CHILDHOOD TRAUMATIC GRIEF
Concepts and Controversies

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Childhood traumatic grief refers to a condition in which characteristic trauma-related symptoms interfere with children's ability to adequately mourn the loss of a loved one. Current concepts of this condition suggest that it overlaps with but is distinct from uncomplicated bereavement, adult complicated grief, and posttraumatic stress disorder. This article describes the core features of childhood traumatic grief; differentiates it from these related conditions; and reviews the current research status of suggested diagnostic criteria, assessment instruments, and treatments for this condition. Implications for future clinical practice, research, and policy are also addressed.

Key words: *children, trauma, grief, bereavement, treatment*

MANY AUTHORS HAVE WRITTEN about childhood bereavement (Harrington & Harrison, 1999; Kaplan, 1992; Wolfelt, 1996; Worden, 1996), and childhood traumatic stress has received increasing attention in recent years (American Academy of Child and Adolescent Psychiatry [AACAP], 1998; Cohen, Berliner, & March, 2000). However, relatively little has been written about children who experience traumatic grief. The current concept of this condition is that it results from the loss of a loved one in traumatic circumstances and is characterized by the encroachment of trauma-related symptoms on the child's ability to negotiate the normal bereavement process (Layne et al., 2001; Nader, 1997). Childhood traumatic grief has not been clearly or consistently differentiated in the literature from adult complicated grief, normal (uncomplicated) childhood bereavement, or posttraumatic stress disorder (PTSD) in the context of bereavement; very little empirical research has been conducted to elucidate differences and similarities among these conditions. Traditionally, childhood traumatic grief has been considered to result from the loss of a

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loved one in a traumatic event, such as interpersonal violence, natural or manmade disaster, severe motor vehicle or other accident, suicide of a loved one, or war conditions. However, we suggest that death from natural causes can also result in traumatic grief if a child's subjective experience of the death is traumatic and trauma symptoms interfere with grieving and resolving the loss of the loved one. In an effort to provide greater clarity and to increase clinicians' awareness with regard to the manifestations of this condition, this article reviews current concepts and controversies with regard to childhood traumatic grief and how it differs from related conditions. Clinical, research, and policy implications of our current state of knowledge about this condition are also addressed.

KEY POINTS OF THE RESEARCH REVIEW

- Childhood traumatic loss refers to the impingement of trauma symptoms on the child's ability to appropriately mourn the loss of a loved one.
- Trauma symptoms in childhood traumatic grief overlap with posttraumatic stress disorder criteria, but many of these children do not meet full posttraumatic stress disorder criteria.
- Characteristic trauma symptoms in childhood traumatic grief include reexperiencing in response to traumatic or loss reminders, exaggerated avoidant symptoms, and traumatic estrangement.
- Treatment should include interventions for both trauma and bereavement symptoms.
- Inclusion of a parent treatment component may be beneficial for resolution of childhood traumatic grief.
- Research is needed to evaluate empirically the relative effectiveness of current treatment models for childhood traumatic grief.

UNCOMPLICATED BEREAVEMENT

Grief is defined as "deep mental anguish or sorrow over a loss" (*American Heritage Dictionary*, 1985). *Mourning* refers to the process of adapting to the loss, i.e., the painful, gradual process of recognizing the serious and permanent nature of the loss of a loved one, transforming the relationship with the deceased from an active interactional attachment to one of memory, and finding meaning in life in the absence of the deceased (Klass, Silverman, & Nickman, 1996; Webb, 2002a). This normal mourning process is characterized by great sadness, feelings of anger, sleep problems, loss of appetite and weight, preoccupation with the death, and difficulty concentrating on normal activities (American Psychiatric Association [APA], 2000, p. 741). The concept of bereavement is similar to mourning, but also encompasses the broader social context in which mourning occurs. To maintain consistency with terminology used by DSM-IV and the consensus criteria for traumatic grief (Prigerson et al., 1999), the terms *uncomplicated bereavement* and *traumatic grief* will be used throughout this article. The clinical presentation of uncomplicated bereavement in children varies according to developmental level; children's understanding of death and ways of expressing grief may also be influenced by factors such as parental modeling and support of grieving and emotional expression, religious and cultural practices, and cognitive and verbal abilities (Grollman, 1995). The following sections describe some child characteristics of uncomplicated bereavement at different developmental stages.

Infants and toddlers (babies to 2-year-olds) experience a sense of "gone-ness" or absence when someone dies (Emswiler & Emswiler, 2000; Wolfelt, 1996). They typically react to the separation from an attachment figure with sleep disturbance, change in eating patterns, fussiness, bowel and bladder disturbances, or difficulty being comforted (Black, 1998; Emswiler & Emswiler, 2000; Grollman, 1995; Wolfelt, 1996). Recent guidelines for treating traumatically bereaved infants and toddlers suggest that the circumstances of death do not typically have an impact on the experience of mourning in children so young, because the loss of a primary attachment figure from any cause is likely experienced as traumatic. These guidelines suggest that the severe or persistent intrusion of trauma symptoms may lead to difficulty in reattaching to remaining or new caregivers (Leiberman, Compton, Van Horn, & Ippen, 2002). Particularly vulnerable children may go on to develop reactive attachment disorder in response to the

ongoing impingement of these symptoms on the very young child's ability to negotiate the grieving process.

Preschoolers (3- to 6-year-olds) cannot typically comprehend the word *forever* and often believe that death is reversible. Thus, even after seeing the deceased in a casket, these children may ask when their parent is coming home. They may engage in "magical thinking" in which they believe that they are powerful enough to influence or reverse death. Preschoolers also struggle with understanding the lack of function of the body after death (Emswiler & Emswiler, 2000; Fitzgerald, 1992; Wolfelt, 1996). They may believe that they can wake the deceased person by making enough noise (Saravay, 1991) or worry about how the deceased will breathe, see, or hear through the dirt surrounding the casket (Fox, 1985). Preschoolers may exhibit regressive behaviors such as thumb sucking, baby talk, and loss of toilet training. They may reenact the death in play and use this as a medium through which to express their feelings (Wolfelt, 1996). Children of this age may also express a desire to die or go to heaven to be reunited with the deceased. This should not be assumed to indicate suicidality, although this possibility should be carefully explored.

Young primary school children (6- to 9-year-olds) tend to see death as something tangible or physical (i.e., a spirit, angel, or ghost). They may struggle to understand how the deceased could be buried in the cemetery and be in heaven at the same time (Saravay, 1991). They may also begin to externalize and personify death (Emswiler & Emswiler, 2000; Fitzgerald, 1992; Grollman, 1995). Thus, these children may believe that death is a being that chases down and catches potential victims and therefore can be escaped or run away from if one is swift and strong enough (Fox, 1985; Webb, 2002a). A clearer understanding of the permanency of death starts to evolve at this age, but these children may continue to express their grief through playing that the deceased is still alive. Children at this developmental level may display aggression or other behavioral problems because they do not know how to appropriately manage their sadness or angry feelings over the loss. Many children this age become anxious about surviving family members' safety and survival; however, most do not worry about their own death because they typically perceive this as occurring very far in the distant future (Webb, 2002a).

Prepubertal children (10- to 12-year-olds) become more realistic about the inescapability of death and the concept of a soul. Thus, children of this age are more able to grasp the concept that even though the deceased's body is buried, the spirit of that person may live on in heaven or in living people's hearts (Lonetto, 1980). Although these children are more able to grasp rational explanations of causality, they may still have some remnants of magical thinking; that is, they may believe that their actions or words may have contributed to the death in some manner.

Adolescents (12-year-olds and older) understand death cognitively but begin to struggle with more existential life issues—that is, "Why me?" or "Why do bad things happen to good people?" Teenagers are often fascinated by death but also view themselves as invincible. They may test their own mortality or protest the loss through inappropriate risk-taking behavior or emotional withdrawal (Emswiler & Emswiler, 2000; Fitzgerald, 1992; Wolfelt, 1996). Teenagers may also feel that life has been unfair to them and display anger in search of meaning. Because of their more mature cognitive ability to understand the permanence and future impact of the death on the rest of their lives, they may develop the profound sadness, sleep and appetite problems, and difficulty concentrating that are typical of adult bereavement.

Reconciliation is defined as the process that occurs as the bereaved child works to integrate the new reality of moving forward in life without the physical presence of the person who died. With reconciliation comes a renewed sense of energy and confidence and a capacity to be reinvolved in the activities of living (Wolfelt, 1996). Worden (1996) and Wolfelt (1996) have described the following tasks of childhood mourning: (a) accept the reality of the loss; (b) experience fully the pain of the loss; (c) adjust to an environment and self-identity without the deceased, which is typically accom-

plished by integrating positive aspects of the deceased into one's own self-concept; (d) convert the relationship with the deceased from one of present interaction to one of memory; (e) find meaning in the deceased's death; and (f) experience a continued supportive adult presence in future years. These tasks require that the child be able to tolerate prolonged thoughts about the deceased, including specific memories about the child's own past interactions with that person; to remember the totality of the deceased person; to tolerate regret or guilt about things left unsaid or undone in that relationship; and to face and tolerate the pain associated with the loss. Because of the persistent intrusion of trauma symptoms, children with traumatic grief are unable to complete these tasks of reconciliation, as will be discussed below.

The current concept of adult complicated grief hypothesizes that a person with an insecure, anxious attachment style (i.e., with ongoing fears of abandonment, excessive dependency, and unstable attachments) and difficulties in self-regulation of affect, goals, values, and impulsivity is at risk to develop a specific symptom constellation (complicated grief) upon the loss of a security-increasing partner.

ADULT COMPLICATED GRIEF

The term *complicated grief* was initially used to describe any bereavement reaction that did not meet the currently accepted definition of uncomplicated bereavement. However, in the 1990s, this term began to be used to describe adults experiencing bereavement complicated by separation distress and traumatic symptoms related to the loss of the relationship (Prigerson et al., 1997; Prigerson & Jacobs, 2001). Two distinct theoretical pathways have been proposed as the basis for complicated or traumatic grief in adults. The first, introduced by Lindemann (1944) and expanded on by Bowlby (1973) and Jacobs (1999), is based on attachment theory. In this conceptualization, separation anxiety, intense yearning, and searching for the deceased are prominent symptoms and are thought to originate from object loss anxiety. The second, proposed by Adler (1943) and Horowitz (1976), is based on the traumatic nature of some deaths. In this conceptualization, PTSD-like symptoms are prominent. Thus, there has been some disagreement about whether the traumatic nature of adult complicated grief is due to the loss of a primary attachment or exposure to the traumatic event that led to the death. Prigerson et al. (1997) have attempted to integrate these concepts, resulting in the currently proposed criteria for complicated grief in adults. This condition typically arises in response to a death that would not be considered objectively traumatic; rather, the traumatic nature of the loss is due to the nature of the relationship and the bereaved's dependency on that relationship. The current concept of adult complicated grief hypothesizes that a person with an insecure, anxious attachment style (i.e., with ongoing fears of abandonment, excessive dependency, and unstable attachments) and difficulties in self-regulation of affect, goals, values, and impulsivity is at risk to develop a specific symptom constellation (complicated grief) upon the loss of a security-increasing partner (Prigerson et al., 1997, 1999).

The proposed diagnostic criteria for this condition include the following symptoms: intrusive thoughts about the deceased; yearning and searching for the deceased; excessive loneliness since the death; purposelessness or feelings of futility about the future; a subjective sense of numbness, detachment, or absence of emotional responsiveness; difficulty acknowledging the death (e.g., disbelief); feeling that life is empty or meaningless or that part of oneself has died; a shattered worldview (e.g., lost sense of security, trust, or control); assumption of symptoms or harmful behaviors of or related to the deceased person; and excessive irritability, bitterness, or anger related to the death (Prigerson & Jacobs, 2002, p. 1371). In addition, these symptoms must last for at least 6 months and cause significant functional impairment.

CHILDHOOD PTSD

Childhood PTSD, like the adult form, requires traumatic exposure in which the child experienced, witnessed, or learned about an event

that involved actual or threatened death, serious injury, or threat to physical integrity to self or others and in which the child's response involved intense helplessness, fear, or horror (APA, 2000). The child must have at least one reexperiencing symptom, such as recurrent distressing recollections about the event (young children may exhibit this as repetitive play with traumatic themes), recurrent distressing dreams of the event (or in young children, frightening dreams of unclear content), a sense of the event recurring (including trauma-specific reenactment in young children), and intense physiological reactivity or psychological distress in response to reminders of the event. The quality and persistence of PTSD-related play distinguishes it from play seen in young children with uncomplicated bereavement: Posttraumatic play has a repetitive, uncreative quality that seems to produce neither emotional relief nor gradual resolution of traumatic (or bereavement) themes.

In addition to reexperiencing symptoms, to meet diagnostic criteria in PTSD, the child must also have at least three avoidance or numbing symptoms, including efforts to avoid thoughts, feelings, or conversations about the event or places, people, or situations that remind the child of the event; inability to recall some aspects of the event; decreased interest in normal activities; feeling detached from others; restricted range of affect; and a sense of a foreshortened future. The child must also have at least two hyperarousal symptoms such as sleep disturbance, irritability or angry outbursts, decreased concentration, increased startle reaction, or hypervigilance. These symptoms must persist for at least a month and cause significant functional impairment (APA, 2000).

There has been much discussion regarding the validity of these features in young children, in part because several of these criteria require the child to be able to accurately describe internal cognitive and affective states. This has led to the proposal of alternative diagnostic criteria for PTSD in infants and young children (Scheeringa, Zeanah, Drell, & Larrieu, 1995). In addition, children who are adept at avoidance strategies may underreport distressing reexperiencing or hyperarousal symptoms because acknowledging (talking about) such symptoms may impinge on the success of this avoidance (AACAP, 1998). Thus, childhood PTSD may not be recognized or treated in many children.

CHILDHOOD TRAUMATIC GRIEF

The concept of childhood traumatic grief (also called "traumatic bereavement" or "traumatic loss") has been fairly uniformly described in the literature as the encroachment of trauma symptoms on the child's ability to grieve (Elder & Knowles, 2002; Layne et al., 2001; Nader, 1997; Pynoos, 1992; Rando, 1993; Webb, 2002b). In this condition, intrusive and distressing trauma-related thoughts, memories, and images may be triggered by trauma reminders (situations, places, people, smells, sights, or sounds that remind the child of the traumatic nature of the death), loss reminders (thoughts, memories, objects, places, or people who remind the child of the deceased person), or change reminders (situations, people, places, or things that remind the child of changes in living circumstances caused by the traumatic death) (Pynoos, 1992). To illustrate, a child whose mother committed suicide by shooting herself may have intrusive reexperiencing symptoms in response to hearing gunshots or other loud noises (trauma reminders), by seeing her mother's picture (loss reminder), or by having to live with relatives or having to bring a substitute adult to a mother-daughter luncheon (change reminders). These trauma-related thoughts then trigger physiological arousal (shaking, pounding heart, headache, dizziness) and extreme psy-

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chological distress (fear, horror, helplessness) characteristic of conditioned (learned) responses that were present at the time of the original traumatic death and that now reoccur when traumatic reminders are present. To not have to experience these unpleasant feelings, the child may either purposely or automatically develop avoidance and numbing strategies. Avoidance allows the child to decrease the frequency or intensity of exposure to trauma, loss, and change reminders, whereas emotional numbing allows the child to minimize the pain and other negative feelings when exposure to such reminders inadvertently occurs. This numbing may take the form of extreme estrangement, in which the child feels alienated, different, or set apart from others, even those in the family who also experienced the traumatic loss (Nader, 1997). Avoidance may extend even to dreams. Normal bereavement-related dreams may be comforting because they remind the child with uncomplicated bereavement of the deceased's loving presence in the past. In contrast, children with traumatic grief often have dreams that emphasize the traumatic nature of the death, leading to intense horror or fear for their own safety. This may result in children trying to delay bedtime or trying to stay awake most of the night in an attempt to escape these frightening images.

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These processes are parallel to what occurs in PTSD in the absence of the death of a loved one. However, in bereaved children, these PTSD coping mechanisms, if pervasive or severe enough, may significantly prevent the successful completion of the tasks of uncomplicated bereavement. Specifically, such children may be unable or unwilling to reminisce, feel the pain of the lost relationship, or transform the relationship with the deceased into one of memory, because such tasks require tolerating loss and change reminders without the excessive use of avoidance or emotional numbing. Remembering and reminiscing about happy times with the deceased are important aspects of normal bereavement (Nader, 1997; Pynoos & Nader, 1990). However, when any reminder of the lost loved one triggers distressing images of the cause of death or horrifying injury and mutilation, children may use avoidant strategies to escape these aversive experiences, thereby interfering with the normal healing process of reminiscing. As Pynoos (1992) noted, "It is difficult to reminisce when a mutilated image is what first comes to mind." This is the essence of our current conceptualization of childhood traumatic grief.

Additional characteristic features of traumatic grief in children include avoidance of identification with the deceased due to fear that if there are resemblances to the deceased, one will share the same fate as the deceased (premature or horrifying death) (Nader, 1997; Pynoos, 1992). This fear interferes with incorporating positive aspects of the deceased into one's self-concept, which is an important step in uncomplicated bereavement, as described above. Children with traumatic grief may also generalize their exaggerated fears to include possible future losses (e.g., "Any man I love will die in the same horrible way my father did"). Such children may attempt to avoid this anticipated future pain by refusing to establish significant attachments to other caring adults, thereby interfering with another important task of uncomplicated bereavement. On the other hand, overidentification with the deceased (adopting an excessive number of characteristics or behaviors of the deceased, changing one's name to that of the deceased) may occur in children with traumatic grief as an attempt to avoid accepting the reality of the loss and thereby forestalling the pain associated with uncomplicated bereavement (Nader, 1997). The violent or horrific nature of traumatic death may contribute to an exaggeration of the self-blame and guilt often seen in children with PTSD (Pynoos & Nader, 1990). In the natural search for meaning and understanding following a traumatic death, children often question why this happened to the loved one and not to themselves. This can result in survivor guilt, characterized by a feeling of guilt for being alive and safe when others have died. Children with traumatic grief may also experience unrealistic self-blame for not being

able to rescue the loved one or revenge fantasies aimed at a perceived or real killer (Eth & Pynoos, 1985). Guilt and/or shame may also be experienced if there is perceived stigma surrounding the death, as may be the case in suicide, a homicide sensationalized by the media, or an AIDS-related death (Eth & Pynoos, 1985; Nader, 1997). Unavoidable trauma reminders, loss reminders, or change reminders that are out of the child's control may result in more extreme emotional numbing or avoidance in children with traumatic grief, whereas such reminders may be beneficial or healing for children with uncomplicated bereavement.

Case example: One child refused to attend the memorial service the community held for his uncle (a fireman who died in the collapse of the World Trade Center), which was held at his school. Subsequently, the school building became another trauma reminder over which he had no control; as a result, this child refused to attend school following the memorial service. Members of the community were dismayed at this apparent lack of appreciation for their efforts and concern. In contrast, his older sister was proud of her uncle's heroism and sacrifice and derived a great deal of comfort from the memorial service and from the ongoing support of her classmates and teachers at school following this service.

The time course of these symptoms may also be important in identifying traumatic grief. Some PTSD symptoms may be normative in the weeks following a traumatic death, but not after a month or more has passed. By definition, PTSD symptoms must be present for at least a month after the traumatic event. More empirical research is needed to determine whether this period of time is appropriate for distinguishing traumatic grief from related conditions.

Differences Between Childhood Traumatic Grief and Uncomplicated Bereavement

In traumatic grief, the child is unable to complete the tasks of uncomplicated bereavement described above, due to the presence and intrusion of trauma symptoms. It should be noted that many children who lose parents or other loved ones in traumatic circumstances follow an uncomplicated bereavement course; that is, they do not focus on the traumatic nature of the death, do not develop significant PTSD symptoms, and are able to mourn the loss in a manner similar to children who experience loss due to nontraumatic causes. Thus, the presence of PTSD symptoms and the interference of these symptoms with the normal bereavement process is not normative for children who lose loved ones in circumstances that would be considered objectively traumatic. This is illustrated by Pfefferbaum et al. (1999, 2000), who documented symptoms in children following the Oklahoma City bombing. Although loss of a loved one and the closeness of the relationship to the loved one did predict higher rates of PTSD symptoms, the majority of bereaved children did not report significant PTSD symptoms or functional impairment 7 weeks postbombing (Pfefferbaum et al., 1999, p. 1375). Similarly, in a study of close friends of adolescent suicide completers, Brent and colleagues (Brent, Perper, & Moritz, 1993; Brent et al., 1995) found that persistent PTSD symptoms occurred in only 5% of this cohort; siblings of suicide completers had no greater incidence of PTSD than nonsuicide exposed controls despite having prolonged elevation in grief symptoms (Brent, Moritz, Bridge, Perper, & Canobbio, 1996a). Thus, it should not be considered normative, even for children losing close relatives or friends in traumatic circumstances, to experience the persistence or intrusion of prominent PTSD symptoms on the grieving process.

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Although this difference may be theoretically clear, differentiating uncomplicated bereavement from traumatic grief may be difficult in practice, particularly if, as described above, the child is successfully using avoidant coping mechanisms to minimize intrusive recollections and the resultant physiological and psychological distress. As with childhood PTSD symptoms in general, clinicians are more likely to elicit accurate reporting of these symptoms if they specifically inquire about them in relation to the traumatic death (AACAP, 1998). Over time, the presence of traumatic grief may become clearer as the child does not become progressively more able to tolerate discussions about the deceased without becoming extremely distressed, avoidant, or emotionally numb and/or estranged.

> Case example: A 9-year-old child refused to enter her twin brother's room after his death in a house fire. When other family members talked about him, she would not join in the discussion but would become busy playing with dolls or watching television. She did not want any of her brother's pictures in her room; she told her parents this was because none of the pictures really looked like him. She refused to keep any of his toys, saying, "Who wants those yucky boy things?" Her parents did not think these behaviors were indicative of significant problems, because she continued to be well behaved at home and to do well in school. However, they became more concerned when she continued over the next 8 months to refuse to say her brother's name or to visit his grave site. Upon assessment, she acknowledged daily intrusive thoughts, visions, and smells of her brother "burning to death" and fears that if she thought "even once" about what he looked like or how much she missed him, she would never be able to get these horrible ideas out of her mind.

Some of the clinical features that distinguish uncomplicated bereavement from childhood traumatic grief were documented by Brent et al. (1995). All of the adolescents in this study had lost a close friend to suicide and thus were presumably experiencing some degree of bereavement, and PTSD symptoms were endorsed to some degree by the entire group. However, the 5% who met full criteria for PTSD (and were therefore more likely to have traumatic grief, as discussed below) reported significantly more severity on the following items of the PTSD Reaction Index (Pynoos, Frederick, et al., 1987): fear when thinking of the death, intrusive and voluntary images of the death, dreams/nightmares related to the death, feelings that other people do not understand, greater tendency to be startled, sleep problems, guilt about the death, staying away from reminders, tension or stress created by reminders, and affected well-being (Brent et al., 1995, p. 212). Interestingly, other PTSD items from the Reaction Index that are characteristic of uncomplicated bereavement were endorsed equally by both the PTSD and no-PTSD groups, including fear that self or others might die, difficulty enjoying things, impaired memory or concentration, and more impulsive or difficult behavior.

Differences Between Childhood Traumatic Grief and Adult Complicated Grief

Childhood traumatic grief is also distinguished from adult complicated grief, primarily because of differences in the source and nature of the trauma. Whereas in adult complicated grief, the trauma is due to the loss of a security-enhancing relationship in the context of attachment and self-regulatory difficulties, in childhood traumatic grief the trauma is due to the objective or subjective horror and fear associated with the manner of death itself. Unlike in the adult condition, there is no implication of preexisting attachment or self-regulatory abnormalities in children who experience traumatic grief (although these may develop later). Another difference in these two conditions is that long-standing dependency needs (retriggered by the loss of the secure relationship) are what impinge on the adult's ability to grieve, whereas the intrusion of traumatic reminders and the resultant use of avoidance strategies are what impinge on the child's ability to grieve.

Although these conditions have somewhat overlapping symptoms, the limited empirical evidence suggests that there are also differences. Only one research group has attempted to empirically examine symptoms of childhood traumatic grief: Layne et al. (Layne, Pynoos, et al., 2001; Layne, Savjak, et al., 2001) developed the UCLA/BYU Expanded Grief Inventory (EGI) to quantify symptoms of both uncompli-

cated bereavement and traumatic grief in children and adolescents. Data were collected from adolescents in Bosnia and Los Angeles who experienced war-related or community violence–related deaths of loved ones. Factor analysis 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). Comparing the 14 proposed diagnostic criteria for adult complicated grief listed above to the 11 items on the traumatic grief subscale of the EGI, four of the items on the EGI correspond closely to adult complicated grief items ("feeling shocked or dazed when thinking about the death," "can't bring self to accept that the person is really dead," "searching for the deceased," "more irritable"). Two additional item partially correspond to the intrusive thoughts criteria for adult complicated grief ("can't stop thinking of the deceased when I want to do other things," "upsetting or scary dreams about the deceased"). The remaining five EGI items do not correspond with proposed criteria for adult complicated grief ("not doing positive things I want or need to do because they remind me of the deceased," "get upset thinking about the death," "don't talk about the deceased because it is too painful to think about it," "unpleasant thoughts about how the person died get in the way of enjoying good memories of him or her," "try not to think about the deceased because it brings up upsetting memories or feelings"). Interestingly, the items in the adult criteria that pertain to the loss of a security-increasing relationship (yearning for the deceased, excessive loneliness, purposelessness, feeling that part of oneself has died, feeling that life is meaningless, shattered worldview) are not characteristic of these adolescents with traumatic grief. Although more research is needed to propose specific diagnostic criteria for childhood traumatic grief, the available data indicate that these criteria will have important differences from those proposed for adult complicated grief.

Differences Between Childhood Traumatic Grief and PTSD

In childhood traumatic grief, the trauma symptoms that are impinging on the child's ability to grieve are classic PTSD symptoms (reexperiencing, avoidance, and hyperarousal); however, in traumatic grief these symptoms are manifested in distinct ways that impinge on the tasks of uncomplicated bereavement (Nader, 1997; Pynoos, 1992; Pynoos & Eth, 1986). PTSD items have been used as a surrogate measure of traumatic grief in studies that were conducted before a specific child traumatic grief measure became available. This is based on the presumption that the more severe or pervasive the PTSD symptoms are, the more likely it is that any thoughts about the deceased (loss reminders) will automatically segue into trauma reminders and lead to associated horror, fear, heightened physiologic reactions, and hyperarousal. The more severe these automatic reactions are, the more likely it is that the child will use avoidance strategies to lessen these distressing symptoms. The generalization of avoidance coping mechanisms (progressing from avoidance of traumatic reminders to avoidance of loss reminders, including positive memories of the deceased) results in children with traumatic grief avoiding the tasks of uncomplicated bereavement to not have to experience these distressing symptoms. Thus, it is assumed that the more severe and pervasive the child's PTSD symptoms following a traumatic death, the more likely it is that the child will develop traumatic grief. In one study, children experiencing the death of a loved one in traumatic circumstances developed significantly higher levels of PTSD than either nonbereaved disaster-exposed or nontrauma control groups (Stoppelbein & Greening, 2000).

In childhood traumatic grief, the trauma symptoms that are impinging on the child's ability to grieve are classic PTSD symptoms (reexperiencing, avoidance, and hyperarousal); however, in traumatic grief these symptoms are manifested in distinct ways that impinge on the tasks of uncomplicated bereavement.

Despite this presumed association between severity, pervasiveness, and/or persistence of PTSD symptoms and the likelihood of developing traumatic grief in bereaved children, some children experience uncomplicated bereavement in the presence of PTSD symptoms; that is, they may have PTSD symptoms that are not interrupting the normal process of grieving. In these children, trauma and loss reminders remain separate; one does not automatically segue into the other, and positive memories of the deceased as well as the pain associated with the loss of the relationship, can therefore be experienced, tolerated, and mourned without interference of PTSD symptoms into this process. Thus, the presence of PTSD symptoms (but not necessarily full PTSD diagnostic criteria) are necessary but not sufficient for the development of childhood traumatic grief. The PTSD symptoms must not only be present but must impinge on the child's ability to successfully complete the mourning process.

Thus, the presence of PTSD symptoms (but not necessarily full PTSD diagnostic criteria) are necessary but not sufficient for the development of childhood traumatic grief. The PTSD symptoms must not only be present but must impinge on the child's ability to successfully complete the mourning process.

Our current concept of childhood traumatic grief does not require the child to actually witness the death or discover the body; learning secondhand about the traumatic nature of the loved one's death (such as hearing that a parent was shot to death or killed in a motor vehicle accident) may be sufficiently traumatic to result in traumatic grief. In cases where the child did not actually witness the death or if the body was not recovered or identifiable (as is the case for the majority of fatalities in the recent terrorist attack on the World Trade Center), children may imagine the worst-case scenario of these events to fill in the gaps of missing information (Nader, 1997; Pynoos, 1992). These fantasized images can trigger intrusive reexperiencing symptoms in the same manner that a witnessed trauma would. We suggest that in some cases, the traumatic nature of the death may stem from the child's subjective experience that the death was traumatic, rather than the objectively traumatic nature of the death. For example, witnessing the "death rattle" struggle to breathe in the minutes before an aged relative dies of cancer could be highly traumatic for one child and not for another. Thus, the type of event required for childhood traumatic grief to be present is somewhat distinct from PTSD-type events, in that the former does not necessarily require that the circumstances of death be objectively traumatic but simply that the child's response to the death involved intense fear, horror, or helplessness.

Case example: In one instance, two siblings witnessed the death from sudden respiratory infection of an infant sister. The 8-year-old brother described, "My sister got sick and stopped breathing. It was really scary. She died and everyone was very sad." The 7-year-old sister described, "My baby sister couldn't breathe; the doctor held her upside down and slapped her on the back; she turned all blue. My mommy ran in the door, and from the look on her face, I thought she was going to die too. It was the most awful look I ever saw." The 8-year-old had nightmares about his sister or himself suffocating (intrusive reexperiencing), no longer wanted to attend afterschool activities (diminished interest), became somewhat disruptive and demanding of parental attention at home, and had trouble sleeping (hyperarousal). However, these symptoms lessened during the weeks after his sister's death, and he was able to look at pictures and talk about his deceased sister with both sadness and happy memories. By 3 months after the death, he resumed his normal functioning and kept a picture of his dead sister in his room. The 7-year-old had frightening recurring dreams of the moment of her sister's death. Her schoolwork and sleep deteriorated. She was unable to view her sister's belongings or think about her sister without remembering with terror the look on her mother's face, which came into her mind several times a day. She avoided talking about her sister or the death because of the intrusion of these traumatic symptoms. She was brought to therapy because of recurrent stomachaches at school. At the initial evaluation, she expressed guilt that she had not "saved" her sister and said "thinking about her is too scary." Her brother had experienced uncomplicated bereavement even in the face of PTSD symptoms, whereas this girl was experiencing traumatic grief.

POSSIBLE MEDIATING FACTORS IN CHILDHOOD TRAUMATIC GRIEF

A particular child's development of or manifestation of traumatic grief symptoms may be

affected by several factors, including the child's past history of trauma or loss; the specific circumstances surrounding the trauma; or the reactions of significant adults in the child's life (Rollins, 1997). Nader (1997) has noted that a child's history of previous losses, overidentification with the deceased, the degree of emotional loss experienced by the surviving parent, the degree of the child's disruption of self-concept, and loss of friends or supportive others may complicate the child's symptom picture as well as his or her recovery. Although it is possible that multiple losses may have a cumulative effect, leading to a greater likelihood of adverse outcomes including traumatic grief, it is also possible that previous experiences of loss, if successfully mourned, may prepare the child for more adaptive coping with subsequent deaths. Additional research is needed to clarify this question.

As discussed in the previous section on uncomplicated bereavement, children's cognitive and emotional development determine to a large extent the ability to comprehend death and master the tasks necessary for both grief and trauma resolution. A child's capacity to sustain emotional pain increases gradually with age and maturity. Consequently, manifestations of traumatic grief may vary according to developmental level (Nader, 1997; Pynoos & Nader, 1990). Some authors have suggested specific clinical presentations of traumatic grief at different developmental stages (Nader, 1997; Pynoos, 1992; Pynoos & Nader, 1990); however, to date these variations have not received empirical validation. Thus, it is probably premature to suggest distinguishing clinical characteristics of this condition according to developmental stage. This is particularly true for infants and very young children, for whom there is not even consensus regarding the clinical assessment of PTSD symptoms (a necessary but not sufficient condition for traumatic grief).

Parental response may have a significant impact on child traumatic grief (Nader, 1997; Pynoos & Nader, 1990). In the case of parental death, surviving parents' hyperarousal and increased parenting demands can result in irritability and anger that can detract from their caretaking activities and consistency in parenting (Nader, 1997). A parent's own avoidance can result in decreased tolerance or support of the child expressing traumatic grief symptoms and may also provide poor modeling for optimal coping (Nader, 1997). School-age children, in particular, monitor their parents' reaction in order to not add to their parents' grief and/or anxiety (Pynoos & Nader, 1990). Ongoing parental reexperiencing or preoccupation with the death can lead parents to be overprotective of their children (Nader, 1997). Overidentification with the child's pain may result in a loosening of normal family boundaries or rules, such as failing to maintain normal bedtimes. This can result in continued and persistent symptomatology in the children as they perceive the message that the world is unsafe. 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, 2000; Fergusson & Lynskey, 1997; Laor, Wolmer, & Cohen, 2001); empirical research is needed to determine whether such associations are present in childhood traumatic grief as well.

Although several child assessment studies have examined mediating factors in symptom formation following the traumatic death of friends or family members, these have measured PTSD rather than traumatic grief per se (Malmquist, 1982; Pfefferbaum et al., 1999; Pynoos, Frederick, et al., 1987). In these studies, severity of PTSD symptoms has been linked with greater exposure, such as witnessing the death (Pynoos, Frederick, et al., 1987), or the closeness of relationship to the deceased (Brent et al., 1993, 1995; Cerel, Fristad, Weller, & Weller, 1999; Pynoos et al., 1997). Brent, Moritz, Bridge, Perper, and Canobbio (1996b) also documented 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. This suggests a possible role of self-perceived guilt, regret, and/or responsibility in the development of traumatic grief.

ASSESSMENT OF CHILDHOOD TRAUMATIC GRIEF

Protocols for assessing children following bereavement have been published by a number of authors (Fox, 1985; Webb, 2002c). These include assessment of individual child factors (developmental stage, temperament, past adjustment, general psychiatric status, and past experience with death); death-related factors (relationship to the deceased, type of death, contact with the deceased, grief reactions); and family/religious and cultural factors (recognition of and response to the death, inclusion of child in bereavement rituals, religious and cultural beliefs and practices related to death). All of these should be addressed in assessing the bereaved child for the presence of traumatic grief.

In addition, specific assessment procedures for children with possible traumatic grief have been suggested, including a structured clinical interview, parent interviews, projective measures, and/or standardized, self-report measures. Pynoos and Eth (1986) developed an interview technique for use with children exposed to trauma that has been used in children experiencing traumatic grief. During this interview, the child expresses the impact of the trauma through a projective free drawing and storytelling task and is then encouraged to describe the trauma in detail, focusing on the worst moment, sensory details, and issues of accountability and responsibilities. Steinberg (1997) outlined recommendations for a less structured interview emphasizing a relational approach, which gathers the "preloss history" of children and parents, exploring the quality of the relationship with the deceased and inquiring about the atmosphere of the home after the loss, available support network, the meaning of death to the child, and the child's hopes and plans for the future.

A variety of standardized measures have been used in the investigation of children and adolescents suffering from traumatic grief (Layne et al., 2001; Nader, 1997; Pynoos, Frederick, et al., 1987; Saltzman et al., 2001). These typically include self-report and/or parent-report measures of child posttraumatic stress, grief, depression, and/or anxiety or semistructured diagnostic interviews administered by a clinician. There is currently only one instrument purporting to specifically measure childhood traumatic grief. This instrument, the UCLA/BYU EGI (Layne et al., 2002), includes 28 items that quantify a variety of bereavement symptoms. Specific items on the Traumatic Grief subscale are described above. Because this instrument has only been used by one group of investigators, broader use and additional psychometric development are needed to establish its validity.

Current consensus regarding the diagnostic criteria for childhood traumatic grief includes (a) death of a child's loved one in circumstances that were objectively or subjectively perceived to be traumatic; (b) the presence of significant PTSD symptoms, including that loss and change reminders segue into trauma reminders, which then trigger the use of avoidant or numbing strategies; and (c) the impingement of these PTSD symptoms on the child's ability to complete the tasks of uncomplicated bereavement. Thus, to assess children for the presence of this condition, it is necessary to evaluate the following issues.

The child's and family's current and previous functioning. The information described above that is included in the assessment of all bereaved children should be obtained through interviewing both the child and parent.

The death. This includes the child's relationship (biological or emotional) to the deceased; the circumstances of the death; how the body was discovered and by whom; how the child learned of the death; the emotional state of significant others present when the death occurred and when the child learned about it; the child's subjective experience of the circumstances surrounding the death; and the child's presence or participation in bereavement rituals (funeral, wake, burial, etc.).

The child's PTSD symptoms. A detailed discussion of the assessment of childhood PTSD has been addressed elsewhere (AACAP, 1998; Scheeringa et al., 1995) and is beyond the scope of this article. Of critical importance is that the

interviewer inquire about all PTSD symptoms in a developmentally appropriate manner (i.e., so that the questions are understood by the child) and in specific reference to the traumatic death (AACAP, 1998). For example, it is insufficient to ask whether the child is having any intrusive thoughts about upsetting things; it is essential to ask whether the child has had upsetting or intrusive thoughts about the death of the deceased or the way this person died. In addition, it is important to include both child and parental informants in assessing the presence of PTSD symptoms and to use clinical judgement in determining who is the more reliable informant with regard to a particular item, as there are frequently disparities between child and parent symptom report. In the case of a young child, the addition of an observational assessment may be essential to identify PTSD symptoms the child cannot verbally describe and for which the parent report is less reliable than clinical observation (Scheeringa, Peebles, Cook, & Zeanah, 2001).

Impingement of PTSD symptoms on mourning. Assessing the degree to which the child's PTSD symptoms impinge on the tasks of normal bereavement is crucial to identifying traumatic grief; unfortunately, with the possible exception of the EGI, there is currently no reliable way to quantify this construct. The following guidelines may be helpful in this regard but have not been empirically validated. All of the following should be assessed through individual interviews with the child and parent. The clinician should inquire whether the child's loss and/or change reminders segue automatically into trauma reminders. Specific examples should be used in addressing this question (e.g., "Do you find that any time you think about your father, even about happy times, that these thoughts lead you to thinking about the way he died or how frightened you felt when he died?"). The interviewer should also inquire about how frequently the child can reminisce about the deceased, for what length of time, in how much detail, and what (if anything) interrupts this process. For example, is reminiscing interrupted because the child starts crying because she misses the deceased (a normal bereavement reaction), or is it because terrifying images of the death, the deceased's real or imagined suffering, or images of similar traumatic events become overwhelming to the child? Does the child avoid thinking or talking about the deceased because of the intrusion of frightening thoughts, images, or memories? Do scary or upsetting thoughts about how the deceased died get in the way of enjoying happy memories of that person? Does the child not do important activities because they remind the child of the deceased person? Does the child who is developmentally able to understand the permanency of death persist in looking for the deceased or denying that the deceased is really dead? Are thoughts of how the deceased died interfering with the child being able to think about other things? Is the child afraid or avoidant of thinking about how he or she is similar to the deceased? Is the child avoidant of hearing the deceased's name, seeing pictures or belongings of the deceased, visiting the gravesite, or of other loss/change reminders? Is the child excessively emotionally numb or flat, beyond what would be expected from normal grief? All of these should be assessed in the context of the child's functioning prior to the death of the loved one, the length of time that has passed since the death, the severity of these symptoms, and to what degree they are interfering with optimal functioning. Although the EGI is still in development, this instrument will likely aid in identifying children with clinical features of traumatic grief. The use of the EGI

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may be particularly helpful in children who are more willing to endorse symptoms when filling out a paper-and-pencil instrument than in a face-to-face interview.

TREATMENT OF TRAUMATIC GRIEF IN CHILDREN AND ADOLESCENTS

Without intervention, traumatic grief appears to have the potential for long-lasting effects on children and adolescents (Nader, Pynoos, Fairbanks, & Frederick, 1990; Pfefferbaum et al., 1999; Pynoos, Nader, et al., 1987). A follow-up study of the children involved in the sniper attack cited above revealed continued trauma and grief symptoms at 6 months as well as 1 year later (Nader et al., 1990; Pynoos, Nader, et al., 1987). Similarly, at 8 to 10 months following the Oklahoma City bombing, responses in bereaved children revealed more significant posttraumatic symptoms than in nonbereaved children (Pfefferbaum et al., 1999, 2000). Therefore, it is important that effective interventions be developed and provided for these children.

As discussed above, grief resolution in childhood traumatic grief is interrupted by the impingement of trauma-related symptoms (Eth & Pynoos, 1985; Pynoos & Nader, 1990). It has therefore been assumed that it is necessary to at least partially resolve the PTSD symptoms to successfully negotiate the mourning process in these children. Exploration of the traumatic death in therapy, including a full description of the child's subjective experience, may provide relief and facilitate trauma mastery, allowing the child to more adequately address bereavement issues (Eth & Pynoos, 1985; Nader & Fairbanks, 1994). Thus, most proposed treatment models for traumatic grief include both trauma and bereavement components, with the components aimed at alleviating trauma symptoms being provided early in treatment. However, as traumatic anxiety decreases, the intensity of grief symptoms may increase; resolving grief issues typically takes longer than resolving symptoms related to acute trauma (Eth & Pynoos, 1985; Hendricks, Black, & Kaplan, 2000). Nader (1997) has observed that children and adolescents in treatment for traumatic grief have their own "rhythm" in processing aspects of the trauma and bereavement and that the therapy process must allow for individual variations in this regard. Children may have frequent shifts in treatment from a focus on trauma-related issues to grief-related issues and back again. When treating children with traumatic grief, it is important to negotiate this delicate balance as well as to have clinical skills in treating both trauma and grief-related symptoms.

Treatment Models

A number of treatment models have been proposed for traumatic grief in children and adolescents (Cohen et al., 2001; Goenjian et al., 1997; Layne et al., 2001; Murphy, Pynoos, & James, 1997; Salloum & Vincent, 1999). All but one of these models uses a group-therapy format (Salloum & Vincent, 1999) or a combination of group and individual therapy (Goenjian et al., 1997; Murphy et al., 1997). The remaining model (Cohen et al., 2001) proposes an individual, child-focused therapy approach with a parallel parental (or caretaker) component. All of these include components of trauma-focused cognitive behavioral therapy (CBT) (Cohen, Mannarino, Berliner, & Deblinger, 2000) which is consistent with recent research suggesting that CBT is effective in decreasing PTSD symptoms in children (Cohen, Berliner, et al., 2000). These descriptive models are briefly described here.

A trauma/grief-focused group psychotherapy model for elementary school children exposed to interpersonal violence has been developed by Murphy et al. (1997). Phases of treatment include individual therapy, group therapy, and mentorship, with each phase consisting of 10 to 12 weekly sessions over the course of 1 year. The individual phase identifies and clarifies issues relating to violence and traumatic loss and provides parent psychoeducation. The group therapy phase includes activities to provide greater peer acceptance of the child's experience, increase affect tolerance, and enhance social skills. The mentorship phase provides an identified mentor who meets with small groups of children to maintain a sense of

connection to the community and decrease the experience of feeling excluded from society. Throughout all three phases, parent interventions, including home visitations, parenting skills building, and joint sessions with children, are provided. Preliminary findings indicate behavioral, educational, and family improvements by the end of treatment (Murphy et al., 1997).

Salloum and Vincent (1999) also developed a school-based group treatment model for inner-city adolescent survivors of homicide victims. This 10-week group treatment focuses on grief and trauma and includes education about the nature of grief and trauma and facilitating expression of thoughts and feelings.

Parallel parent and child cognitive-behavioral group treatment was described for bereaved adults and children who lost parents or other relatives in an air disaster (Stubenbort, Donnelly, & Cohen, 2001). Components include psychoeducation about death and grief; cognitive processing to identify, challenge, and reframe cognitive distortions; limited exposure techniques to discuss what occurred during the disaster; naming the things that had been lost with the death of the loved one; resolving of "unfinished business" with the deceased; moving the relationship with the deceased to one of memory by having the children create "memory books"; problem solving about how to deal with anticipated loss and trauma reminders; strengthening coping skills; and planning for future reminders of the traumatic loss.

An individual CBT model for children with traumatic grief and parallel individual therapy for parents (Cohen et al., 2001) was developed by integrating empirically supported interventions for childhood PTSD (Cohen & Mannarino, 1996, 1998; Deblinger, Lippman, & Steer, 1996) with elements of child bereavement treatment (Wolfelt, 1996; Worden, 1996). The 8-week trauma-focused CBT phase includes cognitive processing, stress inoculation therapy, gradual exposure, and joint child and parent sessions. The 8-week bereavement-focused CBT phase includes mourning the loss, resolving ambivalent feelings about the deceased, preserving positive memories of the deceased, redefining the relationship, committing to present relationships, and attending joint parent-child sessions. The parental component parallels these trauma-focused and grief-focused CBT interventions and also provides parent management training.

RESEARCH ON TREATMENT OF CHILD TRAUMATIC GRIEF

To date, there has been only one randomized clinical treatment trials for traumatic grief in children and adolescents; this study did not explicitly measure traumatic grief (Pfeffer, Jiang, Kakuma, Hwang, & Metsch, 2002). Three treatment studies have measured pre- to posttreatment symptomatic improvement using trauma-focused/grief-focused therapy models (Goenjian et al., 1997; Layne et al., 2001; Saltzman, Pynoos, Layne, Steinberg, & Aisenberg, 2001).

A brief trauma-focused/grief-focused model was developed and evaluated for use with young adolescents exposed to the 1988 earthquake in Armenia (Goenjian et al., 1997). This school-based intervention consisted of four half-hour sessions of group therapy and an average of two 1-hour individual sessions, conducted over a 3-week period. The trauma-focused/grief-focused treatment had five major components: trauma, traumatic reminders, postdisaster stresses and adversities, bereavement, and the interaction of trauma and grief, with developmental factors. Sixty-four young adolescents from four different schools were selected for inclusion in the study. Students in two of the schools received trauma-focused/grief-focused therapy, whereas the students at the two other schools received no treatment. At posttreatment, the treatment group had significantly lower scores on the Child PTSD Reaction Index than the control group, whereas the control group's posttreatment scores were significantly worse than their initial scores. Although treatment condition was not randomly assigned, this study nonetheless provides preliminary support for the efficacy of this brief trauma-focused/grief-focused therapy model for reducing posttraumatic and depressive symptoms in early adolescents after disaster (Goenjian et al., 1997). This study did not spec-

ify how many of the children were bereaved or experiencing traumatic grief (although the specific bereavement focus implies that this was a theme common to many of the participants).

Layne et al. (2001) developed and evaluated a trauma-focused/grief-focused group psychotherapy model for war-exposed adolescents. Fifty five secondary school students, ranging in age from 15 to 20, received this school-based manualized treatment approximately 4 years after the Bosnian war (1992-1995), consisting of four modules and spanning approximately 20 sessions (Layne, Saltzman, Savjak, & Pynoos, 1999). The sessions involved structured group activities focusing on psychoeducation about trauma, loss, and change reminders; PTSD, grief, and depression; and therapeutic exposure, cognitive restructuring, stress management/relaxation skills, and problem solving. Participation in the group was associated with significant reductions in posttraumatic stress symptoms, depression, and traumatic grief symptoms (Layne et al., 2001). In addition, reductions in distress symptoms were associated with improved psychosocial adaptation (i.e., classroom rule compliance and school interest). These findings support the use of trauma-focused/grief-focused group therapy in alleviating distress and promoting adjustment in youths with traumatic grief secondary to war.

Although these studies provide promising data about traumatic grief–focused CBT interventions, there is a clear need for more research to replicate these findings among other groups of children with traumatic grief and to compare these treatment models to alternative treatments in more controlled studies that include random assignment and more systematic measurement of traumatic grief symptoms.

A similar trauma-focused/grief-focused group model was developed and used (Saltzman et al., 2001) with 26 inner-city adolescents exposed to community violence. This school-based treatment protocol was designed to reduce posttraumatic stress and grief symptoms, promote school retention, and improve academic functioning. Components of this 20-week protocol included psychoeducation regarding trauma and loss, exposure and cognitive processing of selected traumatic experiences (i.e., the worst moments), problem-solving skills, identification and challenge of maladaptive core beliefs, and restoration of normal development. At completion of treatment, there were significant improvements in posttraumatic stress symptoms, traumatic grief symptoms, and grade point averages. Although only 27% of the participants reported the death of a close friend or family member, those participants demonstrated a significant decrease in traumatic grief symptoms at the end of treatment.

Pfeffer et al. (2002) randomly assigned 102 children ages 6 to 15 who had experienced the suicide of a parent or sibling to either Bereavement Group Intervention (BGI) or a no-treatment control condition. BGI consisted of ten 1.5-hour groups that included psychoeducation, problem solving, expression of feelings, avoidance of suicidal urges, management of traumatic reminders, resolution of feelings of stigma related to the suicide, and development of new supportive interpersonal relationships. The treated group showed significantly greater improvement in anxiety and depression but not in PTSD symptoms.

Although these studies provide promising data about traumatic grief–focused CBT interventions, there is a clear need for more research to replicate these findings among other groups of children with traumatic grief and to compare these treatment models to alternative treatments in more controlled studies that include random assignment and more systematic measurement of traumatic grief symptoms.

IMPLICATIONS FOR CLINICAL PRACTICE, RESEARCH, AND POLICY

Clinical Practice

Particularly in light of recent traumatic events in the United States, it is important that more mental health providers learn to adequately identify and treat childhood traumatic grief in a timely fashion. To accomplish this goal, there is a pressing need to develop a broad

clinical consensus regarding diagnostic criteria for childhood traumatic grief, to empirically validate such criteria, and to develop reliable and valid measures of this condition. Guidelines for identifying developmental variations in the presentation of this condition should also be developed. Once this has been accomplished, direct service providers should be educated regarding the clinical presentation of and appropriate treatment for childhood traumatic grief. This should include pediatric, school, and family practice providers as well as mental health professionals. One of the goals of the newly created National Child Traumatic Stress Initiative is to improve recognition of and treatment and services for the mental health sequelae of childhood trauma, including childhood traumatic grief (Substance Abuse and Mental Health Services Administration, 2001). Related to this initiative, a task force has been formed on child traumatic bereavement that will attempt to provide education in this regard. Treatment interventions being used for this condition should be subjected to empirical evaluation to determine efficacy; effective treatment models will then need to be disseminated to practitioners in community settings.

Research

As reviewed in this article, there has been almost no empirically rigorous research on the assessment of childhood traumatic grief and only four published research studies evaluating the treatment of this condition. To optimally improve identification and treatment for these children, additional studies should be conducted in the near future. The tragic events of September 11, 2001, provide a window of opportunity to empirically evaluate the usefulness of existing traumatic grief screening instruments such as the EGI, particularly in populations with a high rate of exposure to a fatal traumatic event, and to gather more information about the effectiveness of the available manualized treatment models (Cohen et al., 2001; Layne, Savjak, Steinberg, & Pynoos, 1998). As noted above, given the early stage of development of the concept and diagnostic criteria for this condition, it is likely that further psychometric development of the EGI will be needed. Collaboration among different research groups working with this population can significantly accelerate this process and should be encouraged. It will be important to evaluate whether newly developed screening and treatment strategies are effective for children of different cultural backgrounds, developmental levels, and gender. It will also be important to conduct clinical trials to compare these manualized treatments to other interventions (such as grief counseling), which such children may routinely receive. This type of study is complex and generally requires external funding to be adequately implemented.

Policy

As noted above, federal agencies such as the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, and the Federal Emergency Management Agency have supported increased efforts to identify and provide services for children experiencing traumatic grief in response to the recent terrorist attacks on the United States. It is hoped that this support will continue beyond this particular crisis and be extended to address the needs of children bereaved by other traumatic events.

One empirical policy question is whether it is cost-effective to conduct widespread screening for childhood traumatic grief. Recent studies have indicated that screening for general trauma exposure and PTSD symptoms in routine settings such as schools (March, Amaya-Jackson, Terry, & Costanzo, 1997), pediatric settings, and mental health outpatient clinics have identified many traumatized children whose trauma symptoms had not been previously recognized. Because childhood PTSD may be associated with psychobiological abnormalities, including smaller brains and lower intelligence, and these effects have been reported to be correlated with the duration of PTSD symptoms (DeBellis, Baum, et al., 1999; DeBellis, Keshevan, et al., 1999), it is critically important to identify and treat children with PTSD as early as possible after the appearance of these symptoms. Although many children

with traumatic grief will not meet full criteria for a PTSD diagnosis, by definition all of these children will have significant PTSD symptoms. Thus, it would appear prudent to fund general screening procedures in routine settings, particularly following a fatal disaster in which many children are likely to experience both trauma and bereavement symptoms, and evaluate the cost-effectiveness of conducting such screening.

CONCLUSION

Childhood traumatic grief is experienced by many children following loss of a loved one in circumstances that are either objectively or subjectively perceived to be traumatic circumstances. Although it encompasses elements of uncomplicated child bereavement, adult complicated bereavement, and childhood PTSD, our current concept of traumatic grief suggests that it is distinct from these conditions and may require specialized interventions for optimal recovery. More research is needed to clarify and validate specific diagnostic criteria for this condition and to identify the most effective assessment and treatment strategies for these children. The federal government has recently taken several important steps to address the needs of children with traumatic grief. Sustained efforts will be required to identify and provide optimal care for these children.

IMPLICATIONS FOR PRACTICE, POLICY, AND RESEARCH

- Clinicians (including bereavement and trauma specialists) should receive increased education regarding the identification and treatment of childhood traumatic grief.
- More research is needed to evaluate the relative efficacy of current assessment and treatment strategies for these children. This will require sustained federal funding which is currently being made available.
- Widespread screening for childhood traumatic grief and/or PTSD symptoms may be cost-effective in preventing serious long-term negative sequelae.

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SUGGESTED READINGS

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