SCHOOL-BASED INTERVENTIONS FOR CHILDREN WHO HAVE EXPERIENCED TRAUMA

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Overview of Presentation

- Defining trauma
- Frequency of trauma in children's lives and its implications for development
- Interventions for traumatic stress
  - Trauma-focused CBT (individual intervention)
  - The Trauma Narrative and its Importance
  - Trauma-Focused Coping (group intervention)
  - Adaptations of TF-CBT for Traumatic Grief
- Additional resources/training opportunities

Defining Trauma

What is Trauma?

- A traumatic event involves a single experience, or an enduring or repeating event or events, that completely overwhelm the individual's ability to cope or integrate the ideas and emotions involved with that experience.
- Trauma may occur in 2 ways:
  - Direct experience
  - Second-hand (vicarious) experiences

Van der Kolk et al., 1996

What is Trauma?

- Greater degree of exposure → higher risk for emotional harm (Freyd, 1994)

- Examples include exposure to:
  - Community and domestic violence
  - Natural or man-made disasters (situational trauma)
  - Automobile accidents
  - Neglect, emotional abuse, physical abuse, sexual abuse

Child Sexual Abuse Statistics

- 1 in 4 girls is sexually abused before the age of 18.
- 1 in 6 boys is sexually abused before the age of 18.
- 1 in 5 children are solicited sexually while on the internet.
- Nearly 70% of all reported sexual assaults (including assaults on adults) occur to children ages 17 and under.
- An estimated 39 million survivors of childhood sexual abuse exist in America today.

www.darkness2light.org

Trauma Among A Sample of Hospitalized Adolescents

- One study of 75 adolescents who required psychiatric hospitalization found that 81% of the sample had experience at least one traumatic event in childhood.
  - Loss of a caregiver was the most frequent traumatic event.
  - Many of the adolescents had experience multiple traumatic events, both in early and later childhood.
  - Those with more traumatic experiences had greater functional impairment.

Weine, Becker, Levy, Edell, & McGlashen (1997)

What Happens When an Individual Experiences Trauma?

- Overwhelms an individual's ability to use normal coping mechanisms to adapt to a situation
- Disrupts an individual's frame of reference
  - Beliefs about oneself and the world
- Symptoms
  - Re-experiencing trauma in the face of triggers
    - Often leads to engaging in self-destructive or disruptive coping mechanisms
  - Frequent feelings of intense anger in inappropriate and/or unexpected situations
  - Impaired memory
  - Emotional exhaustion
    - Feelings of despair, loss of self esteem, and depression

Carlson & Ruzek, 2004

Typical vs. Atypical Reactions to Trauma

- Most individuals' symptoms have resolved within 3-6 months
- Post Traumatic Stress Disorder is "non-recovery" from trauma

DSM-IV TR Criteria for PTSD

Criterion A: Stressor
The person has been exposed to a traumatic event

Criterion B: Intrusive Recollection
The traumatic event is persistently re-experienced

Criterion C: Avoidant/Numbing
Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma)

Criterion D: Hyper-Arousal

Persistent symptoms of increasing arousal (not present before the trauma)

Criterion E: Duration
Duration of symptoms in B, C, and D is more than one month

Criterion F: Functional Significance
The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

Missing Unresolved Trauma

- Schools are where students are most likely to receive mental health treatment
  - If not resolved through school-based intervention, trauma may remain unresolved as community and private practice treatments for mental health problems are less accessible and utilized
- Neuroscience research indicates the impact trauma can have on brain processes and emotional regulation
  - Learning problems, mood management, and social problems may result from trauma
  - Strict behaviorally based problem-solving may overlook or downplay this factor

(Bachner & Orwig, 2008)

Individual Trauma-Focused Cognitive Behavior Therapy (TF-CBT

Focusing specifically on childhood sexual abuse

Cohen & Mannarino

Overview of TF-CBT

- Helps children, adolescents, and caretakers overcome trauma-related difficulties
- Reduces negative emotional and behavioral responses
- Treatment is based on learning and cognitive theories
  - addresses distorted beliefs and attributions related to the abuse
  - provides a supportive environment
- Addresses parent coping and skill development

Cohen & Mannarino, 2008

Why TF-CBT?

- Integrates several therapeutic approaches
- Treats both child and parent
- Addresses effects of sexual abuse and trauma
- Sexually abused children are at risk of developing significant emotional and behavioral difficulties (Briere & Elliott, 2003)
  - Maladaptive or unhelpful beliefs and attributions
    - A sense of guilt for their role in the abuse
    - Anger at parents for not knowing about the abuse
    - Feelings of powerlessness
    - A sense that they are in some way “damaged goods”
    - A fear that people will treat them differently because of the abuse
  - Acting out behaviors
  - Mental health disorders (i.e., depression and PTSD)

Child Welfare Information Gateway, 2007

Why TF-CBT?

- Resulting emotional/behavioral difficulties can impact:
  - school performance
  - attention
  - self-perception
  - emotional regulation
- TF-CBT is effective in helping children overcome these and other symptoms (e.g., Cohen, Deblinger, Mannarino, & Steer, 2004).
  - Helps children **process** the traumatic memories, **overcome** problematic thoughts and behaviors, and **develop** effective coping and interpersonal skills

Why TF-CBT?

- Integrates several established treatment approaches
  - **Cognitive therapy**
  - **Behavioral therapy**
  - **Family therapy**

Why TF-CBT?

- Successful in various environments and appropriate for multiple traumas.
  - TF-CBT has shown efficacy with children from diverse ethnicities and geographic locations (see Cohen & Mannarino, 2008 for a review).
  - TF-CBT may be preferable for children who have a history of multiple traumas and/or high levels of depression (Deblinger, Mannarino, Cohen, & Steer, 2004).
  - TF-CBT has also been tested with children who are experiencing traumatic grief (Cohen, Mannarino, & Knudsen, 2004).

Target Population

Appropriate Populations for Use of TF-CBT

- Children and adolescents (3-17) with a history of sexual abuse who:
  - Experience PTSD
  - Demonstrate symptoms of dysfunctional abuse-related feelings or thoughts
  - Demonstrate behavioral problems,
- Children and adolescents who have been exposed to other childhood traumas
- Non-offending parents (or caregivers)

Cohen & Mannarino, 2008

Target Population

Limitations for Use of TF-CBT

- TF-CBT may not be appropriate or may need to be modified for:
  - Children and adolescents with conduct problems or other significant behavioral problems that existed prior to the trauma.
  - Children who are acutely suicidal or who actively abuse substances
    - Gradual exposure may worsen symptoms
  - Adolescents who have a history of running away, cutting themselves, or engaging in other self-injurious behavior.

Cohen & Mannarino, 2008

TF-CBT: Key Components

- Short-term treatment
  - 12 to 18 sessions of 60 to 90 minutes
  - Typically provided in outpatient mental health facilities, but has been used in other settings (e.g., **school**)
- Individual sessions with the child and parent (or caregiver) separately and joint sessions with the child and parent together.
  - Sessions build the therapeutic relationship while providing education, skills, and a safe environment.
  - Joint parent-child sessions help foster effective communication
  - Graded exposure is a core feature of TF-CBT

Cohen & Mannarino, 2008

TF-CBT: Goals

- Reduce children's negative emotional (affective) and behavioral responses to the sexual abuse
- Correct maladaptive or unhelpful beliefs and attributions (cognitive) related to the abusive experience
- Provide support and skills to help **non-offending** parents cope
- Provide non-offending parents with skills to respond optimally to and support their children

Cohen & Mannarino, 2008

TF-CBT: Components

- **P -** Psychoeducation & Parenting skills
- **R -** Relaxation techniques
- **A -** Affective expression and regulation
- **C -** Cognitive coping and processing
- **T -** Trauma narrative
- **I -** In vivo exposure
- **C -** Conjoint parent/child sessions
- **E -** Enhancing safety and future developmental trajectory

Cohen & Mannarino, 2008

TF-CBT: Psychoeducation

- Provide accurate information
  - Psychoeducation helps to clarify inappropriate information and safety issues
  - Helps target maladaptive beliefs
- Psychoeducation typically involves:
  - specific information about the traumatic events the child has experienced
  - body awareness/sex education in cases of physical or sexual maltreatment
  - risk reduction skills to decrease the risk of future traumatization

Cohen & Mannarino, 2008

TF-CBT: Parenting Skills

- Parents receive parallel sessions addressing all components
  - Receive interventions to help optimize parenting skills
- Behavior Management Strategies
  - Provide psychoeducation to parents
    - children have temporary (or sometimes long term) increases in disruptive behavior after they have been victimized

Cohen & Mannarino, 2008

TF-CBT: Parenting Skills

- Behavior Management Strategies, cont'd
  - Using Praise
    - Praise specific forms of behavior
    - Label the praise and praise immediately
    - Be consistent
    - Avoid complicating praise with criticism
  - Selective attention
  - Active ignoring
    - Choosing NOT to react to certain types of undesirable behavior
  - Timeout
  - Contingency reinforcement strategies
  - Role plays with parents

Cohen & Mannarino, 2008

TF-CBT: Relaxation Techniques

- Purpose: stress management
- Controlled breathing
  - Rationale
  - Proper body positioning and technique
    - Hand on your chest stays relatively still while the hand on your belly rises and falls with your breaths
  - Introduce relaxing word
    - Once the child seems to have the hang of exhaling slowly, have him/her choose a word to say silently while they exhale (e.g., calm or relax)
  - Progressive Muscle Relaxation
    - Tense muscles, then relax

Cohen & Mannarino, 2008

TF-CBT: Relaxation Techniques

- Thought stopping
  - Useful for children experiencing intrusive thoughts that interfere with functioning
  - Accomplished by either verbally (saying "go away" to the thought) and/or physically (e.g., rubber band) distracting oneself from an unpleasant thought.
  - The next step is to replace an unwanted thought with a pleasant one
    - Practice in session, at school, and at home
  - Cautionary comments:
    - reinforces avoidance as a means of coping
    - may be misapplied to positive thoughts

Cohen & Mannarino, 2008

TF-CBT: Affective Expression and Regulation

- Feelings identification
- Have child identify as many feelings as possible
  - Gauge feelings and comfort
- Teach child to rate the intensity of emotions
  - SUDS and emotion thermometers
- Teach child how to express feelings appropriately in various situations
  - Identify specific examples of times the child (and you) experienced different emotions in different situations
  - Role-plays are a good strategy to help child demonstrate ways have expressed feelings in real-life situations

Cohen & Mannarino, 2008

TF-CBT: Cognitive Coping and Processing

- Cognitive Coping
  - Emphasize difference between thoughts and feelings
    - Generate relevant social scenarios
    - Prompting identification of feelings and thoughts
    - Provide corrective feedback
  - The cognitive triangle
    - Thoughts, feelings, and behaviors are all related to one another
    - Complete the triangle for real times when child got upset

Cohen & Mannarino, 2008

TF-CBT: Cognitive Coping and Processing

- Cognitive Coping, cont'd
  - Explain how thoughts affect behavior
  - Generate scenarios and have child identify thoughts, feelings, and likely behaviors.
  - Help child identify more accurate or helpful cognitions
  - Explain how to apply this skill to real life
    - Important to tie the skill into the child's everyday experience
    - Be explicit in how the technique applies to their situation

Cohen & Mannarino, 2008

TF-CBT: Trauma Narrative

- The trauma narrative involves in-vivo exposure.
- The child creates a book, story, poem, picture, etc. in which he/she describes the trauma.
- The trauma narrative is central to TF-CBT.
- Everything that is done in TF-CBT leads up to the trauma narrative.
- We will discuss the trauma narrative in much greater detail after we describe the other treatment components.

Cohen & Mannarino, 2008

TF-CBT: Conjoint Parent/Child Sessions

- Rationale for parent-child sessions
  - Parent can model appropriate coping
  - Child has an opportunity to share the narrative and experience a sense of pride
  - Parent-child communication about the trauma is enhanced
  - Lays the groundwork for therapeutic parent-child interactions to continue
  - Added benefits for the child

Cohen & Mannarino, 2008

TF-CBT: Conjoint Parent/Child Sessions

- Assessing the parent's readiness
  - Is the parent emotionally ready?
  - Does the parent have the ability to actively support the child?
  - Does the parent have any specific or unique concerns?
- Assessing the child's readiness
  - Children should be fairly comfortable discussing the trauma narrative before you consider conducting parent-child sessions
- Prepare the parent and child
- Content of sessions
  - Exercise judgment about what the family needs

Cohen & Mannarino, 2008

TF-CBT: Enhancing Safety and Future Developmental Trajectory

- Purpose: Teach additional skills to help child remain safe
  - For example:
    - Healthy sexuality
    - Domestic violence safety plan
    - Bullying safety skills
    - Drug refusal skills
  - Skills practiced in-session

Cohen & Mannarino, 2008

The Trauma Narrative

Step-by-Step Guide and an Example

The Trauma Narrative

- Purpose: to teach children healthy ways to control their fear and distress
- Important for:
  - Controlling intrusive and upsetting trauma-related imagery
  - Reducing avoidance of cues, situations, and feelings associated with trauma exposure
  - Identifying unhelpful cognitions about traumatic events
  - Recognizing, anticipating, and preparing for reminders of the trauma
- Goal: Desensitize the child to thoughts, feelings, and reminders of the trauma through gradual exposure

Cohen & Mannarino, 2008

Creating the Trauma Narrative

- Step 1
  - Start with innocuous information about child (name, age, school, hobbies, etc)
  - Who child lives with
  - What book is about

Creating the Trauma Narrative

- Step 2
  - Relationship with abuser prior to abuse
  - Start with the least traumatic or most general aspect of the event.
  - Example: General information about that type of trauma (may use psychoeducation material)

Creating the Trauma Narrative

- Step 3
  - First Time Trauma Happened
- Step 4
  - Worst Time

Creating the Trauma Narrative

- Encouraging child to “tell what happened” as well as thoughts and feelings during these times
  - Before, during, and after trauma
- Uses expressive art techniques
  - Book
  - Picture
  - Computer
  - Poem
  - Song
- Occurs over several sessions

Quinn's Trauma Narrative

Creating the Trauma Narrative

- Step 5
  - What have you learned?
  - What would you tell other kids who experienced this?
  - How are you different now from when it happened/when you started treatment?

Creating the Trauma Narrative

- Rate distress before, during, and after each session
- Review the child's description at each session
  - Help the child to describe more details
  - Desensitize child to the event
- Be flexible in where you start
- Do not have student work on the narrative outside of the sessions
- Use Wound Analogy

Sharing the Trauma Narrative with the Parent

- Explain why it's important
  - Explore what parent knows about the traumatic event
- Prepare parents
  - Possible temporary increase in child's distress
- Share information as the narrative is developed
- Ensure that parents will be supportive and helpful
- Parallel parent sessions with narrative development

Example

I was reading a book to Amber. Little Princess book. We was sitting on her bed. Dad came in. He said Amber had to pick up her room. I started to get a little suspicious cause I didn't know why dad wanted me to leave the room cause when someone has to clean the room they want someone to help them. I think I refused to get out. He pushed me down against the bed and made me fall on the ground. Then I ran out of the room. I was kinda scared. It was hard to think. I was thinking that Dad was upset about something. I was wondering what he was upset about. I was sweating. It was hot in there. The reason I got out of the room was because my heart started pounding fast. Going in my room. I had told Drake when I was done reading Amber a story I would read him a story. So I read him a story. I was reading a book to Drake. I heard screaming and thought it was Amber I was frightened when I heard Amber screaming. I said Drake can you hold on a minute I'm going to see what's wrong with Amber. I was worried. I thought something bad was happening to her. I saw that Daddy had his arm around Amber's head. I was hiding behind mom, right behind her. I was surprised when I saw Dad hurting Amber. Mom was yelling at him to stop. Mom went and pushed Dad over. I felt ashamed because I couldn't help anyone.

Group-Based TF-CBT

Multimodality Trauma Treatment (MMTT)

Amaya-Jackson, Reynolds, Murray, McCarthy, Nelson, Cherney, Lee, Foa, & March

Multimodality Trauma Treatment (MMTT)

- Targeted for:
  - Youth in grades 4 through 12
  - Youth who experienced single-incident traumatic stressors
- Skills-oriented and graded-exposure model of cognitive-behavior therapy
- Aims to
  - Promote habituation,
  - Revise schemas,
  - Develop skillful coping
  - Reduce collateral symptoms

Amaya-Jackson et al., 2003

Multimodality Trauma Treatment (MMTT)

- Developed and implemented in school settings
  - Not being based in clinical settings is helpful for school psychologists
  - Particularly useful modality if community-based disaster occurred
  - Family participation is not required
    - Avoids roadblocks of difficulties in coordinating with parents

Amaya-Jackson et al., 2003

MMTT: Structure of Sessions

- 50 – 60 minute group sessions
- 14 weekly sessions
- 6-8 students
- Developmentally sensitive recommendations provided to match developmental level of youth
- Each session follows the same format
  - Check in with children (~5 minutes)
  - Review homework (~5 minutes)
  - Teaching/learning tasks for week (~20 minutes)
  - Therapist-assisted practice (~10 minutes)
  - Discuss and agree on homework (~10 minutes)

Amaya-Jackson et al., 2003

MMTT: Session 1—Introduction and Psychoeducation

- Introductory activity and rapport building
- Establishment of group behavioral guidelines
- Explanation of PTSD
- “All About Me” worksheet
  - Basic info about youth and first brief description of trauma
- Storybook or journal titled, “My Scary Story With a Good Ending”

Amaya-Jackson et al., 2003

MMTT: Session 2-4: Cognitive Training & Creating a Tool Kit

- Session 2: Externalization and Anxiety Management
  - Teaches progressive, cue controlled, differential muscle relaxation
  - Externalizing metaphors
  - Students name and describe physical and emotional responses to trauma
- Session 3: Thinking, Feeling, Doing and Stress Thermometer
  - Introduces tripartite model (thinking, feeling, behaving)
  - Introduce the stress thermometer
  - Gradual narrative exposure
- Session 4: Traumatic Reminders & Exposure/Response Prevention
  - Bossing back PTSD through exposure and response prevention with middle level situations from stress thermometer
  - Tools and allies for coping comprise Chapter 3 of story book

Amaya-Jackson et al., 2003

MMTT: Session 5 (optional)

- Session 5: Coping with Anger and/or Grief
  - Optional sessions if youth need additional help with anger, irritability, or aggressive outbursts OR for those who experiencing prolonged grief reactions in the context of PTSD
  - Coping with Anger
    - Teaches Stop-Think-Plan (STP)
  - Coping with Grief
    - Main goals are to normalize grief reaction through psychoeducation, and allow sadness and feelings of loss
    - Optional activity of making a memorial (if appropriate)

Amaya-Jackson et al., 2003

MMTT: Session 6: Narrative Exposure

- Individual pull out sessions
- Different procedure of telling the trauma story than TF-CBT
  - Trauma Replay: Child discusses what happened and their thoughts, feelings, and physical sensations (metaphor of viewing a pretend videotape of child's experience)
  - Build the stimulus hierarchy of traumatic reminders or avoidance behaviors on stress thermometer for later sessions

Amaya-Jackson et al., 2003

Structure of Trauma Replay

Thoughts

Physical Sensations

Emotions

Beginning *Middle* *End*

Details about the Trauma

MMTT: Sessions 7-9

- Session 7: Setting Up the Stimulus Hierarchy
  - Taught imaginal exposure
  - Begin to boss back “transition zone” reminders
  - Complete another sotrybook chapter on traumatic reminders
- Session 8 and 9: Group Narrative Exposure
  - Group members draw and discuss traumatic event further, moving up to medium difficulty exposure, and practice skills from their tool kit
  - Group members support each other in confronting cognitive distortions and help build personal efficacy and control
  - next chapter of storybook, “The way I Used to Think About My Scary Time and the Way I Think Now”

Amaya-Jackson et al., 2003

MMTT: Session 10 and 11

- Session 10: Group Narrative Exposure of Worst Moment
  - Discussion and normalization of “intervention” or “revenge” fantasies
    - e.g., God or Mom will come and stop what is happening
    - When fantasies fail, helplessness follows and defines the worst moment
- Sessions 11: “Worst moment” cognitive and affective processing
  - Continues work from previous session with enhanced cognitive restructuring and affective processing

Amaya-Jackson et al., 2003

MMTT: Sessions 12 and 13

- Generalization training and relapse prevention
  - Discuss expectation for “hiccups”
    - Brief interruption in effective coping with PTSD
    - Learn to prevent hiccups from turning into a relapse through generalization skills (e.g., imagining time in the future when PTSD bothers them again)
    - Engage in problem-solving, using stress thermometer before and after

Amaya-Jackson et al., 2003

MMTT: Session 14

- Session 14: Graduation
  - Celebration of progress towards controlling PTSD symptoms
  - Receive certificate of achievement
  - Encourage members to share group experience with others
  - Other school personnel (principal, teacher) may be invited

Amaya-Jackson et al., 2003

Adaptations of TF-CBT for Traumatic Grief

Working with children who have experienced traumatic bereavement

Layne, Saltzman & Pynoos

Adapted from TF-CBT by:

Deblinger, Cohen, & Mannarino

Adaptations of TF-CBT for Traumatic Grief (Bereavement)

- Addresses both the trauma and the grief
- Focus on treating the trauma THEN the grief
- Treatment Modules:
  - Psychoeducation
  - Stress Management
  - Cognitive Coping
  - Creating the Trauma Narrative
  - Cognitive Processing
  - Behavior Management Training
  - Caregiver Sessions
- Treatment: 6-8 sessions for each child

  6-8 companion sessions for a caregiver.

Layne, Saltzman, & Pynoos, 2005

Signs of Unresolved Grief

- **Intrusive memories about the death:**
  - Nightmares
  - Guilt
  - Self blame about how the person died
  - Recurrent or disturbing thoughts about the terrible way someone died
- **Avoidance and numbing:**
  - Withdrawal/acting as if not upset
  - Avoiding reminders of the person,
  - Avoiding reminders of the way he or she died, or the things that led to the death
- **Physical or emotional symptoms of increased arousal:**
  - Irritability
  - Trouble sleeping
  - Drop in grades
  - Headaches
  - Fears about safety for oneself/others.
  - Anger
  - Decreased concentration
  - Stomachaches
  - Increased vigilance

Layne, Saltzman, & Pynoos, 2005

Treatment Modules: Overview

- **Psychoeducation**
  - Discussion is focused on the cause of death
  - Need to normalize current feelings
    - e.g. statistics regarding this type of death
    - common reactions to death
  - You may need to address the intentionality of death (depending on the cause, i.e. intent, random, due to natural event).
- **Stress Management**
  - Cues, places, routines can serve as a “loss” reminder
  - Focus on enhancing the child’s sense of safety
  - Generate neutral, happy or soothing replacement scenes to use as thought-interruptions.

Layne, Saltzman, & Pynoos, 2005

Treatment Modules: Overview

- **Cognitive Coping**
  - Little modification from the TF-CBT module

- **Creating the Trauma Narrative**
  - Begin in a manner that does not promote a difficult reminder of the deceased or his/her absence
  - Focus on neutral topics (e.g. school, hobbies)
  - Context of death
  - What happened
  - Child's thoughts, feelings and worst moments
  - Emphasize can do good in response to a bad event
    - But the past cannot be changed

Layne, Saltzman, & Pynoos, 2005

Treatment Modules: Overview

- **Cognitive Processing**
  - Examine thought narrative for themes of responsibility for the death
  - Offer alternative ways of thinking about the person's final moments

- **Behavior Management Training**
  - Current caregiver may now be single parent due to the death
  - Caregiver may be overwhelmed due to having to assume total responsibility for the household

- **Caregiver Sessions**
  - Collaborative with both caregiver and child
  - Emphasize that child will benefit from sharing his/her trauma-narrative
  - *Treatment has been successful in cases where caregiver is unavailable to participate in the session

Layne, Saltzman, & Pynoos, 2005

Technique: Grief Psychoeducation

AIM

Find out what they believe & understand about death, provide accurate information about the process of grief, correct misconceptions, address fantasies, and build open communication.

- Directly focus on the topic
  - Let the child know it's okay to ask questions and to talk about death
- Focus on the child's beliefs and understanding
  - Correct any inaccurate information or misconceptions
- Address feelings associated with the death
  - Identification of various feelings
  - Responses to grief
  - Normalize the client's feelings

Layne, Saltzman, & Pynoos, 2005

Grief and Ambivalent Feelings

AIM

Identify different aspects of the past relationship with the deceased and address how the person's death affects the future.

- Explore what is missed
  - Focus on special aspects of the relationship
- Become future-focused
  - Prepare for events where the deceased person will be absent; include current, positive and potentially difficult events.
- Resolve ambivalent feelings
  - Have a "mental conversation" with the deceased person's spirit/soul
  - Write a "healing letter," i.e., say what you wanted the person to know/hear
- Normalize the feelings
  - It is scary and it is okay to have ambivalent feelings
- Work through guilt about the feelings
- Deal with negative aspects of the relationship
  - Do not try to change history or idolize the person
  - Understand the person really wanted the best for them despite the problems

Layne, Saltzman, & Pynoos, 2005

Preserving Positive Memories

AIM

Recount and remember positive aspects of life with the deceased individual; understand that it's okay to feel happy.

- Create a positive memory keepsake
  - A physical "container" of non-trauma, positive memories
- Involve others
  - Talk to others to gain a richer sense of the person
- Continue with memories
  - Add new memories of the person as well as those that occur in the person's absence
- Hold a memorial service
  - In collaboration with the caregiver, plan a time in/out of therapy to remember the person.

Layne, Saltzman, & Pynoos, 2005

Redefining the Relationship

AIM

Future-focused; accept the past relationship and focus on creating new relationships.

- Recommit to new relationships
- Redefine relationships
  - Understand what is past versus still available in the present
  - Balloon technique
- Connect to others
  - Focus on current activities; identify positive/ helpful characteristics of individuals in your life
- Find/let others into your life
  - It is okay to participate in old activities with new people
- Personalize and integrate relationships

Layne, Saltzman, & Pynoos, 2005

Review Treatment

- Assess treatment progress
  - Assess level of distress reactions; ability to talk about the person; ability to adjust to changes in their lives
- Conduct a joint session between caregiver and child
- Make meaning
  - Help the child find meaning & integrate into his/her identity
  - e.g., get involved in public activities: cancer walks for charity
- Prepare for the future
  - Predict
  - Plan
  - Permit
- Termination
- Present it as a graduation
- Readiness to focus on life-affirming activities

Layne, Saltzman, & Pynoos, 2005

TF-CBT Web: A Web-Based Learning Course for Trauma-Focused Cognitive Behavioral Therapy

- http://tfcbt.musc.edu

Additional Resources

- *Abdelnoor, A., Hollins, S. (2004).* How children cope at school after family bereavement. *Educational & Child Psychology. Special Loss, Separation and Bereavement, 21, 85-94.*
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- Dowdney, L. (2005). Children bereaved by parent or sibling death. *Psychiatry*, *4*(9), 118-122.
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Additional Resources

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