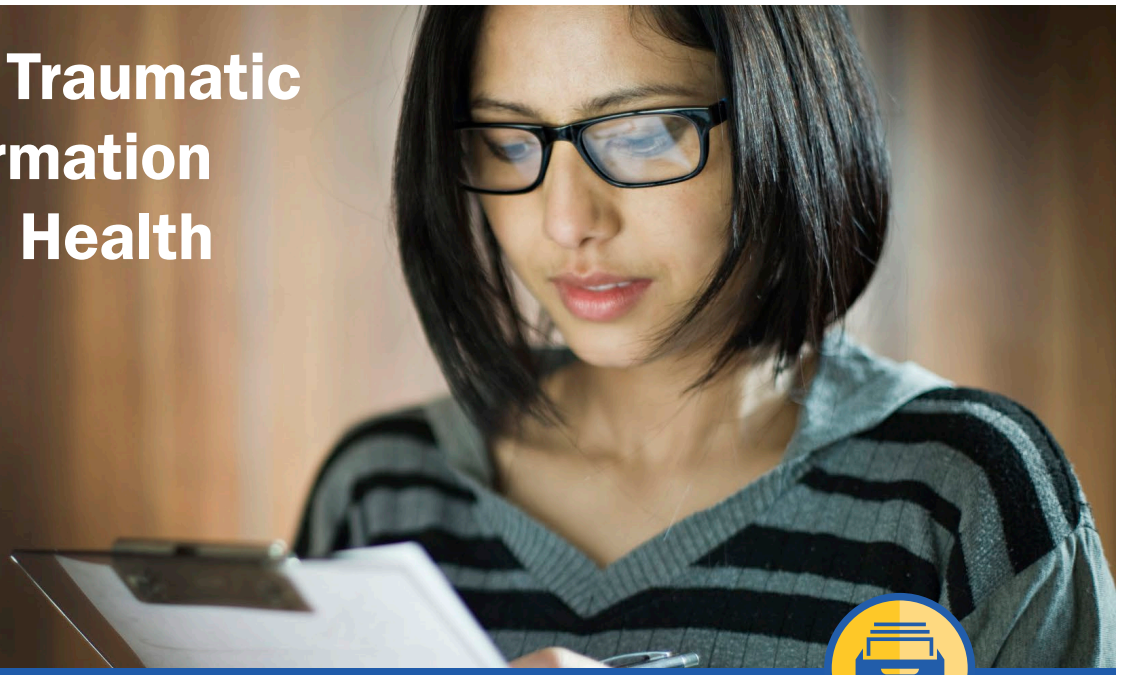**NCTSN** The National Child Traumatic Stress Network

# Childhood Traumatic Grief: Information for Mental Health Providers

## Why are mental health providers important for grieving children?

Following a death, children and teens may be referred to mental health professionals with bereavement as the presenting problem. At other times, grieving youth may be referred for other reasons, and no one (including the child, the parent, and others) has recognized that grief is playing a significant contributing role. It is therefore important that mental health professionals are prepared to recognize cases in which youths' grief reactions to bereavement may be impacting a child's functioning.

### 1    How do children grieve?

Children of all ages grieve after the death of a family member, friend, or other important person. Grieving children can show a range of emotions and reactions. Sometimes they appear sad and talk about missing the person. Other times they play, interact with friends, and do their usual activities. In addition to intense sadness, children may show changes in behavior (e.g., be less interested in usual activities, be irritable, have changes in sleeping or eating habits), changes in their social interactions (e.g., be more withdrawn), and/or question their faith. When adjusting to the loss, children are typically able to participate in "tasks" considered helpful to the grieving process:

- Understanding the person cannot come back
- Coping with feelings about the person and the death
- Adjusting to changes in life without the person
- Talking about memories and what that person meant to them
- Committing to relationships with new people
- Continuing on a healthy developmental path

## 2    What is Childhood Traumatic Grief?

In Childhood Traumatic Grief, children have traumatic stress reactions to a death which interfere with their ability to accomplish the tasks of bereavement. Even happy thoughts and memories of the person remind children of the distressing way the person died. A younger child may be afraid to sleep alone at night due to nightmares about a shooting that she witnessed, while an older child may avoid playing on the school baseball team his father used to coach because it brings up painful thoughts about his father's death in a terrible car accident. These children get "stuck" on the traumatic aspects of the death and cannot process their grief successfully. When children with Traumatic Grief have scary thoughts, upsetting memories, and negative feelings related to how the person died, they may also have uncomfortable physical symptoms. To control and minimize the unpleasant feelings and reactions, they try to avoid the scary memories; avoid talking or thinking about anything related to the person or way the person died; and also avoid people, places, or things that trigger upsetting thoughts and feelings. These reactions and the fear of stirring up scary reminders make it difficult to remember positive things or to talk about the person and what the person meant to them.

## 3    Who develops Childhood Traumatic Grief?

Most children recover and adjust to the death of a family member, friend, or other important person. But a smaller number will develop Childhood Traumatic Grief, which can occur following a death from sudden, unexpected causes such as a homicide or suicide, mass shooting, disaster, accident, or an unexpected medical condition such as a heart attack. However, children can also develop symptoms even if the death was due to natural causes, advanced age, or a terminal illness such as cancer, especially if the child was surprised or scared by the death or was witness to complex or frightening medical procedures.

## 4    What are the signs a child might have Childhood Traumatic Grief?

Grief related traumatic stress reactions may include the following:

- Intrusive reactions such as upsetting thoughts, images, nightmares, memories, or play about the frightening way the person died

- Physical or physiological distress such as headaches, stomachaches, symptoms mimicking the way the deceased died, jumpiness, trouble concentrating

- Avoidance reactions such as withdrawal; acting as if not upset about the death; or avoiding reminders of the person, the way the person died, places or things related to the person, or events that led to the death

- Negative mood or beliefs related to the traumatic death such as anger, guilt, shame, self-blame, loss of trust, believing the world is unsafe

- Increased arousal such as irritability, anger, trouble sleeping, decreased concentration, dropping grades, increased vigilance, and fears about safety of oneself or others; self-destructive or risk-taking behaviors (e.g., substance abuse, suicidality)

## 5     How does Childhood Traumatic Grief impact Children?

Childhood Traumatic Grief can have a significant impact on children's mental and physical health and be indicated by the following:

- Depressed affect
- New behavior problems or worsening of existing psychiatric problems
- Regressive behavior, such as increased separation anxiety
- Changes in eating or sleeping patterns
- Changes in school performance
- Self-injurious or suicidal behaviors
- Drug and alcohol use or other risky behaviors
- New or intensified somatic symptoms with no clear underlying medical cause
- Symptoms related to the person's cause of death (e.g., having chest pain following the person's heart attack)
- Loss of interest in friends and/or usual activities
- Delinquent behavior or associating with problematic peers
- Isolation from others
- Conflict with friends or family members

## 6     What can you do to help children with Traumatic Grief?

Children with Childhood Traumatic Grief often avoid talking about death or the person who died. To evaluate the presence of Childhood Traumatic Grief, mental health providers can do the following:

- Explore the child's responses to the death, as well as the parent/caregiver's adjustment.
- Ask about past deaths that may have been unaddressed and new stress reactions parent has noticed.
- Explore with children and caregivers what and how the child learned and knows about the cause of death and how adults explained the death to the child.
- Routinely and directly ask children about their experiences with trauma, death, and upsetting or scary events. Not asking may inadvertently communicate to the child that it is unacceptable to discuss these things with adults.
- Assess children for Traumatic Grief if indicated using a validated instrument[1]
- Be aware that traumatic grief symptoms may mimic behavioral or emotional problems (e.g., ADHD, depression, anxiety) that commonly occur in school settings and consider that these symptoms may signify traumatic grief
- If your questions make the child's symptoms worse, consider that specific trauma related intervention may be needed (see information below).
- Pay particular attention to children who have experienced traumas in addition to the death of an important person, as exposure to other trauma may worsen Traumatic Grief symptoms.
- Be aware that children may minimize trauma symptoms to protect their parents or to avoid reminders of the trauma.
- Provide psychoeducation about the interaction of trauma and grief to the child and parent/caregiver. Keep materials on hand to educate parents about Childhood Traumatic Grief (available at https://www.nctsn.org/what-is-child-trauma/trauma-types/traumatic-grief)
- Communicate with school professionals about how Traumatic Grief may affect performance.
- Address safety concerns, and help the child develop strategies and skills to aid in coping with trauma reminders.
- Assure the child and parent that the child can fully recover with effective treatment.

- Seek out additional training, resources, or referrals to provide evidence-based treatment for Childhood Traumatic Grief. Currently two treatment models have scientific evidence of helping children recover from Childhood Traumatic Grief:

  Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for children ages 3-18 years and parents or primary caregivers provided in 12-15 individual or group sessions. More information is available at https://www.nctsn.org/interventions/trauma-focused-cognitive-behavioral-therapy

  - Trauma Grief Components Therapy for Adolescents (TGCT-A) for teens ages 13-17 years, provided in groups. More information is available at https://www.nctsn.org/interventions/trauma-and-grief-component-therapy-adolescents

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**Where do you find additional information and help?**

Additional information for children, parents, professionals, pediatricians, and educators is available at the National Child Traumatic Stress Network, www.NCTSN.org with materials specific to Traumatic Grief at www.nctsn.org/trauma-types/traumatic-grief.

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1. Footnotes
   Brown, EJ, Goodman, RF, Falk, S & Swiecicki, CC (2019). Psychometrics of the PTSD and depression screener for bereaved youth. Death Studies, 43, 20-31.

# ABOUT CHILD TRAUMA

## What Is a Traumatic Event?

A traumatic event is a frightening, dangerous, or violent event that poses a threat to a child's life or bodily integrity. Witnessing a traumatic event that threatens life or physical security of a loved one can also be traumatic. This is particularly important for young children as their sense of safety depends on the perceived safety of their attachment

figures.

Traumatic experiences can initiate strong emotions and physical reactions that can persist long after the event. Children may feel terror, helplessness, or fear, as well as physiological reactions such as heart pounding, vomiting, or loss of bowel or bladder control. Children who experience an inability to protect themselves or who lacked protection from others to avoid the consequences of the traumatic experience may also feel overwhelmed by the intensity of physical and emotional responses.

Even though adults work hard to keep children safe, dangerous events still happen. This danger can come from outside of the family (such as a natural disaster, car accident, school shooting, or community violence) or from within the family, such as domestic violence, physical or sexual abuse, or the unexpected death of a loved one.

## What Experiences Might Be Traumatic?

- Physical, sexual, or psychological abuse and neglect (including trafficking)
- Natural and technological disasters or terrorism
- Family or community violence
- Sudden or violent loss of a loved one
- Substance use disorder (personal or familial)
- Refugee and war experiences (including torture)
- Serious accidents or life-threatening illness
- Military family-related stressors (e.g., deployment, parental loss or injury)

When children have been in situations where they feared for their lives, believed that they would be injured, witnessed violence, or tragically lost a loved one, they may show signs of child traumatic stress.

## What Is Child Traumatic Stress?

Children who suffer from child traumatic stress are those who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their daily lives after the events have ended. Traumatic reactions can include a variety of responses, such as intense and ongoing emotional upset, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, problems relating to others or forming attachments, regression or loss of previously acquired skills, attention and academic difficulties, nightmares, difficulty sleeping and eating, and physical symptoms, such as aches and pains. Older children may use drugs or alcohol, behave in risky ways, or engage in unhealthy sexual activity.

Children who suffer from traumatic stress often have these types of symptoms when reminded in some way of the traumatic event. Although many of us may experience reactions to stress from time to time, when a child is experiencing traumatic stress, these reactions interfere with the child's daily life and ability to function and interact with others. At no age are children immune to the effects of traumatic experiences. Even infants and toddlers can experience traumatic

stress. The way that traumatic stress manifests will vary from child to child and will depend on the child's age and developmental level.

Without treatment, repeated childhood exposure to traumatic events can affect the brain and nervous system and increase health-risk behaviors (e.g., smoking, eating disorders, substance use, and high-risk activities). Research shows that child trauma survivors can be more likely to have long-term health problems (e.g., diabetes and heart disease) or to die at an earlier age. Traumatic stress can also lead to increased use of health and mental health services and increased involvement with the child welfare and juvenile justice systems. Adult survivors of traumatic events may also have difficulty in establishing fulfilling relationships and maintaining employment.

# Reminders and Adversities

Traumatic experiences can set in motion a cascade of changes in children's lives that can be challenging and difficult. These can include changes in where they live, where they attend school, who they're living with, and their daily routines. They may now be living with injury or disability to themselves or others. There may be ongoing criminal or civil proceedings.

Traumatic experiences leave a legacy of reminders that may persist for years. These reminders are linked to aspects of the traumatic experience, its circumstances, and its aftermath. Children may be reminded by persons, places, things, situations, anniversaries, or by feelings such as renewed fear or sadness. Physical reactions can also serve as reminders, for example, increased heart rate or bodily sensations. Identifying children's responses to trauma and loss reminders is an important tool for understanding how and why children's distress, behavior, and functioning often fluctuate over time. Trauma and loss reminders can reverberate within families, among friends, in schools, and across communities in ways that can powerfully influence the ability of children, families, and communities to recover. Addressing trauma and loss reminders is critical to enhancing ongoing adjustment.

# Risk and Protective Factors

Fortunately, even when children experience a traumatic event, they don't always develop traumatic stress. Many factors contribute to symptoms, including whether the child has experienced trauma in the past, and protective factors at the child, family, and community levels can reduce the adverse impact of trauma. Some factors to consider include:

- **Severity of the event.** How serious was the event? How badly was the child or someone she loves physically hurt? Did they or someone they love need to go to the hospital? Were the police involved? Were children separated from their caregivers? Were they interviewed by a principal, police officer, or counselor? Did a friend or family member die?
- **Proximity to the event.** Was the child actually at the place where the event occurred? Did they see the event happen to someone else or were they a victim? Did the child watch the event on television? Did they hear a loved one talk about what happened?
- **Caregivers' reactions.** Did the child's family believe that he or she was telling the truth? Did caregivers take the

child's reactions seriously? How did caregivers respond to the child's needs, and how did they cope with the event themselves?

- **Prior history of trauma.** Children continually exposed to traumatic events are more likely to develop traumatic stress reactions.

- **Family and community factors.** The culture, race, and ethnicity of children, their families, and their communities can be a protective factor, meaning that children and families have qualities and or resources that help buffer against the harmful effects of traumatic experiences and their aftermath. One of these protective factors can be the child's cultural identity. Culture often has a positive impact on how children, their families, and their communities respond, recover, and heal from a traumatic experience. However, experiences of racism and discrimination can increase a child's risk for traumatic stress symptoms.

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## Core Curriculum on Childhood Trauma

# The 12 Core Concepts

## Concepts for Understanding Traumatic Stress Responses in Children and Families

NCTSN  The National Child Traumatic Stress Network

### The National Child Traumatic Stress Network

Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) brings a singular and comprehensive focus to childhood trauma. NCTSN's collaboration of frontline providers, researchers, and families is committed to raising the standard of care while increasing access to services. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and dedication to evidence-based practices, the NCTSN changes the course of children's lives by changing the course of their care.

### Citation

NCTSN Core Curriculum on Childhood Trauma Task Force (2012). *The 12 core concepts: Concepts for understanding traumatic stress responses in children and families. Core Curriculum on Childhood Trauma*. Los Angeles, CA, and Durham, NC: UCLA-Duke University National Center for Child Traumatic Stress.

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# 12 Core Concepts for Understanding Traumatic Stress Responses in Childhood

## 1. Traumatic experiences are inherently complex.

Every traumatic event—even events that are relatively circumscribed—is made up of different traumatic moments. These moments may include varying degrees of objective life threat, physical violation, and witnessing of injury or death. Trauma-exposed children experience subjective reactions to these different moments that include changes in feelings, thoughts, and physiological responses; and concerns for the safety of others. Children may consider a range of possible protective actions during different moments, not all of which they can or do act on. Children's thoughts and actions (or inaction) during various moments may lead to feelings of conflict at the time, and to feelings of confusion, guilt, regret, and/or anger afterward. The nature of children's moment-to-moment reactions is strongly influenced by their prior experience and developmental level. Events (both beneficial and adverse) that occur in the aftermath of the traumatic event introduce additional layers of complexity. The degree of complexity often increases in cases of multiple or recurrent trauma exposure, and in situations where a primary caregiver is a perpetrator of the trauma.

## 2. Trauma occurs within a broad context that includes children's personal characteristics, life experiences, and current circumstances.

Childhood trauma occurs within the broad ecology of a child's life that is composed of both child-intrinsic and child-extrinsic factors. Child-*intrinsic* factors include temperament, prior exposure to trauma, and prior history of psychopathology. Child-*extrinsic* factors include the surrounding physical, familial, community, and cultural environments. Both child-intrinsic and child-extrinsic factors influence children's experience and appraisal of traumatic events; expectations regarding danger, protection, and safety; and course of posttrauma adjustment. For example, both child-intrinsic factors such as prior history of loss, and child-extrinsic factors such as poverty may act as vulnerability factors by exacerbating the adverse effects of trauma on children's adjustment.

## 3. Traumatic events often generate secondary adversities, life changes, and distressing reminders in children's daily lives.

Traumatic events often generate secondary adversities such as family separations, financial hardship, relocations to a new residence and school, social stigma, ongoing treatment for injuries and/or physical rehabilitation, and legal proceedings. The cascade of changes produced by trauma and loss can tax the coping resources of the child, family, and broader community. These adversities and life changes can be sources of distress in their own right and can create challenges to adjustment and recovery. Children's exposure to trauma reminders and loss reminders can serve as additional sources of distress. Secondary adversities, trauma reminders, and loss reminders may produce significant fluctuations in trauma survivors' posttrauma emotional and behavioral functioning.

## 4. Children can exhibit a wide range of reactions to trauma and loss.

Trauma-exposed children can exhibit a wide range of posttrauma reactions that vary in their nature, onset, intensity, frequency, and duration. The pattern and course of children's posttrauma reactions are influenced by the type of traumatic experience and its consequences, child-intrinsic factors including prior trauma or loss, and the posttrauma physical and social environments. Posttraumatic stress and grief reactions can develop over time into psychiatric disorders, including posttraumatic stress disorder (PTSD), separation anxiety, and depression. Posttraumatic stress and grief reactions can also disrupt major domains of child development, including attachment relationships, peer relationships, and emotional regulation, and can reduce children's level of functioning at home, at school, and in the community. Children's posttrauma distress reactions can also exacerbate preexisting mental health problems including depression and anxiety. Awareness of the broad range of children's potential reactions to trauma and loss is essential to competent assessment, accurate diagnosis, and effective intervention.

## 5. Danger and safety are core concerns in the lives of traumatized children.

Traumatic experiences can undermine children's sense of protection and safety, and can magnify their concerns about dangers to themselves and others. Ensuring children's physical safety is critically important to restoring the sense of a protective shield. However, even placing children in physically safe circumstances may not be sufficient to alleviate their fears or restore their disrupted sense of safety and security. Exposure to trauma can make it more difficult for children to distinguish between safe and unsafe situations, and may lead to significant changes in their own protective and risk-taking behavior. Children who continue to live in dangerous family and/or community circumstances may have greater difficulty recovering from a traumatic experience.

## 6. Traumatic experiences affect the family and broader caregiving systems.

Children are embedded within broader caregiving systems including their families, schools, and communities. Traumatic experiences, losses, and ongoing danger can significantly impact these caregiving systems, leading to serious disruptions in caregiver-child interactions and attachment relationships. Caregivers' own distress and concerns may impair their ability to support traumatized children. In turn, children's reduced sense of protection and security may interfere with their ability to respond positively to their parents' and other caregivers' efforts to provide support. Traumatic events—and their impact on children, parents, and other caregivers—also affect the overall functioning of schools and other community institutions. The ability of caregiving systems to provide the types of support that children and their families need is an important contributor to children's and families' posttrauma adjustment. Assessing and enhancing the level of functioning of caregivers and caregiving systems are essential to effective intervention with traumatized youths, families, and communities.

## 7. Protective and promotive factors can reduce the adverse impact of trauma.

*Protective* factors buffer the adverse effects of trauma and its stressful aftermath, whereas *promotive* factors generally enhance children's positive adjustment regardless of whether risk factors are present. Promotive and protective factors may include *child-intrinsic* factors such as high self-esteem, self-efficacy, and possessing a repertoire of adaptive coping skills. Promotive and protective factors may also include *child-extrinsic* factors such as positive attachment with a primary caregiver, possessing a strong social support network, the presence of reliable adult mentors, and a supportive school and community environment. The presence and strength of promotive and protective factors—both before and after traumatic events—can enhance children's ability to resist, or to quickly recover (by resiliently "bouncing back") from the harmful effects of trauma, loss, and other adversities.

## 8. Trauma and posttrauma adversities can strongly influence development.

Trauma and posttrauma adversities can profoundly influence children's acquisition of developmental competencies and their capacity to reach important developmental milestones in such domains as cognitive functioning, emotional regulation, and interpersonal relationships. Trauma exposure and its aftermath can lead to developmental disruptions in the form of regressive behavior, reluctance, or inability to participate in developmentally appropriate activities, and developmental accelerations such as leaving home at an early age and engagement in precocious sexual behavior. In turn, age, gender, and developmental period are linked to risk for exposure to specific types of trauma (e.g., sexual abuse, motor vehicle accidents, peer suicide).

## 9. Developmental neurobiology underlies children's reactions to traumatic experiences.

Children's capacities to appraise and respond to danger are linked to an evolving neurobiology that consists of brain structures, neurophysiological pathways, and neuroendocrine systems. This "danger apparatus" underlies appraisals of dangerous situations, emotional and physical reactions, and protective actions. Traumatic experiences evoke strong biological responses that can persist and that can alter the normal course of neurobiological maturation. The neurobiological impact of traumatic experiences depends in part on the developmental stage in which they occur. Exposure to multiple traumatic experiences carries a greater risk for significant neurobiological disturbances including impairments in memory, emotional regulation, and behavioral regulation. Conversely, ongoing neurobiological maturation and neural plasticity also create continuing opportunities for recovery and adaptive developmental progression.

### 10. Culture is closely interwoven with traumatic experiences, response, and recovery.

Culture can profoundly affect the meaning that a child or family attributes to specific types of traumatic events such as sexual abuse, physical abuse, and suicide. Culture may also powerfully influence the ways in which children and their families respond to traumatic events including the ways in which they experience and express distress, disclose personal information to others, exchange support, and seek help. A cultural group's experiences with historical or multigenerational trauma can also affect their responses to trauma and loss, their world view, and their expectations regarding the self, others, and social institutions. Culture also strongly influences the rituals and other ways through which children and families grieve over and mourn their losses.

### 11. Challenges to the social contract, including legal and ethical issues, affect trauma response and recovery.

Traumatic experiences often constitute a major violation of the expectations of the child, family, community, and society regarding the primary social roles and responsibilities of influential figures in the child's life. These life figures may include family members, teachers, peers, adult mentors, and agents of social institutions such as judges, police officers, and child welfare workers. Children and their caregivers frequently contend with issues involving justice, obtaining legal redress, and seeking protection against further harm. They are often acutely aware of whether justice is properly served and the social contract is upheld. The ways in which social institutions respond to breaches of the social contract may vary widely and often take months or years to carry out. The perceived success or failure of these institutional responses may exert a profound influence on the course of children's posttrauma adjustment, and on their evolving beliefs, attitudes, and values regarding family, work, and civic life.

### 12. Working with trauma-exposed children can evoke distress in providers that makes it more difficult for them to provide good care.

Mental healthcare providers must deal with many personal and professional challenges as they confront details of children's traumatic experiences and life adversities, witness children's and caregivers' distress, and attempt to strengthen children's and families' belief in the social contract. Engaging in clinical work may also evoke strong memories of personal trauma- and loss-related experiences. Proper self-care is an important part of providing quality care and of sustaining personal and professional resources and capacities over time.

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# Traumatic Grief in Military Children

## Information for Medical Providers

In Partnership with
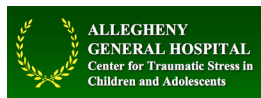
**NMFA** National Military Family Association

**T*A*P*S** Tragedy Assistance Program for Survivors

**ALLEGHENY GENERAL HOSPITAL** Center for Traumatic Stress in Children and Adolescents

**ZERO TO THREE** National Center for Infants, Toddlers, and Families

The Center for Health and Health Care in Schools

**CSTS** Center for the Study of Traumatic Stress Uniform Services University

# The Nature of Grief

As a health-care professional and a trusted adult in many children's and parents' lives, you have an opportunity to help when a military family member dies. By carefully observing children who are experiencing childhood or traumatic grief, by offering empathetic support, and by suggesting referrals to mental health professionals and other resources when appropriate, you play a vital role in caring for children of military families.

## Introduction to Childhood Grief

Like adults, children and teens may feel intense sadness and loss, or "grief," when a person close to them dies. And like adults, children and teens express their grief in how they behave, what they think and say, and how they feel emotionally and physically.  **Each child and parent grieves differently, and there is no right or wrong way or length of time to grieve.**

Some grief reactions cut across children's developmental levels, and children may show their grief in many different ways. For example, bereaved children or teens of any age may sleep or cry more than usual. They may regress and return to earlier behaviors, or they may develop new fears or problems in school. They may complain about aches and pains. They may be angry and irritable, or they may become withdrawn and isolate themselves from family and friends.

Bereaved children may also act in uncharacteristic ways that those around them may not recognize as grief reactions. For example, a quiet toddler may have more tantrums, an active child may lose interest in things he or she used to do, or a studious teen may engage in risky behavior. Whatever a child's age, he or she may feel unrealistic guilt about having caused the death. Sometimes bereaved children take on adult responsibilities and worry about their surviving parent and about who would care for them if that parent died as well. These worries can be especially acute if the surviving parent is also in the military.

## Traumatic Grief in Military Children

Sometimes, the reactions of some children and teens to the death of a parent or someone close to them may be more intense than the common deep sadness and upset of grief. In *childhood traumatic grief*, children develop symptoms associated with *posttraumatic stress disorder* (PTSD). (**Table 1** describes examples of common and traumatic grief reactions at various ages.)

Traumatic Grief in Military Children: Information for Medical Providers                    1
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Children of military families may be more likely to experience these intense reactions if, for example, the death was sudden or traumatic, if it occurred under terrifying circumstances, or if the child witnessed or learned of horrific details surrounding the death. Also, although posttraumatic stress reactions may occur after a deployed parent has been killed in combat, symptoms can also appear when death comes weeks or months after an initial combat injury, even if the death has been anticipated by the child or by adults in the child's life.

**Not all children who experience the death of someone special under traumatic circumstances develop traumatic grief. However, in some cases, children may develop symptoms of PTSD** that interfere with their ability to grieve and to call up comforting memories of the person who died. Traumatic grief may also interfere with everyday activities such as being with friends and doing schoolwork. PTSD symptoms in children with traumatic grief can include:

✦ **Reliving aspects of the person's death or having intrusive thoughts**, for example, experiencing nightmares about the death, not being able to stop thinking about how the person died, imagining how much the person suffered, or imagining rescuing the person and reversing the outcome.

✦ **Avoiding reminders of the death or the person who died**, for example, by avoiding pictures of the deceased person or news about the military, by not visiting the cemetery, by not wanting to remember or talk about the person, or by feeling emotionally numb.

✦ **Increased arousal**, being nervous and jumpy or having trouble sleeping, having poor concentration, being irritable or angry, being "on alert," being easily startled, and developing new fears.

In general, if it becomes apparent that children or teens are having very upsetting memories, avoiding activities or feelings, or experiencing physical, emotional, or learning problems, they may be having a traumatic grief reaction.  (See **Table 1**.)

You may wish to suggest that the family seek help or counseling for a child or teen if grief reactions seem to continue without any relief, if they appear for the first time after an initial period of relative calm, if they get worse, or if they interfere with the child's being with friends, going to school, or enjoying activities.

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2

## Table 1. Children's Understanding of Death and Reactions to Grief

| Age | Understanding of death | Common grief reactions | Traumatic grief reactions |
|---|---|---|---|
| **Preschool and young children** | • Do not understand that death is final. <br> • May think that they will see the person again or that the person can come back to life. <br> • May think it was their fault that the person died. | • May become upset when their routines change. <br> • May get worried or fussy when apart from their usual caregivers and may be clingy and want extra attention. <br> • May express fears, sadness, and confusion by having nightmares or tantrums, being withdrawn, or regressing to earlier behaviors. | • May repetitively engage in play about the death or the person who died. <br> • May have problems getting back on schedule or meeting developmental milestones. <br> • May have difficulty being comforted. |
| **School-age children** | • Gradually gain a more mature understanding of death. <br> • Begin to realize that death is final and that people do not come back to life. <br> • May have scary beliefs about death, like believing in the "boogey man" who comes for the person. | • May ask lots of questions about how the person died and about what death means. <br> • May display distress and sadness in ways that are not always clear, like being irritable and easily angered. <br> • May avoid spending time with others. <br> • May have physical complaints (headaches, stomachaches). <br> • May have trouble sleeping. <br> • May have problems at school. <br> • May have no reaction at all. <br> • May dream of events related to the death or war. <br> • May want to call home during the school day. <br> • May reject old friends and seek new friends who have experienced a similar loss. | • May repeatedly talk or play about the death. <br> • May have nightmares about the death. <br> • May become withdrawn, hide feelings (especially guilt), avoid talking about the person or about places and/or things related to the death. <br> • May avoid reminders of the person (for example, may avoid watching TV news or refuse to attend the funeral or visit the cemetery). <br> • May become jumpy, extra-alert, or nervous. <br> • May have difficulty concentrating on homework or class work, or may suffer decline in grades. <br> • May worry excessively about their health, their parents' health, or the health and safety of other people. <br> • May act out and become "class clown" or "bully." |
| **Teens** | • Have a full adult understanding of death. | • May have similar grief reactions to those of school-age children when at home, with friends, and at school. <br> • May withdraw, become sad, or lose interest in activities. <br> • May act out, have trouble in school, or engage in risky behavior. <br> • May feel guilt and shame related to the death. <br> • May worry about the future. <br> • May hide their true feelings. | • May have similar traumatic grief reactions to those of school-age children when at home, with friends, and at school. <br> • May avoid interpersonal and social situations such as dating. <br> • May use drugs or alcohol to deal with negative feelings related to the death. <br> • May talk of wanting to harm themselves and express thoughts of revenge or worries about the future. <br> • May have low self-esteem because they feel that their family is now "different" or because they feel different from their peers. |

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# Grief in Military Families

Since 2001, thousands of military children have had parents killed in combat operations in Iraq and Afghanistan. Many other children have had siblings, cousins, and other relatives die in war. Children who lose military family members during wartime are similar to other grieving children in many ways. Like other American children, they come from families of varying diversity and configuration. However, those who care for or work with grieving military children should be aware of certain unique aspects of military family loss.

For one thing, many military service parents may have been deployed for extended periods of time before dying. Because of this, children who may already have been dealing with their parent's physical absence for some time may not experience any immediate changes in their day-to-day life when they learn of the death. **Their past experience with the person's absence may make it hard for some children to accept the permanence of their loss or to take part in their family's grieving.**

In addition, military deaths during wartime are part of public events, which diminishes the privacy that families usually have when grieving. This lack of privacy can make it more difficult for family members and other caring adults to protect children from unexpected or unwanted intrusions into family mourning.

Also, given the political nature of war and the public nature of military deaths, military children may feel confused by how the death is reported or framed within their families, in their school, or in their community. A child who overhears conversation that a parent died "needlessly" in an "unnecessary" war may find it much harder to accept and integrate that death than a child whose parent's death is considered "noble" or "heroic." Also, older teenagers may have their own opinions and feelings about the war, and these may either ease or complicate their grief over the loss of their loved one.

Military deaths may be experienced differently by families and communities depending upon how they are perceived. Many military children lose loved ones to combat, and in some cases, the body may be disfigured, for example, if the death was caused by an improvised explosive device (IED). Many other deaths occur as the result of accidents, risk-related behaviors, medical illnesses, or suicide. Any of these circumstances can further complicate children's reactions and affect their ability to integrate their loss.

Bereaved families who live on military installations will likely be surrounded by community support and interest. However, the combination of sadness and fear brought about by a death can be challenging for bereaved military children when they are with other military classmates who are not bereaved.

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Also, Reserve and National Guard families, or families who live outside military communities, may find that their unique grief is less well understood by others around them, and children who attend schools with few other military children may find themselves isolated in their experiences of loss. They may feel that others do not fully understand what they are going through.

After a parent dies, military children often experience additional stresses that further magnify the effects of their loss. For example, they may have to move from the military installation where they have lived to a new community where those around them are unaware of their military identity or of the nature of their family member's death. In such circumstances, military children may find themselves suddenly no longer "military" in that they lose that identity in addition to leaving behind their friends and familiar activities, schools, or child-care providers. Once in their new community, children and families must also decide what they want to share with others about the person and about their military-related experience.

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## How You Can Help Military Children and Their Families in Your Health-Care Practice

The previous sections and Table 1 describe important grief reactions that you may observe, encounter, or be told about by attending adults during health-care visits with military children who have lost a loved one.

Empathetically acknowledging the death of the loved one and recognizing its impact are important to providing care to children of military families. Let them know that you care. The following strategies and tips will help you to support children of any age.

### How to Help Children and Family Members

✦ **Become aware.** Many military children in your practice may have family members deployed away from home to operations in Iraq, Afghanistan, or elsewhere. In such cases, the children may be brought to clinical appointments by a caregiver or someone other than their parent. When a child's parent has died, the child or the accompanying adult may not realize the value of sharing the history of the parental death with the clinician.

> **TIP:** Ask questions about parents or other family members who may currently be serving or have served in the armed forces.

✦ **Maintain contact.** Children who have lost loved ones as a result of military service may experience changes in their regularly scheduled health care. Some may continue to come in for well-child care on a routine basis, but many may not follow up for scheduled well-child appointments, or they may present with more frequent unscheduled appointments as crises develop.

> **TIP:** If you become aware of a death in the family and a child is missing appointments, consider having your office call the family to reschedule and to gain insight into what might facilitate routine care.

✦ **Ensure continuity of care for children in families who have lost someone in combat.** Developing relationships with these children and their families will ensure that you can monitor their health and adjustment over time.

> **TIP:** Assign a single health-care practitioner for well-child appointments, rather than rotating providers to families where a military death has occurred. This will ensure that important changes or deteriorations in health or development are not missed and will reinforce a sense of security for the child and the family.

✦ **Watch for emotional and behavioral symptoms.** Children who have emotional concerns often manifest them through physical symptoms such as stomachaches or headaches, changes in sleeping or eating patterns, lack of energy or listlessness, developmental

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regression, or vague pains. As a result, children who have lost loved ones in war may present to health-care clinics or emergency rooms with symptoms that are more representative of an emotional rather than a physical etiology.

> **TIP:** You may encounter children whose physical symptoms represent emotional rather than physical concerns. Ask questions about stresses that may be contributing to these symptoms.

Children of all ages may present with "internalizing" symptoms such as sadness, worry, or preoccupation as a result of a family member's death, but they may also present with "externalizing" symptoms such as oppositionality or uncontrolled behavior that may be interpreted as disciplinary problems rather than expressions of emotional worries.

> **TIP:** Look for and ask about uncharacteristic changes in behavior in military children that might indicate an emotional response to the death of a loved one.

Typically, teenagers pose unique challenges to health care. After the death of a loved one, teens may try to deal with conflicts between their desire for emotional closeness and their normal need for greater independence by initiating or escalating risky behaviors such as substance use or abuse, or unsafe sexual practices.

> **TIP:** Screen teenagers for high-risk behaviors, educate them about potential consequences of these behaviors, and connect them with appropriate resources.

Adults are often unaware of the impact that the loss of a parent has on infants and toddlers, so they may assume that these children are "too young" to be affected. However, even children under three years of age will experience grief when a parent has died. Sleep challenges, feeding difficulties, and clinginess and/or withdrawal are some behaviors that other family members and caregivers may see.

> **TIP:** During office visits, explore changes in a young child's behaviors with the accompanying family member or caregiver, and be prepared, as with teenagers, to provide additional resources and age-appropriate support.

✦ **Ask about dates and events that may trigger grief reactions.** Meaningful anniversaries, for example the anniversary of a death or the birthday of the deceased, may elicit either overt or covert symptoms that result in unscheduled health-care appointments. Similarly, military-related national holidays (Memorial Day, Independence Day, Veterans Day) or key events, such as the return home of the deceased's unit from the war zone, may also result in an increase in symptoms.

> **TIP:** Be sensitive to, and ask questions about, meaningful events and calendar dates.

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✦ **Know your resources.** Grieving is a normal process and may result in periods of sadness or anger, or in overall behavioral change. Keep in mind that the grief process differs from depression and may not require medical or pharmacological treatment. You can help direct grieving children and their families to the support they need by familiarizing yourself with available grief support resources in your community, particularly those associated with the armed forces.

> **TIP:** Be cautious in choosing to prescribe medication to children, particularly shortly after a death. Instead, seek or refer to professional mental health resources.

✦ **Understand the differences between common and traumatic grief reactions.** Listen and watch for signs that children, especially those with undeveloped verbal skills, may be experiencing difficulty with the grieving process, as described in **Table 1**.

> **TIP:** Children who seem to be having difficulty resolving their grief, or who are having difficulty in different areas of their life such as home or school, or who are avoiding people or places, should be referred to professional mental health resources. Your assistance in coordinating supporting resources will help to ease the family's transition into further care.

**Table 3** is a list of useful references for families. You might want to makes copies to give to accompanying adults. You may also wish to refer them to the NCTSN fact sheet, *Traumatic Grief in Military Children: Information for Families*, available at www.nctsn.org. (That document also contains the resource list.)

## How to Cope with Your Own Feelings and Reactions

✦ **Be aware of your own responses and reactions.** If you as a clinician are uncomfortable addressing death and grieving, this can complicate your ability to listen to children. Your own unease may lead you to believe that it is not safe or permissible to raise your concerns with the child or with accompanying adults.

> **TIP:** If you find that you are avoiding contact with bereaved families or finding it hard to talk with children about their loss, seek guidance from colleagues or professionals.

Also, **Table 2** offers a list of groups and organizations that offer information and resources for medical providers.

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## Table 2. Resources for Medical Providers

| Organization | Contact Information |
|---|---|
| **American Psychological Association (APA)** | http://www.apa.org<br>800-374-2721<br>Advances creation, communication, and application of psychological knowledge; site includes extensive references to materials on child traumatic grief and PTSD |
| **Center for the Study of Traumatic Stress, Uniform Services University** | http://www.cstsonline.org<br>Serves as NCTSN (see listing below) expert in military child and family trauma, focusing on helping military families and children impacted by and/or exposed to trauma, including deployment of military parents to combat, parental injury or illness, or parental death |
| **Center for Traumatic Stress in Children and Adolescents, Allegheny General Hospital** | http://www.pittsburghchildtrauma.org<br>412-330-4328<br>Serves children and families experiencing traumatic or stressful events by offering evaluation and treatment, especially of children who have experienced traumatic life events including death of a family member; site offers resources and research on child traumatic grief; member site of NCTSN (see listing below) |
| **Children's Grief & Loss Issues** | http://griefnet.org<br>Internet resources for grieving caregivers and a special section with a community of support for children |
| **Military Health System (MHS)** | http://www.health.mil<br>A partnership of  medical educators, medical researchers, and healthcare providers that delivers healthcare to the Department of Defense (DoD), military service members, retirees, and families worldwide (see also TRICARE listing below) |
| **Military OneSource** | http://www.militaryonesource.com<br>800 342-9647 (Stateside, CONUS)<br>877-888-0727 (en Español)<br>24/7 toll-free information and referral telephone service available to active duty, Reserve, and National Guard military members and their immediate families as well as to deployed civilians and their families, providing information on a wide range of concerns including coping with the loss of a military spouse |
| **National Association of Home Care and Hospice (NAHC)** | http://www.nahc.org/<br>202- 547-7424<br>Association representing home-care agencies, hospices, and home-care aide organizations; site offers extensive links for consumers |
| **National Child Traumatic Stress Network (NCTSN)** | http://www.nctsn.org<br>Mission of raising the standard of care and improving access to services for traumatized children, families, and communities nationwide, including extensive and comprehensive resources on child traumatic grief and PTSD in military children and families |

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| Organization | Contact Information |
|---|---|
| **National Institute of Mental Health (NIMH)** | http://www.nimh.nih.gov/health/topics/coping-with-traumatic-events/index.shtml<br>866-615-6464 (NIMH Information Center)<br>Link to "Coping with Traumatic Events" page, with list of resources on trauma and PTSD |
| **Operation Healthy Reunions, Mental Health America** | http://www.mentalhealthamerica.net/reunions/infoWarChildLoss.cfm<br>800-969-6642 (Mental Health America main number)<br>Link to "Helping Children Cope with Loss Resulting from War or Terrorism," offers a brief overview of child grief, with additional links to other resources |
| **Substance Abuse and Mental Health Services Administration (SAMHSA)** National Mental Health Information Center | http://www.mentalhealth.samhsa.gov/databases<br>800-789-2647<br>Link to state-by-state Mental Health Services Locator map and further links to other resources |
| **TRICARE** | http://www.tricare.mil<br>TRICARE Management Activity (a component of the Military Health System, or MHS, see listing above) serves active duty service members, National Guard and Reserve Members, retirees, families, survivors, and certain former spouses worldwide; also has information related to survivor benefits; brings together uniformed services and civilian health-care resources |

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## Table 3. Support Groups and Organizations for Families

| Name | Contact Information |
| --- | --- |
| Army Morale Welfare and Recreation (MWR) | http://www.armymwr.com |
| Centering Corporation | http://www.centering.org<br>866-218-0101 |
| Local Veterans Centers | http://www.vetcenter.va.gov<br>800-827-1000 (for benefits issues) |
| Military Child Education Coalition (MCEC) | http://www.militarychild.org<br>254-953-1923 |
| Military OneSource | http://www.militaryonesource.com<br>800-342-9647 |
| National Association of Home Care and Hospice (NAHC) | http://www.nahc.org/<br>202-547-7424 |
| National Child Traumatic Stress Network (NCTSN) | http://www.nctsn.org |
| National Military Family Association (NMFA) | http://www.nmfa.org<br>800-260-0218 |
| National Suicide Prevention Lifeline Veterans Hotline | http://www.suicidepreventionlifeline.org/Veterans/Default.aspx<br>800-273-8255 (800-273-TALK)<br>(Veterans press "1") |
| Tragedy Assistance Program for Survivors (TAPS) | http://www.taps.org/youth/<br>800-959-8277 (800-959-TAPS)<br>(24-hour hotline) |
| Tricare: Your Military Health Plan | http://www.tricare.osd.mil<br>http://tricare.mil/mybenefit/ |
| ZERO TO THREE (Military Families) | http://www.zerotothree.org/ site/PageServer?pagename=key_military<br>202-638-1141 |

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**National Child Traumatic Stress Network**
Established by Congress in 2000, the National Child Traumatic Stress Network (NCTSN) is a unique collaboration of academic and community-based service centers whose mission is to raise the standard of care and increase access to services for traumatized children and their families across the United States. Combining knowledge of child development, expertise in the full range of child traumatic experiences, and attention to cultural perspectives, the NCTSN serves as a national resource for developing and disseminating evidence-based interventions, trauma-informed services, and public and professional education.

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You have finished reading Study Guide 4 (i.e., Part 4) of this course.  If you have enrolled in this course, Quiz 4 is ready for you to take, inside your account.  You may take it now or later.

When you are ready to take Quiz 4, log in to your My Home Page, click the name of this course (Course 5T), and then click the link to Quiz 4.

Thank you,
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# Sexual Health and Trauma

Sexual health is a fundamental part of your physical and emotional health, and has an impact on your overall well-being. Defining sexual health, however, can be complex as the concept varies widely across cultures, societies, individuals, and even geography. According to the World Health Organization, "sexual health is the state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity.  Sexual health requires a positive and respectful approach to sexuality and sexual relationships, the possibility of having pleasurable and safe sexual experiences, free of exploitation, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."[1]

Most youth in the United States face significant barriers for accessing accurate and informed sexual health information. Receiving trauma treatment should not be another barrier for youth to access sexual health conversations and information.

> When a child enters trauma treatment, it is an opportunity to engage in a positive sexual health conversation.

You, as a professional, are trained to address relationship components as well as any psychological and medical symptoms of traumatic events and their consequences. Trauma treatment offers an effective method for healing and developing coping strategies that integrate traumatic events with the hope of preventing future harm.

When you work with youth who have experienced violence and trauma which includes sexual, intimate partner, or physical abuse, trauma treatment necessitates a discussion of medically accurate sexual information concerning sexually transmitted infections (STIs), pregnancy, and the retelling of their story with specific and detailed sexual content (trauma narrative). As a trauma treatment professional, you develop significant experience in guiding and discussing clinical treatment in terms of risks, consequences, and danger associated with non-consent and sexual exploitation. Prioritization of sexual safety, while essential to current best practices for trauma treatment, often fails to address client sexual health.

## Challenges

Most professionals are unprepared to talk about sex with youth until a negative outcome occurs, like a STI, unwanted pregnancy, or relational trauma. Nevertheless, there is still an expectation for you to guide these conversations without training or adequate supervision. A youth's physical, emotional, spiritual, and sexual health can alter as a result of traumatic experiences. You must begin to expand trauma treatment methods that address the complicated link between sexual health and overall health and well-being.

Our culture perceives sexual health conversations as taboo. Many myths perpetuate the idea that talking to youth about sex will increase the likelihood of youth engaging in sexual activity too early in their development, or under circumstances disapproved of by their family, culture, religion, law, and society. Research consistently shows that when youth have access to reliable and accurate sexual health information, youth wait longer to engage in sexual activity and are more likely to avoid negative sexual health outcomes.[2]

Another challenge you may face is your own cultural beliefs about sex or sexual health. These beliefs may include fear or stigma around talking about sex or sexual issues, especially as these may vary between households, families, cultures, or communities. However, as with many other difficult topics, addressing it is much more effective for increasing knowledge and developing skills to manage it. As such, acquiring the ability to engage in sexual health discussions and practices serves as a protective factor, even if a youth has yet to experience such trauma.



## Suspending Judgment

A fundamental characteristic of good clinical practice is developing self-awareness, reflection, and suspension of judgment. In discussing issues of sexual health, it is imperative to practice and to model these for youth so they are able to do so themselves and with their current or prospective partner(s).

To engage effectively in a sexual health conversation, it is important to understand that as human beings we make judgments and have our own biases. You need to be aware of these and their effect on how you engage in any discussion on topics that may feel uncomfortable.

A respectful and open dialogue that acknowledges differences in cultural and other beliefs and practices between you and your client, can facilitate a more supportive and meaningful clinical relationship. These conversations increase the likelihood of helping youth develop healthier sexual relationships that are consensual, non-exploitive, honest, of shared values, safe, protective, AND pleasurable.

# Sexual Health Principles

Sexual health is not a value-free concept. It is based on individual value systems, not the prescribed sociocultural values that define what is or is not acceptable sexuality. Sexual health principles help youth construct unique and healthy sexual relationships that align with their identity and beliefs. Keep in mind, the choices made by a youth in your care, may not align with how you define or construct healthy sexual relationships. Everyone's ideas or values of sexual health are fluid and change over the course of our lifetime.

The objective for integrating sexual health into trauma treatment is to assist youth with identifying, communicating, and developing a sexual health language and lifestyle that promote both physical and emotional sexual well-being within themselves and their relationship(s). As a provider, if you do not already, you will need to think about how to incorporate trauma-informed sexual health conversations as part of psychoeducation. Sexual health information needs to be part of all conversations about health and development. The more educated and informed youth are about their sexual development reduces risk of future harm.

Many youth receive erroneous, medically inaccurate sexual health education and information in unsafe and unhealthy environments. Youth who have experienced sexual abuse or any type of relational trauma, may have negative cognitions about the ownership of their own body and own experience. Psychoeducation with sexual health content will help youth build autonomy over their bodies and choices, and create a shared language to help them advocate for themselves. It will also help reverse the negative messaging they have encountered. These skills will benefit them in other domains of their lives, as well.

There are six fundamental sexual health principles to guide sexual health conversations as core concepts with **ALL** children and families. (Braun-Harvey, 2009).

**Consent** – Sexual health is founded on the universal principle of consent. Yet it remains a far too common sexual health violation. Consent is both a legal and an ethical concept. Ethical consent is non-coerced, positive, sober approval or agreement to do a clearly specific activity. People who are intoxicated, intellectually or developmentally disabled, or underage are not capable of giving affirmative consent. Age of consent is a legal concept that varies by country and between U.S. states. Non-consent is the sexual health principle most often the focus of clients reporting sexual abuse, assault, rape, etc.

To find state specific information go to the following page for more information

https://apps.rainn.org/policy/

**Non-Exploitation** – Sexual health is non-exploitative sexual practices that are interactive, respectful, and collaborative. Sex becomes exploitative when there is misuse of one's power over another. Using a position of power to gain access to another person for sexual gratification is a common form of sexual exploitation of children and youth.

**Protected from STIs, HIV, and unwanted pregnancy** – Sexual health requires you to know your STI and HIV status (and your partners') and to be cognizant of the possibilities of an unwanted or unplanned pregnancy. Sexual health includes access to contraception methods, condoms and PrEP (pre-exposure prophylaxis), as well as access to affordable and medically accurate treatment for STIs.

**Honesty** – Sexual health involves individuals who are responsible for determining their standards for honesty about sexual health with their sexual partners, medical providers, community, and themselves. As a professional, you are expected to provide medically accurate, factual, honest, consistent, and transparent sexual health communication.

**Shared Values** – Sexual health understands that human sexual activity and relationships have meaning. Shared values need to be actively and verbally expressed to the individuals involved. Sexual health conversations about values are too often avoided all together by making assumptions that we know our partner's values. Studies have consistently identified the high priority youth place on opportunities to explore and clarify their sexual values and choices.[3]

**Pleasure** – Sexual health is giving and receiving desired touch and connection. Pleasure is a fundamental element of human sexuality. Sexual response or excitation can happen and be unwanted in the context of a non-consensual or exploitative situation. Sexual pleasure is a wanted and desired sexual response within a consensual context.

# 2 Trauma and Sexual Health Conversations

If at any point in your clinical practice with youth and families, you have used or addressed even one of these sexual health principles, you have the foundation for a sexual health conversation.

Here are steps to consider in continuing to develop these sexual health conversations with youth.

- Consider the connection between sexual health principles and trauma treatment. Best practice indicates that we incorporate sexual health conversations into trauma-informed trauma treatment.

- Make sure you are not working with youth in isolation. Parents, caregivers, and other adults in every youth's life needs psychoeducation too, which includes sexual health content.

- Incorporate sexual health conversations during psychoeducation at the beginning and throughout trauma treatment.

- Explore with a youth what a relationship may look like if it was based upon the principles of sexual health. This is exceptionally important to include when working with a youth who has experience relational trauma. This will allow you to help them define intimacy for themselves.

- Increase your self-awareness of your own comfort, knowledge, and ability for initiating or responding to sexual health concerns.

  Address the everyday sexual language of our culture and societal practices, which may be a barrier to meaningful and respectful sexual health conversations with youth and families. The positive language used in these six principles of sexual health offer a helpful place to start.

- Consider where your client is developmentally – make sure you are breaking down age specific information and language. If you need help, check out the resources included.

- Listen while suspending your personal judgments, regulate your personal opinions while remaining present and attentive to the sexual health question or concern presented.

- Understand current data and research information about sexual health and prevention.
  https://nationalcoalitionforsexualhealth.org/

- Know the policies and procedures of your setting. Some providers may be very comfortable talking about sex, yet they remain uninformed about current policies.

- Help youth develop assertive communication skills, which will aid them in having these conversations with their peers and partners.

- Seek out training and information on how to develop sexual health conversations.

# Examples

Here are a few examples of how you can incorporate sexual health content throughout treatment – assessment to termination. As well as how youth could have a conversation with a prospective partners, and how youth would negotiate uncomfortable situations:

**1** **Listen while suspending your personal judgments**
You are meeting with a transitional age youth and the topic of sexual health emerges. They begin sharing about their beliefs and experiences that make you feel uncomfortable or do not align with your own upbringing, past, or beliefs.

Over time, you create a safe space for the youth and yourself by focusing on actively listening while engaging in some quiet, controlled breathing. You also focus on developing a greater understanding of their question or concern, while also considering where they are coming from. You internally acknowledge your own judgment, and remember that people can vary greatly in their views, feelings, and experiences in sexual and intimate relationships; you can also take this opportunity to reassure them of this perspective as well.

By utilizing resources that you have prepared for the session, you can facilitate the discussion of sexual health principals and facts while being trauma-informed and objective. This allows you to explore and listen to their thoughts and feelings regarding the different areas they address.

Using the materials as a guide and continuing to remain calm, you proceed without judgment toward yourself or the youth, knowing that this can be sensitive and difficult for either or both of you.

**2** **Use Sexual Health Language**
A 15-year-old male is homeless, living on the street and has engaged in sexual acts as a means of survival. He has engaged in various sexual acts with both men and women in exchange for money, food, and sometimes a place to stay for the night. This youth does not see himself as a "victim" of commercial sexual exploitation because he "willingly" engaged in sex acts in order to meet his basic needs.

This provides an opportunity to educate the youth on consent and non-exploitative principles of sexual health. Explain to the youth that as a minor, he cannot consent to being bought or sold for sex. While the youth may feel like that they consented, this would be a good opportunity for you to introduce the concept of exploitation.

**3** **Discuss Sexual health during psychoeducation for relational trauma**
You are providing a trauma-informed evidence-based treatment to a 9-year-old girl who experienced ongoing emotional abuse by her father and physical abuse by her stepfather. Her non-offending mother is also participating in treatment.

During the initial psychoeducation session, you introduce the concept of sexual health to mother by saying, "After having experienced boundary violations by men who should have protected her and kept her safe, it would really help your daughter to learn some things about healthy relationships, like consent, non-exploitative, and other principles of sexual health."

You describe the principles of sexual health and her mother agrees for you to discuss this with her daughter. You introduce sexual health principles to the child in a similar manner during her parallel psychoeducation session.

- The Harvey Institute: http://www.theharveyinstitute.com/

- Improving LGBTQ Treatment Outcomes through Integration of Sexual Health
  https://learn.nctsn.org/mod/nctsnwebinar/view.php?id=10463

- World Association for Sexual Health – developed a Declaration of 16 Sexual Rights:
  http://www.worldsexology.org/resources/declaration-of-sexual-rights/

- Love Is Respect – http://www.loveisrespect.org/healthy-relationships/ - provides guidelines for health communication, boundaries and relationship boosters:

- The Relationship Foundation: http://www.therelationshipfoundation.org/

- Sex Positive Families - https://sexpositivefamilies.com/

- Five Action Steps to Good Sexual Health - https://www.fiveactionsteps.org

- National Coalition for Sexual Health - https://nationalcoalitionforsexualhealth.org/

- For more information please go to www.nctsn.org

- For Youth
  http://www.iwannaknow.org/teens/sexualhealth.html
  https://www.teensource.org/relationships/healthyrelationships
  https://advocatesforyouth.org/
  https://amaze.org/

## End Notes:

1. World Health Organization (2006) *Defining sexual health: report of a technical consultation on sexual health, 28–31 January 2002*, Geneva: World Health Organization.

2. *Consequences of Sex Education on Teen and Young Adult Sexual Behaviors and Outcomes.* Journal of Adolescent Health. Volume 51, Issue 4, October 2012, Pages 332-338.

3. Braun-Harvey, D. (2009). *Sexual Health in Drug and Alcohol Treatment: Group Facilitator's Manual.* Springer Publishing Company.

## CEU By Net Participants, please note the following:

**You have finished reading Study Guide 5 (i.e., Part 5) of this course.  If you have enrolled in this course, Quiz 5 is ready for you to take.  You may take it now or later.  When you are ready to take Quiz 5, log in to your My Home Page,  click  the name of this course (Course 5T). and click the link to Quiz 5.   Thanks!  CEU By Net**

# Part 6, Course 5T
## (Study Guide 6)

**NCTSN** — The National Child Traumatic Stress Network

# Sibling Death and Childhood Traumatic Grief:

## Information for Families

### Introduction to Childhood Grief

Like adults, children and teens may feel intense sadness and loss, or *grief,* when a person close to them dies. And like adults, children and teens express their grief in how they behave, what they think and say, and how they feel emotionally and physically. **Each child grieves differently, and there is no right or wrong way or length of time to grieve.**

Some grief reactions cut across all age groups and developmental levels, and children may show their grief in many different ways. For example, grieving children or teens of any age may sleep or cry more than usual. They may regress and return to earlier behaviors, or they may develop new fears or problems in school. They may complain about aches and pains. They may be angry and irritable, or they may become withdrawn and isolate themselves from family and friends.

Bereaved children may also act in ways that those around them may not recognize as grief reactions. For example, a quiet toddler may have more tantrums, an active child may lose interest in things he or she used to do, or a studious teen may engage in risky behavior. Whatever a child's age, he or she may feel unrealistic guilt about having caused the death. Sometimes bereaved children take on adult responsibilities and worry about surviving family members and who would care for them if something happened to their caregivers.

# Childhood Traumatic Grief

After someone important dies, some children and teens may experience greater than usual sadness and upset and have a more intense reaction known as *childhood traumatic grief.* In childhood traumatic grief, children develop symptoms associated with posttraumatic stress disorder (PTSD).

Children may be more likely to experience traumatic grief if the death was sudden or traumatic, if it occurred under terrifying circumstances, or if the child witnessed or learned of horrific details surrounding the death. Also, although posttraumatic stress reactions may occur after someone has been killed suddenly, they may also occur when the death was expected (such as following a long illness or disabling injury).

Not all children who experience the death of someone special under traumatic circumstances develop traumatic grief. However, in some cases, children may develop symptoms that interfere with their ability to grieve and to have comforting memories of the person who died. Traumatic grief may also interfere with everyday activities such as being with friends and doing schoolwork. PTSD symptoms in children with traumatic grief can include:

- Reliving aspects of the person's death or having intrusive thoughts, for example, experiencing nightmares about the death, not being able to stop thinking about how the person died, imagining how much the person suffered, or imagining rescuing the person and reversing the outcome.

- Avoiding reminders of the death or of the person who died, for example, by avoiding pictures of the deceased person or by not visiting the cemetery, by not wanting to remember or talk about the person, or by feeling emotionally numb.

- Increased arousal, being nervous and jumpy or having trouble sleeping, having poor concentration, being irritable or angry, being "on alert," being easily startled, and developing new fears.

In general, if it becomes apparent that your child or teen is having very upsetting memories, avoiding activities or feelings, or experiencing physical, emotional, or learning problems, he or she may be having a traumatic grief reaction. (See **Table 1** for examples of common and traumatic grief reactions in children at various ages.)

You may wish to seek help or counseling for your child or teen if grief reactions seem to continue without any relief, if they appear for the first time after an initial period of relative calm, if they get worse, or if they interfere with your child's being with friends, going to school, or enjoying activities.

## Grief and Sibling Death

The death of someone special can be very difficult and sad for a child or teen, but when it is a sibling who dies, the family faces a unique set of challenges. Siblings often have very complicated relationships. Sisters and brothers experience a range of sometimes conflicting feelings for each other—they may love and look up to one another, older siblings may feel responsible for, enjoy and/or resent caring for younger ones, or they may be jealous and fight—and their relationships can change over time.

When a sibling dies, these past relationships and feelings can affect the surviving child's grief and the family's bereavement process. Grieving siblings may show some or all of the following common reactions, and there are many ways in which parents and caregivers can help them cope.

- **Survivor's guilt about being alive.** This can stem from a sibling questioning why he or she was spared because they feel no better than—or even inferior to—the sibling who died.

  **Tip:** Acknowledge that many siblings feel guilty, but correct inaccurate thoughts and information. Reassure the child that all children are different and unique, and that he or she is just as important and loved as the child who died. You should also pay attention to friends or family members' comments comparing a surviving sibling to the child who died. You should comfort your child and help others understand that this can be hurtful.

- **Regrets and guilt about previous "bad" behavior.** Surviving siblings may express regrets or remorse about things they did or said to the sibling who died. For example, they may think that they should have been nicer to or more patient with the sibling while he or she was still alive. Surviving children who fought with the deceased sibling or at times "wished" that he or she would disappear or die may believe that their own thoughts and feelings caused the death.

  **Tip:** "Normalize" children's feelings by reassuring them that all brothers and sisters fight or disagree at times—that this is a natural part of sibling relationships. It may be helpful to explain what actually caused the sibling's death. Also, it is important to acknowledge surviving siblings' thoughts that they could have prevented the death, while also letting them know that they were not responsible. Explain that all children feel angry or have unkind thoughts about family members from time to time, but that feelings or wishes cannot cause a death to happen.

## Table 1. Children's Understanding of Death and Reactions to Grief

| Age | Understanding of death | Common grief reactions | Traumatic grief reactions |
|---|---|---|---|
| **Preschool and young children** | • Do not understand that death is final.<br>• May think that they will see the person again or that the person can come back to life.<br>• May think it was their fault that the person died. | • May become upset when their routines change.<br>• May get worried or fussy when apart from their usual caregivers and may be clingy and want extra attention.<br>• May express fears, sadness, and confusion by having nightmares or tantrums, being withdrawn, or regressing to earlier behaviors. | • May repetitively engage in play about the death or the person who died.<br>• May have problems getting back on schedule or meeting developmental milestones.<br>• May have difficulty being comforted. |
| **School-age children** | • Gradually gain a more mature understanding of death.<br>• Begin to realize that death is final and that people do not come back to life.<br>• May have scary beliefs about death, like believing in the "boogey man" who comes for the person. | • May ask lots of questions about how the person died and about what death means.<br>• May display distress and sadness in ways that are not always clear, like being irritable and easily angered.<br>• May avoid spending time with others.<br>• May have physical complaints (headaches, stomachaches).<br>• May have trouble sleeping.<br>• May have problems at school.<br>• May have no reaction at all.<br>• May dream of events related to the death or war.<br>• May want to call home during the school day.<br>• May reject old friends and seek new friends who have experienced a similar loss. | • May repeatedly talk or play about the death.<br>• May have nightmares about the death.<br>• May become withdrawn, hide feelings (especially guilt), avoid talking about the person, or about places and/or things related to the death.<br>• May avoid reminders of the person (for example, may avoid watching TV news, may refuse to attend the funeral or visit the cemetery).<br>• May become jumpy, extra-alert, or nervous.<br>• May have difficulty concentrating on homework or class work, or may suffer a decline in grades.<br>• May worry excessively about their health, their parents' health, or the health and safety of other people.<br>• May act out and become the "class clown" or "bully." |
| **Teens** | • Have a full adult understanding of death. | • May have similar grief reactions to those of school-age children when at home, with friends, and at school.<br>• May withdraw, become sad, or lose interest in activities.<br>• May act out, have trouble in school, or engage in risky behavior.<br>• May feel guilt and shame related to the death.<br>• May worry about the future.<br>• May hide their true feelings. | • May have similar traumatic grief reactions to those of school-age children when at home, with friends, and at school.<br>• May avoid interpersonal and social situations such as dating.<br>• May use drugs or alcohol to deal with negative feelings related to the death.<br>• May talk of wanting to harm themselves and express thoughts of revenge or worries about the future.<br>• May have low self-esteem because they feel that their family is now "different" or because they feel different from their peers. |

- **Ongoing connections with the deceased sibling.** The sibling who has died may remain an influence in the surviving children's lives. Although this can be comforting—for example, through pleasant memories of shared experiences and goals—it can also have a negative impact if surviving children idealize the deceased sibling, feel inadequate when they compare themselves to the deceased sibling, or try to "replace" the sibling by being just like him or her.

    Tip: Focus on comforting connections with the sibling who died, perhaps by talking with surviving children about happy memories or special life lessons they shared. At the same time, help surviving children to see and appreciate their own unique strengths and abilities and their special place within the family.

- **Questions related to their beliefs and faith.** Surviving children's perceptions of—and reactions to—the death of a sibling are often influenced by the cultural and religious background of their family and community. Although the rituals conducted after a death can be comforting, very young children do not fully understand the abstract concept of death, and some older children may question such explanations (for example, questioning a faith that could let their brother or sister die). When talking to children about their sibling's death, try to incorporate not only your cultural and religious understanding of the death, but also a concrete, age-appropriate explanation of what happened.

## Caregiver and Family Grief

If you have lost a child, the way in which you handle your grief can affect the bereavement process for your surviving children. In some parents and caregivers, grief over a lost child causes them to pull away or become emotionally absent from their surviving children. When this occurs, the surviving siblings may feel guilty for being happy or for needing their parents' support. They may fear that their parents will never recover from the loss and feel a need to take care of their parents or be perfect to avoid upsetting them further. Children may believe their parents blame them for the sibling's death and even act out because they feel they need to be punished, or to try to do everything right in an effort to "make up" for what they did.

If you are dealing with the loss of a child, it is important to have an active support network as well as safe places to express your grief. When you manage your own grief effectively, it eases the burden felt by the surviving children, offers them a positive role model for coping, and creates a more supportive environment for them to express their own grief. Here are a few other tips for helping your child—and yourself—to manage grief.

■ **Don't be afraid to talk about the child who died.** It can be difficult to talk about a child who has died, especially if you feel that the surviving children are too young to understand and should be protected. Some family members may want to keep the death a secret—particularly when a child dies at birth or if one of a set of twins dies—or to remove all reminders of the child who has died. However, learning of the death by accident, by overhearing a conversation, or by finding a reminder such as a photo, can leave children shocked or overwhelmed. Sometimes parents believe that limiting conversations about the deceased child will help the other children to "get back to normal" or to move on with their lives. Children may misinterpret these actions to mean that it is not okay to talk about their own feelings about the death, or that the grownups can't handle seeing how sad they are. These children may try to hide their feelings, develop physical symptoms, or even develop traumatic grief symptoms. They may believe that this secrecy means that there was something shameful or bad about the child who died, about the survivors, or about the death itself. This may make children distrust their caregivers and other information they may be given.

Tip: Open communication will help you to understand your surviving children's feelings, fears, and understanding about their sibling's death. Although difficult, it is important to give children honest, age-appropriate information about their deceased sibling so that they can feel comfortable coming to you with their questions, concerns, and feelings. You can also look for and use opportunities to talk about the deceased child, sharing stories and memories about the child who died at special times as well as in everyday conversation.

■ **Manage reminders:** After the death of a child, it is common to go through the child's belongings deciding what to store, remove, give to others, or keep. When parents or caregivers put away all physical reminders of the child who died, surviving children who have memories of their deceased sibling may be confused and upset by the disappearance of their brother's or sister's belongings. They may feel guilty for wanting the things in sight or for remembering the sibling. On the other hand, if parents or caregivers find it difficult to change anything and keep things exactly as they were, surviving siblings may feel afraid to touch any of the things or feel an ongoing sadness throughout the home.

Tip: Consider the impact of where and how many of your deceased child's things are kept visible in the home. Try to include the siblings in some of the decision making in ways that are appropriate to their age. Physical reminders such as pictures, toys, and clothing can be comforting for surviving children and let them know that the person who died was a valued member of the family. If you yourself find these reminders too upsetting, look for ways that the surviving children can keep some reminders.

## Traumatic Grief Among Surviving Siblings

In come cases, the death of a sibling can lead to traumatic grief in surviving children, particularly if the sibling's death was itself traumatic (for example, a traffic accident, community violence, abuse, war, or a natural disaster) or stigmatizing (suicide, HIV/AIDS, drug use).

Since children may not express their feelings directly, it is important to **be aware of any changes in surviving children's play and behavior that may indicate their distress**. In addition to the traumatic grief reactions discussed earlier, children who are experiencing a traumatic grief reaction to sibling loss may exhibit or express it in the following ways:

- Feeling helpless or hopeless. After losing a cherished brother or sister, surviving children may feel adrift and lonely. They may give up, not enjoy life or, in extreme cases, feel they want to join the sibling and think about their own death. Sometimes they may feel suicidal or even talk about suicide.

  Tip: Acknowledge surviving children's sadness and tell them that it's an understandable response to the family's loss. Encourage children to return to their regular, life-affirming activities. Playing and socializing with friends can increase children's sense of accomplishment and give them vital social support. However, be especially alert if children become extremely withdrawn or isolated, and seek professional help immediately if they express thoughts about suicide.

- Wanting to change the past. Surviving siblings may become preoccupied with thoughts that they could have or should have prevented the death. They may keep imagining or thinking of ways they could have saved their brother or sister if only they had called for help sooner or pushed the sibling out of the way of the speeding car. These thoughts can interfere with everyday activities, especially with schoolwork.

  Tip: If children show recurring feelings of responsibility and guilt, reassure them that the death was not their fault. Explain that things often look different when we look back and think about "what might have been," but that there was nothing they could have done at the time. Let children know that you don't blame them for their sibling's death.

- Feeling vulnerable and afraid. The death of a sibling can change children's perceptions of themselves and of the world. They may feel more fearful, vulnerable, and aware of their own mortality and the mortality of the people they love. This can lead to their being overly cautious and overly protective of other siblings and of their parents or caregivers because they fear that something will happen to them.

**Tip:** Acknowledge surviving children's fears and talk about them without dismissing them. Reassure children about their safety, for example, by reviewing safety plans and establishing check-in times. Also, monitor your own fears and maintain a sense of control and calm.

■ **Worry about physical symptoms.** If the sibling's death was related to a particular illness or to physical pain and suffering, symptoms related to those conditions can take on new meaning for surviving siblings. Parents and children alike may associate previously benign physical ailments with death. For example, if a sibling's death was due to a brain tumor, other family members may feel frightened or panicked when they have a headache. Caregivers should be aware that children can also develop physical symptoms due to anxiety (for example, children who refuse to go to school or frequently get sick at school may be fearful of parents or other siblings dying).

**Tip:** If surviving children express concerns about physical symptoms, avoid talking about your own fears but don't ignore their complaints. Show concern and, if need be, make an appointment with a trusted pediatrician who can objectively assess the situation. It may also be helpful to provide realistic reassurance about other family members' health and point out everyday healthy behaviors.

■ **Avoiding reminders of the deceased sibling.** Surviving children may avoid people, places, or things that remind them of the sibling who died because these things can trigger memories of the death itself. This avoidance may or may not be obviously related to the death. For example, if siblings shared a bedroom, it may be difficult for the grieving sibling to sleep alone. Or a surviving sibling may no longer want to play Little League because he and his deceased brother or sister always played catch after dinner.

**Tip:** Look for changes in behavior and consider whether these can be linked to memories or reminders of the deceased sibling. Acknowledging the changes and the accompanying sadness is important, but finding alternatives can also be helpful, for example, rearranging the furniture in the bedroom or talking with a sympathetic baseball coach. If siblings are still intensely bothered by painful memories or denying their avoidant behavior, a mental health professional can help them develop positive coping skills and memories.

## Sibling Identity

The death of a child often leads to changes in the structure of the family and in the roles of the surviving siblings. Depending on the number of children and their birth order, for example, a surviving child may now be the oldest or youngest child, the only girl or boy, or perhaps an only child. Parents and caregivers may rely on or change their expectations of the remaining children.

These changes may give surviving siblings a sense of pride in their new found responsibilities, but they may also result in feelings of pressure or even resentment if children are expected to replace or live up to the behavior and goals of the deceased sibling. Surviving siblings may respond by acting out or by rejecting their new place in the family. Caregivers should consider that negative changes in family functioning may be due to such shifting of roles. A family meeting or one-on-one talks with children about different feelings, with a goal of discussing different household jobs, can be a good way for everyone to share feelings and take responsibility for creating new family routines.

The death of a sibling also impacts surviving children in many small and large ways throughout their lives. For example, responding to a casual or typical question such as "Do you have any brothers or sisters?" can be difficult. To help children move on in a life without their sibling, **prepare surviving siblings for difficult questions** by helping them to develop and practice responses. Explore together what kinds of responses feel most comfortable and also what they mean to the surviving brother or sister. Reassure your child that he or she can choose how and when to talk about the deceased child. For example, in group situations or when dealing with new people, it may be simplest to talk about surviving siblings. In more private conversations, a more direct answer such as "my brother died two years ago" may feel more natural. Be aware that this topic may need to be revisited as children mature and face new situations.

### Accepting New Siblings

The birth or introduction of a new child into the family following the death of another child can lead to mixed reactions. Surviving children may welcome the new child, but they may also feel that they were "not good enough" on their own to satisfy their parents' needs. In addition, the surviving children may believe that children who die are easily replaced.

How to help: Be ready for mixed reactions. Talk with the surviving children about their feelings and reassure them about what makes them special. Emphasize that you can love more than one child and talk about what the new child represents to everyone in the family. Whenever possible, set aside special one-on-one time with the surviving siblings.

## Sibling Death Resources

Dates and experiences that are strongly associated with the deceased child may bring up difficult feelings in surviving family members. For example, the deceased sibling's birthday, or specific experiences such as a surviving sibling going to summer camp alone, can bring up a range of memories and reactions. Try to **anticipate important anniversaries and take time to talk with surviving children about their feelings**. As a family, you can plan how to remember the deceased child and how to move toward the future.

The resources below offer information, guidance, and support to siblings of all ages who have lost a brother or sister, and to those who care for them. They cover the following areas:

- Information about the grief process at different ages
- Guidance and support in coping with "difficult" emotions such as anger
- Information for family members, friends, caregivers, professionals, and others who are involved with sibling survivors

Unless otherwise noted, the resources listed below are available from your local or online bookseller.

## Books for Children and Young People

### Preschool and Early Grades

Blanford, C. (2008). *Something happened: A book for children and parents who have experienced pregnancy loss*. Western Springs, IL: Cathy Blanford Publishing.

> This paperback picture book is designed especially for children between the ages of two and six whose families have experienced a miscarriage, stillbirth, or neonatal death. The simple, clear story helps children to understand what has happened and to deal with their feelings and fears. It also reassures them that they are loved and secure.

Johnson, J., Johnson, M. (1982). *Where's Jess? For children who have a brother or sister die.* Omaha, NE: Centering Corporation.

> This easy-to-understand picture book for children aged three to six is considered a classic about sibling grief. The authors wrote it after losing their daughter Jess to sudden infant death syndrome (SIDS).

Keough, P. (2001). *Remembering our baby: A workbook for children whose brother or sister dies before birth*. Omaha, NE: Centering Corporation.

> This workbook for children aged four to nine begins with the family finding out that the expected baby has died before birth. The book offers activities that allow children to express and share their feelings and to remember the brother or sister they never had a chance to know.

Munoz-Kiehne, M. (2000). *Since my brother died: Desde que murio mi hermano.* Omaha, NE: Centering Corporation.

> In this bilingual Spanish-English paperback book for children aged four to eight, the young narrator talks about what it was like to lose his brother and how he learned to keep memories in his heart. The book includes a bilingual section for caregivers and teachers.

Old, W.C. (1994). *Stacy had a little sister*. Morton Grove IL: Albert Whitman & Company.

> In this illustrated hardcover book for children aged four to nine, Stacy is so jealous of her new little sister that she sometimes wishes the baby would "go away." When the baby dies of sudden infant death syndrome (SIDS), Stacy feels guilty and begins to fear that she too might die in her sleep. Her parents try to comfort and reassure her. The book includes information and resources about SIDS for parents.

Roper, J. (2001). *Dancing on the moon*. Cheverly, MD: SIDS Educational Services.

> This paperback for toddlers to preschoolers tells the story of five-year-old Carly, who is jealous of her new baby brother Nigel. But when he dies of sudden infant death syndrome (SIDS), she feels confused and sad. She dreams that she flies to the moon to find him but he tells her that he will always be with her in her heart.

Schwiebert, P. (2007). *Someone came before you*. Portland, OR: Grief Watch.

> This paperback picture book is for very young children through preschool age who were born after their parents lost a child born earlier. It describes the parents' grief and sadness and how they eventually decide they want to bring another child into their lives. The book offers ideas for keeping the deceased child's memory alive.

Schwiebert, P. (2003). *We were gonna have a baby, but we had an angel instead*. Portland, OR: Grief Watch.

> This illustrated paperback helps children aged two to eight to confront and deal with their grief when a baby brother or sister dies before or shortly after birth. It includes practical suggestions for parents on how to help children cope and remember the baby who died.

Temes, R. (1992). *The empty place: A child's guide through grief*. Far Hills, NJ: Small Horizons.

> In this paperback for children aged four to eight, a nine-year-old boy has trouble facing the reality of death and the pain of his loss when his beloved older sister dies. His babysitter, who had lost her own brother as a child, becomes an empathetic role model who helps him learn to cope and heal.

Yeomans, E. (2000). *Lost and found: Remembering a sister*. Omaha, NE: Centering Corporation.

> In this paperback for children aged five to nine, a young girl explores what it means to "lose" her older and only sister to death. She copes with her grief as she tries to "find" Paige, and she learns that she and her family will always keep Paige in their lives.

## Middle Grades

Aiken, S. (2001). *Anna's scrapbook: Journal of a sister's love*. Omaha, NE: Centering Corporation (www.centering.org).

> This spiral-bound book for middle-school readers tells the story of Anna, whose preschool sister Amelia dies from an accidental fall. Anna deals with her grief by keeping a diary and then decides to create a scrapbook in which she can keep her memories of Amelia. The rest of the book offers readers blank pages in which they can create their own diary and scrapbook.

Couloumbis, A. (2000). *Getting near to baby.* New York: Putnam.

> Intended for sixth- to eighth-graders, this novel (a 2000 Newbery Honor Book) tells the story of Willa Jo and Little Sister, whose family falls apart after their baby sister dies. When their mother sinks into a serious depression, the two older girls are sent to live with their strict Aunt Patty and their more sympathetic Uncle Hob. But no one understands what the girls are going through until the morning they climb up onto Aunt Patty's roof and refuse to come down. During that long, sad day, the girls and their family realize the healing power of love in the face of grief and loss.

Gryte, M. (1999). *No new baby: For siblings who have a brother or sister die before birth*. Omaha, NE: Centering Corporation (www.centering.org).

> This paperback, for children aged nine to twelve, is a first-person account about the different feelings children may have when a sibling dies before birth. It answers children's most-asked questions and includes a section for parents and grandparents.

Jackson, A. (2004). *Can you hear me smiling? A child grieves a sister*. Washington, DC: Child & Family Press.

> This paperback, for grades two to four, recounts the illness and death of African-American author Aariane Jackson's beloved older sister at age twelve. Both girls were adopted, and

Jackson describes their sibling intimacy and the difficult and conflicting emotions she had to cope with following her sister's death. The book includes a preface by the girls' mother and an afterword by grief counselors that offers advice on how to help children cope with the anguish of losing a sibling.

Jampolsky, G.G. (Ed.). (1983). *Straight from the siblings: Another look at the rainbow*. Millbrae, CA: Celestial Arts.

This collection of images and quotes from bereaved brothers and sisters, for children aged nine to twelve, is a memorial to love between siblings. The quotes and stories by the bereaved siblings who contributed to the book describe not only the sadness but also the difficult feelings, such as jealousy and guilt, that have troubled them.

Park, B. (2009). *Mick Harte was here*. New York: Scholastic.

In this paperback for sixth- through ninth-graders, eighth-grader Phoebe must come to terms with the death of her fun-loving brother Mick after he is killed in a bicycle accident at age twelve. The story leavens sorrow and grief with humor in capturing the pain that Phoebe and her family go through as they try to cope with their loss.

Rothman, J.C. (1996). *A birthday present for Daniel: A child's story of loss.* Amherst, NY: Prometheus Books.

In this paperback for children aged seven to twelve, young Ellen shares what her brother Daniel's death means to her, and especially how she and her parents resolve the painful issue of how to acknowledge his birthday each year. Highly recommended by grief counselors and support groups, the book helps parents support their children as family members explore different ways of grieving and communicating their feelings about their loss.

Samuels, V.R. (2006). *Always my twin.* (N. Clemmons, Illus.). Victoria, BC: Trafford Publishing.

This illustrated paperback, for children aged seven through twelve, tells the story of a young girl who loses her twin sister shortly after their birth. Based on the experience of the author, who lost a twin daughter in infancy, it is a story of heartache, healing, and hope. The book includes interactive pages that readers can respond to by using pictures and describing feelings. It also lists support resources for families that have experienced the death of a baby, including a twin or other multiple sibling.

Simon, J. (2002). *This book is for all kids, but especially my sister Libby. Libby died*. Kansas City, MO: Andrews McMeel Publishing.

In this hardbound book for children aged nine to twelve, the author tells of the death of his younger sister Libby from a rare medical condition when she was 3½ years old. Jack was

only five and, like other small children facing such a huge loss, he thought no one else could understand how he felt. However, the universality of his story captures the emotions of every grieving sibling.

Thomas, C. (2005). *Hugs & kisses from Brittany: A children's book about the death of another child, from a child's point of view*. Orchard Hill, GA: Brittany's Books.

This paperback for children aged eight to twelve explores how one young girl coped with the death of a younger sibling. Shelby's discovery of the importance of hugs and kisses after her baby sister Brittany dies of a brain tumor opens the way for talks and sharing about grief, loss, hope, and healing.

## High School and Beyond

Linn-Gust, M. (2001). *Do they have bad days in heaven? Surviving the suicide loss of a sibling.* Albuquerque, NM: Chellehead Works.

This paperback for teen and adult readers recounts the author's personal experience of losing her younger sister to suicide. Considered the first comprehensive resource for sibling suicide survivors, it offers a journey of hope. It includes available research and practical advice for survivors and those who care about them and want to help them. The author is the creator of Sibling Survivors (www.siblingsurvivors.com; see listing in "Web Sites" section below).

Ruiz, R.A. (2001). *Coping with the death of a brother or sister.* New York, NY: Rosen Publishing Company.

This hardbound book for seventh- to twelfth-graders offers honest, descriptive narratives in which young survivors of sibling loss talk about how they handled their grief. When a brother or sister dies, everything changes for the survivors, even if the death occurred when the surviving child was very young. A chapter on finding additional help and resources speaks to youngsters who may be coping with feelings of anger or rage in the aftermath of their loss.

## Books for Caregivers

Davies, B. (1998). *Shadows in the sun: The experiences of sibling bereavement in childhood*. New York: Routledge.

This study summarizes a great deal of information about how the death of a sibling affects the remaining children. The author discusses the bonds among siblings and how the survivors may react to their loss, how children understand death, how a sibling's death affects the overall functioning of the family, and the long-term effects of the death. The book includes practical guidelines for those seeking to help grieving siblings, children, and families.

DeVita-Raeburn, E. (2007). *The empty room: Understanding sibling loss*. New York, NY: Scribner.

> The author, a science journalist, tells how the death of her older brother at age seventeen of aplastic anemia (which forced him to live in a sterile hospital "bubble room" for almost half his life) affected her. She uses powerful interviews with more than 200 sibling survivors to explore how difficult it can be, and how long it can take, to finally come to terms with the grief of losing a brother or sister.

White, P. G. (2006). *Sibling grief: Healing after the death of a sister or brother*. Lincoln, NE: iUniverse.

> The author, a psychologist who specializes in working with people who have lost a sibling, was only fifteen when her sister died of a rare form of soft-tissue cancer. White draws on her own experience as well as on her professional background to explain the griefwork involved in sibling loss. She also explores how grief and healing are reflected in siblings' dreams. White is the creator of The Sibling Connection, a not-for-profit support organization and web site (http://www.counselingstlouis.net) for bereaved siblings (see listing in "Web Sites" section below).

## Videos

Compassionate Friends. (1993). *This healing path*. Northbrook, IL: Film Ideas, Inc. (VHS video).

> This 35-minute video addresses issues and concerns that affect those who are grieving the loss of a sibling. It includes an introduction by former Chicago Bears middle linebacker Mike Singletary, himself a bereaved sibling, and a discussion guide. The siblings interviewed share their pain, sadness, anger, and fear. They also discuss issues such as parental overprotectiveness and their own hope for the future as they meet the challenge of their loss.

## Web Sites

Open to Hope (http://opentohope.com/hope-online/dealing-with-grief/dealing-with-loss/death-of-a-sibling/)

> This link on the web site of the Open to Hope Foundation (www.opentohope.com), a general online grief resource, focuses specifically on sibling grief. It offers a series of first-person accounts and reflections on sibling loss, and visitors are invited to leave comments.

The Compassionate Friends (http://www.compassionatefriends.org/Local_Chapters/Frequently_Asked_Questions.aspx)

> This national organization, with chapters throughout the United States and worldwide, is dedicated to helping parents following the death of a child at any age by offering peer support groups for grieving parents. The web site also provides a list of resources.

The Sibling Connection (http://www.counselingstlouis.net/)

> Created by psychologist P.G. White, author of *Sibling grief: Healing after the death of a sister or brother* (see the listing in "Books for Caregivers"), The Sibling Connection, offers support to anyone who has lost a sibling. It includes extensive information, articles, and resources about sibling grief at different ages along the life cycle. It also lists resources on sibling loss in films, art, and psychology. Visitors can submit their own stories and communicate through the site's message board.

## CEU By Net Participants, please note the following:

**You have finished reading Study Guide 6 (i.e., Part 6) of this course.  If you have enrolled in this course, Quiz 6 is ready for you to take.  You may take it now or later.  When you are ready to take it,  log in to your My Home Page, click the name of this course (Course 5T). and then click the link to Quiz 6.**

**Thank you,**
**CEU By Net**

# The New York Life Foundation's Bereavement Survey:

**Key Findings**

In our 2017 Bereavement Survey—the latest in a series of polling initiatives on grieving children and their families—we polled 1,004 Americans and 587 Millennials/Gen Xers who had lost a parent before age 20. The survey was conducted by Pollara Strategic Insights.

## IMPACT, SCOPE, AND SUPPORT OF LOSS

**Americans Who Lost a Parent Growing Up Attest to the Long-Term Nature of Grief—Yet Support From Family, Friends Wanes Within Three Months**

- When asked how long it took before they could be happy again/move forward, the mean time among those who lost a parent growing up was 6+ years, and the most common response was "I've never been okay with my loss" (30%)

- But, over half (57%) reported that, following the loss, support from family and friends tapered off within the first 3 months; 20% say support tapered off after the first week and 21% say after the first month

- Top misperceptions about grief identified by those who lost a parent growing up include "Just because you seem okay on the outside means you must be fine on the inside" (50%), "You will eventually get over the loss" (42%), and "Feelings of grief continue to get better over time" (31%)

### LOSING A PARENT GROWING UP HAS A PROFOUND AND ENDURING IMPACT

- Nearly 80% of those who lost a parent growing up agree that losing a parent was the hardest thing they have ever had to face; 77% agree that they will always feel like a part of them is missing and 78% agree that they still think about their departed parent every day

- 72% say that they didn't know how to talk about what they were going through and 65% agree that after their parent died, they felt like there was no one they could talk to

- 59% of grievers say they have experienced more feelings of sadness or depression in their life compared to most adults

- Yet most bereaved children demonstrate resiliency: nearly four in five (79%) of those who lost a parent before age 20 felt that they had been able to move forward well after the death of their parent, and 68% felt that experiencing that loss made them better prepared to handle other adverse circumstances in their life

### FOR THOSE LOOKING TO OFFER SUPPORT TO GRIEVING FAMILIES, SIMPLEST ACTS OFTEN THE MOST POWERFUL

- Those who lost a parent growing up identified the most helpful things family and friends said or did after their loss as simple gestures like sharing stories about their loved one (37%, highest cited), remembering important dates like birthdays and death anniversaries (26%), spending holiday time with them (24%), and continuing to ask how they were doing well after the loss (23%)

- At the same time, the second most cited helpful action was to engage with them in the same manner as they did before their loss (31%)

## PUBLIC AWARENESS AND RESOURCES

### Public Dialogue About Death Is on the Rise, Yet Discomfort and Avoidance Persists

- A full 70% of Americans believe that today people are more open about issues of death and dying than they were 5-10 years ago

- 50% believe that social media has helped to open the dialogue about death and loss

- At the same time, 60% of Americans believe that grief is a private matter and 45% acknowledge that thinking and talking about death makes them uncomfortable

- Well over half (63%) of Americans say they have sometimes avoided talking to someone about their loss because they were worried they'd say the wrong thing; over half (56%) of those who lost a parent growing up say that their peers didn't know how to act around them after the loss

- Among those who lost a parent growing up, 68% say that it would have been easier to cope with their grief if our society was more open to talking about death and loss

- 85% of Americans affirm that there is a lot more we can all do to better support kids who lose a loved one growing up

#### MOST AMERICANS HAVE DEALT PERSONALLY WITH GRIEF, BUT DON'T KNOW WHERE TO TURN FOR HELP

- 80% of Americans have experienced the loss of a close friend or relative that has had a profound impact on them – however, only 46% indicate that they would know where in their community to turn for help if they suffered a loss

- 54% of those who lost a parent growing up say they struggled to find grief resources after the loss of their parent

#### ROOM FOR TEACHERS, SCHOOL COMMUNITIES TO OFFER MORE SUPPORT FOR GRIEVING STUDENTS

- Only 25% of those who had lost a parent growing up said that their school was well prepared to help them when they returned to the classroom; only 31% indicated that a teacher/administrator/counselor sought them out to offer help

- 75% of Americans agree that schools have a pivotal role to play in supporting grieving students and 81% affirm that schools should be better prepared with resources to support grieving students



## BEREAVEMENT AND FAMILY RELATIONSHIPS

### As the Loss of a Parent Forever Changes the Family Dynamic, Many Point to Need for More Family Resources and Support

- 71% of those who lost a parent growing up wish that there had been more resources available to help their surviving parent cope with his/her grief

- 62% say it was hard to balance the needs of their surviving parent with their own grief process, 68% worried a lot that something might happen to their surviving parent, and 47% said that the struggles of their surviving parent to cope with the loss had a negative impact on them

- And while many say that the loss brought them closer to their surviving parent and siblings, 62% say they wish their immediate family had done more to help them following the death of their parent (cited highest among all groups)

#### Experiencing Childhood Loss Impacts Parenting, Legacy Considerations

- 71% of those who lost a parent growing up feel that the early death of their parent affected or affects the way they parent their own child(ren)

- 72% said that losing their parent had helped them become a better parent overall, including conveying to their child(ren) the importance of never taking anyone for granted (86%) and developing more family traditions with their child(ren) (78%)

- 75% said their loss made them more concerned about making sure their own family would be cared for if something were to happen to them, and 78% said their loss prompted them to make a greater effort to document/record family memories for their own child(ren)

- Loss has an intergenerational impact: 79% said when they became a parent, they really missed having the perspective/guidance of their deceased parent and 85% wish that they could talk to their departed parent about their life as an adult
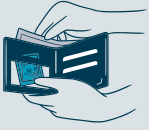
- Only a minority of Americans have taken concrete steps to prepare for their death, including purchasing life insurance (43%), discussing last wishes with family members (43%), preparing a will (33%), establishing a health care directive (17%), preparing or revising a financial plan (13%), and designating guardians for their children (10%)

- Americans cite stress, confusion, procrastination around end-of-life planning: 56% of Americans say they feel stressed out when they think about it; 65% say it's hard to know whom to trust when you're faced with big end-of-life financial planning decisions; and 68% think that planning now in the event of their death is a good idea; they just haven't done it

- Among those who lost a parent growing up, 69% agree that losing a parent made them more aware of the importance of protecting their family's finances and 47% agree that losing a parent prompted them to take steps to be better prepared financially for their own death