurman, 2008). The range of emotionality can be random in nature and confusing

for both the child and the family. Groups can help children and adolescents begin to move through the process of grieving.

Group therapy as a modality of intervention for adolescents has historically been utilized for a wide variety of issues and concerns that have an impact on this population (Gitterman & Shulman, 2005; Malekoff, 2004). Groups provide a framework toward understanding the impact of grief and loss (Balk, 1996) and effectively build support, mutuality, and connection among group members (Gitterman & Shulman, 2005). There is a positive connection between social support and the adjustment of adolescents which is understandable given the importance of peer relationships in the development of cognitive and social skills during adolescence (Tedeschi, 1996). This makes group therapy especially significant since grief, and particularly traumatic grief, can be an isolating, private experience for many adolescents (Lattanzi-Licht, 1996).

Art Therapy

Integrating art therapy into other interventions and grief therapy milieus to include individual, group, and family therapy, helps both children and adolescents to communicate, understand, and cope with grief and its effects on them (Goodman, 2002). Art therapy includes drawing, painting, modeling with clay or Play Doh, writing or journaling, as well the creation of memory boxes. Obtaining direct access to a child's or adolescent's world can be achieved via his/her imagination, where thoughts, ideas, and emotions make connections with factual information (Goodman, 2002). Therapeutic communication may be easier and at times more direct "through the use of symbols or images rather than through the complex world of spoken language" (Goodman, 2002, p.

299). "Symbols restore a sense of unity by integrating and connecting emotions, perceptions, and thoughts not previously brought into juxtaposition and, in so doing, create a complex subjective experience that is deeply moving and cathartic" (Lewis & Langer, 1994, p. 232).

Play Therapy

The use of both formalized (directive) and free-form (nondirective) play therapy, drawing, and games creates an environment that can elicit the stories, fears, thoughts, concerns, and perceptions of children who have experienced a trauma or crisis event. Initiating play therapy with children is an approach that allows for the reinterpretation and modification of traumatic impressions and emotions. "Using directive methods while recognizing the child's own rhythms, timing, needs, strengths, and weaknesses, the practitioner can expedite the child's resolution of difficult aspects of traumatic response and experiences" (Nader, 2002, p. 218). Directive play may elicit deeper levels or variations of traumatic emotions such as rage or fear, and may require further sessions that focus on the specific crisis event (Nader, 2002). Nondirective play is led predominantly by the child. For example, the child may assign a role to the practitioner such as that of family member, victim, perpetrator, witness, rescuer, or another character (Nader, 2002). The activity gets played out at the child's own pace, with the child directing the actions.

Play therapy with adolescents may fall along the lines of demonstrations or role play where the adolescent assigns a specific role to the practitioner. These may be the same roles as mentioned above that children may assign such as that of family member,

victim, perpetrator, witness, rescuer, or another character (Nader, 2002). This is similar to directed play therapy with younger children, where traumatic reenactments, or demonstrations of the scenes from the crisis event may be elicited.

The treatment room needs to be well equipped with toy people, stuffed animals, various people puppets and animal puppets, buildings and blocks, clay and Play Doh, toy weapons, and an array of drawing materials (various sizes and colors of paper, crayons, markers, and colored pencils). Traumatized children and adolescents may express their grief and loss in age-related and developmentally appropriate ways, act more mature than their age, or relapse into younger play. Nader (2002) outlines the following guideline for play therapy at various ages:

- Preschoolers: the practitioner focuses on play while verbalizing reactions and sequences for the child.

- Younger school-age children: the practitioner uses a combination of play and drawing with cognitive review and discussion.

- Adolescents: the practitioner emphasizes discussion along with some role play and/or demonstration.

The Use of Trauma Narrative Construction

Children and adolescents can be "assisted in constructing a coherent, temporally organized trauma narrative that includes objective and subjective features of the traumatic experience, and the worst moments of extreme fear, horror, and helplessness" (Saltzman et al., 2001, p. 52). With the practitioner's guidance, the child or adolescent explores their thoughts about what occurred during the trauma or crisis event, to include

their thinking about what they or someone else could have done to stop or intervene to prevent the injurious or lethal consequences (Saltzman et al., 2001). The worst moments of the trauma or crisis event get explored, with links made between those moments and trauma reminders. This initial narrative allows the practitioner insight into the range of possible trauma reminders and trauma avoidance, which can then be used in creating a coping plan.

Interventions with Families

Children and adolescents are highly influenced in their coping with a crisis or loss by how those around them respond to it (Rosen, 1991). Many children and adolescents who have been exposed to a traumatic event evidence a loss of trust in adults and maintain a fear that the event will recur. If a family constructs a taboo about talking about the trauma, crisis event, or loss, then many children and adolescents never get the opportunity to inform anyone about their responsive thoughts, beliefs, and feelings. Included in their ensuing silence will be questions about their own safety, their belief about what actually occurred, their imagined guilt, as well as their own grief (Rosen, 1991). Also, if following a crisis event the functioning of the family or adult caretakers is impaired, then children and adolescents may be both directly and indirectly traumatized further (Miller, 1998). Interventions with families need to focus on assisting children and adolescents in regaining a sense of safety, while validating their emotional reactions as opposed to discouraging or minimizing them.

Family Therapy

Families may benefit from family grief therapy that focuses on the trauma, crisis event, or loss. An initial assessment must be made to determine the family dynamics, family strengths, and the family's need or desire for intervention. It is imperative to assess how the family copes with loss as well as the family's thoughts and beliefs about the trauma, crisis event, or loss. How the family makes meaning of the crisis event provides a framework for assessment and a direction for intervention (Nadeau, 2001).

Finding or making meaning is critical for a family's successful adjustment to a crisis (Armour, 2003; Davis, 2001). Personal losses must be appraised and the crisis experience must have some meaning attributed to it to prompt movement toward grief resolution. Family therapy can aid in this process to allow children and adolescents the emotional environment in which to find positive meanings to mitigate the negative aspects of the trauma, crisis event, or loss. The focus of family therapy is a process of meaning reconstruction. For example, experiencing a traumatic event can lead to a growth in character, a shift or gain in perspective, a strengthening of familial relationships, or an increased sense of connectedness with others (Davis, 2001).

Another important focus of family therapy is to assist parents and caretakers to promote an appropriate environment that reduces the frequency of traumatic reminders, reduces unnecessary reexposures, including graphic depictions of the trauma or crisis event (Pynoos et al., 1996). This serves to reduce parents' own reactivity to traumatic reminders which may accentuate children's and adolescent's anxieties (Pynoos et al., 1996). Practitioners can help families identify traumatic reminders in order to anticipate them and to increase the family's ability to tolerate expectable reactivity. This can help rebuild parents' confidence in their own ability to protect their children.

The Use of Ritual

Rituals can be very powerful and rich in meaning. Funerals, loss anniversaries, and remembrance or memorial ceremonies are common examples of rituals. Rituals provide guidance about behavior, time, and emotions in response to death and loss. They organize emotional expression and pattern behavior during a chaotic period of transition (DeVries, 1996). Rituals allow for both collective and individual expression. The significance is both social and personal (Doka, 2002; 2008). Grief therapy with families can focus on creating an appropriate and meaningful ritual to commemorate the loss of a loved one. Practitioners can offer ritual as a form of intervention and can help the family create a therapeutic ritual which emerges from the narrative of the family's experience of the trauma, crisis event, or loss. It is imperative that children and adolescents be included in planning the ritual because it empowers them to be part of the healing process. Doka (2002) outlines various therapeutic rituals beyond the funeral ritual.

- Rituals of continuity identify the importance of the ongoing presence or impact of the trauma, crisis event, or death. An example is the lighting of a candle on an anniversary, holiday, or birthday to commemorate a person or event. This offers an opportunity to grieve.

- Rituals of transition indicate movement or growth since the trauma, crisis event, or death. This may include a child moving from elementary school to middle school, an adolescent graduating high school and going on to college, or children welcoming a stepparent.

- Rituals of reconciliation allow people to offer or accept forgiveness or to complete unfinished business regarding the trauma or crisis event.

- Rituals of affirmation acknowledge the lessons learned or growth gained from the experience of the trauma, crisis event, or loss.

Working with Schools and the Community

Practitioners can work effectively with schools and community leaders to provide post-disaster or post-crisis interventions, to include large group or small group interventions, didactic sessions, and one-on-one counseling with children and adolescents. The provision of this service addresses a trauma or crisis event that occurred within the community, such as the violent and sudden death of a peer or teacher, a local disaster, or urban violence. The school environment is an excellent setting for the delivery of support and crisis intervention because the school can provide a "developmentally appropriate environment that encourages normalcy and minimizes stigma" (Pfefferbaum, 1997). The school setting can aid children and adolescents in returning to a pretrauma level of functioning and routine. It is important that schools and students be assisted to understand that all reactions are normal, because there is no one response that is appropriate for all people.

Children and adolescents come together in school following the occurrences of crisis events, whether or not they actually happen on the school premises, which make the school the ideal setting for implementing an intervention program in a group format (Webb, 2002). Groups can be time limited, from 8-10 weeks, constructed as short-term bereavement groups that utilize a planned agenda of drawing, writing, and other group

activities and experiences. This format enables children and adolescents to express their thoughts and feelings about trauma, crisis, grief and loss. The peer support inherent in the group setting allows children and adolescents to receive validation and normalization regarding their responses to a trauma or crisis event.

Practitioners can offer a single, extended group intervention in response to a disaster, trauma, or crisis event that affects an entire school community. The practitioner meets with the student community in the familiar and supportive atmosphere of a school assembly. Specific information and details about what actually happened are provided in a calm and direct manner. Questions about the trauma or crisis event are answered, and feelings and reactions are appropriately addressed. Ensuring that children and adolescents have accurate information about and understand the "who, what, when, where, and why" circumstances of the trauma, disaster, or crisis event, then healthy coping is facilitated and a sense of control and stability can be regained (Bouton, 2003). post-disaster or post-trauma intervention includes a didactic portion that explains and normalizes stress-related symptoms and provides information and education on healthy grief responses and adaptive coping efforts (Weinberg, 1990).

School systems can be assisted by practitioners as they prepare to provide efficient and effective interventions to children and adolescents in response to a trauma, disaster, or crisis event. These may include the following (Bouton, 2003):

- Gather facts about trauma, disaster, or crisis event
- Assemble a crisis response team to include practitioners and school personnel
- Ensure appropriate notification about the trauma, disaster, or crisis event
- Provide school-based education, support, and intervention

- Respond to news media as needed

- Participate in debriefing sessions as needed

- Assist with memorial or other ritual observances.

Practitioners can assist school personnel and community leaders with the important use of ritual. This includes the creation of memorials, as well as commendations and awards presented to those who helped with survivors of a disaster or crisis event. The symbols created in these rituals represent a powerful aspect of the recovery and healing process within a school or wider community (Miller, 1998).

Resources for Practitioners

Association for Death Education and Counseling
www.adec.org
60 Revere Dr., Ste. 500
Northbrook, IL 60062
847-509-0403
adec@adec.org

The Dougy Center
www.dougy.org
PO Box 86852
Portland, OR 97286
866-775-5683
help@dougy.org

Common Ethical Dilemmas

All practitioners maintain that confidentiality is a critical concept when working with people who divulge their thoughts, feelings, and behaviors. The concept is typically viewed as respecting privacy of information shared by an individual as well as protecting his or her identity. Threats to confidentiality may arise when working with a family when practitioners ask family members to describe their thoughts and feelings that may

be information not previously shared with other family members who are present in the session. There may also be confidentiality concerns in a practitioner's work with adolescents and children. For example, an adolescent who describes suicidal ideation within the context of a traumatic grief response presents an ethical dilemma of maintaining that confidence and of sharing what might represent a very real safety issue. Practitioners need to clarify the parameters of confidentiality to children, adolescents, and families.

Practitioners have the ethical responsibility of pursuing knowledge and remaining educationally current about evidence-based practice in the area of traumatic grief and loss. They must be knowledgeable about the spectrum of interventions and treatments for traumatically children and adolescents, and be aware of the scientific evidence that validates their potential effectiveness (Raphael, Minkov, & Dobson, 2001). Practitioners must possess proficiency in the developmental and grief and loss aspects of traumatized children and adolescents, and have the ability to assess who is at risk for pathologic reactions.

Cultural Considerations

Culture places people in a protective and supportive system that provides norms and values, lifestyles, and knowledge. Disruption of culture through disaster, trauma, or crisis event can lead to a deep sense of loss of people, place, and coping mechanisms. Culture can create a meaning system that explains the causes of traumatic events (DeVries, 1996). "Cultural customs and rituals help individuals control their emotions,

order their behavior, link the sufferers more intimately to the social group, and serve as symbols of continuity" (DeVries, 1996, p. 405).

Consideration must be given to how grief and loss is faced and explained within each family unit, social setting, and cultural context. Culture influences the experience, expectations, and expression of grief and loss in response to a trauma or crisis event. It is important to explore and know what children and adolescents have been taught and what they believe about grief and loss, death, and disasters. Culture also influences patterns of attachment, defines the meaning of different types of losses, as well as the extent of who grieves (Doka & Martin, 2002). Cultural expectations also define appropriate support and interventions. Cultures differ in how support is offered and accepted, as well as the applicability of interventions such as group, individual, or family therapy.

Case Example

The following example illustrates how a crisis impacts an adolescent and the treatment that effects positive change. Concepts in this chapter are incorporated in the case example.

Jennie was 15 years old when she witnessed the violent murder of her 18 year-old cousin Paul. They had been at a dance club and were leaving when Paul was verbally accosted by a group of young men with whom he had had some previous problems. There was arguing, yelling, and some pushing and shoving. Paul and Jennie got away and ran into the parking lot to Paul's car. Jennie got into the passenger seat and Paul got behind the steering wheel where he was prompting shot in the face by someone in the group of young men.

Prior to Paul's murder, Jennie had been an A/B student who was outgoing, very social and well-liked by her peers. Following this crisis, she quickly became a C/D student, and refused to go anywhere with friends. For months afterward, Jennie complained of headaches and stomachaches, and became both nauseous and "unable to move" whenever she heard sirens. It became difficult for her to go to school or to leave home because of her fear of hearing sirens. In addition to her somatic complaints, Jennie also mentioned having difficulty concentrating on her school work. Often while she was reading, she would hear the gun shot and then begin to tremble and cry.

Jennie was brought to the initial assessment session by her mother who was visibly distraught over her daughter's failing grades and fear of her former life. Her mother stated that the entire family was mourning the loss of Paul and that they saw him as "in a better place" since he had been hanging out with a tough crowd that "only predicted more trouble down the road". It had been 3 months since his murder when Jennie's mother sought help for her.

Jennie's visual memory was of "red, red, just everything covered in blood, sticky blood", and of her cousin, Paul's face "just completely blown away". She described a persistent auditory memory of hearing her screams mixed with the sound of sirens. Jennie was first taught some relaxation techniques as a way of calming and controlling her somatic symptoms. This included breathing retraining where she learned to inhale slowly and deeply, while clearing her mind, and envisioning her breathes as a healing force throughout her body. Thought stopping was also utilized in getting Jennie to recognize when disturbing thoughts and images began to run through her mind. She learned to clear her thinking, take a deep breath, and replace thoughts of danger with

thoughts of safety. She was able to ground herself in the moment by observing her surroundings and telling herself that she was safe. This was her coping plan for use throughout her trauma work.

During individual treatment with Jennie, the focus was initially on assisting her in the construction of a trauma narrative by helping her to identify links between the traumatic experience of witnessing Paul's murder, her reactions at the time, and her current maladaptive behavior of attempting to avoid hearing sirens by staying home and not socializing with friends. In constructing the trauma narrative, Jennie had to explore and describe the worst moments of this horrific experience, while utilizing her coping techniques. She gained insight into her range of traumatic reminders and traumatic avoidance. Over subsequent sessions, she was able to increase her tolerance of trauma-related thoughts and reactions by improving her use of her coping techniques.

Psychoeducation about grief and loss reactions and reactivity was a component of therapy with Jennie. She needed to understand the interplay between trauma and grief, and have her thoughts, feelings, and behaviors normalized and validated. She learned to recognize loss reminders and to identify the ways in which her trauma and loss disrupted her life.

Eventually, the focus of therapy became aiding Jennie to recall pleasant and positive memories and aspects of Paul. Jennie was able to remember Paul's smile and sense of humor. During one session, she described how he liked to try new things and would tease her about doing things "out of my comfort zone." She quickly retreated into tears and stated that this is what got him killed and her so traumatized, "going outside the safety of home." She was able to successfully ground herself in safety by using her

coping techniques and then proceed calmly with the session. Therapy continued to focus on Jennie's use of loss reminders to understand the impact and personal meaning of losing her cousin, Paul. It was necessary for her to live her life without Paul present and to construct a non-traumatic image of him with which she could reminisce. She needed to hang on to the sound of his laughter and remember his playfulness and ability to live fully in the moment. Jennie created a memory box of Paul that included a photo of them together as well as a picture of a red corvette, which was something he always wanted to drive. She wrote a poem about him that she included in her memory box, and plans to continue to add positive mementoes about Paul.

One of the difficulties in this traumatic grief work with Jennie involved the fact that she witnessed the murder of her cousin but could not identify his killer. The faces of the group of young men were a blur to her. However, she feared that these young men did not know this and would come after her. This, coupled with the blending of her screams and the sound of sirens, impaired her ability to venture far from home. She was eventually able to hear sirens as a helping response but still got knots in her stomach whenever she heard them. Her grades gradually returned to As and Bs and she did begin socializing minimally.

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