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ORIGINAL PAPER

Trauma-Focused CBT for Traumatic Grief in Military Children

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Abstract Although military children are typically as resilient as the general child population, the ongoing conflict has exposed military children to unusual stressors such as repeated deployment, severe injury, or the death of a parent or sibling. U.S. forces have experienced more than 5,600 casualties during Operation Iraqi Freedom and Operation Enduring Freedom, with growing numbers of suicides among Service members. These deaths have affected thousands of military children. Most bereaved military children experience adaptive grief characterized by deep sadness, longing for the deceased person, and being comforted by positive memories of the deceased. A smaller number of military children develop childhood traumatic grief, characterized by trauma symptoms that interfere with adaptive grieving. Children with traumatic grief get "stuck" on the traumatic aspects of the death such as picturing the imagined or real details of the death; imagining the pain their loved one experienced in the moments before dying; wishing for revenge; and becoming angry at those who do not understand or share the child's thoughts and feelings about the death. These children avoid reminders of the deceased person. Trauma-focused cognitive behavioral therapy (TF-CBT) is an evidence-based treatment for children with trauma symptoms including those with traumatic grief. TF-CBT may be particularly suitable for military families. This article describes the clinical application of TF-CBT for traumatic grief in military children.

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Military children are similar to civilian children in exhibiting a range of emotional and behavioral problems in the context of generally high resilience. Although many military children adjust well to parental deployment, growing evidence from Operations Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) suggests that this conflict is resulting in increased stress for military children with anxiety problems in particular being elevated above community norms(Lester et al. 2010).

A unique stressor for military children is the military-related death of a Service family member. More than 5,600 American Service members have died in OIF/OEF, including increasing deaths from suicides. This paper describes childhood traumatic grief (CTG) after the death of a Service parent, and the application of an evidence-based treatment, Trauma focused cognitive behavioral therapy (TF-CBT) for military children.

Childhood Adaptive and Traumatic Grief

After a death most children experience adaptive grief (APA 2000, p. 740). Sometimes referred to as "normal" or "typical" grief, adaptive grief is characterized by deep sadness, longing for and missing the person who died. During adaptive grief children accomplish several tasks. These include (a) experiencing the deep pain of losing someone close; (b) accepting the permanence of the death (very young children do not have the cognitive ability to understand this concept so will typically ask at regular intervals when the deceased parent will come back);

(c) adjusting to life without the deceased and incorporate certain positive aspects of the deceased into one's own identity; (d) converting the relationship with the deceased from one of ongoing interaction to one of memory; (e) finding meaning in the deceased's death; and (f) establishing ongoing supportive relationships with other adults (Wolfelt 1996; Worden 1996). These tasks require children to tolerate ongoing memories about the person who died, including thinking about their own interactions with the deceased.

Some children react to the death of a loved one with horror, fear or helplessness. Children with a predominance of such trauma responses after a death may have a condition called Childhood Traumatic Grief (CTG, also called "complicated grief"). Trauma responses may arise because of recurrent intrusive images of their parent's death. These images are often shocking, gory or terrifying. If children have limited information about the circumstances of the death they may imagine or "fill in" these details (e.g., what the parent felt or said). This may occur even if the death was anticipated rather than sudden (e.g., after a severe combat injury). Because the feelings associated with traumatic grief are so negative, children usually don't want to experience them. This desire to avoid negative feelings may cause children to avoid thinking about the deaths. Often this generalizes to avoiding any thoughts, conversations or memories about the deceased parent, because even happy memories of the deceased parent may quickly and unpredictably segue to frightening thoughts about the way the parents died. Military children with traumatic grief thus may begin to avoid any reminders of the deceased parent, the military, OIF, OEF, visiting the cemetery, or participating in other military rituals.

When faced with memories or reminders of the deceased person or the death, children with traumatic grief may become very upset, angry or agitated. They may have difficulty sleeping, paying attention or concentrating at school, fight more and be more jumpy or irritated. These behaviors may be difficult for other family members to understand. Children's avoidance of talking about their deceased parents or participating in memorial rituals may hurt or offend those who wish to honor the parents' memories. It is particularly important to understand ways in which manifestations of children's traumatic grief may lead to direct conflict with military rituals. More information about childhood traumatic grief in military children is available at http://www.nctsnet.org/nctsn_assets/pdfs/Military_Grief_Families_final3.pdf.

Children with traumatic grief may have difficulty when confronted with trauma, loss, and change reminders (www.nctsn.org) *Trauma reminders* are stimuli that remind the child of the trauma, in this case the event that caused the parent's death. *Loss reminders* are stimuli that remind children of the deceased person, for example, pictures, clothing, favorite activities or foods of the deceased person may serve as loss reminders. *Change reminders* are stimuli that remind children how their situations have changed as a result of the traumatic death. Military children often experience more change reminders than civilian children after parental death as described below.

Unique Aspects of Military Deaths

Bereaved military children often face unique challenges related to the parent's military status in addition to universal grief and traumatic grief issues addressed elsewhere (e.g., Cohen and Mannarino 2004). These include the following:

Stage of Deployment and Nature of the Military Death

Understanding the context of the deployment cycle and how the Service member died is often important to understanding a child's risk for developing CTG. For example, families are typically less prepared for deaths prior to deployment and may view such deaths as not being heroic. Deaths are typically most expected during deployment, but such deaths may be complicated by long separations from the parent and by the child's maladaptive cognitions or omen formations (e.g., "I should have warned mommy something bad would happen that night"), regret (e.g., "I was mad at my sister and forgot to tell daddy 'I love you' the last time we skyped"); or self-blame ("If daddy hadn't been so worried about me he would have been paying more attention and wouldn't have gotten shot").

Post deployment deaths typically occur due to severe disfiguring wounds, intubation and medical procedures which children may have witnessed with little preparation or explanation (Cozza et al. 2010); or from suicide related to PTSD or TBI. After suicide children often experience guilt ("I should have been able to do something to stop him"), anger ("how could he have done this?"), inadequacy ("didn't he love me enough to stay here for me?") or shame ("how can I be proud of him now?").

Military Rituals

The military honors its fallen Service member through military bereavement rites and rituals. While these provide needed comfort to many military families, they may not perfectly meet the needs of children with traumatic grief. This can lead to increased difficulties when families are

least prepared to cope with more stress. Military rituals that may affect military children include the following:

Death Notification

Even young military children are familiar with the ritual of death notification and are often frightened when uniformed service members come to their door, knowing they are bringing dreaded news. If there has been a divorce or marital separation the child may find out about their parent's death from the media or a phone call, possibly without the other parent's presence to provide support.

Return of Remains

When Service members die in combat their remains are returned to families. However all remains may not be recovered simultaneously, or recovered at all. Recovery of one father's new remains which occurred on two occasions, led to significant worsening of his son's nightmares and intrusive thoughts about the death.

Military Funerals

If the family requests a military funeral, rituals include the presence of an honor guard, draping the American flag over the casket, firing three rifle volleys, a bugler playing Taps, folding the flag after the service, and giving the flag to the fallen Service member's widow or mother. While these rituals may comfort many family members, children with traumatic grief may find these military images very upsetting. One military widow videotaped her husband's military funeral for her young children so that they will have the opportunity to view it in the future when they are old enough to better understand what occurred.

Political Protests

Since the media often cover funerals of OIF/OEF Service members, these funerals sometimes attract political protesters, e.g., carrying signs saying "Thank God for dead soldiers". One child asked her mother, "Why are those people glad that daddy died? Wasn't he a good soldier?"

Changes in Military Status

Family members obtain a new Service identification card that changes the family member's designated military status to "deceased". If the family lives on a military installation, they must move off base within 6 months of the Service member's death. These changes may serve as ongoing reminders of the parent's death and thus potentially lead to trauma symptoms in vulnerable children.

TF-CBT for Traumatic Grief

TF-CBT is an evidence-based treatment for traumatized children and teens and their parents or caregivers. TF-CBT has been used successfully with children who have experienced diverse traumas including sexual abuse, domestic violence, disaster, multiple traumas and traumatic grief. With eight randomized controlled trials and a number of open studies published, TF-CBT has the strongest empirical support of currently available trauma-focused treatments for children and families. As a family-and resilience-focused model, TF-CBT may be especially well suited for bereaved military families.

TF-CBT is a components-based treatment, which implies a balance of fidelity and flexibility. Gradual exposure is a core feature of the TF-CBT model and is included in each component (Cohen et al. 2010). The TF-CBT components are summarized by the acronym PRACTICE (Cohen et al. 2006). The TF-CBT PRACTICE components are summarized in Table 1 and are described in more detail in the free web-based course TF-CBTWeb, available at www.musc.edu/tfcbt.

Military Traumatic Grief TF-CBT Treatment Case Description

Initial assessment: Susie,[1] an 11 years old 6th grader was brought for evaluation 15 months after father's death. She lived with mother, Maria, and 9 years old brother Danny. The family had been living near an Army base until 1 year ago when they moved to mother's hometown in order to live closer to maternal grandparents. Mother worked as a secretary. Father, Mark, was 33 years old when he died after serving in the Army for more than a decade. Father had been deployed to Iraq three times. Four months before father was due to return from his 3rd deployment a car bomb blew up a truck he was in; father was thrown from the truck and suffered a serious head injury. Everyone else in the truck was killed. Father was medically discharged due to a Traumatic Brain Injury (TBI).

Mother said father "changed" after his discharge. He was restless, couldn't sleep, became increasingly irritable, short-tempered and did not want to interact with the children. Susie's problems began around this time. She was hurt that father didn't want to spend time with her and she did not understand or accept mother's explanations about TBI. Susie's friends didn't want to come over due to father's temper outbursts. Mother's many friends among the military wives also became less available.

[1] This is a composite case description. Names and details have been changed.

Table 1 TF-CBT PRACTICE and grief-focused components

PRACTICE components	Grief-focused components
P: Psychoeducation: information about grief and trauma, traumatic grief, PTSD	Acknowledge the death: address the scope of what as been lost
P: Parenting component: parents receive parenting and other PRACTICE skills	Address ambivalent feelings: acknowledge ambivalence in the relationship as appropriate
R: Relaxation skills: relaxation strategies in relation to trauma cues	Preserve positive memories: create lasting memorial of the deceased
A: Affect modulation: feeling expression and management skills in relation to trauma cues	Develop new relationships: commit to ongoing positive relationships
C: Cognitive coping: cognitive triad and correcting maladaptive cognitions	Treatment closure: planning for future reminders
T: Trauma narration and processing: develop narrative; process maladaptive trauma-related cognitions	
I: In vivo mastery: overcome generalized trauma-related fears	
C: Conjoint child–parent sessions: share child's narrative and improve communication	
E: Enhancing safety: acknowledge and address child's fears about safety	

Father got a temporary job selling computers but he had temper outbursts on the job and was fired within a month. He started yelling at mother and acts of domestic violence towards mother began at this time. He would verbally demean mother, hit her and push her in front of the children. All of these were completely out of character behaviors that were frightening to the children. Mother pleaded with father to get treatment. Father refused saying he was not "crazy". During the most serious domestic violence episode father punched mother in the face. Susie ran between her parents and yelled, "No! Get out of here! Leave mommy alone!" Mother said, "Susie, please, he can't help it" as father sank to the floor crying. Susie tried to pull her mother out of the room. Danny screamed at Susie to "shut up". Mother would not let Susie call 911 and Susie ran to her room crying.

The above episode occurred on a Friday night. Father isolated himself all weekend. When Susie came home from school on Monday she found her father in the parents' bedroom dead of a self-inflicted gunshot wound to the head.

Mother was at work when the police called her. They had taken Susie to a neighbor's where she was "incoherent" and crying. A military funeral was held several days later in the parents' hometown. Susie did not want to attend and only did so reluctantly. She would not talk to her friends about her father's death.

Mother received support from military wives but most of them seemed uncomfortable talking about father's suicide. She did not tell anyone about the domestic violence. As mother's friends' husbands returned from deployment she felt more and more like an outsider to the rest of the military community. Mother decided to return to her hometown where her parents would help with childcare so she could work full time.

Since father's death mother was increasingly worried about Susie. Susie was completely "closed up" about father. Every time mother tried to talk about him Susie changed the subject. She also refused to come along when the rest of the family went to the cemetery to visit father's gravesite. Susie was increasingly more irritable, easily angered and jumpy, more vigilant, and had trouble sleeping. Her only friends were her cousins. Danny was fighting with Susie and seemed very mad at her for fighting with father before he died. Mother thought that Danny was mostly reacting to Susie's current refusal to talk about father or visit the cemetery and did not believe he needed therapy.

During her individual interview Susie said, "My father was in the Army. Then he died. I don't want to talk about it now." Her affect was flat when describing this. She scored a 6 on the UCLA PTSD Reaction Index (RI); endorsed items included avoidance and being irritable.

Susie's clinician, Julie told mother that Susie displayed many symptoms of PTSD and traumatic grief and that it was common for children to initially score low on the RI due to trauma avoidance. Julie recommended that mother and Susie participate in TF-CBT for traumatic grief. Julie said that she would provide mother with psychoeducational materials about Susie's traumatic grief; mother could share these with Danny to help him understand Susie's current problems. Mother was enthusiastic about this plan since it was consistent with her understanding of why Danny was angry and also with mother's desire for Julie to use a family-focused approach.

Susie was reluctant to participate in treatment but mother told her that she didn't have a choice about this. During the first treatment session Julie initially engaged Susie by asking her about what she liked and what she would like to change at home. When Susie said she did not

want to talk, Julie used this as an opportunity to educate Susie about avoidance and other symptoms of PTSD, and to normalize avoidance as being very common among children who had lost loved ones and also among Service members including Susie's father and many other Service members. Susie was very surprised to hear how many OIF/OEF veterans other than her father had these problems because of her belief that they were "so strong". She acknowledged that she felt sad and ashamed because her father had not been "tough". She agreed to read the written information that Julie gave her about PTSD in military families. At Julie's request Susie agreed to bring some of her favorite music the following session.

Julie met with mother to provide psychoeducation about military and childhood PTSD, TBI and childhood traumatic grief. Mother wished someone had provided her with information that so accurately described Susie's problems immediately following father's death because it would have helped her to understand why Susie didn't want to be reminded of her father. This had been very confusing and upsetting at the time. Mother practiced introducing this information to Danny, and felt confident that she could help him understand his sister's response in a helpful way. Julie suggested that mother involve the children in the Tragedy Assistance Program for Survivors' Good Grief programs for bereaved military children (www.taps.org) to meet other bereaved military children. Mother agreed to do so.

During the following session Julie addressed physical signs of stress and asked Susie how she experienced these. Susie described feeling stress in her stomach and general muscular tension, especially at nighttime. At this point they listened to one of the music selections that Susie had brought to the session and Julie used guided muscle relaxation to help Susie experience the difference between feeling "tight" or stressed, and feeling "loose" or relaxed. Susie acknowledged having more trouble falling asleep since father's death, and said that in the past her father used to help her fall asleep by coming to her room and telling her jokes. She acknowledged that bedtime had been a particularly physically tense time for her since father's death. Susie agreed to try listening to relaxing music paired with muscle relaxation or visualization using the beach and sunrise. Although Susie continued to not like talking about her father or his death, she showed more tolerance of Julie making reference to father and his death in this context, and agreed to try to use the relaxation strategies. After she had practiced these several times in the session she agreed to have her mother come in so she could teach her these exercises. Mother was very impressed by Susie's ability to learn this and reinforced it.

During mother's individual session mother said she had a talk with Danny about childhood traumatic grief, and Danny was surprised to find the very behaviors of Susie's that made him so angry (e.g., not going to the cemetery, not talking about father) in the written information that mother provided. Mother said the information had more credibility because it included military references. Julie further reinforced with mother the use of relaxation when Susie experienced trauma or loss reminders during the week.

In introducing parenting skills Julie determined that mother was feeling overwhelmed from the move, the transition into being the single parent of two children who were sometimes fighting with each other, and struggling with her personal grief and guilt issues. Mother said that she could probably use therapy herself but she didn't have the time or energy for one more thing. Julie said that this reminded her of what flight attendants say on airplanes: you have to put your own oxygen mask on before assisting your children. Mother laughed and promised to consider taking more time for her own needs. Julie focused on modeling praise by telling mother what a wonderful mother she was being to her children and what a wonderful role model she was for her daughter. Julie validated mother's wish that her children would not have had to go through this experience and normalized the children's different responses to their father's TBI and suicide. Julie then normalized their different responses to father's suicide. This helped to decrease mother's distress. Mother and Julie role-played praise and selective attention until mother felt comfortable using these techniques with her children at home.

The following session Susie reported that the relaxation strategies "didn't work" to help her sleep. She said she tried to show Danny how to do progressive muscle relaxation but Danny told her she was stupid. They got into a physical fight and now both were grounded. Julie used this as an introduction to feeling identification and affective modulation. Susie had a very good range of affective expression and could describe situations in which she would feel different emotions. Julie then introduced the concept of mixed emotions, i.e., that it was possible to experience a variety of different, even conflicting emotions towards the same person simultaneously. For example, Susie could feel angry and loving towards Danny at the same time. At this point Julie asked Susie to complete the RI; this time she scored 48 (in the severe PTSD range).

Susie had difficulty managing negative emotions particularly when these were prompted by fights with Danny. She continued to experience unpredictable and frequent periods of irritability. Susie said that although she loved her cousins, she didn't feel like she fit in well with the other kids in her new town which made it hard to relax. She felt different because she had never lived among civilian kids and felt that they were not as accepting of her as military children had been. This emphasized the importance of

addressing change reminders with Susie. Julie asked Susie about the social skills Susie had learned from moving a lot of times. Susie said, "You just find one person you can talk to. You just have to make one friend to start with, and go from there." Julie said that this was how it worked with civilian kids too, that Susie had a lot of expertise in making new friends from having moved a lot during her time as a military kid, and that this made her pretty much a "Making Friends Expert". In this way, Julie helped Susie to view this "difference" as an asset rather than a liability. Susie practiced positive self-talk, saying "I am an Expert in making new friends, I've done it way more times than these kids have". Susie and Julie role played starting a conversation with a new friend. Julie then confirmed that Susie indeed had the requisite skills and encouraged her try her Making Friends skills in school the coming week. They also addressed other strategies for affective modulation, for example, seeking social support from mother when Danny was bothering her; use of appropriate distraction (removing herself from the situation, reading a good book in her room or doing something else enjoyable rather than getting into it with Danny), and problem solving skills, rather than getting into fights with Danny. Susie practiced these and said that she would try to use them in the next week.

Julie met with mother to review additional parenting skills including positive parenting techniques such as spending special time with each child each week and especially praising positive behaviors as they occurred. Mother acknowledged that she had not had the energy to do this during the past week but she would try hard to use positive parenting skills during the coming week. Julie also reviewed with mother the skills she had taught Susie and asked mother to praise and support Susie when she saw Susie trying to use these.

During the next session Susie reported that she had tried what Julie suggested and had made a new friend, Lauren, at school. Julie then introduced the cognitive triangle. Susie understood this easily and said, "That happened this week. My new friend Lauren didn't invite me over like she said she would and I thought it was because she didn't want to be my friend. It turned out that her little brother was really sick and they weren't letting her have anyone over because of that." Julie encouraged Susie to use cognitive coping in other situations during the coming week whenever she was feeling upset, and to replace inaccurate or unhelpful thoughts with more positive thoughts.

Julie met with mother and provided parallel information about cognitive coping. They specifically addressed Mother's self-blame for not having been able to convince her husband to seek mental health treatment. Mother was able to change this maladaptive thought to "I did the best that I could". Through use of the cognitive triangle mother was able to begin processing her painful personal feelings about father's suicide. Around this time mother began individual therapy.

Through the ongoing use of GE Susie was increasingly able to tolerate trauma reminders. During the following session Julie introduced the trauma narrative by asking Susie to read part of the book "After a Suicide: An Activity Book for Grieving Kids" (available from www.dougycenter.org). She then suggested that Susie write a book about her own life and family, including telling the story about father's death. Susie was initially reluctant but agreed to give it a try.

Susie started by writing a chapter about herself, her friends and her favorite activities. She enjoyed writing and illustrating this and agreed to continue her narrative activity during the next session. Susie created her trauma narrative during two more treatment sessions. She described many details about the domestic violence and discovering father's body that she had never shared with anyone before. With Julie's help Susie identified several maladaptive cognitions which she addressed during the cognitive processing portion of the narrative. For example she initially wrote, "It made me really mad that Danny always took Daddy's side." She corrected this to read, "Danny didn't think that I understood Daddy's problems. I was worried about Daddy too, but I was more worried about him hurting Mom." After describing her father's suicide she initially wrote, "Daddy did this because he was mad at me for yelling at him" but changed this to, "He had TBI and PTSD. His brain was not working right. When someone commits suicide they made a big mistake."

With Susie's permission Julie shared the narrative with mother during the individual parent sessions. Mother said it helped her to understand how much Susie had blamed herself and how worried she had been about mother. She said, "I would never have known any of this if she hadn't come to therapy and told her story."

During the next session Julie prepared mother and Susie for the conjoint session, asking each of them individually to prepare some questions to ask the other. They then had a conjoint session during which Susie read her narrative to mother. Mother was extremely supportive of Susie during the narrative, telling Susie how proud she was of her for creating this book. Mother and Susie both cried and held each other afterwards and agreed that this had been the most difficult time of their lives but that they were lucky to have each other. Mother told Susie that she regretted that Susie and Danny had been exposed to domestic violence and most of all that Susie had found her father's body. Mother then strongly reinforced Susie not being responsible for father's decision to commit suicide. Another conjoint session focused on safety about suicide and domestic violence as well as healthy sexuality and drug refusal skills. Susie and mother submitted questions that they would like to ask each other on these three topics and they

took turns developing safety strategies with Julie facilitating. This session had many humorous moments and further reinforced the growing closeness between mother and daughter. Susie completed another RI; at this point her score was 14 (within the normal range).

Susie was now doing much better. She had made several new friends at school and was feeling better about living among civilian kids. Julie transitioned from trauma-focused to grief-focused interventions. Susie chose to play the Grief Game board game (Searle and Streng 1998). Susie had age-appropriate knowledge about grief but had heard someone at her church say that people who commit suicide can't go to heaven. Susie said, "I think people with diseases can go to heaven. My father died from a disease. If people with TBI can't go to heaven, neither can people with cancer or heart attacks or any other disease and no one would be in heaven." Julie then suggested that Susie write her father's name down on a piece of paper, with one line for each letter of his name. For each letter of father's name, Julie encouraged Susie to describe one characteristic of father that was special about him. Susie wrote the following (Fig. 1).

As Susie wrote these she started to cry. She said, "I forgot those things about him. It's been so long since I thought about him like that." Julie said, "It was really hard when your dad came back from Iraq, but now we can remember everything else about your dad." Susana said, "I really want to. But it's so hard." Julie validated Susie's pain and said that this was what grief feels like. During the session with mother Julie similarly transitioned to grief-focused interventions. Mother confirmed that her religion believed that people go to heaven even if they committed suicide and that she would reassure Susie in this regard. She was moved by Susana's memories of her father and looked forward to sharing these in upcoming conjoint sessions.

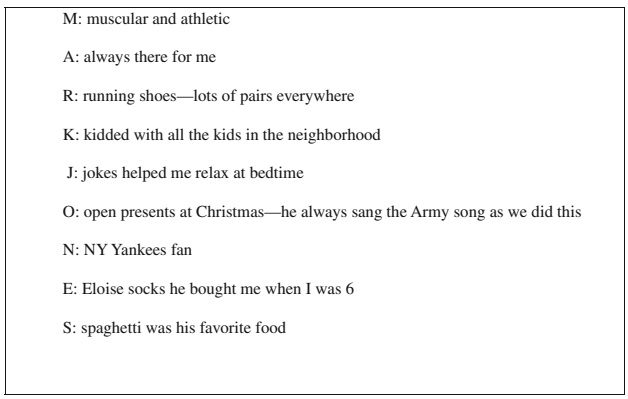

Fig. 1 Mark Jones acronym

In the next session Julie addressed the issue of ambivalent feelings that Susie had towards father. Julie helped Susie to address her difficult ambivalent feelings towards her father after he returned home from Iraq and began hurting her mother and then committed suicide ("I could not be proud of him anymore; I was ashamed of him"). Julie validated these feelings and helped her explore related thoughts by writing an imaginary letter to her father in heaven, and writing an imagined letter from her father back to herself. Susie was able to express her anger and sorrow at her father in her letter to him. Her imagined return letter from father included the following: "I am so sorry for hurting you and your mother. I hope you can forgive me. More than anything I want you to take care of yourself and get the help you need. Not getting help was my biggest mistake."

Julie suggested doing a project using different colors for different emotions. Julie drew a timeline of 11 years with the years marked at the bottom, and invited Susie to fill in important dates during her life with her father in the timeline, such as birthdays, Christmas, the dates of different moves the family experienced, dates when father was deployed, the date when father was wounded, when he returned from Iraq, and when he died. Susie then used different colors to denote her different feelings towards father during her life. In completing this project Susie said she learned that even though she had felt very badly about her negative feelings towards father, this project had helped her to see that the vast majority of her feelings toward father had been very positive and loving; and even during the time when she was feeling angry at her father, she also continued to love him and worry about him. This concrete process enhanced Susie's positive ongoing connection with her father and decreased her guilt related to negative feelings towards him. She asked to share this with mother and also asked whether Danny could participate in the next session. Julie agreed that this would be a great idea.

During the session with mother Julie addressed mother's ambivalent feelings towards father. Mother said that her anger and frustration were related to father's refusal to seek help and his decision to end his life. She explained that father was adamantly opposed to violence against women or children and that his violence towards her confirmed for mother the severity of his TBI and his need for treatment. She felt angry about being unable to "break through" father's brain damage to convince him to get help. She was also frustrated with the VA, legal and medical systems that could not force him to get help for his condition and that this led to her children being exposed to her husband's suicide. However, she recognized that in the end, it was Mark's decision to take his own life. Mother believed that it was father's recognition that his brain damage was "turning him into a person he could not stand to

be—someone who hurt me and our children, and he couldn't live with that." She believed that deep down her husband was afraid that treatment would not help his condition to improve and that he might always be "damaged". Mother was very sad about this but resigned to father's decision since she could not change it now. Mother was very happy to hear about Susie's project and agreed to meet together with her and Danny to share this during the following session. Julie asked that mother, Danny and Susie go through the family's and father's belongings and pick out some of their favorite reminders of him—pictures, mementoes, things he liked to do or eat, or places he liked to take the family, etc. Mother and Susie agreed to do this during the coming week.

The following session focused on the family sharing positive memories of father. Julie first met with Susie alone to introduce this topic and to discuss with Susie how she would like to share her project from the previous week with mother and Danny. Susie said that she would tell her family that she had done a lot of work in therapy and talking about different feelings was part of that. She wanted to share with her family how helpful talking about different feelings about her father has been, and to tell them that she wanted to talk with them about her feelings about her dad and hoped that they would talk about their feelings too. Julie pointed out that this was a big change from when Susie had started therapy and asked how Susie thought Danny would respond. Susie said, "Danny will probably be mad at me because I haven't wanted to talk about Daddy for so long. It's okay. I don't mind if he says that." Julie said that it sounded like Susie was ready for the family session and invited Danny and mother in.

When Susie showed them her project and explained her different feelings throughout her life with her father, and explained what she had learned from doing this project, Danny said, "I didn't know that. I'm glad you loved Daddy like me." Mother said, "Danny, of course Susie loved Daddy. That's why she was so upset about how different he was. She wanted him to get better and be okay. We all wanted that." Susie and Danny looked at each other and nodded. Then both children said that that's what they had hoped for when father returned from Iraq. Julie asked Danny, Susie and mother whether they would like to do a project together as a family and they all said yes.

Julie took a large piece of cardboard and drew a life-sized outline of a person. She said, "I didn't get the chance to meet your father, but I've heard so many wonderful things about him that I'd really like to get to know about him through you. I'd like you to look at the memories of your father you brought with you, and put together a collage that tells me about him as a person—a father, a husband, a Soldier, a guy, whatever you think would be the most important things for you to tell me about him. This is one way for you to preserve good, important, positive memories of who your dad was during his life." Working together Susie, Danny and mother lovingly reminisced about father as they put together a large collage of pictures and other materials. At the end of the session the kids took the lead in narrating these materials, laughingly telling story after story about happy times with their father. Danny and Susie both said how much fun it was to talk about father and how much they liked doing the project. They asked to take the collage home. At the end of the session mother hugged and thanked Julie.

During the next session Julie met alone with Susie to ask how she thought the last session went. Susie said it was great and she and Danny were getting along much better. Julie addressed committing to new relationships and asked what other adults Susie was spending time with besides her mother. Due to father's deployments the family had accommodated to a single parent household prior to father's return from Iraq. Susie reported that the kids had put up the collage of father in the living room and had invited both mother's extended family to come over to see it during the week. Susie and Danny together had given them a "tour" of the collage. Susie was very close to several aunts and uncles and also spent a fair amount of time with her best friend Lauren's family. Susie spontaneously suggested that maybe she would like to invite her paternal grandparents for a visit. She had not wanted to see or speak to them since father's death but now wanted to hear more about father's childhood from them. Julie invited mother in and mother was delighted to hear that Susie wanted to invite Mark's parents to visit. They agreed to call them after the session to arrange this.

Two final treatment sessions focused on treatment closure issues. Susie, mother and Danny had recently attended a regional TAPS Good Grief camp and were going to attend the annual TAPS Survivors Seminar and Good Grief Camp during the coming Memorial Day weekend. Both children had made several friends at the TAPS camp and were very excited about meeting other military children whose parents had died. Susie had even met one girl her age whose father had committed suicide. She said "She totally gets what I feel." The family had invited father's parents to visit and Susie and Danny were excitedly preparing for this visit. Julie, mother and Danny together planned how they would cope with future trauma, loss and change reminders using the Circle of Life perpetual calendar exercise (Cohen et al. 2006, p. 228) to identify dates that would be difficult for them. They included the children's and mother's birthdays, Father's Day, father's birthday, Christmas, Easter, New Years, Thanksgiving, Memorial Day, Veteran's Day, the first day of school, the day father returned from deployment, and the day father died as potentially difficult anniversary dates. Since most

of these dates occurred in the fall and winter the family particularly focused on September through New Years, and made specific plans for whom to rely on and whom to ask for help during this particularly challenging period. Julie helped the family recognize that this period might be difficult in coming years; that each person might respond differently, and that they needed to give each other permission to cope differently. This plan allowed the family to feel prepared and to better understand why they had had such a difficult time the previous winter.

One the date of termination the family came for a therapy graduation party. Susie's RI at termination was 5. They had plans to attend the TAPS program and Susie was in touch with her friend from the regional camp. Mother had been in touch with several friends from the family's previous home and the family was planning on a trip to their previous base during the summer.

Conclusion

Bereaved military children may develop childhood traumatic grief. Clinicians and other professionals should be aware of unique aspects of military deaths in trying to optimally serve the needs of military families following a parental death. Trauma-focused cognitive behavioral therapy is a family-focused intervention with evidence of improving child and parent PTSD, depression, behavior problems and adaptive functioning after traumatic bereavement. For more information about TF-CBT for bereaved children, mental health professionals can receive free web-based training at www.musc.edu/tfcbt and www.musc.edu/ctg.

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