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Traumatic Loss in Children and Adolescents

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Although different types of childhood trauma have many common characteristics and mental health outcomes, traumatic loss in children and adolescents has a number of distinctive features. Most importantly, youth who experience a traumatic loss may develop childhood traumatic grief (CTG), which is the encroachment of trauma symptoms on the grieving process and prevents the child from negotiating the typical steps associated with normal bereavement. This article discusses the distinctive features of CTG, how it is different from normal bereavement, how this condition is assessed, and promising treatments for children who experience a traumatic loss.

Keywords grief, loss, trauma, children, adolescents

Epidemiologic studies indicate that the majority of children in the United States have experienced exposure to potentially traumatic events (PTEs). A recent population study (Copeland, Keeler, Angold, & Costello, 2007) found that 68% of surveyed children had experienced at least one PTE and more than half had experienced multiple traumas. Another study (Lipschitz, Rasmussen, Anyan, Cromwell, & Southwick, 2000) similarly documented that over 90% of children seen in an inner city pediatric clinic had experienced traumatic exposure. Although most children are resilient after trauma exposure, others develop significant mental health problems including symptoms of posttraumatic stress disorder (PTSD), depression, anxiety, behavior problems, substance use disorder, and physical health problems. As many as 25% of children have significant PTSD symptoms following exposure to a PTE (Lipschitz et al., 2000), suggesting that this disorder alone is a serious public health problem. The Adverse Childhood Experiences Study (Felitti et al., 1998) demonstrated that traumatic experiences during childhood confer significantly increased risk for many of the leading cases of early death in adulthood. Thus, youth in the United States are in need of prompt identification and effective intervention for symptoms related to trauma exposure.

Until the present time, child trauma treatments have been developed and tested for specific traumatic experiences, so-called silo treatments (e.g., for child sexual abuse, community violence, domestic violence, war). However, the great majority of children in all of these studies have experienced multiple types of traumas (e.g., Cohen, Deblinger, Mannarino, & Steer, 2004; Lieberman, Van Horn, & Ippen, 2005; Stein et al., 2003), thereby suggesting that studies of children affected by distinct types of trauma may, in fact, be evaluating and treating largely overlapping populations. Moreover, Saunders (2003) proposed that treatments that successfully target PTSD and other symptoms in children experiencing one type of trauma are likely to successfully treat children who have the

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same symptoms related to another type of traumatic event. In a nationally representative sample of youth, Finkelhor, Ormrod, Turner, and Hamby (2005) documented that multiple types of victimization or "polyvictimization" predicted the highest rates of trauma symptoms. These findings implied that the negative mental health sequelae from childhood trauma may primarily be the result of the cumulative impact of polyvictimization rather than exposure to any specific type of trauma. These results provide additional support for conceptualizing traumatized children as having significant similarities regardless of their specific types of victimization and traumatic experiences. Such a conceptualization seems warranted given that the previously mentioned treatment outcome studies indicate that most treated children have experienced multiple traumas.

Despite the conclusions from the previously mentioned research and the commonalities across different types of childhood trauma, children and adolescents who lose a family member, other loved one, or significant other through traumatic circumstances clearly face unique challenges. In addition to dealing with the traumatic event (e.g., act of terrorism, natural disaster, homicide, suicide, automobile accident), children and adolescents are also confronted with the sadness, grief, and loss associated with no longer having their family member or loved one in their life. Moreover, it is this combination of traumatic stress and loss that uniquely characterizes childhood traumatic grief (CTG) but that has also posed challenges to researchers and clinicians alike in terms of definitional issues, clinical description, and treatment.

This article examines traumatic loss in children and adolescents. Epidemiologic, definitional, conceptual, and assessment issues are discussed as well as current ideas about treatment for this population.

Differentiating Normal Bereavement From CTG

Many children lose a close significant other to death during childhood. It is estimated that 400,000 youth younger than age 25 will experience the death of a family member each year. Also, current statistics indicate that 1.9 million children younger than age 18 have lost one or both parents (Children's Bereavement Center of South Texas, 2008). Accordingly, many children have some experience with bereavement as they are growing up (Cohen & Mannarino, 2010).

In the lay literature and sometimes in the professional literature as well, the terms bereavement and grief are used interchangeably, but for the purposes of this article, we propose different definitions. Bereavement is the condition of having had a significant other die. In contrast, grief is the intense emotion and pain that one feels on having a significant other die. Uncomplicated bereavement in children and adolescents may resemble clinical depression in many ways, with youth experiencing intense sadness or grief, crying, not wanting to spend time with friends or classmates, loss of appetite, sleep difficulties, decline in academic performance, and/or lack of interest in normal activities. Younger children may search for the deceased person or ask questions about what has happened to this person. Like adults, children may experience "pangs" of grief, which are sudden intense waves of painful feelings of loss that can seemingly come from nowhere, although, unlike adults, children may display these symptoms or behaviors more intermittently. Even soon after a loss, children may be observed playing or laughing, which can be confusing and perhaps disturbing to adults whose grief may be more constant. The intermittent nature of children's grief responses is characteristic of children's general affective states in general, which are often more changeable and reactive than those of adults (Cohen & Mannarino, 2010).

After a death, children are confronted with the reality of going forward with their lives without their loved one. Wolfelt (1996) used the term "reconciliation" to describe this process. Childhood bereavement experts (Wolfelt, 1996; Worden, 1996) have identified a number of tasks as significant in the reconciliation process, including accepting the reality of the loss; fully experiencing the emotional distress of the loss; adjusting to one's environment and sense of self without the loved one; finding meaning in the loved one's death; and becoming engaged with other adults who can provide ongoing comfort, security, and nurturance. These tasks require children to tolerate sustained thoughts about the deceased loved one and their past interactions with the deceased and to face and bear the pain associated with the loss. It is important to note that children can experience intensely painful normal grief reactions that may include great sadness, periods of crying, and withdrawal from peers and activities. Nonetheless, these normal grief reactions are not the same as traumatic grief, and clinicians and researchers are faced with the challenge of distinguishing between them. As discussed later, children with traumatic grief are unable to complete the tasks of reconciliation because remembering the loved one typically serves as a trauma reminder, with the subsequent development of trauma symptoms (Cohen & Mannarino, 2004).

CTG has been described as a condition in which children whose loved ones die under traumatic circumstances develop trauma symptoms that impinge on the children's ability to progress through typical grief processes (Cohen, Mannarino, Greenberg, Padlo, & Shipley, 2002; Layne et al., 2001). As discussed elsewhere (Cohen & Mannarino, 2006), these children get "stuck" on the traumatic aspects of their loved ones death such that when they start to remember their loved one, including happy memories, their memories tend to segue into thoughts about the terrifying or horrific manner in which the person died. When this process occurs, children begin to avoid reminiscing about the loved one and may avoid any reminders about the deceased because of the propensity of these reminders to stimulate the children's painful trauma memories.

CTG is different from uncomplicated bereavement in several ways. First, the nature of the death is often (but not always) qualitatively different in cases of CTG, with these deaths typically being from sudden, unexpected, tragic, and/or violent causes such as suicide, homicide, accidents, war, terrorism, and disasters. When CTG results after medical deaths, the medical causes are often from sudden conditions such as heart attacks or strokes. However, CTG can also result from chronic medical conditions because children may not anticipate or comprehend that their loved one was going to die. Accordingly, for these children, the death may be unexpected and sudden. In a parallel way, deaths from anticipated causes can be extremely disturbing to children if they observe frightening events such as their loved one gasping for air, frantic attempts at resuscitation, or severe bodily deterioration. Thus, any cause of death can lead to CTG as long as the child subjectively experiences it as traumatic (Cohen & Mannarino, 2010).

Another way that CTG is different from normal bereavement is with regard to the presence and severity of PTSD symptoms. Some PTSD symptoms, including sleep difficulties, loss of interest in peer and other social activities, and trouble concentrating, can normally be expected in bereaved children. However, core PTSD symptoms such as intrusive re-experiencing of the deceased's death, persistent avoidance of death reminders or even avoidance of reminders of the loved one, and hyperarousal as manifested through angry outbursts or hypervigilence are less typical of uncomplicated bereavement but very characteristic of CTG (Cohen & Mannarino, 2010).

It is important to recognize that developing CTG is not the norm for children who lose loved ones, even if the cause of death is objectively traumatic. A good example of the nonnormative nature of CTG is a study by Pfefferbaum and colleagues (1999) who

studied children who were directly affected by the bombing of the federal office building in Oklahoma City in 1995. Specifically, they reported that although PTSD was significantly associated with the loss of a loved one and the closeness of the relationship to the deceased, the majority of children who lost loved ones did not report elevated PTSD symptoms or functional impairment 7 weeks after the bombing (Pfefferbaum et al., 1999).

Another study with similar findings was reported by Brent et al. (1995). In a study of adolescents who had friends who committed suicide, only 5% of these adolescents reported persistent PTSD symptoms (Brent, Perper, & Moritz, 1993; Brent et al., 1995). In another study by this same research group, siblings of adolescents who had committed suicide did not demonstrate an increased incidence of PTSD symptoms compared to a control group who had not been exposed to suicide, despite the former group having prolonged grief symptoms (Brent, Moritz, Bridge, Perper, & Canobbio, 1996a, 1996b). Thus, it appears that the majority of children who lose loved ones under traumatic circumstances do not develop CTG, and development of persistent PTSD symptoms that intrude on children's ability to grieve should not be viewed as normative for such children (Cohen & Mannarino, 2004).

Core Features of CTG

With many childhood traumas, such as sexual abuse, physical abuse, or domestic violence in which no death has occurred, there can be numerous types of mental health sequelae, including PTSD symptoms, other anxiety problems, depression, and ongoing behavioral difficulties. Although children and adolescents who experience a traumatic loss may display a variety of symptoms and problems, being "stuck" on the traumatic aspects of the loved one's death is the essence of CTG as we currently understand it.

PTSD symptoms associated with CTG may include recurrent upsetting and intrusive thoughts or dreams of the traumatic event that led to the loved one's death or even a sense of the event happening over again. Additionally, children may have intense physiological reactivity or psychological distress in response to reminders of the traumatic cause of death (e.g., "traumatic reminders"; Pynoos, 1992).

Avoidance or numbing symptoms may include efforts to avoid thoughts, feelings, or conversations about the death or people, places, or situations that remind them of the traumatic cause of death. Children with CTG may also experience a diminished interest in normal activities, feeling emotionally distant or detached from others, a restricted affective range, or a sense of a foreshortened future. Hyperarousal symptoms may include sleep disturbance, irritability or angry outbursts, decreased concentration, increased startle reaction, or hypervigilance (American Psychiatric Association, 2000).

It is worth noting that children who suffer from CTG have some degree of functional impairment (Cohen & Mannarino, 2010). This impairment may be manifested through declining academic performance, increased difficulty in relating to peers or family members, or general struggles with everyday tasks such as homework and routine chores.

In CTG, intrusive and disturbing trauma-related thoughts, images, and memories may be triggered by at least three types of reminders, as described by Pynoos (1992). "Trauma reminders" are situations, people, places, sights, smells, or sounds that remind the child of the traumatic nature of the death. For example, storm clouds, thunder and lightning, or hurricane warnings may be trauma reminders for children whose loved one died during Hurricane Katrina. "Loss reminders" are people, places, objects, thoughts, or memories that remind the child of the deceased loved one. A loved one's birthday or seeing pictures of their loved one may be loss reminders for these children. "Change reminders" are situations, people, places, or things that remind the child of changes in living circumstances

caused by the traumatic death. Attending a new school or having one's aunt attend a class play instead of one's mother who died may be change reminders for these children (Cohen & Mannarino, 2004).

In CTG, trauma reminders, loss reminders, and change reminders may all segue into memories, thoughts, and images of the traumatic nature of the loved one's death and may be accompanied by physiological symptoms of hyperarousal. To illustrate, when a child whose sister committed suicide in her bedroom at the family's residence enters her bedroom (a trauma reminder), he or she may have intrusive images of the sister lying on the floor in a pool of blood and experience heart palpitations and intense anxiety (i.e., PTSD re-experiencing and hyperarousal symptoms). The distress that such children experience on exposure to trauma, loss, or change reminders leads them to try to avoid such exposure in order to minimize their distress. For example, the child described previously may refuse to enter the sister's bedroom or even experience significant distress when he or she is on the same floor as the sister's room. Such avoidance may result in these children having less exposure to trauma, loss, or change reminders or at least reduce their intensity (Cohen & Mannarino, 2004).

However, when children have lost a loved one, these reminders are typically ubiquitous and usually impossible to totally avoid. Some children may develop emotional numbing to cope with those unavoidable or uncontrollable reminders. Numbing may take the form of extreme detachment or estrangement in which children feel different and set apart and alienated from others, even those in his or her own family or circle of friends who may have experienced the same traumatic loss (Nader, 1997).

For children with traumatic grief, even thinking about happy times with their loved one leads to thoughts, memories, and emotions related to the traumatic nature of the person's death. This, in turn, sets off the cascade of reactions described previously in which reminiscing about the loved one leads to thoughts of the horrible way in which the person died and which then results in PTSD symptoms (re-experiencing, hyperarousal, physiological hyperreactivity, and intense psychological distress). These are extremely disturbing symptoms for children and hasten the development of numbing and/or avoidance, which in turn interfere with the child's ability to reminisce about the loved one. Thus, in CTG, PTSD trauma symptoms impinge on the child's ability to reminisce about the loved one and to achieve reconciliation, which is necessary for the successful negotiation of normal bereavement (Cohen & Mannarino, 2004). As Pynoos (1992) stated, "It is difficult for a child to reminisce . . . when an image of . . . mutilation is what first comes to mind" (p. 7). This is the essence of the current concept of CTG.

Other Components of CTG

In addition to the encroachment of trauma symptoms on children's ability to grieve, some children avoid acknowledging any similarities between themselves and the deceased, as they are afraid that they may also die in a tragic and horrific manner (Nader, 1997; Pynoos, 1992). Integrating some positive aspects of the deceased into one's own self-perception is a key task of reconciliation. Accordingly, children who are afraid of any identification with the deceased may be unable to successfully reconcile themselves to the loss of this person (Cohen & Mannarino, 2004). In contrast, some children may identify too strongly or intensely with the loved one who died. For example, they may wear clothing that belonged to the loved one or take his or her name to avoid accepting the loss. These may well be attempts to not face the emotional pain associated with the normal bereavement process (Nader, 1997).

Children with traumatic grief may blame themselves for the death of the loved one or feel intense guilt that their loved one has died while they have survived. This may be particularly true in large mass disasters (e.g., weather-related events or terrorism; Nader, 1997; Pynoos & Nader, 1990). Additionally, some children may develop rescue or revenge fantasies. In the former, some children may unrealistically blame themselves for not being able to rescue or save the deceased person and may develop rescue fantasies in which they successfully do so. Revenge fantasies may also occur in which children imagine that they hurt or punish the individual(s) who are responsible for the death of their loved one (Eth & Pynoos, 1985).

Children face additional challenges when their loved one dies in circumstances to which society attaches a stigma. Such circumstances might include suicide, homicide that is drug-related, or death as part of family or domestic violence. In these situations, children may experience significant embarrassment and shame (Eth & Pynoos, 1985; Nader, 1997). Unlike children whose loved ones died in circumstances viewed as heroic (e.g., police officers or rescue workers who die in the line of duty), these children typically do not receive an outpouring of public sympathy or financial support. It is possible that the added stigma or negative community judgment about the manner of death may constitute a risk factor for developing CTG (Cohen & Mannarino, 2004).

After the death of a family member, children may experience secondary adversities such as the loss of the family's home, family income, or health insurance. If the family has to relocate, children may also be required to change schools and be faced with loss of close friends, a new peer group, different place of worship, and a completely unfamiliar social support system. These adjustments can be extremely stressful even in the absence of losing a loved one but are added burdens after a family member has died. These adversities, as well as preexisting family stressors, increase children's likelihood of developing CTG (Cohen & Mannarino, 2004).

The ability to comprehend death and master the tasks associated with grief and trauma depend on children's cognitive and emotional development, at least in part. Accordingly, some authors have suggested that children at different developmental levels may manifest traumatic grief in unique ways consistent with their developmental stage (Nader, 1997; Pynoos, 1992; Pynoos & Nader, 1990). To date, however, there has not been any empirical research to support the concept of developmental variation in the clinical presentation of CTG.

Discussions about developmental variation in CTG are further complicated by the ongoing controversy regarding the diagnostic criteria for and clinical assessment of PTSD symptoms in very young children. Specifically, child PTSD researchers have raised concerns that the current diagnostic criteria for PTSD (e.g., presence of three avoidance symptoms) are not appropriate for young children and need to be modified. Moreover, no consensus exists regarding how PTSD symptoms should be evaluated in this young population (e.g., interview with parent only vs. combination of child and parent interviews). Accordingly, at the present time, it is difficult to support the notion of developmental variation in the clinical presentation of CTG when the nature and assessment of PTSD symptoms (a necessary but not sufficient condition for traumatic grief) in very young children have not achieved any type of consensus among experts in the field (Cohen et al., 2002).

Parental response may have a significant impact upon the development and intensity of traumatic grief in children (Nader, 1997; Pynoos & Nader, 1990). Particularly when a parent has died, the surviving parent may have increased caretaking responsibilities and work demands that can result in higher levels of general distress as well as irritability

and fatigue. These symptoms can reduce the parent's emotional availability and affect the consistency of parenting (Nader, 1997). Moreover, a parent's own avoidance can make it difficult to tolerate a child's expression of normal grief symptoms. Thus, the combination of parental distress and avoidance can make it more probable that a child will develop traumatic grief (Nader, 1997).

Observing a child's grief and pain over the loss of a loved one is extremely hard for most parents. They may feel that their child has been through "too much" and that the world is no longer a safe place. In response to these perceptions, parents may become lax in their limit setting or overly protective, both of which can create increased insecurity and anxiety in the child. If normal routines are disrupted and children are not permitted in engage in activities consistent with their developmental level (e.g., sleepovers, school activities), they will likely begin to perceive their world as unsafe and unpredictable. This, in turn, will make it harder for children to negotiate the normal grieving process and contribute to persistent symptomatology. It should be noted that parental emotional distress in response to traumatic events and lack of parental support are associated with more severe and persistent PTSD symptoms in some cohorts of traumatized children (Cohen & Mannarino, 1996, 2000). Empirical research is needed to determine whether such associations are present in CTG as well (Cohen et al., 2002).

A number of studies have examined mediating factors in symptom formation following the traumatic death of friends or family members; however, PTSD symptoms, not traumatic grief, have been the primary focus (Malmquist, 1982; Pfefferbaum et al., 2000; Pynoos et al., 1987). In these studies, severity of PTSD symptoms has been associated with greater exposure, such as witnessing death (Pynoos et al., 1987) or the closeness of the relationship to the deceased (Brent et al., 1993; Brent et al., 1995; Cerel, Fristad, Weller, & Weller, 1999). Additionally, Brent et al. (1996b) reported that having a conversation with the deceased within the 24 hours before the deceased committed suicide predicted both PTSD and depressive symptoms 3 years later. The latter study suggests the potential contribution of perceived guilt, regret, and/or responsibility for the death in the development of CTG, particularly in adolescents.

Assessment of CTG

The general assessment of CTG should include a comprehensive evaluation of the past and current functioning of the child and family as would be the case in any psychiatric or psychological evaluation. Additionally, the child's experience and perceptions of the loved one and his or her death, the child's PTSD symptoms, and the encroachment of these symptoms on the child's ability to engage in the normal bereavement process should be examined (Cohen et al., 2002).

Specific assessment procedures for children with possible traumatic grief have been suggested by some authors. Pynoos and Eth (1986) developed an interview technique for children exposed to trauma that can be used to assess the likelihood of traumatic grief. As part of the interview process, the child describes the impact of the trauma through an unstructured free drawing and storytelling task. The child is then encouraged to describe the trauma in detail, including the "worst moment," sensory details, and who was responsible for what occurred. Steinberg (1997) recommends a less structured interview approach that is relationship-oriented. This approach evaluates the family's history before the death, the quality of family relationships, home atmosphere after the loss, available social support system, the meaning of the death to the child, and the child's hopes and plans for the future (Cohen et al., 2002).

Although there has been increased empirical attention over the past decade to recognizing and defining CTG and identifying its correlates, there has been relatively little work in the area of developing psychometrically sound assessment instruments to evaluate it. Thus, there are few options in terms of validated assessment instruments. The UCLA/BYU Expanded Grief Inventory (EGI; Layne et al., 2001) is the only published instrument that assesses CTG and has been validated by two independent groups (Brown & Goodman, 2005; Layne et al., 2001). The EGI includes 28 items to which children respond on a 5-point Likert scale. The EGI is appropriate for children ages 7 to 17 years (Layne et al., 2001). Factor analysis (Layne et al., 2001) has revealed distinct scales for uncomplicated bereavement (i.e., able to experience positive memories, dreams, conversations, and connections with the deceased) versus traumatic grief (i.e., traumatic intrusion and avoidance interfering with normal bereavement). The Characteristics, Attributions and Responses to Exposure to Death-Youth and Parent Versions (CARED-Y and CARED-P; Brown et al., 2008) is a 39-item self-report measure that gathers information about peritraumatic aspects of the loved one's death as well as information about the child's premorbid relationship with the deceased and participation in mourning rituals. The psychometric properties of the latter instrument are reasonable despite it being a relatively new instrument (Brown & Goodman, 2005; Brown et al., 2008). There is no validated instrument available to assess CTG in very young children (Cohen & Mannarino, 2010).

Treatment for CTG

Without intervention, traumatic death appears to have the potential for long-term effects on children and adolescents (Nader, Pynoos, Fairbanks, & Frederick, 1990; Pfefferbaum et al., 1999; Pynoos et al., 1987). A follow-up study of the children involved in a sniper attack revealed continued trauma and grief symptoms at six months as well as one year later (Nader et al., 1990; Pynoos et al., 1987). Similarly, at eight to ten months following the Oklahoma City bombing, children who lost a loved one reported more significant PTSD symptoms than nonbereaved children (Pfefferbaum et al., 2000; Pfefferbaum et al., 1999). Therefore, it is important that effective interventions be developed and provided for these children.

Given that CTG has been defined as the encroachment of PTSD symptoms on the child's ability to negotiate the normal bereavement process, it makes sense that treatment for CTG would include both PTSD and grief-focused interventions. The treatment models that have been developed for CTG to date have indeed made this assumption. The following section is adapted from Cohen and Mannarino (2010).

Traumatic Grief Cognitive Behavioral Therapy (TG-CBT)

TG-CBT is derived from Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and is the application of TF-CBT principles to children who have experienced a traumatic loss. TF-CBT has the greatest amount of empirical support of any treatment model that has been developed for traumatized children. Ongoing research has demonstrated that TF-CBT results in a significant reduction of PTSD symptoms, depression, and behavioral problems in traumatized children and similar reductions in emotional distress and depression in their caretakers (Cohen, Mannarino, & Deblinger, 2006). Similar to TF-CBT, TG-CBT is typically provided in parallel sessions to the child and the parent or caretaker, with some joint child–parent sessions. However, with TG-CBT, grief-focused components are added to the trauma-focused opponents. Moreover, the grief-focused components are typically implemented after the child has successfully resolved ongoing trauma symptoms. Grief-focused

components in TG-CBT include grief education, grieving the loss and resolving ambivalent feelings about the loved one who died, preserving positive memories, and redefining the relationship with the person who died to one of memory.

It should be noted that the parallel sessions with the parent or caretaker are critical to TG-CBT as they are with TF-CBT. In this regard, parents are provided psycho-education about how children of different ages perceive death so that they can better understand what their children are experiencing. Also, behavior management is an important part of the parent sessions to address any ongoing behavioral problems. Joint sessions with the child and parent can be used to help the family to anticipate future loss and change reminders (e.g., anniversaries, graduations, birthdays) and to develop plans to effectively cope with the painful memories these important events may evoke.

There is beginning to emerge some empirical support for TG-CBT, which suggests that it has the potential to help children suffering from traumatic grief. In two open trials (i.e., no comparison or control group) of TG-CBT, children suffering from traumatic grief had significant reductions in CTG and PTSD symptoms (Cohen, Mannarino, & Knudsen, 2004; Cohen, Mannarino & Staron, 2006). Also, there has been one randomized clinical trial (RCT) involving TG-CBT that was conducted in the New York City area for children whose uniformed parents died in the rescue efforts related to the September 11 terrorist attack. In this investigation, Brown, Goodman, Cohen, and Mannarino (2004) reported that the mothers in the TG-CBT group experienced significantly greater improvements in PTSD symptoms and general distress than mothers in the client-centered therapy group. There were no significant group differences in child outcomes.

UCLA Trauma/Grief Program for Adolescents

This treatment model (Layne et al., 2001) is provided on a group basis and has been adapted for children as young as 11. Treatment modules include processing the traumatic experience through exposure and cognitive restructuring, dealing with trauma and loss reminders, addressing secondary adversities, focusing on the interrelationship between trauma and grief, and helping teenagers to move forward developmentally.

The UCLA model has been examined in two open studies. The first was with Bosnian adolescents after the civil war and the second was with adolescents exposed to community violence in Los Angeles (Layne et al., 2001; Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001). Both studies demonstrated that participants experienced significant improvement in CTG and PTSD symptoms as well as improved adaptive functioning (e.g., academic achievement).

Group and Trauma Intervention for Elementary-Aged Children

Salloum, Avery, and McClain (2001) described a pilot group model for adolescent survivors of homicide victims. Subsequently, Salloum (2004) adapted this model for adolescents exposed to other traumatic experiences and is currently evaluating this model with children whose significant others died related to Hurricane Katrina. Components of this model include reducing traumatic reactions associated with the traumatic death, trauma and grief psycho-education, offering a safe environment for children to share thoughts and feelings, and various bereavement tasks (Salloum, 2004). It includes Rynearson's (2001) restorative retelling approach, which attempts first to foster resilience, followed by a healing narrative experience, and then reconnecting.

This treatment model has been tested in two open studies and is currently being tested in an RCT for children whose family members or other significant others died after

Hurricane Katrina. Both pilot studies included youth exposed to homicide or other violence (Salloum, 2006; Salloum et al., 2001) and both demonstrated significant improvement in PTSD symptoms.

Child–Parent Psychotherapy (CPP)

Lieberman and Van Horn (2005) developed CPP, a relationship-based treatment for infants and preschool children exposed to domestic violence. CPP involves joint sessions with parents and their young children that focus on resolving maladaptive behaviors, supporting developmentally appropriate interactions, and guiding the child and parent in creating a joint narrative of the traumatic events (Lieberman et al., 2005). More recently, Lieberman et al. (2005) have adapted CPP for very young children whose parents died under traumatic circumstances.

Empirical support for CPP largely comes from one RCT for young children who experienced domestic violence. In this study, some of the children lost a primary caretaker as a result of this violence (Lieberman et al., 2005). To date, CPP has not been investigated in terms of its direct impact on traumatic grief in children.

To summarize, CTG shares some common features with other childhood traumas but has some unique characteristics and core components. CTG is not typical even after a traumatic death and must be differentiated from normal bereavement. Some promising interventions have been developed to treat children who suffer from traumatic grief. However, these treatments will need to be refined as our understanding of the specific nature and scope of CTG evolves based on ongoing research and clinical program development for this population.

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