Journal of Creativity in Mental Health, 5:158–176, 2010

ISSN: 1540-1383 print/1540-1391 online
DOI: 10.1080/15401383.2010.485090

Routledge
Taylor & Francis Group

Resolving Child and Adolescent Traumatic Grief: Creative Techniques and Interventions

MEREDITH EDGAR-BAILEY and VICTORIA E. KRESS
Youngstown State University, Youngstown, Ohio, USA

This article presents a review of creative interventions that can be helpful in facilitating the resolution of traumatic grief in children and adolescents. Traumatic grief is conceptualized as a condition in which a person loses a close loved one (e.g., a parent or a sibling) in a traumatic manner, and ensuing trauma-related symptoms disrupt the normal grieving process. The presented creative interventions will be conceptually linked to an evidence-based, cognitive behavioral treatment model that can be used in addressing traumatic grief. The creative interventions presented will include the use of writing, storytelling, drawing, commemorating, and ritualizing in relation to traumatic grief.

KEYWORDS grief, traumatic grief, children, treatment, counseling, trauma, creativity

It is estimated that 3.5% of U.S. youth—children and adolescents under the age of 18—have experienced the death of a parent (Social Security Administration, 2000). The leading causes of death for men and women living in the United States aged 35 to 54—the most common age range of parents—include heart attacks, homicide, suicide, traffic accidents, and other accidents (World Health Organization, 2009). The unanticipated and often traumatic nature of these leading causes of parental death raises the question of how children cognitively process the traumatic aspects of their loss, in addition to navigating the typical grief process.

The loss of a parent can impact a child in a variety of clinically significant ways, and as such, the *Diagnostic and Statistical Manual of Mental*

Address correspondence to Victoria E. Kress, Department of Counseling and Special Education, Youngstown State University, Beeghley Hall, Youngstown, OH 44555, USA. E-mail: victoriaekress@gmail.com

Disorders (DSM) V-Code of Bereavement can be used when the focus of clinical counseling attention is related to the loss of a loved one (American Psychiatric Association, 2000). In addition, while there are great cultural variations, some people present for counseling with severe traumatic grief symptoms that are similar to a major depressive disorder (MDD). When these depressive symptoms last less than 2 months, they are typically coded and considered typical bereavement unless they affect the person's functioning to the point that an MDD diagnosis is warranted. Although the DSM provides a basic assessment system that can be used to diagnose bereavement, a number of more detailed conceptualizations relate to the understanding of bereavement and grief.

Adult complicated bereavement refers to a condition in which bereavement is complicated due to the nature of losing a relationship that provided significant security and dependency for the bereaved (Cohen & Mannarino, 2004). In complicated bereavement, trauma symptoms and separation distress ensue upon the loss of the relationship (Prigerson, Shear, & Jacobs, 1999). Childhood complicated bereavement or complicated grief is a construct designed to reflect a clinical syndrome that focuses on separation distress and yearning as the central features of the condition (Brown et al., 2006). Childhood and adolescent *traumatic* grief (CTG; the focus of this article) is conceptualized as a condition in which a child or adolescent loses a close loved one in a traumatic manner and subsequently develops trauma-related symptoms. These trauma symptoms are conceptualized as disrupting the typical grieving process (Cohen & Mannarino, 2004).

It is important to note that most children and adolescents who experience the loss of a loved one do not develop long-term symptoms of posttraumatic stress disorder (PTSD) or CTG (Brent, Perper, & Moritz, 1993; Brent et al., 1995; Worden & Silverman, 1996). Thus, CTG is not a typical or expected reaction to a traumatic loss and should not be treated as such (Cohen & Mannarino, 2004). In other words, it is necessary to provide the appropriate bereavement interventions and not to over-pathologize a client's experience. Currier, Holland, and Neimeyer (2007) suggest that the tendency for some mental health professionals to pathologize bereavement can contribute to a decrease in applying established grief interventions and thus delay effective intervention. When a child experiences CTG, the trauma-related symptoms associated with the death take precedence over the child's experience of the loss (Cohen & Mannarino, 2004). In these situations, the child can be inhibited—sometimes indefinitely—toward the end of normal grieving, and thus, resolving and integrating the loss he or she has encountered becomes problematic.

There is a paucity of literature related to the use of specific interventions that can be helpful in intervening with CTG. This article will present a review of creative interventions that can be helpful in facilitating the resolution of traumatic grief in children and adolescents. Because cognitive-behavioral

therapy (CBT) is an evidence-based approach to treating CTG (Cohen & Mannarino, 2004), the presented creative interventions will be linked—theoretically—to this model. More specifically, the creative interventions presented will include the use of writing, storytelling, drawing, commemorating, and ritualizing in relation to treatment of traumatic grief. Examples of specific creative techniques that counselors may employ in addressing CTG will be presented.

COGNITIVE-BEHAVIORAL THERAPY

Much of the treatment literature related to addressing CTG focuses on the use of either play therapy or CBT (Brown, Pearlman, & Goodman, 2004; Cohen & Mannarino, 2004; Salloum & Overstreet, 2008; Webb, 2003). CBT, and more specifically, trauma-focused cognitive behavioral therapy (TFCBT), is widely considered to be the most effective, evidence-based approach to treating CTG (Cohen & Mannarino, 2004), and as such, in this article, it will be the theoretical model used to support the use of creative interventions.

A combination of trauma-focused and grief-focused interventions demonstrate the largest reduction of PTSD and depressive symptoms in children and adolescents with CTG symptoms (Layne et al., 2001). Trauma-focused interventions focus on affective expression skills, stress management skills, creation of the child's trauma narrative, and cognitive processing (Cohen & Mannarino, 2004). Grief-focused interventions focus on talking about death, mourning the loss, addressing ambivalent feelings, preserving positive memories, redefining the relationship, committing to other relationships, and meaning-making out of the loss (Cohen & Mannarino, 2004). Trauma- and grief-focused interventions typically both include joint parent-child sessions.

TFCBT is a demonstrated effective treatment for decreasing an array of child psychological problems (Cohen & Mannarino, 1996, 1998). Many malleable risk factors and protective factors for bereaved youth are related to cognitions and can be increased or decreased—as appropriate—using CBT interventions (Haine, Ayers, Sandler, & Wolchik, 2008). For example, enhanced self-esteem can be facilitated by creating positive self-statements/self-talk related to general or bereavement-specific themes. Alternatively, exploring the problems created by negative self-statements can encourage the use of more hopeful cognitive schemas. CBT can also be used to focus on increasing a child's adaptive beliefs regarding control. Healthy control beliefs involve recognition of the inability to control uncontrollable events and recognition of events that are under one's control (Haine et al., 2008).

Before beginning CBT-related creative interventions, it is important to assess and enhance a client's ability to self-regulate emotional reactions and thus to self-soothe. Early childhood experiences of trauma, especially

ongoing traumas, affect the development of the brain's lower regulatory areas (brainstem and diencephalons). Perry and Hambrick (2008) assert that primitive coping mechanisms developed early in life due to trauma create an oversensitive stress response that will make even the best CBT interventions difficult to use. Therefore, Perry and Hambrick (2008) suggest that when counseling this population, it is first necessary to focus on issues of arousal, impulsivity, self-regulation, and attention by using somatosensory activities that provide new "patterned neural activation necessary for reorganization" (p. 42). These interventions could include promoting sensory-based, calming activities such as music, regulated movement, or yoga (Krout, 2007; Perry & Hambrick, 2008). After improvements have been made in these lower regulatory systems, it is more appropriate to work toward goals that use the cortical and limbic brain systems, such as improving relational issues, gaining insight, and focusing on shifting cognitions. Thus, prior to the application of the cognitive interventions discussed in this article, it may be necessary to help children and adolescents develop their emotion-regulation capacities. Crenshaw (2007) discusses this in terms of creating a sense of safety, primarily through establishing a safe and secure counseling space and a strong therapeutic relationship founded in a genuine connection with the child. The aforementioned goal can be achieved by using soothing music, peaceful imagery, and controlled breathing in session. Krout (2007), in a review of research on music listening to facilitate relaxation, found that although research is not conclusive, in general, music that is chosen by clients is more effective than counselor-generated selections. Therefore, due to the subjectivity involved, it is best if counselors allow clients to make music selections.

Counselors who choose to use CBT-related creative interventions with clients must also be adequately prepared before the implementation of such techniques (Ponniah & Hollon, 2009). Ehlers et al. (2010) noted that to obtain the maximum desired impact, it is important that therapeutic techniques be competently delivered. Based on past training and experiences, counselors may require a different amount of formal training and practice to gain a sufficient understanding and ability to use certain therapeutic techniques. However, it is imperative that every counselor reaches a level of mastery before using the techniques presented in this article (Benish, Imel, & Wampold, 2008). CBT-based creative interventions can create a strong reaction within clients, and counselors should be fully prepared and capable to help clients manage these reactions.

USING CREATIVE ARTS IN RESOLVING TRAUMATIC GRIEF

In this article, as related to a CBT foundation, creative interventions that facilitate shifts in clients' cognitions and meanings related to the traumatic

loss will be emphasized. Children experiencing CTG may feel as though they have lost control and are often inhibited from progressing through the grieving process due to their trauma-related symptoms (e.g., reexperiencing and hyperarousal; Cohen & Mannarino, 2004). Using creative interventions can facilitate a sense of control by allowing clients to have choices in how the grief treatment is approached; regardless of the intervention chosen, the child is able to garner a sense of control by choosing the words, colors, and artistic mediums used and the topics to be explored.

Reminiscing, an ability necessary for resolving uncomplicated bereavement, is often inhibited in CTG due to disturbing images that come to mind when children think about their lost loved one (Cohen & Mannarino, 2004; Pynoos, 1992). Creative arts provide an opportunity for children to create visual and tangible alternatives to disturbing images. Creative interventions also provide opportunities for the counselor to identify cognitive distortions related to a child's sense of responsibility for the trauma, ideas regarding future safety, and feelings of guilt and shame (Cohen & Mannarino, 2004). The ability to create something of beauty, or even just a new and different image, opens the door to the possibility of cognitive shifts and the construction of different meanings related to the traumatic loss. The use of creative arts enhances the creation of personal meaning as the child's own unique imprint is imbedded in the work.

Interventions using creative modalities are helpful, as people are often able to express feelings or experiences through creative venues such as poems, drawings, and songs in a way they are not able to express verbally (Crenshaw, 2005; Webb, 2003). Clients with CTG often struggle with connecting to a wide range of painful and complicated feelings; an expansive continuum of modalities helps the clients connect with these experiences. Singing, dancing, and other movement techniques may help to connect someone's mental, physical, emotional, and spiritual experiences, and these creative modalities often provide rich material that can be used in counseling (Webb, 2003). Although a functional level of affect modulation in a child is recommended before beginning creative interventions (Crenshaw, 2007; Perry & Hambrick, 2008), using creative interventions later in counseling can also enhance affect regulation.

Children and adolescents often have conflicted feelings related to their loss, and the use of creativity in counseling can be an excellent way to help them identify and manage these feelings. A child can express painful emotions through creative arts and still maintain a protective distance from his or her own personal experience. Clients need to acknowledge and better understand their sometimes-conflicting feelings about the deceased (e.g., "I love and miss my parent, yet I am angry at him/her for leaving me"). Depending on the client's developmental level, he or she may find it difficult to understand that he or she can have diametrically opposed feelings about the deceased (Crenshaw, 2007). Detaching from emotions is

detrimental for a child's future relationships, and connecting with their emotions is essential to their healing (Crenshaw, 2007). On a more practical level, engaging in creative activities may enhance a child's skill set in language and communication, and specific artistic skills may contribute to feelings of positive self-esteem and self-worth.

The social isolation experienced by some bereaved people—especially those whose loss circumstances are particularly traumatic—can be helped with creative interventions that promote self-expression (O'Connor, Nikoletti, Kristjanson, Faaaai, & Willcock, 2003). The ability of a child to trust an adult enough to express painful emotions is a key component to breaking down feelings of isolation, mistrust, and cynicism. Expressing these emotions can be extremely difficult for a child, and expressive therapies can assist in this process (Crenshaw, 2007). When the subject matter associated with the traumatic event is particularly stigmatizing (i.e., suicide or criminal activity) or if the family unit and/or culture in which the child lives does not openly embrace the topic for discussion, the use of symbolism and metaphor connected to creative arts can provide the child with a sense of liberation from an emotionally repressive environment. Creative arts allow children to expose themselves to the traumatic aspects of their loss through the lens of personal ownership of their work. These experiences may promote a strengthened internal locus of control and enhance the child's perception that he or she can cope with grief and loss.

TFCBT treatment goals of decreasing avoidance behaviors related to triggers of the traumatic event may be better achieved when engaging a child in a therapy process incorporating pleasurable and purposeful creative activity. Jensen-Doss, Cusack, and de Arellano (2008) stated that it is imperative that therapists who deliver treatment through this modality have adequate training that will allow them to use this technique effectively. Workshops are an acceptable and effective way for counselors to gain the necessary training and preparation for the use of TFCBT, but more extensive on-the-job training and consultation are also recommended (Jensen-Doss et al., 2008).

SPECIFIC CREATIVE COUNSELING INTERVENTIONS

In this section, specific creative counseling interventions will be introduced and described. Ways in which these creative interventions can be used in conjunction with CBT when addressing traumatic grief will be addressed. It is important to note that none of these techniques are intended to stand alone as a means of treating CTG, but rather, they serve as tools to enhance CBT-based therapy and the resolution of traumatic grief. Supplemental techniques provide maximum effectiveness when used in conjunction with a strong understanding of CBT (Benish et al., 2008; Ehlers et al., 2010;

Ponniah & Hollon, 2009). A well-developed understanding of CBT and specific CBT-related creative techniques can be achieved through workshops, seminars, consultation, or trainings; the necessary intensity and frequency of these educational techniques will vary with each counselor (Jensen-Doss et al., 2008).

Writing and Drawing Trauma Narratives

In their model of TFCBT for treating CTG, Cohen and Mannarino (2004) suggest having the client develop a trauma narrative. This technique includes cognitively processing the traumatic event(s) at length and specifically addressing the "worst moment" in an attempt to raise the client's tolerance for experiencing the reality of such events. After the client describes the "worst moment" in session, the counselor should review any thoughts the client has that are inaccurate or unhelpful. The client also needs to understand how these distorted thoughts may have affected his or her behavior and feelings in the situation (Cohen & Mannarino, 2004). If a child experiences a high level of reactivity, previously taught relaxation techniques should be employed. Increased tolerance, in conjunction with emotion regulation and stress management training, is believed to reduce the likelihood of the child engaging in destructive avoidance behaviors in response to future traumatic triggers (Cohen & Mannarino, 2004).

One way to punctuate the telling of the narrative is to write about the experience. Eppler and Carolan (2005) discuss how using narratives or talking about one's traumatic experiences and/or biblionarratives, such as when a client writes about their traumatic experiences, can help counselors better assess and understand the client's relationship to the experience and can facilitate meaningful client cognitive shifts.

Writing about the story can deepen the reprocessing of the events. After the child shares his/her verbal story with the counselor, the written story is completed and discussed. A biblionarrative storyboard template can be provided to assist in the writing process that includes prompts such as:

> Before my mom/dad died . . . ;
> When I found out my mom/dad died . . . ; and
> Now when I think about my mom/dad . . . (Eppler & Carolan, 2005, p. 36)

These prompts are intended to be open ended and provide direction to the child's story while allowing the child to be the driving force in the story's construction. If the child should appear stuck, the counselor can ask more general prompts, such as, "Who else was involved?" or "What happened

next?" This intervention can assist in the cognitive reprocessing of events prior to, during, and after the traumatic event. Coping skills and social supports can be identified as well. By paying special attention to the child's word choice in the narrative, the counselor can use the same words to join with the clients, or the counselor can reframe language to cast a new light on the situation (Eppler & Carolan, 2005). Additionally, drawing a trauma narrative is another means of enhancing the trauma narrative experience. Especially with younger children who cannot write, drawing the trauma narrative can provide a means of facilitating cognitive shifts.

Through the use of verbal prompts, life stories/narratives can be rewritten or redrawn from stories of tragedy to stories of hope. Counselors can ask their clients to rewrite the narrative as they believe it will be in the near future when they have healed more. Regardless of the modality employed, the construction and cognitive processing of the trauma narrative provides a systematic order to cognitively process traumatic material that is often overwhelming and confusing to a child. Understanding the cognitive triangle, or the interconnected relationships between thoughts, feelings, and behaviors, is an essential aspect of resolving traumatic grief (Cohen & Mannarino, 2004). Specifically, it is important for children to understand how their negative/problematic feelings and behaviors may be related to cognitions about the trauma that are inaccurate or unhelpful. When there is awareness of such relationships, there is opportunity to modify the distorted cognitions (Cohen & Mannarino, 2004).

These writing and drawing techniques can be used with clients individually or with other family members. Using this technique with different family members can provide the counselor with insight into the varying perspectives of family members as well. Using the technique with the family as a whole can demonstrate family dynamics and foster an emotional connectedness amongst members as they work on a common task. The counselor can use prompts like, "What will the family do when the grief is not so intense?" to foster hope and a solution focus. The counselor can use the biblionarrative technique in a family session to assess boundaries, communication styles, unwritten family rules, and other dynamics (Eppler & Carolan, 2005). Before using creative arts interventions in this way, counselors should have clinical competency and/or supervision in family interventions and should be skilled in incorporating a systems approach (Kissane, Bloch, McKenzie, McDowall, & Nitzan, 1998).

Epitaphs

Neimeyer (1999) provides several strategies that facilitate the cognitive or meaning reconstruction that is critical to the traumatic grieving process. Children need to integrate their traumatic experiences into a broader meaning for their life appropriate to their cognitive developmental level. This

involves recognizing how the loss has affected and changed their personhood, as well as acknowledging the stable aspects of themselves, which were not changed by the loss (Andrews & Marotta, 2005; Cohen & Mannarino, 2004). Identifying themes of a hopeful and optimistic nature and transforming traumatic events into pieces of a larger, more hopeful "story" of the client's life can facilitate meaning reconstruction (Neimeyer, 1999). An epitaph, a short text honoring a deceased person, is one such strategy. Although the epitaph itself is a short statement, if it is to help in facilitating meaning reconstruction, it should be created with contemplation for the complexity of the experience it commemorates (Neimeyer, 1999). Epitaphs can be used as a new cognition to interrupt unhelpful cognitions regarding the loss. Creating epitaphs is one way of clarifying the meaning of a loss in the form of a brief affirmation regarding the meaning of the relationship. The creation of this short statement of meaning can be something a client is able to access and easily remember, and it provides a quick connection to a source of strength when painful emotions arise. Although the process of creating an epitaph can take time, the brevity of the statement makes it accessible for younger children with limited writing skills. Although all epitaphs are personalized, some examples are provided here:

> Hush my dear, be still, and rest: An angel guards your bed.
> A mother's love will inspire me for all days.
> Happy memories of my brother can never be removed from my heart.

Acrostic Poems

Poetry therapy has been effectively used in conjunction with CBT to assist clients in processing the totality of a loved one's life, not just the traumatic circumstances surrounding the death (Mazza, 2001; Stepakoff, 2009). Acrostic poems are one of many facilitated/guided expressive forms used by poetry therapists that provide an outlet for containing strong emotions via a written format (Stepakoff, 2009). This technique is useful in CTG because it focuses attention on commemorating the loved one in positive images that may counterbalance the traumatic imagery associated with the death (Stepakoff, 2007). First, the loved one's name is written vertically down the side of the page, then each letter of the name is used to begin a line that captures a positive quality or memory of the loved one (Stepakoff, 2009). Following is an example of an acrostic poem developed by the first author:

> **S**mile spread across a room
> **Al**ways knew how to comfort a friend
> **S**illy and serious

Hopeful about the future
A connection to joy coming from within

A discussion of memories of the loved one may help the client identify appropriate descriptive words that can be used with this activity. Clients may also be invited to develop accompanying pictures that visually depict their acrostic poem.

Unfinished Sentences/Writing Prompts

Unfinished sentences or sentence stems are a way to engage younger children in a writing activity that elicits discussion of emotion-laden topics (Robinson, Rotter, Robinson, Fey, & Vogel, 2004; Sandler et al., 1996). These writing prompts are most useful when they foster an understanding of the cognitive triad. Sentence stems should help the child make connections between their thoughts, feelings, and behaviors. These activities can facilitate cognitive processing and reframing of irrational and/or unhelpful cognitions. Following are some examples of unfinished sentences:

> When I (see, pass by, hear) _____, I think about_____, and I feel_____.
> During the _____, I was scared when_____.
> When I heard that _____, I felt_____.
> The times when I feel most sad about my parent's death are_____.
> (Robinson et al., 2004; Sandler et al., 1996)

Counselors can also develop sentences unique to their clients based upon information the counselor is attempting to garner or encourage the client to explore.

Life Imprints

One way to memorialize a deceased loved one is to trace his or her imprint on the life of the bereaved (Neimeyer, 1999). By exploring the impact of the lost loved one on the child's perceptions, behavior, and manner of communicating, a dialogue is opened up regarding the cognitive connections between feelings and behavior. Understanding the cognitive triangle can help children improve affective modulation, problem-solving, and social skills, which are essential components of TFCBT (Cohen & Mannarino, 2004). Crenshaw (2007) also stresses the importance of the counselor to not focus solely on what has been lost but to emphasize the aspects of attachment between the client and the deceased that are timeless. These lessons may include lessons learned, values internalized, and the influence of the deceased upon the client's life. Neimeyer (1999) provides a template to

facilitate this task and he suggests having clients address the following in relation to the deceased:

> The person whose imprint I want to trace is _____.
> This person has had the following impact on _____.
> My mannerisms and gestures _____.
> My way of speaking and communicating _____.
> My hobbies and pastime activities _____.
> My basic personality _____.
> My values and beliefs _____.
> The imprints I would most like to affirm and maintain are _____.
> The imprints I would most like to let go of or change are _____. (p. 76)

The last two items on the template lend themselves to exploring ambivalent feelings that a client may be experiencing related to the deceased. Because youth often tend to identify with one emotion to the extreme, it is important for the counselor to help them put conflicting emotions into a meaningful and balanced perspective (Crenshaw, 2007). It can be empowering for the child to explore their choices and determine which legacies they want to hold onto and which they want to relinquish.

Journaling

Daily journaling about traumatic loss and emotional/cognitive/physical reactions to the loss can provide clients with material for reflection both in and out of counseling sessions. Inaccurate or unhelpful cognitions that need to be addressed can be modified through journaling (Cohen & Mannarino, 2004; Neimeyer, 1999). Journaling can highlight connections between thoughts, feelings, and behaviors and provide an outlet for a range of emotions that the child may not yet feel comfortable verbally expressing. The counselor can encourage the client to note physiological and psychological reactions experienced or to monitor the severity of traumatic symptoms that may not be presented or experienced directly in counseling sessions. It is important to encourage the client to observe how the writing changes over time, perhaps from a state of anguish to a more reflective state, or from making strides toward acceptance to emotional setbacks (Neimeyer, 1999). When the writing process taps into strong emotion, it is important that a client has learned in therapy to utilize a transitional, anxiety-management activity (i.e., controlled breathing or progressive muscle relaxation) to return to other daily activities successfully (Neimeyer, 1999). O'Connor et al. (2003) found higher levels of self-care among grieving individuals participating in a journal writing intervention. Enhanced self-care is important, as it is an indicator of adjustment to loss and a protective factor against the negative psychological and physical impacts of bereavement (O'Connor et al., 2003).

Bibliotherapy and Creative Writing

Bibliotherapy and journaling can be combined as a way to assist clients in talking about grief and loss. When clients can connect with a character's feelings in a story or poem, it can assist them in expressing similar emotions (Heath et al., 2008; Stepakoff, 2009). Therefore, trauma symptoms, such as feeling estranged or disconnected from others and experiencing a restricted range of affect, may be reduced. Heath et al. (2008) and O'Connor et al. (2003) provide resource lists of children's books dealing with loss and activities and writing prompts to accompany the bibliotherapy assignments. Incorporating poetry therapy into counseling practice is detailed in the classic text *Biblio/Poetry Therapy: The Interactive Process* (Hynes & Hynes-Berry, 1994). The writing prompts should focus on how the child can relate to characters' losses in the story, how loved ones can be remembered, and how to develop coping skills and support systems. These resources are categorized according to age/developmental level and according to socio-cultural factors to ensure that assignments are developmentally appropriate and align with the families' cultural traditions. Bibliotherapy selections should not include any magical explanations for death but should provide hope for the future (Heath et al., 2008).

Letter Writing

Writing letters to the deceased is another creative intervention that can be helpful in addressing CTG (Stepakoff, 2009). When letters are discussed in therapy, it provides a window into cognitions a child may have related to unrealistic self-blame, fear, or other fantasies of revenge (Cohen & Mannarino, 2004). CTG often contains elements of unfinished business in that the traumatic nature of the loss often prevented the child from having the opportunity to say good-bye. A critical step of mourning is gradually withdrawing the client's emotional investment in the deceased to move forward with living. This can be even more difficult if the child feels there was much left unsaid to the deceased (Crenshaw, 2007). Letter writing is a way to provide the means to say what was unsaid and facilitate a future orientation. As letters can be saved and reviewed at a later date, letter writing may also be helpful in coping with the difficult reminders of the loved one during special occasions, such as birthdays, anniversaries, and holidays, by creating an ongoing connection with the deceased (Stepakoff, 2009).

Drama

Drama therapy uses role-play to concretize moments in a client's life and provides an opportunity to process material on a psychological, emotional, and sensorial level (Dayton, 2005). Dramatic enactments engage clients in

grounding to the present moment and to being aware of their presence in their own body. Some clients may not be ready or able to talk about a trauma directly upon entering counseling. Creating stories through play is a way to talk with a child about death and validate feelings of anger, fear, and sadness about the death without initially talking directly about the loss. These stories can be acted out using puppets or dramatized by the child or the counselor. Integrating the dramatic process in therapy incorporates children's earliest-developed skills of gestural communication into the expressive process (Dayton, 2005). This process fosters a here-and-now orientation, requiring participants to be attentive to each other's spontaneous gestural and emotional communication, thereby increasing self-awareness and body awareness, enriching relational skills, and promoting emotional and physical integration (Curtis, 1999; Dayton, 2005).

For older children who are prepared to address the traumatic loss directly, the empty-chair technique can be useful in revising a conversation with the deceased that the child would like to change or by providing an opportunity for an interaction that never occurred. The best-friend role-play can be used when a child is having difficulty identifying alternative thoughts to challenge their unhelpful or inaccurate ones (Cohen & Mannarino, 2004). With this technique, the child is asked to role-play what he or she would say to a friend regarding how to think about the situation. This approach can incorporate writing techniques, such as letter writing, and has the added dimension of immediacy, which is inherent in such an experiential technique.

Commemoration/Rituals

Commemorating rituals provide children with an opportunity to engage in the present moment by creating meaningful behavior that reframes their tragedy in light of a significant purpose (Cohen & Mannarino, 2004). Commemorating a lost loved one can be achieved through planning a memorial service, funeral, or vigil and by finding a meaningful way to honor the life of the deceased (Crenshaw, 2007). While planning a funeral would be a one-time event, vigils, memorials, and other rituals celebrating the lost loved one's contribution could occur monthly or annually, according to each client's needs and abilities. These rituals can take place within sessions or within the community.

Planting

Part of making meaning out of traumatic loss involves children reconciling the experience into a broader understanding of themselves and the world in which they live (Cohen & Mannarino, 2004). Discussing problems and emotions outdoors can provide the client and counselor with a new perspective. Being physically positioned against the backdrop of nature can aid

in viewing problems from a broader, more holistic perspective, promoting openness to cognitive shifts targeted in treatment. Nature can be a useful therapeutic setting as it acts as a neutral territory, enhancing feelings of equality and connectedness as opposed to an indoor office, which has the intended purpose of counseling (Berger, 2008). Interacting with others in an outdoor setting enhances the client's ability to adapt and develop more flexibility. Additionally, nature per se can be used as an intervention. For example, planting a memorial tree or garden has been a long-standing tradition for commemorating a lost loved one (Crenshaw, 2007). Even deeper meaning can be garnered from this experience by purposefully choosing the plant(s)/tree according to the preferences of the deceased and the blooming season. It may give the child special comfort to see the plant/tree blooming during a particular season, such as the loved one's birthday or the time that the death occurred, as an ongoing reminder of the lingering presence of the deceased.

Linking Objects

Linking objects, or objects kept with a child to maintain their relationship with the deceased, can provide comfort and a sense of connection to the bereaved (Andrews & Marotta, 2005). Andrews and Marotta (2005), using a qualitative methodology, interviewed six children aged 4 to 9 years and found that linking objects were used by the children to maintain and develop their relationship with the deceased. Examples of linking objects the children used were clothing or jewelry items of the deceased, pictures, and toys.

Affective modulation can be enhanced by identifying objects and images that provide comfort secondary to the traumatic images a child encounters surrounding the loss. Deliberately deciding which items will be kept as keepsakes and mementos and how these objects will be incorporated into the child's life is a strategic way of preserving the memory of the deceased rather than keeping every item belonging to the lost loved one (Neimeyer, 1999). There is much opportunity for cognitive processing regarding the child's choice of items and what these items represent.

Drawing/Painting/Collage

Artistic expression through drawing, painting, and other mediums provides children with opportunities to convey thoughts and feelings they may not have otherwise expressed and may provide indications of cognitive distortions to be explored in therapy. Webb (2003) provided some examples of visual art techniques that could be used with children: a) drawing with color the location of different feelings associated with grief on a body profile; b) painting or drawing a picture of the funeral or other experience

connected to the death; c) making paper plate masks showing on one side the feelings shown to the outside world and on the other, one's inner, private feelings; and d) creating a memory book or box containing items and reminders specifically related to the person who died. Especially when the child has few positive memories or in extremely traumatic circumstances, the child is likely to deeply treasure any positive memories that can be preserved in a memory book, box, or collage. Photographs of the child being held or cherished by the deceased help to concretize the image in the child's mind (Crenshaw, 2007).

Crenshaw (2005) discussed several projective drawing techniques to help clients who may be less inclined toward verbal expression and/or those who feel a need to keep a safe distance from the profound loss. By using symbolism and metaphor—rather than directly confronting the trauma—some clients are able to better cognitively process their experiences. Crenshaw (2005) suggested using stories as a way to address the issues associated with traumatic grief. For example, *The Magic Key* is a projective drawing technique proposed by Crenshaw (2005) that prompts the child to imagine they have been given the magic key to a room that contains the one thing missing from their life or the one thing they always believed would make them happy. After visualizing a clear picture, the child is then asked to draw what is seen as accurately as possible. Other prompts for painting, drawing, or collage work that can be useful surround the themes of the circle/cycle of life. This concept can be artistically explored and later discussed by having a child focus on a tree growing and changing through various seasons, a caterpillar becoming a butterfly, or a melting snowman providing water to nourish the seeds of spring's new life (Curtis, 1999). Nature often provides such fitting metaphors for life and the challenges it presents. These metaphors, when processed creatively, can be useful tools for enhancing a child's feeling of connectedness with their larger environment during a time wrought with alienation.

DISCUSSION

In summary, this article has addressed specific, creative ways that counselors can use to work toward helping child and adolescent clients decrease traumatic grief and facilitate the normal grieving process. The creative techniques discussed all relate to an evidence-based cognitive behavioral model for addressing traumatic grief (Cohen & Mannarino, 2004).

CBT-related creative techniques can be very effective and very powerful; counselors should be sure they are adequately trained and prepared to deliver such techniques. Developing emotion-regulation techniques, creating a strong, connected therapeutic bond, and facilitating a reasonable measure of safety are all precursors to the creative interventions being suggested. Due

to the sensitive nature of the material being processed in therapy, counselors need to be able to discern when there is a need to downshift the level of therapy intensity (Crenshaw, 2005). A counselor using these interventions should be skilled in incorporating a transitional period into the session to provide many opportunities for the client to reorient and become grounded to the present moment prior to ending a session.

As previously mentioned, it is important that clients are able to regulate strong emotions and have basic affect-regulation and anxiety-management skills prior to implementing any of the interventions discussed in this article. Upon completion of a thorough assessment, counselors might spend time developing a client's affect-regulation skills prior to implementing various creative interventions.

In addition to difficulties with basic anxiety management, additional general client contraindications to the use of creative counseling intervention are as follows: active psychotic processes, active homicidal or suicidal ideation, severe substance abuse, strong narcissistic or borderline personality traits or features, and clients who cannot discuss abuse experiences without intense, uncontrollable anxiety, dissociative, or depressive episodes (Kress, Hoffman, & Thomas, 2008).

Creative counseling techniques are a potentially useful treatment modality for CTG survivors. These creative interventions may facilitate this population's ability to connect with new, more adaptive realities.

REFERENCES

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.

Andrews, C. R., & Marotta, S. A. (2005). Spirituality and coping among grieving children: A preliminary study. *Counseling and Values, 50*, 38–50.

Benish, S. G., Imel, Z. E., & Wampold, B. E. (2008). The relative efficacy of bona fide psychotherapies for treating posttraumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28*, 746–758. doi:10.1016/j.cpr.2007.10.005

Berger, R. (2008). Building a home in nature: An innovative framework for practice. *Journal of Humanistic Psychology, 48*, 264–279. doi:10.1177/0022167807306990

Brent, D. A., Perper, J. A., & Moritz, G. (1993). Psychiatric sequelae to the loss of an adolescent peer to suicide. *Journal of the American Academy of Child & Adolescent Psychiatry, 32*, 509–517. doi:10.1097/00004583–199305000–00004

Brent, D. A., Perper, J. A., Moritz, G., Liotus, L., Richardson, D., Canobbio, R., . . . Roth, C. (1995). Posttraumatic stress disorder in peers of adolescent suicide victims: Predisposing factors and phenomenology. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*, 209–215. doi:10.1097/00004583-199502000-00016

Brown, E. J., Amaya-Jackson, L., Cohen, J., Handel, S., Bocanegra, H. T., Zatta, E., . . . Mannarino, A. (2006). Childhood traumatic grief: A multi-site empirical examination of the construct and its correlates. *Death Studies, 32*, 899–923.

Brown, E. J., Pearlman, M. Y., & Goodman, R. F. (2004). Facing fears and sadness: Cognitive-behavioral therapy for childhood traumatic grief. *Harvard Review of Psychiatry, 12*, 187–198. doi:10.1080/07481180802440209

Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry, 35*, 42–50.

Cohen, J. A., & Mannarino, A. P. (1998). Interventions for sexually abused children: Initial treatment findings. *Child Maltreatment, 3*, 17–26. doi:10.1097/00004583-199601000-00011

Cohen, J. A., & Mannarino, A. P. (2004). Treatment of childhood traumatic grief. *Journal of Clinical Child and Adolescent Psychology, 33*, 819–831. doi:10.1207/s15374424jccp3304_17

Crenshaw, D. A. (2005). Clinical tools to facilitate treatment of childhood traumatic grief. *Omega: Journal of Death and Dying, 51*, 239–255.

Crenshaw, D. A. (2007). An interpersonal neurobiological-informed treatment model for childhood traumatic grief. *Omega: Journal of Death and Dying, 54*, 319–335.

Currier, J. M., Holland, J. M., & Neimeyer, R. A. (2007). The effectiveness of bereavement interventions with children: A meta-analytic review of controlled outcome research. *Journal of Clinical Child and Adolescent Psychology, 36*, 253–259.

Curtis, A. M. (1999). Communicating with bereaved children: A drama therapy approach. *Illness, Crisis, & Loss, 7*, 183–190.

Dayton, T. (2005). The use of psychodrama in dealing with grief and addiction-related loss and trauma. *Journal of Group Psychotherapy, 58*, 15–34. doi:10.3200/JGPP.58.1.15–34

Ehlers, A., Bisson, J., Clark, D., Creamer, M., Pilling, S., Richards, D., . . . Yule, W. (2010). Do all psychological treatments really work the same in posttraumatic stress disorder? *Clinical Psychology Review, 30*, 269–276. doi:10.1016/j.cpr.2009.12.001

Eppler, C., & Carolan, M. T. (2005). Biblionarrative: A narrative technique uniting oral and written life stories. *Journal of Family Psychotherapy, 16*, 31–43. doi:10.1300/J085v16n04_04

Haine, R. A., Ayers, T. S., Sandler, I. N., & Wolchik, S. A. (2008). Evidence-based practices for parentally bereaved children and their families. *Professional Psychology: Research and Practice, 39*, 113–121. doi:10.1037/0735–7028.39.2.113

Heath, M. A., Leavy, D., Hansen, K., Ryan, K., Lawrence, L., & Gerritsen Sonntag, A. (2008). Coping with grief: Guidelines and resources for assisting children. *Intervention in School & Clinic, 43*, 259–269. doi:10.1177/1053451208314493

Hynes, A., & Hynes-Berry, M. (1994). *Biblio/poetry therapy: The interactive process*. St. Cloud, MN: North Star Press.

Jensen-Doss, A., Cusack, K. J., & de Arellano, M. A. (2008). Workshop-based training in trauma-focused CBT: An in-depth analysis of impact on provider

practices. *Community Mental Health Journal, 44*, 227–244. doi:10.1007/s10597-007-9121-8

Kissane, D. W., Bloch, S., McKenzie, M., McDowall, A. C., & Nitzan, R. (1998). Family grief therapy: A preliminary account of a new model to promote healthy family functioning during palliative care and bereavement. *Psycho-Oncology, 7*, 14–25. doi:10.1002/(SICI)1099-1611(199801/02)7:1<14::AID-PON313>3.0.CO;2-D

Kress, V. E., Hoffman, R., & Thomas, A. M. (2008). Letters from the future: The use of therapeutic letter writing in counseling sexual abuse survivors. *Journal of Creativity in Mental Health, 3*, 105–118. doi:10.1080/15401380802226497

Krout, R. E. (2007). Music listening to facilitate relaxation and promote wellness: Integrated aspects of our neurophysiological responses to music. *The Arts in Psychotherapy, 34*, 134–141. doi:10.1016/j.aip.2006.11.001

Layne, C. M., Pynoos, R. S., Saltzman, W. S., Arslanagic, B., Black, M., Savjak, N., . . . Houston, R. (2001). Trauma/grief-focused group psychotherapy: School-based postwar intervention with traumatized Bosnian adolescents. *Group Dynamics: Theory, Research, and Practice, 5*, 277–290. doi:10.1037/1089–2699.5.4.277

Mazza, N. (2001). The place of the poetic in dealing with death and loss. *Journal of Poetry Therapy, 15*, 29–36. doi:10.1023/A:1012962923701

Neimeyer, R. A. (1999). Narrative strategies in grief therapy. *Journal of Constructivist Psychology*, *12*, 65–85. doi:10.1080/107205399266226

O'Connor, M., Nikoletti, S., Kristjanson, L. J., Faaaai, R. L., & Willcock, B. (2003). Writing therapy for the bereaved: Evaluation of an intervention. *Journal of Palliative Medicine, 6*, 195–204. doi:10.1089/109662103764978443

Perry, B. D., & Hambrick E. P. (2008). The neurosequential model of therapeutics. *Reclaiming Children and Youth, 17*(3), 38–43.

Ponniah, K., & Hollon, D. (2009). Empirically supported psychological treatments for adult acute stress disorder and posttraumatic stress disorder: A review. *Depression and Anxiety, 26*, 1086–1109. doi:10.1002/da.20635

Prigerson, H. G., Shear, M. K., & Jacobs, S. C. (1999). Consensus criteria for traumatic grief: A preliminary empirical test. *British Journal of Psychiatry, 154*, 1003–1009.

Pynoos, R. S. (1992). Grief and trauma in children and adolescents. *Bereavement Care, 11*, 2–10.

Robinson, E. H., Rotter, J. C., Robinson, S. L., Fey, M. A., & Vogel, J. E. (2004). *Fears, stress, and trauma: Helping children cope*. Greensboro, NC: CAPS Press.

Salloum, A., & Overstreet, S. (2008). Evaluation of individual and group grief and trauma interventions for children post disaster. *Journal of Clinical Child & Adolescent Psychology, 37*, 495–507. doi:10.1080/15374410802148194

Sandler, I. N., Ayers, T. S., Twchey, J. L., Lutzke, J. R., Li, S., & Kriege, G. (1996). *Family Bereavement Program group leader intervention manual for child program*. Tempe, AZ: Arizona State University Program for Prevention Research.

Social Security Administration. (2000). *Intermediate assumptions of the 2000 trustees report*. Washington, DC: Office of the Chief Actuary of the Social Security Administration.

Stepakoff, S. (2007). The healing power of symbolization in the aftermath of massive war atrocities: Examples from Liberian and Sierra Leonean survivors. *Journal of Humanistic Psychology, 47*, 400–412. doi:10.1177/0022167807301787

Stepakoff, S. (2009). From destruction to creation, from silence to speech: Poetry therapy principles and practices for working with suicide grief. *The Arts in Psychotherapy, 36*, 105–113. doi:10.1016/j.aip.2009.01.007

Webb, N. B. (2003). Play and expressive therapies to help bereaved children: Individual, family, and group treatment. *Smith College Studies in Social Work, 73*, 405–422. doi:10.1080/00377310309517694

Worden, J. W., & Silverman, P. R. (1996). Parental death and the adjustment of school-age children. *Omega: Journal of Death and Dying, 29*, 219–230.

World Health Organization. (2009). *Health situation in the Americas: Basic indicators*. Retrieved from http://www.paho.org/English/DD/AIS/HSA2006_Table1.htm

Meredith Edgar-Bailey *is a graduate student in the Department of Counseling and Special Education at Youngstown State University, Youngstown, Ohio.*

Victoria E. Kress *is a Professor in the Department of Counseling and Special Education at Youngstown State University, Youngstown, Ohio.*