CHAPTER 1

The Impact of Trauma and Grief on Children and Families

What Constitutes Childhood Trauma?

Many children[1] experience stressful events as they are growing up. They are faced with challenging situations, such as parental divorce or the death of a beloved elderly relative, which may be difficult, painful, and stressful to varying degrees. Yet these experiences would not usually be considered traumatic, which by definition is a qualitatively different experience. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013) has revised the definition of events that qualify as "traumatic" (i.e., those that can lead to trauma-specific diagnoses such as posttraumatic stress disorder [PTSD]) to include those that the child directly experiences, witnesses, or learns about that involve actual or threatened death, serious injury, or sexual violence (American Psychiatry Association, 2013, p. 271). Some examples include, but are not limited, to child physical, emotional, or sexual abuse or neglect; witnessing or being the direct victim of domestic, community, or school violence; severe motor vehicle and/or other accidents; natural and human-made disasters; violent or accidental death of a parent, sibling, or other important attachment figure; exposure to

[1]Throughout this book, the term *children* is used to refer to children and adolescents and *parent* to refer to the nonoffending parent(s) or primary caregiver(s) attending treatment with the child, recognizing that this adult is often not the child's birth parent.

war, terrorism, or refugee conditions; and multiple or complex traumas. There is lively discussion within the child trauma field about whether the DSM concept of trauma is too narrow, both in conceptualizing the types of experiences that can lead to trauma responses and the nature of those trauma responses. Many believe a new diagnostic entity is needed to capture these two concepts (Briere & Spinazzola, 2005)

Even after experiencing such traumatic events, many children are resilient and do not develop enduring trauma symptoms. Several factors, including developmental level, inherent or learned resiliency, and external sources of support, may influence which children will develop difficulties. A child's response to a traumatic event may be mediated by his/her age and developmental level. For example, it appears that for short-lived traumas, younger children are more dependent on their parents' reaction to that trauma than older children (regardless of how great their exposure); if their parents cope well and are supportive of the child, many younger children do not develop serious or long-lasting trauma symptoms (Laor, Wolmer, & Cohen, 2001). However, ongoing interpersonal traumas that start early in life have the potential to cause even more serious trauma symptoms in young children than older children. Younger children do not have the developmental capacities for understanding or self-regulating when the person who should be protective is unable to shield the child or is even perpetrating the violence (Lieberman & Van Horn, 2008, pp. 22–24). Thus, in some traumatic circumstances, younger age may be protective whereas in other circumstances, it may confer greater risk.

Another documented factor that significantly impacts children's response to trauma is the amount and quality of trauma-related emotional support that they receive. In fact, parental support was found to be a significant predictor of children's mental health outcomes in two Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT) treatment outcome studies (Cohen & Mannarino, 1996b, 1998b, 2000). Moreover, it is important to note that parental support can be learned and modeled by treatment providers. Parents can concretely demonstrate support to their children after trauma in various ways. These include reassuring their child that they will remain present and available to protect him/her; showing and expressing love and support; helping the child understand that things will work out using positive statements; modeling affective and behavioral modulation; and expressing belief in the child verbally and in other ways. The impact of a similar (or even a co-experienced) stressor may vary considerably from child to child depending on each child's inherent resiliency, learned coping mechanisms, and the availability of external sources of physical, emotional, and social support. Even stressors that are considered to be traumatic universally (e.g., being the

victim of rape, witnessing a murder) are experienced as less traumatic by some children than by others. This variability is illustrated by the contrasting presentations of two 13-year-old girls who were raped by perpetrators they met online. In each instance, the girl believed that she was meeting a 15-year-old boy in a private location for their first face-to-face date; in both cases the girl instead was confronted by a much older man who forced her into his car, drove her to a secluded spot, and violently raped her while making berating and victim-blaming statements. Each girl reported the rape within a few months to a parent who believed, supported, and sought help for her respective daughter. Neither girl had a previous psychiatric history. The first girl presented with moderate PTSD symptoms. In contrast, the second girl presented with severe PTSD and depressive symptoms, as well as self-injurious (cutting) behaviors, substance abuse, school truancy, and questions about her gender identity. The first girl believed that the rape happened because of the perpetrator's criminal behavior. The second girl believed that the rape occurred because "I'm stupid and worthless, just like he [the perpetrator] said." These contrasting cognitions suggest very different coping responses (and perhaps inherent resilience based on genetic or other factors), as well as ways that intervention might be individually tailored to meet these respective girls' needs.

It is common to observe a marked range of responses to the same traumas experienced even among siblings in the same family exposed to the same horrific events. For example, in one case of ongoing neglect and parental substance abuse, after the mother had been absent for several days, the 10-year-old son and 13-year-old daughter found their mother lying in the hall, dead of an apparent overdose. The son developed severe PTSD symptoms whereas his 13-year-old sister denied any PTSD or sadness about her mother's death, presenting primarily with anger at her mother and externalizing behavior problems. In another situation in which there was a long-standing history of domestic violence, the father shot the mother in front of the children, killed the youngest son, and then turned the gun on himself. All of the surviving children were present when this occurred. However, all three children had markedly different responses. The youngest surviving child, a 7-year-old girl, had severe symptoms of PTSD; the 14-year-old son had no apparent PTSD or depressive symptoms but had serious aggression problems that required inpatient hospitalization; the 12-year-old daughter had only moderate depressive symptoms and focused on caring for and comforting her younger sister. Clearly, the reasons for the vastly different responses are complex, but the bottom line is that the experience of trauma depends not only upon exposure to a traumatic event but also on the individual child's response to that event.

This variation in response occurs, in part, because children have unique ways of understanding traumatic events, making meaning of these events in relation to themselves, accessing familial and other forms of support, coping with the psychological and physiological stress associated with these events, and integrating these events into their larger sense of self. Particularly when children experience interpersonal traumas (e.g., child abuse, domestic violence, traumatic deaths), they not only develop "typical" PTSD responses such as overgeneralized fear or maladaptive cognitions and hyperarousal, but they also often struggle with the loss of their primary attachment figure and of their identified role in the family. Frequently, children report that the latter changes are the most difficult and painful. One teen experienced chronic neglect and commercial sexual exploitation by her mother's drug dealers. This teen took care of her younger siblings, frequently missing school or going without food herself to fulfill this role. After her teachers reported her truancy, Child Protective Services (CPS) investigated and removed the children from the mother's care. The teen was separated from her younger siblings because they were placed together in a different foster home. Shortly thereafter, her mother was found dead of a heroin overdose. When starting treatment, the teen stated that her "worst" trauma was being removed from her mother's care and separated from her younger siblings. She blamed her mother's death on CPS for removing them from the home, suggesting that this prevented her from being able to "keep an eye on my mom." She worried constantly about her younger siblings and exhibited extreme anger at "the system" for hurting her family. She had PTSD symptoms related to sexual abuse and neglect, but her most urgent initial presenting symptoms were related to separation from her siblings and loss of her role as the person who protected them. This response made sense in the context of her perceptions of what had helped her family survive.

The treatment model described in this book, TF-CBT, was developed for traumatized children. Like any treatment model, TF-CBT is not a "one-size-fits-all" approach. This model is not appropriate for every child who has been exposed to a traumatic experience, but only for children who have trauma-related emotional or behavioral problems ("trauma responses") *to serve as the treatment target(s) in TF-CBT.*

These trauma responses often, but do not always, correspond to symptoms of PTSD. Children do not need to meet full PTSD diagnostic criteria to receive or benefit from TF-CBT. Some children may have relatively few symptoms associated with typical PTSD but may have other types of trauma responses. As described in the following section and in more detail in the next chapter, children's trauma responses may include dysregulation of affect, behavior, biology, cognitions, interpersonal/attachment relationships, and/or perceptions. Children with a wide range of

symptoms benefit from TF-CBT. With that said, not every behavioral or emotional symptom is necessarily related to a child's trauma experience. Careful and skillful assessment and case formulation are critical initial steps in effectively implementing TF-CBT. This process is detailed in the following chapter.

The TF-CBT model can also be tailored to meet individual children's needs. For example, a child with complex trauma may need modifications that include providing more TF-CBT treatment sessions (up to 25 for children with complex trauma), changing the proportionality of TF-CBT phases to focus more on the initial stabilization skills, and implementing the enhancing safety component at the beginning of treatment as described elsewhere (Cohen, Mannarino, Kliethermes, et al., 2012).

As described in detail below, this book also describes the application of TF-CBT for children who have experienced traumatic grief. We define childhood traumatic grief as the development of significant trauma symptoms following the death of a parent, sibling, or other important attachment figure that interfere with typical grief responses, leading to co-occurring trauma and maladaptive grief responses. Debate continues about how to best define, describe, and assess traumatic, complicated, or maladaptive grief responses across development. The most recent example is the inclusion of persistent complex bereavement disorder in DSM-5 as a "condition for further study" (American Psychiatric Association, 2013, p. 789). Regardless of how such difficulties are defined in the future, effective interventions are needed to ameliorate children's mental health symptoms, particularly when these persist for many months or even years following the death of an important attachment figure. The traumatic grief treatment approach described in this book integrates trauma- and grief-focused components in a sequential manner, such that once trauma symptoms have abated, the therapist helps the child and parent to resume a more typical grief process. The trauma-focused treatment components are described in Part II of this book, and the grief-focused treatment components are described in Part III.

What Are Trauma Symptoms?

We use the term *trauma symptoms* to refer to emotional, behavioral, cognitive, physical, and/or interpersonal difficulties directly related to the traumatic experience. These symptoms often, but not always, correspond to symptoms of PTSD, but they also encompass many other symptom constellations, often those associated with depression, anxiety, behavior, and/or substance use problems. Children with trauma symptoms may experience a profound change in the way they see themselves, the world,

and/or other people as a result of their exposure to one or more traumatic events. These changes are expressed in their cognitions as well as in their affective responses, both of which are reflected in the new DSM-5 cluster of negative alterations in cognitions and mood associated with the trauma (Cluster D). There is growing evidence that many of these children also experience psychobiological changes, which may contribute to the development and maintenance of these psychological symptoms. We have divided these symptoms into several general categories: *affective*, *behavioral, cognitive, interpersonal, complex trauma,* and *biological* trauma symptoms. These divisions are somewhat arbitrary in that these areas of difficulty overlap and continuously interact. For example, as we described earlier, two critical changes that may occur after trauma are loss of important attachment relationships and loss of family roles. We have chosen to include these in the affective, cognitive, and interpersonal categories, but they could easily have merited separate categories.

Trauma symptoms often occur in response to trauma reminders (sometimes called *triggers*). *Trauma reminders* are internal or external cues that remind children of their original trauma experiences. Trauma reminders may include people, places, things, conversations, activities, objects, situations, thoughts, memories, sounds, smells, or internal sensations that the child associates with the traumatic event(s). When the child is confronted with a trauma reminder, he/she may experience feelings similar to those experienced during the original trauma. This can lead the child to think and act as if the trauma were recurring, even though he/she is now safe. One perpetrator would use a loud and threatening voice to intimidate a child from disclosing the physical and sexual abuse. When the child was subsequently placed in foster care and her foster mother or teachers at school raised their voices to discipline her, she became extremely dysregulated and angry. On one occasion, the child ran away in fear that the foster mother would abuse her after using a harsh voice to correct her. Neither the child nor her foster mother was aware that she was responding to the trauma reminder of loud or harsh voices. Once they recognized this during TF-CBT treatment, they were able to develop successful alternative strategies.

Children are often brought to treatment because of behavioral or emotional dysregulation rather than because of their trauma history. This is particularly the case for youth with complex trauma who present with significant dysregulation in multiple domains of functioning. Since parents and other adults often do not understand that these problems are related to the child's previous trauma experiences, it is critical to recognize, identify, and make connections between trauma reminders and the child's presenting symptoms. Doing so helps the family conceptualize

the child's problems as trauma responses, which then often allows family members to embrace the child's need for trauma-focused treatment.

Children who experience traumatic grief also are triggered by loss reminders and change reminders. *Loss reminders* cue the child to remember the person who died. These reminders include seeing pictures of or hearing people talk about the deceased person; birthdays or anniversaries; or significant holidays, such as Mother's or Father's Day. *Change reminders* are cues that trigger thoughts about how a child's way of life or identity has changed after the death. For example, when a child who has lost his Army father in combat has to transition from living among service members to a neighborhood of civilian families, he has not only lost his father, he has lost his way of life. The child whose newly widowed mother becomes the sole breadwinner may experience considerable disruption in the continuity of her life, not to mention the loss of her father.

Affective Trauma Symptoms

Common *affective* trauma symptoms include fear, sadness or depressive symptoms, anger, and/or severe affective dysregulation (i.e., frequent mood changes and/or difficulty tolerating negative affective states). *Fear* is both an instinctive and learned reaction to frightening situations. Children instinctively experience fear in life-threatening situations; the autonomic nervous system responds to this perceived danger by releasing large amounts of adrenergic neurotransmitters, which further reinforce anxiety. Fearful memories are also encoded in the brain differently than those from nontraumatic memories. Some children will subsequently experience the same physiological and psychological fear reactions when exposed to reminders of the traumatic event (e.g., a child who was in a serious car accident, which may have included a fatality, may become terrified whenever he/she rides past the site of the accident). This fear response can then become generalized so that people, places, things, or situations that are inherently innocuous but that remind the child of the traumatic event will cause the same level of fear as the original trauma (e.g., this child might experience intense fear when riding anywhere in a car). The intrusion of fearful memories is characteristic of PTSD; children may have intrusive, frightening thoughts during the day or scary dreams at night. In younger children the content of these scary dreams may not be related to the traumatic event in an obvious way, but may instead depict other frightening things; the development of new fears (with no apparent relationship to the trauma other than temporal proximity) may be a PTSD symptom in very young children (Scheeringa, Zeanah, Myers, & Putnam, 2003).

In addition to specific fears, more diffuse *anxiety* may develop due to the sudden, unpredictable nature of the trauma. This anxious state may leave children feeling generally unsafe and hypervigilant, on guard to protect themselves from being taken by surprise the next time. A sense of impending danger can impinge on children's ability to engage in developmentally appropriate tasks and contribute to their taking on responsibilities well beyond a maturity level typical for their age; or alternatively, to disengage from school, appropriate peers, and family and become proactively aggressive in the belief that this is the only way to survive. General anxiety can result in the "parentification" of a child or contribute to a child's effort to be "perfect" to ward off potential threats in the future. A constant vigilance for possible omens of future threats and other anxiety-driven behaviors can also take hold. All of these behaviors interfere with healthy adjustment and can lead to the development of comorbid generalized anxiety disorder as well as other comorbidities.

Children may develop overwhelmingly sad or *depressive feelings* after a trauma. These may arise in response to an abrupt loss of trust in other people and the world (e.g., loss of innocence, faith, or hope in the future). Many traumatized children experience more concrete losses, which lead to extreme sadness. Specifically, after a death or traumatic separation that might occur suddenly, perhaps due to parental incarceration, deportation, the child's placement in foster care, or other circumstances, children may develop intense sadness, yearning for the attachment figure, and the longing to be reunified. A child with traumatic grief might develop persistent suicidal ideation in an attempt to effect a reunification with a deceased parent or other deceased attachment figure. Other children also experience concrete losses during their trauma and may develop significant sadness; for example, the child who is shot or hit by a car or one who is severely beat or burned during physical abuse often experiences physical pain as well as loss of function or damaged appearance of body parts. Sexual abuse may result in painful genital injuries and/or one or more sexually transmitted diseases. A fire or natural disaster may result in children's loss of personal belongings, their homes, or even the lives of loved ones. In the face of these real losses, children often develop maladaptive beliefs or cognitions (described below), which significantly contribute to depressive and other negative affective states. For example, children's developmentally appropriate egocentric view of the world may lead to self-blame for the traumatic event, which in turn may lead to depressive symptoms that include guilt, shame, diminished self-esteem, feelings of worthlessness, and even a longing to die. Negative self-image—an important issue for many traumatized children—can contribute to maladaptive choices in peers and romantic partners and self-destructive behaviors such as substance abuse, cutting, unsafe sexual

practices, and suicide attempts, all of which are strongly associated with a history of child abuse or other traumas. The bottom line: Significant sadness and other depressive symptoms may occur as part of PTSD Cluster D (negative change in affect).

Anger may result from the awareness that the traumatic event was unfair in the sense that the child didn't do anything to "deserve" the trauma. Other children, particularly those experiencing physical abuse or bullying, may develop anger as they observe the behavior of caretakers or others who cope inappropriately with difficulties or frustrations. Children experiencing domestic violence may develop "traumatic bonding" (Bancroft & Silverman, 2002, pp. 39–41), in which they align themselves with the abuser (described in more detail later in the chapter). Anger in traumatized children may take the form of noncompliant behavior, unpredictable rages or tantrums, or physical aggression toward property or other people. Children who have experienced sexual abuse may also engage in sexual aggression toward others. It is important to keep in mind that some children have significant anger or externalizing behavioral problems that predated traumatic events; this point again emphasizes the importance of conducting a careful assessment and case formulation in determining whether trauma treatment is appropriate for an individual child.

Severely or chronically traumatized children may become highly *sensitive* and *overreactive* to trauma reminders (e.g., behaviors or situations that they associate with previous traumas). For example, one study indicated that children who have been physically abused perceive angry faces (a trauma reminder for such children) much more readily than nonphysically abused children (Pine et al., 2005). Children with complex trauma commonly develop a dysfunctional degree of hypersensitivity or anger to perceived rejection because parental or other rejection in their past experience was associated with, and served as an early warning signal for, abusive or other traumatic acts. Severely traumatized children often display *affective dysregulation*, that is, sudden and/or extreme changes in affect accompanied by difficulty regaining affective modulation. Severe affective dysregulation occurs more commonly in children who have experienced multiple or complex trauma experiences as described below (e.g., child abuse or domestic violence), than in children who have experienced a single, nonintentional traumatic event. Far from receiving the nurturing, supportive, and well-modulated coping response from parents after the trauma that would model for children how to manage upsetting affective states, much complex trauma is perpetrated by parents who then disregard, invalidate, or even punish the child for displaying fear, sadness, or anger. For example, a child who witnessed domestic violence was told by his perpetrating parent to "shut up," which was followed by his battered mother smacking him and yelling at him. Thus the parents not

only failed to acknowledge the child's legitimate emotions, comfort, or soothe the child, or to model effective affective coping, but compounded the affective dysregulation by punishing the child.

Traumatized children also have neurobiological alterations, including chronic elevation of stress hormones and adrenergic neurotransmitters such as epinephrine (adrenaline) that increase the difficulty of modulating affect (DeBellis et al., 1999a). Thus, there may be both psychological and neurobiological components to affective dysregulation in chronically traumatized children.

Behavioral Trauma Symptoms

In an attempt to avoid painful feelings, children may develop behaviors that, although meant to protect them from pain, may lead to more difficulties. *Avoidance* of trauma reminders is a hallmark of PTSD. In order to escape overwhelming negative feelings, children may try to avoid trauma reminders such as thoughts, people, places, or situations that trigger recollection of their traumatic experiences. If these reminders extensively generalize, significant constriction of developmentally appropriate activities may occur and can lead to secondary problems. For example, a child who was sexually abused at night became generally fearful at night. As this fear became more generalized, she avoided being in unfamiliar settings at night, and became increasingly unable to tolerate situations that she previously enjoyed, including going for sleepovers at friends' homes. As a result she became increasingly socially isolated and sadder; she also began to think that the abuse occurred because "something is wrong with me, I don't have any friends." A gay youth was bullied, severely beaten, and sexually assaulted in the shower after physical education class in junior high school. He became avoidant of taking showers even at home. This led to problems with personal hygiene and even more bullying and social rejection, contributing to his serious suicide attempt.

It is usually difficult, if not impossible, for children to avoid all trauma reminders. For a child who witnessed ongoing domestic violence, both parents may be trauma reminders; for a child experiencing pervasive ongoing community violence, his/her whole neighborhood may become a trauma trigger. For children whose trauma reminders have become generalized to the point of being ubiquitous, avoidance is rarely a successful long-term management strategy. When avoidance is unsuccessful in protecting children from overwhelming negative emotions, they may develop emotional *numbing*, or in more severe cases, *dissociation*.

Trauma-related behaviors may also develop in response to modeling or traumatic bonding (Bancroft & Silverman, 2002). *Modeling* occurs when children who grow up in abusive or violent homes and communities have

many opportunities to observe and learn *maladaptive behaviors* and coping strategies. They may also see those behaviors being rewarded repeatedly. For example, a child who experiences physical abuse and domestic violence may erroneously conclude that anger and abuse are accepted ways of coping with frustration. If this child also sees the abusive parent as having control over the family's activities, emotional tone, finances, etc., whereas the battered parent is repeatedly injured and powerless, he/she may conclude that battering is an acceptable and even advantageous behavior. As another example, *sexualized behaviors* are modeled during sexual abuse; if the sexually abused child learns that these behaviors are rewarding (either through the power they confer to the abuser over the abused or because they are physically stimulating), this child may develop ongoing sexualized behaviors. A final example is that of a community bully or drug dealer. If such people are perceived as powerful and admired by others for being rewarded for their bullying, violent, or illegal behaviors, then children may conclude that these behaviors are desirable and therefore copy them, unless alternative positive models are present in their immediate environment.

Traumatic bonding involves both modeling of inappropriate behaviors and maladaptive attachment dynamics. It also involves acceptance of inaccurate explanations for inappropriate behaviors. It has been described in the psychoanalytic literature as identification with the aggressor and in law enforcement as the Stockholm syndrome. When children are under the control of a violent or aggressive parent and the other parent is ineffectual at self- or child protection, their natural needs for parental attachment and affiliation become distorted and conflicted. In this situation, it is difficult to remain equally affiliated with both parents without experiencing great confusion and conflict. Often such children both fear and love the abusive parent, and may have experienced abuse personally if they attempted to defend the abused parent. Such children may bond with the violent parent out of self-preservation. To manage the guilt and cognitive dissonance associated with turning against the victimized parent, these children may adopt the violent parent's views, attitudes, and behaviors toward the victimized parent and become abusive or violent themselves. For example, a parent who batters his/her spouse may blame the battering behavior on the battered parent (e.g., "If you had dinner ready on time, this never would have happened"), and the child who is traumatically bonded may display anger or aggression toward the battered parent for "making" the batterer perpetrate this episode of battering. Thus, it is clear that modeling and traumatic bonding can contribute to aggressive behaviors in traumatized children.

Traumatic bonding is also an issue among youth who have experienced commercial sexual exploitation. Such bonding often contributes to traumatic behaviors following commercial sexual exploitation, including

running away (returning to the exploiter and "the life"), substance abuse, stealing, lying, recruiting other youth into commercial sexual exploitation, and/or aggression toward other exploited youth to reinforce the exploiter's wishes or the hierarchy of his/her "stable." These behaviors are often related to the youth's cognitions about the perpetrator, as described in detail below.

Other trauma-related behaviors may emerge in children. For example, they often avoid healthy age-appropriate peer interactions, preferring to associate with kids who share emotional and behavioral problems. Their choice of friends likely relates to the negative self-image that many traumatized children develop, as discussed below; they may fear rejection by "normal" peers and find that associating with children experiencing similar situations, such as those with ongoing interpersonal maltreatment, feels more familiar or comfortable. The *anger* that many traumatized children develop is typically manifested through oppositional, aggressive, and/or destructive behaviors. Traumatized children are also at greater risk for *substance abuse*, which may be used as a strategy for avoiding trauma reminders, a way of coping with negative self-image, or may arise as a result of associating with other troubled children.

Self-injury, such as cutting, burning, or other forms of self-mutilation, as well as suicidal behaviors, are also associated with childhood trauma. Some self-injurious youth describe these as methods for reversing the numbness that they feel. For example, one youth said, "When I hurt from cutting myself, it's the only time I know that I am real." Others may be seeking attention that they feel unable to gain in more adaptive ways; still others may be reacting to the despair and unbearable pain they feel by truly trying to harm themselves. Some youth describe the cutting behavior as a means of managing anxiety. Other trauma-related *risk-taking behaviors* may include engaging in high-risk sexual behaviors; driving under the influence of drugs or alcohol; using guns or other weapons without considering the consequences; and various other reckless, high-risk behaviors that place the youth in circumstances in which there is a high likelihood of experiencing and/or causing serious injury or death. Reckless and self-destructive behaviors are such common traumatic outcomes that they have been included as a new PTSD diagnostic criterion in DSM-5 (American Psychiatric Association, 2013, p. 272). The serious dangerousness of some youth's behaviors warrants beginning TF-CBT with the enhancing safety component in order to diminish these behaviors and enhance their safety; in the most extreme cases (e.g., active suicidality), youth may require inpatient hospitalization to stabilize the dangerous behaviors prior to considering the initiation of trauma-focused treatment.

Another behavioral issue that is often overlooked is that of overfunctioning or "parentification." All too often, parental mental illness,

substance abuse, and/or situational factors contribute to children's trauma experiences. In these scenarios, one child in the family may take on caretaking tasks for younger children and/or a challenged or impaired parent. Over time, the family often comes to expect that one child to take on caretaking tasks and he/she comes to believe that this is his/her indispensable family role, both of which contribute to maintaining the child's overfunctioning. Often this parentification persists even if the child is removed from the home. Helping such children learn appropriate developmental functioning (i.e., to "be a child") is often an important treatment goal.

Cognitive Trauma Symptoms

Childhood trauma can also change children's (and parents') cognitions (thoughts) about themselves, the perpetrator(s) of trauma, other people, the social contract, and the world. Following a traumatic event, children typically search for an explanation for why something so terrible has happened to them or their loved ones. If no rational explanation is found, children may develop *inaccurate* or *irrational cognitions* about causation in order to gain some sense of control or predictability. A very common irrational belief involves children blaming themselves, either by taking responsibility for the event itself ("He sexually abused me because I wore a dress") or for not foreseeing and avoiding the event (e.g., "I should have known Dad would be in a bad mood—why didn't I warn Mom to be especially nice so he wouldn't have beaten her up?"; "I should have stopped my brother from going to school today so he wouldn't have gotten shot on the way home"). Alternatively, although not blaming themselves directly for the traumatic event, children may come to believe that they are bad, shameful, or otherwise lacking in some way that "justifies" bad things happening to them (e.g., "I must be stupid for this to have happened to me"). In this manner the world remains fair, predictable, and makes sense; it is only *they* who are deserving of bad fortune. Children exposed to ongoing interpersonal trauma (e.g., child abuse or neglect, domestic violence) seem particularly prone to these types of cognitions, perhaps because these acts are intentional, personally directed, and typically perpetrated by parents or other adults who would ordinarily be expected to protect rather than harm children. Developing realistic cognitions of responsibility (i.e., blaming the parent perpetrator) is often more difficult and painful for children than blaming themselves.

Other inaccurate cognitions may develop in relation to other people (i.e., to nonperpetrators). Children may generalize their experience of betrayal by one person to mean that *no one* is trustworthy. This belief can lead to difficulties in peer relationships or in the child's attachment to

the nonoffending parent and other adults, which may further contribute to the child's impaired self-image (i.e., the child undermines these relationships, then attributes the disappointment to his/her own personal failings). Alternatively, children may respond to a betrayal of trust by repeatedly trying to "correct" or reverse their experience by seeking out inappropriately close relationships with peers or adults who may or may not be safe. This strategy often leads to additional painful experiences in the form of repeated maltreatment or through rejection of the child's inappropriate or unwarranted expectations for closeness. After experiencing sexual abuse, some children develop the maladaptive cognition that "the only way anyone will love me is if I am sexual with them." Finkelhor & Browne (1985) described this as "traumatic sexualization" and considered it a fundamental dynamic of sexual abuse. A large majority of youth that experiences commercial sexual exploitation has a past history of interpersonal trauma, with research documenting that more than 70% of these youth report a history of child sexual abuse (West Coast Children's Clinic, 2012). It is very common for youth who are experiencing commercial sexual exploitation to initially describe the exploiter as a "boyfriend" rather than a perpetrator, and as the person who "cares more about me than anyone else ever has." Underlying these descriptions are often long-standing maladaptive cognitions about what it means to be involved in a loving relationship—for example, "The more someone loves you, the worse he hurts you"; "Every good relationship has some violence"; or "Beating me is just his way of showing that he cares about me." Adjusting these beliefs is a critical component for successfully treating these youth (Cohen, Mannarino, & Kinnish, 2016).

Traumatized children may also develop cognitions that contribute to their loss of faith in justice, God, or a benign future. This line of thinking can lead to behavioral choices that become "self-fulfilling prophecies." For example, a teen's older brother and several friends died following acts of community violence, contributing to his maladaptive belief that since it was unlikely that he was going to live to see his own 20th birthday, what was the point of trying to live a productive life. As a result, he began to use drugs, joined a gang, and dropped out of school. These behaviors greatly diminished his chances of experiencing a positive future; in addition to experiencing multiple new traumas, he was convicted of serious drug and gun charges, leading to a several-year prison sentence. His own negative expectations or "prophecy" of self-failure led to the very failure he feared.

As noted earlier, separation from attachment figures and loss of family roles are often salient issues for children who experience interpersonal traumas, but the degree to which these become traumatic may be strongly influenced by the child's cognitions related to these issues.

For example, after a 13-year-old disclosed sexual abuse by her father, her father denied the abuse. No one in father's family believed that the father abused her. She was always closer to her paternal grandparents and was the godmother to her young nephew, whom she was no longer allowed to see. The girl was devastated by the loss of her paternal grandparents and especially by not being allowed to see her godchild, for whom she used to babysit weekly. Her cognitions were, "It's my fault. Being abused wasn't so bad. I should have kept it secret like he told me to. Now I've lost everything."

In addition to the above illustrations of inaccurate cognitions, children may develop *accurate but unhelpful cognitions.* Unhelpful thoughts can also contribute to negative affective states and behaviors because they are not contextualized to accurately reflect reality, or they focus only on the negative aspects of situations. For example, the cognition "You never know who will sexually abuse you" might be true in a given environment, but equally true is the alternative cognition, "Most men do not sexually abuse children." It is clear that the first thought is likely to promote fear and avoidance, whereas the second, equally accurate thought is more reassuring and hopeful. Traumatized children often focus on inaccurate and/or unhelpful cognitions that reinforce their negative expectations of others and their destructive self-views. These cognitive symptoms contribute significantly to the maintenance of PTSD, other forms of anxiety, and depressive and behavioral difficulties.

Interpersonal Trauma Symptoms

Children who experience trauma often develop changes in their interpersonal relationships. In milder forms, children may withdraw from peers or have difficulty enjoying usual activities. Over time, this tendency to withdraw may interfere with social interactions to varying degrees. Children who feel shame or stigma related to their trauma experiences may not share these even with very close friends, leading to a change in the tenor of such friendships at times when children are in even greater need of close friends. A girl who was sexually abused by her uncle when sleeping over at his house disclosed to her parents, who told her not to talk about it to anyone because it was "a secret that needs to stay in the family." The girl felt ashamed and confused, and developed a fear of sleeping away from home. She stopped sleepovers with her best friend, who was hurt that her repeated invitations to sleep over were refused; her friend believed that the girl no longer wanted to be friends with her, and the girl lost her best friend at the very time when she really needed a best friend. This girl thus experienced separation distress from losing multiple attachment figures (both her favorite aunt, the wife of the perpetrator, whom she was no

longer allowed to visit, and her best friend, who believed she no longer wanted to be friends). She lost her identities as a niece and a best friend, both of which were important to her. Her parents communicated to her that she had lost her virginity and would not be desired by "nice" boys as a result of what had happened to her—yet another loss of identity for the girl.

Parents who perpetrate severe and ongoing interpersonal traumas (e.g., child abuse or neglect; domestic violence) also disrupt the primary child–parent attachment relationship upon which children learn and model future trusting interpersonal relationships. The result of such disruption is typically profound: These children often experience ongoing challenges when attempting to establish new relationships, since the possibility of any trusting relationship itself serves as a trauma reminder of the parent who perpetrated the initial trauma(s). As noted above, after trauma experiences, some youth feel that their usual peers will not understand their experiences, and they begin to affiliate with deviant peers based on the assumption that only these youth can relate to their feelings of being different and "on the outside." Such affiliation can place the youth at heightened risk for additional trauma exposure and the development of more severe trauma responses.

Complex PTSD

In the face of early interpersonal traumas, particularly those that are perpetrated by caregivers (e.g., child maltreatment, domestic violence), some children develop severe and pervasive dysregulation across multiple domains of functioning. The diagnosis of PTSD is a relatively new one, having only been introduced into the DSM in 1980. There have been various initiatives to evaluate the need to include a complex PTSD subtype versus whether a separate disorder (e.g., developmental trauma disorder) should be included for individuals who develop complex trauma outcomes related to childhood experiences of trauma. The DSM-5 does not include a formal diagnosis of complex PTSD, but the 11th edition of the *International Classification of Diseases* (ICD-11; World Health Organization), due out in 2018, will include this diagnosis. Differences between complex PTSD and PTSD will be noted as follows: (1) Individuals with complex PTSD must have experienced chronic (typically interpersonal) trauma; and (2) in addition to core PTSD features of intrusion, avoidance, and sense of threat, individuals with complex PTSD must also exhibit prominent features of affective dysregulation, negative self-concept, and interpersonal disturbance (Cloitre, Garvert, Brewin, Bryant, & Maercker, 2013). Youth with complex PTSD also prominently exhibit dissociation, biological dysregulation, and risky behaviors.

Although there is still no single instrument that assesses complex trauma outcomes in children and adolescents, TF-CBT treatment studies have generally examined multiple domains of functioning that correspond with those associated with complex trauma impact. Since TF-CBT was originally developed to treat children who had experienced sexual abuse (a prototypical complex trauma experience), it should not be surprising that TF-CBT has been effective for addressing the problems experienced by youth who have complex trauma. As described in Chapter 4, several studies have documented positive outcomes for youth with complex trauma experiences and impact, following TF-CBT treatment (e.g., Cohen, Deblinger, et al., 2004; Cohen et al., 2016; McMullen et al., 2013; Murray et al., 2015; O'Callghan et al., 2013). A new study completed in eight community clinics across Germany specifically compared children who met the proposed ICD criteria for complex PTSD to those who met the criteria for PTSD: Both groups experienced significantly greater improvement from TF-CBT than children randomized to a wait-list control condition, with parallel improvements between the complex PTSD and PTSD subgroups of children (Goldbeck et al., 2016). These studies suggest that the efficacy of TF-CBT applies to children who have complex PTSD as well as for more typical PTSD symptoms. More information about how to implement TF-CBT with youth who have complex trauma is described in the following chapters and elsewhere (Cohen, Mannarino, Kliethermes, et al., 2012).

Biological Trauma Symptoms

Children's brains and bodies are integrally involved in the development and manifestation of emotions, cognitive processes, and behaviors. It is important to understand that everything a person does, thinks, or feels, however transient or inconsequential, is associated with brain activity. Thus it is not surprising that trauma has the potential to alter brain functioning. When these changes in brain functioning are maintained over a long period (in some cases, long after the traumatic events have ended), they may contribute to the maintenance of many of the trauma symptoms described earlier. In some cases, these chronic functional alterations may also contribute to *structural* changes in the brain.

The physical structure of the brain is dynamic—which means that, within limits, *brain structure interacts with brain functioning*. For example, the number of receptors in the brain for different neurotransmitters can be increased or decreased in response to many factors, including stress. Stress is known to change neurotransmitter and hormonal activity both in the brain and in other parts of the body (e.g., adrenal glands), which

in turn produce physiological responses such as increased heart rate, respiration, and blood pressure; diversion of blood flow to skeletal muscles; and increased alertness. Childhood trauma, and PTSD in particular, are associated with chronic changes in these areas of physiology; that is, traumatized children may have higher resting pulse rates and blood pressure, greater physical tension, and hypervigilance. Other alterations in brain function and structure have been documented in traumatized children, particularly those who have experienced interpersonal traumas such as child abuse or domestic violence. For example, in one study, children who had a history of sexual abuse, physical abuse, or exposure to domestic violence were found to have smaller intracranial volume (brain size), lower IQs, poorer grades, smaller corpus collosi (the part of the brain that connects the right and left hemispheres), and higher dissociation scores than children who did not have such trauma histories. Furthermore, the severity of these changes was correlated with the length of time the maltreatment had occurred (DeBellis et al., 1999b).

Given that the function and structure of the brain are interactive with our life experiences, thoughts, feelings, and behaviors, it would make sense that a return to more adaptive psychological functioning would be associated with corresponding normalization of brain function and, perhaps, structure. This line of thinking suggests that therapeutic (or other) interventions that result in reregulation of children's emotional, cognitive, and behavioral functioning can minimize or reverse the adverse impact of trauma on their brains and bodies. Specifically, just as new neurobiological connections develop after trauma experiences, new responses can be learned that can compete with these fear responses. Practicing these new, more resilient responses over time can lead to extinction of fear responses (Craske et al., 2008).

Some professionals advocate the view that only certain types of therapeutic activities (e.g., directed eye movements or body therapy techniques) can access pathways for brain changes and that CBT and other "talk" therapies cannot create meaningful brain or bodily changes in traumatized children. We believe that it is possible to restore adaptive psychobiological functioning in a variety of ways, including through the TF-CBT model. We are currently collaborating with colleagues at several academic institutions across the United States to evaluate the neurobiological impact of TF-CBT, and we welcome well-designed neurobiological studies using other treatment modalities for traumatized children. Research into the neurobiology of trauma treatment is in early stages, and it is premature to draw scientific conclusions about the neurobiological impact of child trauma treatment. However, even if trauma-related functional or structural brain changes do not reverse,

as predicted in response to TF-CBT and other forms of psychotherapy, this will not diminish the value of psychotherapy in reducing children's psychological symptoms and improving their adaptive functioning and quality of life.

Traumatic Grief in Children

Children may develop traumatic grief following the death of an important attachment figure, manifest by significant trauma symptoms that interfere with typical grief responses. In childhood traumatic grief, the child's experience of the death leads to the development of the trauma symptoms described above, as well as complicated or maladaptive grief responses. This dynamic is described in more detail below.

Childhood traumatic grief may occur following unexpected, violent, or accidental deaths, such as those from motor vehicle or other accidents, homicide, suicide, natural disasters, war, or acts of terrorism. However, children can also develop traumatic grief after deaths that are not unexpected, violent, or sudden. For example, a study of school-age children and adolescents showed that those who experienced the death of a parent due to a prolonged illness were *more* likely to develop PTSD and maladaptive grief symptoms than those who experienced the death of a parent due to sudden natural causes (e.g., heart attacks) (Kaplow, Howell, & Layne, 2014). This finding suggests that children may develop childhood traumatic grief after many different types of deaths, including those that might not be judged objectively to be "traumatic."

Uncomplicated Grief

Individuals' grief responses vary, and there is no single "right" or "normal" way to grieve following the death of an important attachment figure. *Uncomplicated* ("typical") *grief* refers to the process of grieving that is experienced by most children following the death of an important attachment figure. Uncomplicated grief resembles major depressive disorder (MDD), with several notable differences (American Psychiatric Association, 2013, p. 126). For example, in grief the main feelings are emptiness, sadness, and longing for the deceased person, whereas in MDD the predominant feeling is persistent depressed mood and lack of happiness or pleasure (anhedonia). The negative affect associated with grief typically decreases gradually over days to weeks, and also comes in waves or "pangs" that are often associated with reminders of the person or his/her death, and the sadness is interspersed with positive memories about the deceased person.

In contrast, the negative affect of MDD is persistent and is not connected to specific thought content. In typical grief, the child does not have guilt or poor self-esteem, whereas these features are characteristic of MDD. If the child is preoccupied with death as part of typical grief, it is due to a desire to join the deceased loved one, not because of a true desire to die; in MDD thinking about ending one's own life is related to feelings of worthlessness or inability to cope with the pain of depression. Interestingly, a population-based study recently documented that children who experienced parental death remained at increased risk for suicide for at least 25 years, especially for boys (Guldin et al., 2015). It is not clear whether or not some of these children had traumatic grief.

Although early writings suggested that there are standard *stages* of grieving, as described by Kübler-Ross and others, more recent conceptualizations describe *tasks* of typical child grief (Worden, 1996; Wolfelt, 1991). Children accomplish these tasks in different ways, different sequences, and over variable periods. Generally, when grieving children address these tasks without significant barriers or complications, they are considered to have typical grief. These tasks include (1) experiencing the deep pain associated with the death of the deceased; (2) accepting the permanence of the death (appropriate to the child's developmental abilities); (3) reminiscing about and accepting the totality of the deceased person; (4) converting the relationship from one of interaction to one of memory; (5) incorporating important positive aspects of the deceased into the child's own self-identity; (6) committing to positive relationships in the present; and (7) regaining a healthy developmental trajectory.

Complicated Grief Responses

There is ongoing controversy about how and at what point to differentiate "typical" from "complicated" grief responses (e.g., Melhem, Porta, Payne, & Brent, 2013). It is important to balance the desire to avoid providing unneeded treatment (e.g., to children whose typical grief responses would spontaneously resolve) with the equal desire to prevent unnecessary suffering from treatable problems (e.g., PTSD or other symptoms that carry potentially long-term risks). It has been challenging to determine which children fall into which category, and how soon after a death this distinction can be made.

Different terms and conceptual frameworks have been used to describe atypical grief responses, including *complicated grief*, *maladaptive grief*, and *traumatic grief*. For example, DSM-5 proposes a condition for further study, prolonged complex bereavement disorder, which requires a specified number of symptoms in each of three distinct symptom clusters

(separation distress, reactive distress to the death, and social/identity disruption) (American Psychiatric Association, 2013, p. 790; Kaplow, Layne, Saltzman, Cozza, & Pynoos, 2013). Interestingly, these symptom clusters also characterize other types of interpersonal traumas, as described earlier in this chapter. An assessment instrument for this disorder is described in Chapter 2. In this proposed condition, traumatic bereavement is restricted to deaths due to homicide or suicide, "with persistent distressing preoccupations regarding the traumatic nature of the death" (American Psychiatric Association, 2013, p. 790).

An alternative approach for understanding and assessing children's complicated grief responses uses the Inventory of Complicated Grief—Revised for Children (ICG-RC), which does not divide symptoms into three distinct clusters but combines all of the symptoms into one continuous score. This approach was found to be significantly superior to the proposed DSM-5 criteria for identifying children who develop complicated grief responses after parental death (Melhem, Porta, Shamsedden, Payne, & Brent, 2011; Melhem et al., 2013). Melhem and colleagues (2013) provide an assessment and a brief screening instrument for identifying children at risk for developing complicated grief, described in Chapter 2.

Childhood Traumatic Grief

Consistent with our focus on treating childhood traumatic responses, we use the term "traumatic grief." This is supported by data documenting that a substantial proportion of bereaved children develop trauma symptoms and maladaptive grief symptoms (Kaplow et al., 2014; Melhem et al., 2004, 2011, 2013; Melhem, Walker, Moritz, & Brent, 2008; Wilcox et al., 2010), and that providing sequential TF-CBT trauma- and grief-focused interventions significantly improves trauma and maladaptive grief symptoms, respectively (Cohen, Mannarino, & Knudsen, 2004; Cohen, Mannarino, & Staron, 2006; O'Donnell et al., 2014). For example, one study showed that about 40% of children had significantly elevated complicated grief, PTSD, depression, and anxiety scores at 9 months after parental death; furthermore, 10% of children had complicated grief, PTSD, depression, and anxiety scores that remained high 33 months after parental death (Melhem et al., 2011). We believe these children can benefit from effective mental health treatment to mitigate the negative impact of trauma symptoms and to enhance their ability to grieve in a more typical manner. From both our theoretical understanding of the origins of traumatic grief and these data, we believe that providing the trauma- and grief-focused components of TF-CBT sequentially is likely to resolve children's traumatic grief symptoms. However, as noted above, our conceptualization of

children's traumatic grief is broader than the proposed DSM-5 definition (i.e., that traumatic grief may develop following deaths from a variety of causes, not only homicide or suicide) (American Psychiatric Association, 2013). We have often seen traumatic grief in young children who did not anticipate or understand that their parent or sibling was going to die from a serious illness. In many cases, seeing and hearing vivid images of the dying person and other family members' suffering was highly frightening (and may have been confusing or disorienting as well). In other cases, the attachment and loss of role are most prominent in the child's traumatic grief. For example, one girl helped her younger brother with homework and took her brother to friends' homes while their mother worked long hours. When this brother was diagnosed with cancer, the girl watched as her brother deteriorated and was present when her brother died. The mother became extremely depressed and emotionally unavailable after her son's death. The girl had repeated intrusive images and nightmares about her brother's death, avoided mentioning or reminiscing about him, and blamed herself for "not saving" her brother. She developed somatic symptoms at school and her grades fell. In our conceptualization, she had traumatic grief, with significant trauma symptoms that were interfering with her adaptive functioning and ability to negotiate tasks of normal grief related to her brother's death. Despite her prominent PTSD symptoms, her lost/disrupted attachments (with brother and mother, respectively) and lost identity as a "big sister" or family caregiver were most immediately distressing to her. When treating children with traumatic grief, it is important to be cognizant of these issues and to address them along with PTSD symptoms. Including this girl's mother in treatment was essential in this regard, and emphasizes again the critical role of parents in TF-CBT treatment.

In summary, there is controversy about how to define and measure maladaptive grief in children. When children develop death-related trauma symptoms that interfere with their ability to negotiate tasks of typical grieving as described above, we call this "childhood traumatic grief." It is likely that most of these children will benefit from sequential TF-CBT trauma- and grief-focused treatment.

Trauma- and Grief-Focused Treatment

Based on the work of many authors as well as our clinical experience, it appears that when trauma and grief symptoms are both present, it is advisable, and often essential, to address and at least partially resolve the

trauma issues before the grief issues can be successfully addressed (Nader, 1997; Rando, 1996; Layne, Saltzman, Savjak, & Pynoos, 1999; Cohen, Mannarino, & Knudsen, 2004; Cohen et al., 2006). This principle may be particularly applicable for certain traumatic reminders; for example, when a child is fixated on the most horrifying aspects of the death, does not have accurate information about how the person died, and/or has maladaptive cognitions related to the death (e.g., self-blame). Often in such children even positive memories of the deceased (an important aspect of negotiating the grief process) segue into traumatic reminders—that is, these children can't think of the deceased without remembering the terrifying details of the death and getting stuck on negative thoughts and feelings related to the death. Additionally, children who have avoidance symptoms may be so detached from their feelings that they are unable to experience their grief. For these reasons, some trauma-focused interventions are typically utilized in the beginning phase of treating childhood traumatic grief, with grief issues addressed later in treatment. However, individual children progress at their own pace and on their own path. Some children will resolve most or all trauma symptoms before moving on to grief issues, but many children will need to intersperse grief and trauma work, according to which issues are most problematic at different times. Thus, the trauma and grief phases of treatment may be interwoven, as clinically indicated.

External factors may also influence the phasing of treatment. For example, investigation, media attention, or litigation related to the deceased's death, or an intervening traumatic event or familial death (even if by natural causes), may retrigger traumatic reminders, excessive avoidance, anger, or other PTSD symptoms that had previously dissipated. Returning to trauma-focused interventions may be warranted in such situations. In order to address trauma and grief issues sequentially, we present trauma-focused components and grief-focused components separately in this book.

Summary

Although some children who experience traumatic events are resilient, many others develop trauma symptoms that can have a profound and long-lasting negative impact on their development, health, and safety. These trauma symptoms include affective, behavioral, biological, interpersonal, cognitive, and complex trauma problems, among others. Regardless of the child's diagnosis, trauma-related difficulties have significant

negative impacts on child and family functioning. Children may develop childhood traumatic grief, a condition in which children develop trauma symptoms that interfere with typical grief and lead to maladaptive grief responses. The trauma- and grief-focused TF-CBT components described in this book help children with these types of difficulties. The next chapter focuses on assessing children who have experienced traumatic stress and/or traumatic grief reactions, and how to determine whether TF-CBT is an appropriate treatment approach for a particular child.

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