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Trauma Resources

Trauma Resources

NCTSN The National Child Traumatic Stress Network

What Is a Traumatic Event?

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

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

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

What Experiences Might Be Traumatic?

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

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

What Is Child Traumatic Stress?

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

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

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

Reminders and Adversities

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

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

Risk and Protective Factors

Fortunately, even when children experience a traumatic event, they don't always develop traumatic stress. Many factors contribute to symptoms, including whether the child has experienced trauma in

the past, and protective factors at the child, family, and community levels can reduce the adverse impact of trauma. Some factors to consider include:

- **Severity of the event.** How serious was the event? How badly was the child or someone she loves physically hurt? Did they or someone they love need to go to the hospital? Were the police involved? Were children separated from their caregivers? Were they interviewed by a principal, police officer, or counselor? Did a friend or family member die?
- **Proximity to the event.** Was the child actually at the place where the event occurred? Did they see the event happen to someone else or were they a victim? Did the child watch the event on television? Did they hear a loved one talk about what happened?
- **Caregivers' reactions.** Did the child's family believe that he or she was telling the truth? Did caregivers take the child's reactions seriously? How did caregivers respond to the child's needs, and how did they cope with the event themselves?
- **Prior history of trauma.** Children continually exposed to traumatic events are more likely to develop traumatic stress reactions.
- **Family and community factors.** The culture, race, and ethnicity of children, their families, and their communities can be a protective factor, meaning that children and families have qualities and or resources that help buffer against the harmful effects of traumatic experiences and their aftermath. One of these protective factors can be the child's cultural identity. Culture often has a positive impact on how children, their families, and their communities respond, recover, and heal from a traumatic experience. However, experiences of racism and discrimination can increase a child's risk for traumatic stress symptoms.

Warning Signs and Risk Factors for Emotional Distress

Learn about the common warning signs and risk factors for emotional distress that children, adults, and first responders often experience.

It is common to feel stress symptoms before or after a crisis. Natural and human-caused disasters can have a devastating impact on people's lives because they sometimes cause physical injury, damage to property, or the loss of a home or place of employment. Anyone who sees or experiences this can be affected in some way. Most stress symptoms are temporary and will resolve on their own in a fairly short amount of time. However, for some people, particularly children and teens, these symptoms may last for weeks or even months and may influence their relationships with families and friends. Common warning signs of emotional distress include:

- Eating or sleeping too much or too little
- Pulling away from people and things
- Having low or no energy
- Having unexplained aches and pains, such as constant stomachaches or headaches
- Feeling helpless or hopeless
- Excessive smoking, drinking, or using drugs, including prescription medications
- Worrying a lot of the time; feeling guilty but not sure why
- Thinking of hurting or killing yourself or someone else
- Having difficulty readjusting to home or work life

For those who have lived through a natural or human-caused disaster, the anniversary of the event may renew feelings of fear, anxiety, and sadness. Certain sounds, such as sirens, can also trigger emotional distress. These and other environmental sensations can take people right back to the disaster, or cause them to fear that it's about to happen again. These "trigger events" can happen at any time.

Warning Signs and Risk Factors for Children and Teens

Children are often the most vulnerable of those impacted during and after a disaster. According to the National Child Traumatic Stress Network, a growing body of research has established that children as young as infancy may be affected by events that threaten their safety or the safety of their parents or caregivers.

Disasters are unfamiliar events that are not easily understood by children, who can find them emotionally confusing and frightening. During the time of turmoil, they may be left with a person unfamiliar to them and provided with limited information. Some warning signs of distress in children ages 6 to 11 include:

- Withdrawing from playgroups and friends
- Competing more for the attention of parents and teachers
- Being unwilling to leave home
- Being less interested in schoolwork
- Becoming aggressive
- Having added conflict with peers or parents
- Having difficulty concentrating

For teens, the impact of disasters varies depending on how much of a disruption the disaster causes their family or community. Teens ages 12 to 18 are likely to have physical complaints when under stress or be less interested in schoolwork, chores, or other responsibilities.

Although some teens may compete vigorously for attention from parents and teachers after a disaster, they also may:

- Become withdrawn
- Resist authority
- Become disruptive or aggressive at home or in the classroom
- Experiment with high-risk behaviors such as underage drinking or prescription drug misuse and abuse

Children and teens most at risk for emotional distress include those who:

- Survived a previous disaster
- Experienced temporary living arrangements, loss of personal property, and parental unemployment in a disaster
- Lost a loved one or friend involved in a disaster

Most young people simply need additional time to experience their world as a secure place again and receive some emotional support to recover from their distress. The reactions of children and teens to a disaster are strongly influenced by how parents, relatives, teachers, and caregivers respond to the event. They often turn to these individuals for comfort and help. Teachers and other mentors play an especially important role after a disaster or other crisis by reinforcing normal routines to the extent possible, especially if new routines have to be established.

Access SAMHSA publications on helping youth cope with disaster-related emotional distress:

- Tips for Talking to Children and Youth After Traumatic Events: Guide for Parents and Educators – 2012
- Trinka and Sam: The Rainy Windy Day – 2008 (PDF | 1.5 MB). Also available in Spanish (PDF | 1.4 MB).

Learn about coping tips for dealing with natural and human-caused disasters.

Warning Signs and Risk Factors for Adults

Adults impacted by disaster are faced with the difficult challenge of balancing roles as first responders, survivors, and caregivers. They are often overwhelmed by the sheer magnitude of responsibility and immediate task of the crisis response and recovery at hand. They must also take the time to address their own physical and emotional needs as well as those of their family members and community.

Warnings signs of stress in adults may include:

- Crying spells or bursts of anger
- Difficulty eating
- Losing interest in daily activities
- Increasing physical distress symptoms such as headaches or stomach pains
- Fatigue
- Feeling guilty, helpless, or hopeless
- Avoiding family and friends

Adults most at risk of experiencing severe emotional stress and post-traumatic stress disorder include those with a history of:

- Exposure to other traumas, including severe accidents, abuse, assault, combat, or rescue work
- Chronic medical illness or psychological disorders
- Chronic poverty, homelessness, or discrimination
- Recent or subsequent major life stressors or emotional strain, such as single parenting

Adults most at risk for emotional stress include:

- Those who survived a previous disaster
- Those who lost a loved one or friend involved in a disaster
- Those who lack economic stability and/or knowledge of the English language
- Older adults that may lack mobility or independence

As with children and teens, adults also need time to get back into their normal routine. It is important that people try to accept whatever reactions they have related to the disaster. Take every day one-at-a-time and focus on taking care of your own disaster-related needs and those of your family.

Read SAMHSA's Tips for Survivors of a Disaster or Other Traumatic Event: Managing Stress – 2007 for additional information. Learn about coping tips for dealing with natural and human-caused disasters.

Laying the Groundwork for Trauma-Informed Care

By Meryl Schulman and Christopher Menschner, Center for Health Care Strategies

IN BRIEF

Adopting a trauma-informed approach to care has the potential to improve patient health outcomes as well as the well-being of providers. While becoming a trauma-informed health care organization can be time and resource-intensive, there are relatively simple, foundational steps that providers can take to move toward fully adopting a trauma-informed approach to care. This brief includes practical recommendations for health care organizations interested in becoming trauma-informed. It draws from the experiences of pilot sites in *Advancing Trauma-Informed Care (ATC*), a national initiative made possible by the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies (CHCS). Foundational steps include:

(1) Building awareness and generating buy-in for a trauma-informed approach;
(2) Supporting a culture of staff wellness;
(3) Hiring a workforce that embodies the values of trauma-informed care; and
(4) Creating a safe physical, social, and emotional environment.

Pursuing these activities will help organizations move toward a more comprehensive approach to trauma as outlined in an earlier CHCS brief, ***Key Ingredients for Successful Trauma-Informed Care Implementation***.

Health care providers increasingly recognize how an individual's history of trauma may influence his or her health, relationships, and ability to adopt healthy behaviors. Integrating this recognition into a fully trauma-informed approach, however, requires intensive organizational and clinical practice changes.[1,2] While not all organizations may be ready to commit to full adoption of trauma-informed care, there are foundational steps that providers can take to embrace the principles of patient empowerment, choice, collaboration, safety, and trustworthiness.[3]

This brief outlines initial steps for health care organizations interested in adopting a trauma-informed approach to consider. It draws from the experiences of pilot sites participating in *Advancing Trauma-Informed Care (ATC)*, a national initiative made possible by the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies. Foundational trauma-informed steps include: (1) building awareness and generating buy-in; (2) supporting a culture of staff wellness; (3) hiring a workforce that embodies the values of trauma-informed care; and (4) creating a safe physical, social, and emotional environment.

A comprehensive approach to trauma-informed care involves changes at both the *organizational* as well as the *clinical* level. Experts recommend that when transitioning to a trauma-informed approach, a health care organization should start with organizational changes before implementing clinical changes.[4] Well-intentioned providers, however, often train staff in trauma-specific treatment approaches while neglecting to first make changes to fundamental organizational practices, which can undermine the organization's overall efforts to be trauma-informed. Therefore, the recommendations in this brief are predominantly organizationally oriented in order to help health care organizations build a foundation for trauma-informed care.

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Building Awareness and Generating Buy-In for a Trauma-Informed Approach

Helping a health care organization's workforce understand the impact of trauma on both patients and staff is a key first step in becoming trauma-informed. Following are strategies for building awareness and generating buy-in:

- **Promote the potential to improve patient outcomes as well as staff wellness** when educating the health care workforce about the impact of trauma on health and the value of trauma-informed care.[10] This should be done prior to the start of any trauma-informed care trainings to encourage attendance and buy-in.
- **Incorporate patient voice and choice** early on in the planning and awareness-building processes and find ways to solicit ongoing patient and community member feedback. Some *ATC* sites have done this through more formal arrangements such as patient advisory boards, focus groups, or the use of peer navigators, while others have created more informal opportunities for patients to share feedback and build relationships with employees. The University of California San Francisco (UCSF) Women's HIV Program, for example, offers a hot breakfast for both patients and staff in an open conference room. Not only does offering breakfast create a more relaxing environment for those waiting for an appointment, it also gives patients the opportunity to build relationships with clinic staff and feel more comfortable in sharing their opinions and experiences and potentially joining a more formal advisory group in the future. In addition, the UCSF clinic convenes a monthly stakeholder meeting to discuss ways to improve the clinic experience that includes a staff member from each discipline (e.g., nursing, social work, medicine, medical assistants, etc.) and four patient participants.
- **Offer trainings for all staff, including clinical, non-clinical, and senior leadership** on trauma and its impact on health and behavior. Ideally, organizations should have buy-in from senior leadership, whose support may be needed to encourage all staff to participate. Because non-clinical staff — including front-desk reception area workers, security guards, and drivers — often interact with patients, they can play an important role in making patients feel safe and welcome and should be included in all awareness-building events or trainings. In addition, trauma-informed trainings can help staff better understand

Trauma-Informed Care Online Training Resources

There are a number of web-based, publicly available foundational trauma-informed care training resources that may serve as a starting place for organizations lacking the financial resources to hire a trainer or the capacity to create their own materials.

- ✓ ACEs Too High, a news site that compiles trauma-informed care related research and articles, catalogues resources on adverse childhood experiences and the neurobiology and epigenetics of trauma, and contains online courses and presentations on early adversity and TIC.[5]
- ✓ Substance Abuse and Mental Health Services Administration's "Concept of Trauma and Guidance for a Trauma-Informed Approach" is a comprehensive resource that defines trauma and the implementation domains of a trauma-informed approach.[6]
- ✓ Center for Health Care Strategies' brief, "Key Ingredients for Successful Trauma-Informed Care Implementation," identifies the clinical and organizational key ingredients necessary for successful trauma-informed care implementation. Companion slide decks and an infographic can serve as handy training tools.[7,8,9]

patient behavior and thereby improve patient/staff interactions. The San Francisco Department of Public Health (SFDPH), a county health agency dedicated to promoting the health of all San Franciscans, is focused on training all 9,000 employees — from entry-level to senior executives — through its Trauma-Informed Systems (TIS) initiative.[11]

- **Identify early champions or natural leaders to help build awareness about trauma** and its impact on health and general wellness. These individuals are often in a position to identify the greatest needs within an organization, and they should be encouraged by leadership to develop their knowledge-base and skills on issues related to trauma, adverse childhood experiences (ACEs), toxic stress, and trauma-informed care. Examples of ways that champions can generate further interest in trauma-informed care include employee workgroups, book clubs, or staff brown bag lunch sessions. Early champions are critical to sustaining momentum when adopting new organizational practices, and can act as resources for staff with questions about trauma, trauma-informed care, and how these efforts relate to them and their work.

- **Identify opportunities for sustaining upfront investments in trauma training**. Some organizations, for example, adopt a "train-the-trainer" model to extend training opportunities to more staff. The Greater Newark Healthcare Coalition (GNHCC), a group of community leaders seeking to improve health care quality and access in Newark, New Jersey, trained a staff member in the Nurtured Heart Approach, which is focused on improving how individuals work with academically, socially, and behaviorally challenged children.[12] This team member will introduce the Nurtured Heart Approach to GNHCC's ACE Impact Team, the stakeholder group leading efforts for Newark to become a trauma-informed city. The SFDPH's TIS initiative is also using a robust train-the-trainer model. Trainings may be recorded to sustain initial investments made in hiring outside consultants. The UCSF Women's HIV Program videotaped its series of employee training sessions on trauma-informed primary care to share with future hires during the onboarding process.[13]

  Because non-clinical staff often interact with patients, they can play an important role in making patients feel safe and welcome and should be included in all awareness-building events or trainings.

- **Incorporate trauma training into regularly scheduled staff meetings** since it is often difficult to find time slots to accommodate new staff training programs. Montefiore Medical Group, for example, a large health care system located in the Bronx, built trauma-informed care trainings into existing monthly meeting times for clinical staff, who likely have the least time available due to the daily demands of seeing patients.

Supporting a Culture of Staff Wellness

Fostering a culture of staff wellness is key to a trauma-informed approach. When working with patients who have trauma histories, it is important that staff take the time to care for themselves, so they are able to provide the best care possible for patients.[14] Staff members may also come to this work with their own histories of trauma. Organizations without safeguards in place to allow staff to safely process their emotions may be exposing employees to secondary traumatic stress, vicarious

trauma, and burnout, all of which may inhibit their ability to provide high-quality care and may increase staff turnover.[15] Following are strategies for promoting a culture of staff wellness:

- **Educate staff on secondary traumatic stress**, vicarious trauma, burnout, and the importance of self-care. This can be done through a staff training or by displaying posters[17] around the office that outline the signs of burnout, such as emotional exhaustion and feeling disconnected from one's body or thoughts,[18] and promote wellness, such as the importance of work/life balance and self-care. Organizations can also support staff wellness by giving employees the space to destress. The Center for Youth Wellness (CYW), a San Francisco-based nonprofit organization dedicated to addressing the impact of early adversity on children, has adopted a "listening partners" approach. A listening partner is a designated colleague that each staff member can check-in with on an as-needed basis. This provides support above and beyond weekly supervision, and CYW has noted that these partners are especially beneficial for clinical staff, who are more prone to compassion fatigue and burnout. Furthermore, CYW notes that the use of listening partners has supported a natural progression toward an environment of understanding in which team members can check-in with any colleague about concerns.

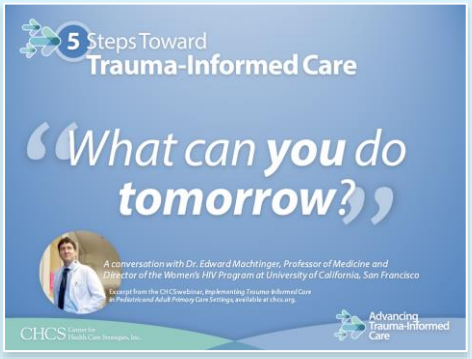
- **Engage leadership to promote a culture of wellness** by demonstrating that they value their employees' well-being. Supervisors should be encouraged to take a liberal stance on approving paid time off (PTO) to demonstrate to employees that they are respected and deserving of time away from work. Leadership should also ensure that staff have adequate PTO to address their health and mental health needs. In doing so, it is important that leadership sets an example by making it clear that taking time off due to stress or anxiety — "mental health days" — is as legitimate as taking time off when physically sick. Managers should encourage their direct reports to use their PTO to mitigate the likelihood of burnout and foster a sense of work/life balance. In addition, managers should be cognizant of increases in stress or anxiety of those they supervise and encourage them to take time away from work as needed.

- **Incorporate staff wellness activities into meetings and daily work/life**. SFDPH has begun to incorporate three-to-five minute facilitated "check-ins," breathing activities, or mindfulness exercises into the beginnings of staff meetings. These exercises allow staff to leave behind the stress that they may carry into a meeting and reinforces the importance of wellness. The SFDPH notes that, as an added benefit, these practices help focus the group on the task at hand and

What Can You Do Tomorrow to Support Trauma-Informed Care?

Eddy Machtinger, MD, director of the Women's HIV Program at University of California, San Francisco, offers a simple roadmap to help organizations promote trauma-informed care:[16]

1. **Realize** that a lot about who we are and what we do is because of things that happened to us.
2. **Embrace** trauma-informed values for yourself.
3. **Distribute literature** in the waiting room about the impact of trauma on health.
4. **Get training (ideally for the whole organization)** about the impact of trauma on health, trauma-informed skills, and screening for interpersonal violence and the impacts of lifelong trauma.
5. **Assemble a team** that is interested in this issue to get educated, collaborate on steps forward, and support one another in the process.



View a related video, *"5 Steps Toward Trauma-Informed Care: What Can You Do Tomorrow?"* Available at: www.chcs.org/5-steps-toward-trauma-informed-care/.

seem to improve meeting productivity. The UCSF Women's HIV Program incorporated a similar approach into their morning clinic huddles. The clinical team starts the huddle by taking a "mindful minute," allowing them to breathe, relax, and get ready for the day's work ahead. The "mindful minute" has been so well-received by staff that some care team members have begun convening 15 minutes early to engage in a longer group meditation. CYW has incorporated wellness breaks into the daily work/life of its employees to decrease stress and increase connection among employees. Every day staff voluntarily gather before lunch to engage in a five-minute wellness activity like stretching, deep breathing, or guided meditation. Staff are then encouraged to take lunch, ideally away from their desk.

- **Promote in-house and external opportunities to foster staff wellness**, including free or low-cost activities in the area that allow staff to engage in practices like mindfulness, meditation, and yoga. If possible, organizations can consider bringing wellness activities in-house so that they are more accessible and integrated into the organization's culture. The Stephen and Sandra Sheller 11th Street Family Health Services (11th Street) in Philadelphia offers fitness, yoga, and other mind/body classes to both staff and patients and has designed additional innovative low-cost methods to promote staff wellness. For example, the organization created a "fitness scavenger hunt" to help employees incorporate short physical activity breaks into their workdays. This involves hanging lists of simple exercises throughout the office, and having employees voluntarily sign-off on all completed exercises. CYW also promotes staff wellness through weekly on-site yoga sessions, as well as periodic mindfulness trainings. Similarly, a large hospital that participates in SFDPH's TIS initiative created a wellness space where employees can meditate or exercise, and another agency within SFDPH started a walking group to encourage staff to engage in physical activity during the workday.

Hiring a Trauma-Informed Workforce

Hiring a workforce that embodies and embraces a trauma-informed approach is key to creating and sustaining this kind of organizational change. Managers should seek to hire staff who have similar life experiences as the patient population served, have participated in trainings in trauma-informed care, and/or possess personality characteristics that naturally align with trauma-informed care values. To identify new employees who align with trauma-informed values and approaches to care, health care organizations should consider the following techniques:

- **Include interviewers from a variety of cultural and racial backgrounds**, as well as different levels within the organization, during the interview process. A more collaborative hiring process will not only yield multiple perspectives on the same candidate, but also give lower-level staff a greater voice in organizational decision-making. Including these staff in the interview process demonstrates to employees that their opinions and perspectives are valued, and may also help organizations identify the candidate that will work best with the entire care team.
- **Incorporate behavioral interviewing strategies to look for characteristics**, such as empathy and a tendency toward non-judgement. Behavioral interviewing includes asking job candidates about how they have handled previous situations to better understand how they may behave in future, similar scenarios.[19] These characteristics indicate an employee is more likely to embody trauma-informed principles.

- **Ask potential new hires about their knowledge around trauma and ACEs**, and whether or not they have received any prior trauma-informed training. Montefiore Medical Group, for example, encourages their 22 outpatient practices to incorporate questions about trauma knowledge into the interview process to assess whether a candidate is knowledgeable about the impact of trauma on health, the importance of trauma-informed care, and whether or not they would be a good fit for their organization. By reframing interview questions with a trauma-informed lens (see sidebar), organizations will more likely attract job candidates that share the organization's trauma-informed mission and values.

Trauma-Informed Interview Questions

Interview questions can be framed with a trauma-informed lens. Below are sample questions from the National Council for Behavioral Health.[20]

1. ***Tell us about a time when you had to remain calm when dealing with a hostile client.*** *What did you learn from the experience? How did you handle the situation?*
2. ***Describe a time when you had to approach people with different perspectives for support or cooperation.*** *How did you approach them? What was the result?*
3. ***What strategies would you use to build resilience on your team****, recognize secondary traumatic stress risk, and address this risk for the team or an individual?*
4. ***What techniques have you found to be effective in developing trusting relationships*** *and rapport with clients?*
5. ***What have you done to display healthy self-care skills during the past year?*** *What have you done to maintain a healthy work/life balance?*

Creating a Safe Environment

People with histories of trauma often feel unsafe in unfamiliar environments, leading to anxiety and stress. Minor changes to a provider and/or health care organization's physical, social, and emotional environments can improve patients' feelings of safety, and create an atmosphere that reduces the likelihood of re-traumatization. While many organizations cannot afford a complete redesign of their facilities, below are a number of less resource-intensive approaches that may improve patient experience for those who have experienced trauma:

Physical Environment

- **Make sure all parking lots, common areas, bathrooms, entrances, and exits are well lit**, so patients feel safe and comfortable. This is especially important during weekend and evening hours when there are fewer people around.
- **Ensure security guards are readily available** in settings where necessary, and consider stationing them at building entrances and exists to monitor the flow of traffic in and out of the building. Some organizations note that positioning security personnel at entrances and exits has helped prevent groups of people congregating, loitering, or smoking directly outside of the building which may provoke anxiety for some patients.
- **Noise levels in the waiting room should be kept low**, and staff should avoid using overhead loudspeakers when possible. Montefiore Medical Group encourages their outpatient providers to control the noise levels in waiting rooms and to avoid playing news stations on televisions, which can create stress for patients. In addition, they also encourage their providers to play soothing music for those waiting to be seen by a practitioner.

Decorate with warm colors and artwork and create spaces for staff to relax to foster a more calming and enjoyable environment. 11th Street has enhanced its clinic walls with pictures and murals that were painted by members of their community. This makes community members who receive care at the clinic feel welcome and fosters a sense of inclusivity and ownership. 11th Street has also utilized empty offices and open spaces in the building to create safe spaces with comfortable seating, soft lighting, and stress relieving tools and activities. Staff can go to these spaces when they need a moment to themselves or a place to regroup and relax.

Social and Emotional Environment

- **Use positive and welcoming language on waiting room signage,** and request rather than command. For example, "Please Refrain from Using Your Cellphone in the Lobby" vs. "No Cellphone Use in the Lobby!"
- **Ask patients whether they are comfortable with having the door shut during exams or meetings.** This will help patients feel in control and allow them to exit if desired.
- **Send medical forms that require patients to provide sensitive information ahead of time** so they can be filled out in privacy. In addition, if there is a quiet place in the office, it should be offered to patients for filling out forms with personal information in order to further foster feelings of safety and security.
- **Train front desk staff to greet patients in a warm and welcoming manner.** This simple practice can set the tone for the patient's entire experience. In addition to including their receptionists in trauma-informed training, UCSF Women's HIV Program has a designated host who greets patients as they enter the clinic and helps orient them to the different activities and services that are available.
- **Train all clinical and non-clinical staff how to effectively communicate with patients** about scheduling changes or delays to their appointment. Basic communication and de-escalation techniques convey respect and prevent patients from getting upset. This communication is greatly facilitated if the entire clinic agrees on a uniform policy for such situations so front line staff are not routinely overruled and can convey an accurate message.

Taking the Leap to Trauma-Informed Approaches to Care

Organizations that take the initial steps outlined in this brief, may be ready to take the more major step to becoming fully trauma-informed.

Comprehensive, organizationally focused trauma-informed care models to consider include:

- Sanctuary Model, which is a theory-based approach to changing and sustaining organizational culture to be more trauma-informed; and
- SFDPH's Trauma-Informed Systems Initiative, which uses a common language, guiding principles, and champion and leadership learning communities to transform the health department from one that induces trauma to one that reduces trauma, and ultimately toward being a healing organization.

Looking Ahead

Adopting a trauma-informed approach to care holds great promise for enhancing patient outcomes, decreasing costs, and improving staff wellness. However, becoming a fully trauma-informed organization may entail significant time and financial investments, and continuous staff and leadership commitment. Opportunities outlined in this brief, such as training all staff, incorporating patient voice and choice, and identifying early champions may serve as a starting place to help organizations generate awareness of the impact of trauma, encourage staff wellness, improve hiring practices, and enhance organizations' physical, social, and emotional environments. Successful implementation of these initial changes may help make the case for future investments in trauma-informed care, including the adoption of a comprehensive trauma-informed care model.

Learn More

This brief is a product of *Advancing Trauma-Informed Care*, a national initiative focused on better understanding how trauma-informed approaches can be practically implemented across the health care sector, made possible by the Robert Wood Johnson Foundation and led by the Center for Health Care Strategies (CHCS). CHCS is a nonprofit policy center dedicated to improving the health of low-income Americans.

For more information, visit CHCS' *Trauma-Informed Care Implementation Resource Center* at **TraumaInformedCare.chcs.org**.

Endnotes

[1] Substance Abuse and Mental Health Services Administration. "SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach." *Substance Abuse and Mental Health Services Administration*, Rockville, MD (2014). Available at: https://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf.

[2] C. Menschner and A. Maul. *Key Ingredients for Successful Trauma-Informed Care Implementation.* Center for Health Care Strategies. April 2016. Available at: https://www.chcs.org/resource/key-ingredients-for-successful-trauma-informed-care-implementation/.

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NCTSN The National Child Traumatic Stress Network

Parent Guidelines for Helping Youth after the Recent Shooting

The recent shooting has been an extremely frightening experience, and the days, weeks, and months following can be very stressful. Your children and family will recover over time, especially with the support of relatives, friends, and community. But families and youth may have had different experiences during and after the shooting, including those who may experienced physical injury, involvement in police investigation, worry about the safety of family members and friends, and loss of loved ones. How long it takes to recover will depend on what happened to you and your family during and after this event. Some adults and children have been seriously injured and will require medical treatment and long-term rehabilitation. Over time, some youth and adults will return to normal routines, while others may struggle. Children and teens may react differently to the shooting depending on their age and prior experiences. Expect that youth may respond in different ways, and be supportive and understanding of different reactions, even when you are having your own reactions and difficulties.

Children's and teen's reactions to the shooting are strongly influenced by how parents, relatives, teachers, and other caregivers respond to the event. They often turn to these adults for information, comfort, and help. There are many reactions that are common after mass violence. These generally diminish with time, but knowing about them can help you to be supportive, both of yourself and your children.

Common Reactions

- Feelings of anxiety, fear, and worry about the safety of self and others
- Fears that another shooting may occur
- Changes in behavior:
  - Increase in activity level
  - Decrease in concentration and attention
  - Increase in irritability and anger
  - Sadness, grief, and/or withdrawal
  - Radical changes in attitudes and expectations for the future
  - Increases or decreases in sleep and appetite
  - Engaging in harmful habits like drinking, using drugs, or doing things that are harmful to self or others
  - Lack of interest in usual activities, including how they spend time with friends
- Physical complaints (headaches, stomachaches, aches and pains)
- Changes in school and work-related habits and behavior with peers and family
- Staying focused on the shooting (talking repeatedly about it)
- Strong reactions to reminders of the shooting (seeing friends who were also present during shooting, media images, smoke, police, memorials)
- Increased sensitivity to sounds (loud noises, screaming)

Things I Can Do for Myself

- **Take care of yourself.** Do your best to drink plenty of water, eat regularly, and get enough sleep and exercise.
- **Help each other.** Take time with other adult relatives, friends, or members of the community to talk or support each other.
- **Put off major decisions.** Avoid making any unnecessary life-altering decisions during this time.
- **Give yourself a break.** Take time to rest and do things that you like to do.

Things I Can Do for My Child

- **Spend time talking with your children.** Let them know that they are welcome to ask questions and express their concerns and feelings. You should remain open to answering new questions and providing helpful information and support. You might not know all the answers and it is OK to say that. At the same time, don't push them to talk if they don't want to. Let them know you are available when they are ready.
- **Find time to have these conversations.** Use time such as when you eat together or sit together in the evening to talk about what is happening in the family as well as in the community. Try not to have these conversations close to bedtime, as this is the time for resting.
- **Promote your children's self-care.** Help children by encouraging them to drink enough water, eat regularly, and get enough rest and exercise. Let them know it is OK to take a break from talking with others about the recent attacks or from participating in any of the memorial events.
- **Help children feel safe.** Talk with children about their concerns over safety and discuss changes that are occurring in the community to promote safety. Encourage your child to voice their concerns to you or to teachers at school.
- **Maintain expectations or "rules."** Stick with family rules, such as curfews, checking in with you while with friends, and keeping up with homework and chores. On a time-limited basis, keep a closer watch on where teens are going and what they are planning to do to monitor how they are doing. Assure them that the extra check-in is temporary, just until things stabilize.
- **Address acting out behaviors.** Help children/teens understand that "acting out" behaviors are a dangerous way to express strong feelings over what happened. Examples of "acting out include intentionally cutting oneself, driving recklessly, engaging in unprotected sex, and abusing drugs or alcohol. You can say something like, "Many children and adults feel out of control and angry right now. They might even think drinking or taking drugs will help somehow. It's very normal to feel that way - but it's not a good idea to act on it." Talk with children about other ways of coping with these feelings (distraction, exercise, writing in a journal, spending time with others).
- **Limit media exposure**. Protect your child from too much media coverage about the attacks, including on the Internet, radio, television, or other technologies (e.g., texting, Facebook, Twitter). Explain to them that media coverage and social media technologies can trigger fears of the attacks happening again and also spread rumors. Let them know they can distract themselves with another activity or that they can talk to you about how they are feeling.

- **Be patient.** Children may be more distracted and need added help with chores or homework once school is in session.
- **Address withdrawal/shame/guilt feelings.** Explain that these feelings are common and correct excessive self-blame with realistic explanations of what actually could have been done. Reassure them that they did not cause any of the deaths and that it was not a punishment for anything that anyone did "wrong." You can say, "Many children, and even adults, feel like you do. They are angry and blame themselves, thinking they could have done more. You're not at fault. There was nothing more you could have done."
- **Manage reminders**. Help children identify different reminders (people, places, sounds, smells, feelings) and to clarify the difference between the event and the reminders that occur after it. When children experience a reminder, they can say to themselves, "I am upset because I am reminded of the shooting because the potato chip bag popped. But now there is no shooting and I am safe." Some reminders may be related to the loss of friends and/or family (photos of the person, music listened to together, locations of time spent together). Help your child cope with these loss reminders and provide them extra comfort during these times.
- **Monitor changes in relationships.** Explain to children that strains on relationships are expectable. Emphasize that everyone needs family and friends for support during this time. Spend more time talking as a family about how everyone is doing. Encourage tolerance for how your family and friends may be recovering or feeling differently. Accept responsibility for your own feelings, by saying "I want to apologize for being irritable with you yesterday. I was having a bad day."
- **Address radical changes in attitudes and expectations for the future**. Explain to children that changes in people's attitudes are common and tend to be temporary after a tragedy like this. These feelings can include feeling scared, angry, and sometimes revengeful. Find other ways to make them feel more in control and talk about their feelings.
- **Get adults in your children's life involved.** If there has been a serious injury, death in the family, death of a close friend, or if your child is having difficulties, let your child's teacher or other caring adults know so that they can be of help.
- **Empower your child to get involved in their medical care.** For children or teens with injuries and long-term medical needs, encourage them to participate in medical discussions and decisions as much as possible. Have them ask their own questions and give opinions about different procedures. Teens are especially concerned about their physical appearance, fitting in, and their privacy. Talk with them about their concerns, problem-solve ways to address them, and respect their privacy.
- **Seek professional help.** If teens have continued difficulties for a couple of months after the attacks, parents should consult a trusted helper—a doctor or mental health professional.

COPING IN THE AFTERMATH OF A MASS SHOOTING

We live with the expectation that if we don't harm others, they won't harm us; a mass shooting shatters our sense of safety. When ordinary citizens doing ordinary things are killed or wounded by the bullets of a shooter, life turns upside down. We don't have a roadmap for how to feel or what to do. For those directly impacted – witnesses, survivors, first responders, loved ones of those killed or injured – finding the way forward can be a long and challenging process. Many struggle with anger, fear, guilt, and crushing grief. But we can all be touched by these tragic and senseless events. We can be left with feelings of helplessness, sorrow, and outrage. How can we manage these difficult emotions and find a way forward?

- **Allow your feelings.** Don't try to ignore or deny them. You may feel grief, anger, anxiety, exhaustion, or something else. You may just feel numb. These are all normal reactions. Talking about them (sometimes over and over) with people who care about you can help you process unsettling emotions. Vent feelings of anger in healthy ways. Allow yourself to grieve. Some people find it helpful to let feelings flow out on paper or address them in some creative way, such as painting or music.
- **Focus on what you do have control over**. The images we see, the stories we hear, and our own thoughts about what happened or what could happen can increase our anxiety. It can leave you feeling overwhelmed and helpless. Try to bring your focus to what you can control, such as learning how to respond in the face of danger. Or helping others, such as volunteering or making a donation.
- **Minimize your exposure to news media**. Once you have the facts, it's a good idea to limit watching coverage of the event**.** While it's important to stay informed, constant exposure may add to feelings of distress. Try to give yourself a break from the tragedy and thoughts and feelings stirred up by emotional news stories**.**
- **Lean into your routines as much as possible.** When an attack occurs, life can feel chaotic in many ways. The structure and predictability of doing daily tasks can help us to feel more grounded. This is also a simple but powerful way to help children feel safer after an attack. Some find it is emotionally liberating to stand up to fear in this way.
- **Give yourself a break.** It may be hard to focus and concentrate at times after a traumatic event. Your energy level may be low. Be patient with yourself. Don't overload your schedule. Give yourself a little more time to do tasks. There is no right or wrong way to feel, nor is there a right or wrong way to feel better.

Understand unique challenges for those directly impacted

When you live through a mass shooting, the trauma and emotional shock doesn't just go away. You have to work through it; finding your own way, in your own time. This process can be impacted by thoughts, emotions, and even how the brain is wired. It's important to understand that some people may struggle to recover after a traumatic event. Issues that may point to the need for more help include:

Survivor's guilt.

A person experiences intense feelings of shame and remorse. They feel they should have done more to save others or guilty for having survived when others died. The person may struggle with flashbacks, irritability, nausea, and feel disconnected from others. It can be a symptom of post-traumatic stress disorder.

- **Turn to others for support.** Being alone with your thoughts and emotions means there is no other voice in the conversation. Others offer different perspectives, while giving you a chance to talk about how you feel. This can bring comfort and help you move forward. It can be especially helpful to talk to others who've shared the same experience.
- **Help children process what has happened.** Be honest but measured when talking with a child about the attack. Think about what you will say and how you want to say it. Focus on reassuring them that they are safe. If they're struggling, help them process their feelings, don't just push them to feel better. Talking through worries and questions can help. Give them a way to respond, such as writing a thank you note to first responders.
- **Channel your feelings into action.** Be of service in some way. Even small moves can help release the paralyzing sense of helplessness. Reaching out and supporting others shifts your mental and emotional focus. Doing helpful things and offering kindness to others can open your heart and renew your spirit. It can be a powerful antidote to the inhumanity of a violent attack.
- **Increase your sense of safety.** Understand what is being done to protect your community**.** The more you know about what has happened, the more effective steps you can take to minimize your risk. Make sure you are getting your information from a reputable source. Be sure to follow directions from state and local authorities, including law enforcement.
- **Balance your thoughts.** When feeling overwhelmed by tragic events, it's easy to forget the good in the world. Try to balance feelings of pessimism by deliberately thinking about acts of goodness and kindness that people are doing every day. Adding some balance to your viewpoint can help when you feel the world is in a dark place.
- **Take care of yourself.** Do what you can to make sure you get enough sleep to feel well rested. Work to maintain a healthy diet and regular meals. Remember that exercise and being physically active can reduce stress. Avoid overuse of alcohol and/or substances.
- **Try relaxation techniques such as deep breathing or meditation.** Even taking a short time-out to bring your thoughts to the here and now can help. These gentle techniques can help calm the physical symptoms of anxiety and slow down racing thoughts.

Your Employee Assistance Program (EAP) is here to help

If you're having a difficult time, your EAP is here to support you. You can call your EAP and ask for a telephone consult. You will be connected to a professional who can help you work through your concerns.

Post-traumatic stress disorder (PTSD)

Experiencing or witnessing a terrifying, life-threating event triggers a hard-wired fight or flight response in the body. When this response doesn't stop after the danger passes, it may lead to post-traumatic stress disorder. Symptoms include high anxiety, avoidance of reminders, emotional numbness, hyper-vigilance, intrusive memories or nightmares of the event.

Complicated grief

Losing someone in a violent act can make working through grief an even more challenging process. When normal grief symptoms linger and deepen over time, it may point to complicated grief. Symptoms include continued, extreme focus on the death, numbness, intense pining for the person who died, withdrawing from others and inability to enjoy life.

Your EAP is a 24/7 resource

It's important to seek help if your reactions to the event continue long term or become overwhelming. Your EAP can provide professional help and connect you with resources for support in your community.

American Academy of Pediatrics
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Providing Psychosocial Support to Children and Families in the Aftermath of Disasters and Crises

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abstract

Disasters have the potential to cause short- and long-term effects on the psychological functioning, emotional adjustment, health, and developmental trajectory of children. This clinical report provides practical suggestions on how to identify common adjustment difficulties in children in the aftermath of a disaster and to promote effective coping strategies to mitigate the impact of the disaster as well as any associated bereavement and secondary stressors. This information can serve as a guide to pediatricians as they offer anticipatory guidance to families or consultation to schools, child care centers, and other child congregate care sites. Knowledge of risk factors for adjustment difficulties can serve as the basis for mental health triage. The importance of basic supportive services, psychological first aid, and professional self-care are discussed. Stress is intrinsic to many major life events that children and families face, including the experience of significant illness and its treatment. The information provided in this clinical report may, therefore, be relevant for a broad range of patient encounters, even outside the context of a disaster. Most pediatricians enter the profession because of a heartfelt desire to help children and families most in need. If adequately prepared and supported, pediatricians who are able to draw on their skills to assist children, families, and communities to recover after a disaster will find the work to be particularly rewarding.

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INTRODUCTION

Disasters are "one-time or ongoing events of human or natural cause that lead groups of people to experience stressors including the threat of death, bereavement, disrupted social support systems, and insecurity of basic human needs such as food, water, housing, and access to close family members."[1] In a representative sample of more than 2000 US children 2 through 17 years of age, nearly 14% were reported to have been exposed to a disaster in their lifetime, with more than 4% of disasters occurring in the past year.[1] Disasters, thereby, affect the lives of millions of children

every year, whether through natural disasters, such as earthquakes, hurricanes, tornadoes, fires, or floods; human-made disasters, such as industrial accidents, war, or terrorism; or as a result of pandemics or other naturally occurring disease outbreaks. Children are particularly vulnerable to the effects of disasters and other traumatic events because of a lack of experience, skills, and resources to be able to independently meet their developmental, social-emotional, mental, and behavioral health needs.[2,3] Disasters also have the potential to cause short- and long-term effects on the psychological functioning, emotional adjustment, health, and developmental trajectory of children, which even may have implications for their health and psychological functioning in adulthood; children, as a group, are among those most at risk for psychological trauma and behavioral difficulties after a disaster.[4]

Pediatricians and other pediatric health care providers are in an excellent position to (1) encourage families and communities to prepare for potential disasters; (2) provide support to children and families in the immediate aftermath of a disaster, as well as throughout the recovery process; (3) share advice and strategies with caregivers on how to promote and support children's adjustment, coping, and resilience; (4) provide timely triage to identify and refer children with or at considerable risk of developing adjustment difficulties to appropriate services; (5) serve as a consultant to schools, child care centers, and other child congregate care sites on preparedness, response, and recovery efforts; and (6) advocate at the local, state, and national levels for a state of preparedness and services to meet the needs of children affected by disasters.[3] Stress is intrinsic to many major life events that children and families face, including the experience of significant illness and its treatment. The information provided in this clinical report may, therefore, be relevant for a broad range of patient encounters, even outside the context of a disaster.

Emotional distress also may interfere with the accurate reporting of symptoms and may even mimic physical conditions. Effective management of medical conditions may be compromised, thereby reducing the quality of pediatric care provided both in the aftermath of disasters and in situations involving patient/family distress. Despite the increased call for psychosocial support in the aftermath of a disaster, surveys of practicing pediatricians consistently indicate that most pediatricians perceive themselves to be unprepared to address the needs of children in such crises.[5,6] This clinical report presents information about children's common adjustment reactions to disasters, their risk factors for addressing and dealing with challenges, and practical strategies to help patients and families increase coping skills and resiliency.

CREATE A SAFE HEALTH CARE ENVIRONMENT IN THE AFTERMATH OF A DISASTER

Sites that may deliver care in the aftermath of a disaster should be designed to minimize the likelihood of contributing additional stress to children. When delivering medical care, attempts should be made to minimize the use of invasive or painful procedures or treatments and provide appropriate sedation or analgesia whenever required. Parents and family members should remain with children to the extent possible throughout the evaluation and treatment process, provided that they are able to cope with their own discomfort or distress. Parents may be guided in supporting their children, such as by using coping strategies they have found effective in the past (eg, distraction or attention-refocusing techniques, like a calming touch or use of gentle humor). Parents should be allowed to temporarily leave the examination room if they are feeling overwhelmed, but should notify the child before leaving that they will be in an adjacent area and that the pediatrician or nurse will remain with them for a few minutes until they return.

Practical steps can be taken to minimize children's exposure to frightening images and sounds that may compound their distress or serve as triggers or reminders of a disaster. Doors/curtains in the health care setting should be closed to reduce exposure to others who are injured or in pain. Televisions in waiting, examination, and inpatient rooms can be turned off if they are broadcasting coverage of the crisis event. Staff members are encouraged to remember that children can often overhear and understand their conversations.

Parents and doctors can provide explanations about medical treatments and care in positive terms that emphasize how these interventions are intended to keep children safe and/or help them feel better. Potential risks may be presented in supportive ways, for example, "We are going to put this belt around your waist so that you remain safe and secure in the ambulance," rather than "We will put this belt on so that you don't go flying out of the ambulance if we have to stop quickly on the way to the hospital." This advice is relevant even outside the context of a disaster.[7]

COMMON ADJUSTMENT REACTIONS OF CHILDREN TO DISASTERS

The effect of a disaster on each individual child varies depending on a number of factors, including (1) the nature of the event and the amount of death, destruction, and disruption; (2) the degree of personal

involvement of children and their families; (3) the duration of time before children's daily environment, and that of the overall community, returns to a safe, predictable, and comfortable routine; (4) whether the stressor is a 1-time or chronic event; (5) the level of coping ability of the children's caregivers; (6) the children's preexisting mental health, developmental level, and baseline resiliency and coping skills; and (7) the nature of the secondary stressors and losses that follow the crisis event. In communities recovering from a disaster, it is therefore often helpful for pediatricians not only to inquire about children's symptoms, but also to ask families about what children were exposed to as a result of the disaster, what they understand about what has happened to their community, any ongoing stressors that may complicate recovery, and additional questions that explore and identify these risk factors (see Table 1).

Most children who are experiencing adjustment difficulties after a disaster may demonstrate no observable symptoms. Children might try to avoid revealing concerns and complaints to not seem odd and not further burden adults in their lives who are having difficulty coping as well. Even children suffering from posttraumatic stress disorder (PTSD) may go undetected unless pediatricians screen or directly inquire about symptoms and adjustment. One of the core criteria of PTSD is an active avoidance of thinking about or talking about the triggering event and one's associated reactions to that event. Making the diagnostic process even more difficult, most of the symptoms of an acute stress disorder or PTSD may not be externally expressed at all (eg, intrusive thoughts). As a result, parents, teachers, and other caregivers tend to underestimate the level of children's distress after a disaster and overestimate their resilience, especially if relying on the observation of overt behaviors rather than inquiring specifically about feelings and reactions. The adults' own reactions to the event also may diminish their ability to identify their children's needs with optimal sensitivity or reliability.[8] Finally, the parents' own difficulty adjusting to an event may, in turn, threaten children's sense of safety and security and serve as a negative model of emotional regulation.[9]

TABLE 1 Common Symptoms of Adjustment Reactions in Children after a Disaster[24]

Sleep problems: difficulty falling or staying asleep, frequent night awakenings or difficulty awakening in the morning, nightmares, or other sleep disruptions.
Eating problems: loss of appetite or increased eating.
Sadness or depression: may result in a reluctance to engage in previously enjoyed activities or a withdrawal from peers and adults.
Anxiety, worries, or fears: children may be concerned about a repetition of the traumatic event (eg, become afraid during storms after surviving a tornado) or show an increase in unrelated fears (eg, become more fearful of the dark even if the disaster occurred during daylight). This may present as separation anxiety or school avoidance.
Difficulties in concentration: the ability to learn and retain new information or to otherwise progress academically.
Substance abuse: the new onset or exacerbation of alcohol, tobacco, or other substance use may be seen in children, adolescents, and adults after a disaster.
Risk-taking behavior: increased sexual behavior or other reactive risk-taking can occur, especially among older children and adolescents.
Somatization: children with adjustment difficulties may present instead with physical symptoms suggesting a physical condition.
Developmental or social regression: children (and adults) may become less patient or tolerant of change, revert to bedwetting, or become irritable and disruptive.
Posttraumatic reactions and disorders: see Table 2.

Research has shown that after a major disaster, a large proportion of children in the affected community will develop adjustment reactions, with many qualifying for a diagnosis of a mental health condition, often related to trauma, anxiety, or depression.[10] In a study conducted 6 months after the terrorist attacks of September 11, 2001, involving a representative sample of more than 8000 students in grades 4 through 12 attending New York City public schools, 27% met criteria for 1 or more probable psychiatric disorders on the basis of self-reporting of symptoms and impairment in daily functioning. The study reported the following:

- 11% of students had PTSD;
- 8% of students had major depressive disorder;
- 12% of students had separation anxiety disorder;
- 9% of students had panic attacks; and
- 15% of students had agoraphobia (or fear of going outside or taking public transportation).

Perhaps of even greater concern, at least two-thirds of those students who self-reported mental health symptoms and impairment in daily functioning also reported that they had not sought care, even though free mental health services had been available in their schools. In addition, the vast majority (87%) of all students surveyed reported at least 1 ongoing symptom that persisted 6 months after the event, reported as follows:

- 76% of students reported often thinking about the attacks;
- 45% of students were actively trying to avoid thinking or talking about the event;
- 25% of students were experiencing difficulty concentrating;
- 24% of students were having sleep problems (including 17% with nightmares); and
- 18% of students stopped going to places or doing things that reminded them of the events of September 11.[11]

Because most children experience at least some long-term reactions to a disaster and because many children and families cannot or do not access mental health services for reasons including cost and perceived stigma,

it is important to explore strategies that provide interventions and support to all children after a major disaster, rather than relying exclusively on the traditional clinical approach of triage and referral for those patients identified as needing care.

Anticipatory guidance and advice can be provided to families by pediatricians on how to identify and address the most common adjustment reactions that can be anticipated among children after a disaster (see Table 1). For example, sleep problems are common after a disaster, and children who have difficulty sleeping may develop problems with concentration, attention, learning, and academic functioning. Promoting sleep hygiene (eg, providing a consistent, quiet, and comfortable location and time for sleep that is free of noise or other distractions, preceded by a quiet and consistent bedtime ritual), may be difficult but is nonetheless important, especially when families are living in shelters or other temporary sites. Posttraumatic stress reactions are frequently observed immediately after a disaster and can be best explained to children as the way their body automatically responds after an event frightens them. Less commonly, PTSD may develop a while after the traumatic event occurred, especially among children who perceived at the time of the event that their life was in jeopardy or experienced intense fear, helplessness, or horror. Table 2 includes the diagnostic criteria for PTSD, as outlined in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)*,[12] which include symptoms of intrusion, avoidance, negative alterations in cognitions and mood, and increased arousal that persist for at least 1 month and result in significant impairment in social, academic, or other areas of functioning.

Distress that occurs as a result of children's involvement in a disaster often creates an additional burden for the children who may have had unresolved predisaster psychopathology or adjustment difficulties. Psychological issues that children have attempted to suppress may resurface, even if these issues are not directly related to the disaster.[10,13] As a result, unrelated events and experiences (eg, previous traumatic events or worries about the health of parents) may be the cause for what appear to be reactions to the disaster itself. This distress may be seen among adults, such as parents, as well.

In a related manner, future events and references that remind children of the losses or disturbing images, sensations, and emotions associated with the disaster event may serve as later triggers of their grief or trauma symptoms. Some examples include anniversaries of the disaster, severe weather that reminds a child of a natural disaster, persistent signs of destruction in the community, sounds of emergency vehicles, allusions to similar events on television or in classroom lessons, or visits to health care facilities. These reminders may result in an unanticipated, acute resurgence of some of the feelings associated with the loss or crisis and catch children off guard. Parents, educators, and others who work with children should anticipate that such triggers may occur and help children anticipate and plan for how to address these feelings.

TABLE 2 Symptoms of Posttraumatic Stress Disorder[24]

Exposure: The child is exposed to actual or threatened death, serious injury, or sexual violence. This may be through the child's direct experience; by witnessing the traumatic event, especially when involving a caretaker; or by the child learning that the traumatic event occurred involving a close family member or friend without any direct experience or witnessing of the event by the child.

The following symptoms must occur for more than 1 month's time:

1. Intrusion
   - The child has repeated distressing memories and/or dreams (nightmares) about the traumatic event; it is not required for children to remember the content of these distressing dreams. For some children, repetitive play activities may involve themes or aspects of the traumatic event.
   - The child may display a loss of awareness of present surroundings (dissociation) and act as if the traumatic event is reoccurring (flashbacks).
   - The child may experience intense or prolonged psychological distress and/or physiologic reactions at exposure to internal or external cues that symbolize or resemble the traumatic event.
2. Avoidance
   - The child attempts to avoid distressing memories, thoughts, feelings, activities, and/or places that remind him or her of the traumatic event.
3. Negative alterations in cognitions and mood
   - The child has problems remembering important aspects of the traumatic event.
   - The child maintains negative beliefs or expectations about oneself, others, or the world.
   - The child has thoughts about the cause or consequences of the traumatic event that lead to blame of self/others.
   - The child experiences negative emotional states, such as depression, and has trouble experiencing and expressing positive emotions.
   - The child shows a markedly diminished interest or participation in significant activities, including play.
   - The child feels distant from others, which may lead the child to become socially withdrawn and avoid people, conversations, or interpersonal situations.
4. Increased arousal and reactivity associated with the traumatic event
   - Irritable and angry outbursts (extreme temper tantrums).
   - Reckless or self-destructive behavior.
   - Hypervigilance.
   - Exaggerated startle response.
   - Problems with concentration.
   - Sleep disturbance.

BEREAVEMENT AND SECONDARY STRESSES

Whereas the adjustment difficulties (as outlined in Table 1) that children experience after a disaster may be

related to posttraumatic reactions, many will not be directly attributable to the disaster itself. Disasters may worsen preexisting problems, such as financial strain, parental depression, parenting challenges, or child behavior problems, which may have been adequately compensated or addressed in a setting of less stress.[14] Disasters often also initiate a cascade of secondary losses and stressors that may become the primary concern for a particular child or family. A child presenting with sleep problems months after a flood may be responding to marital conflict or parental distress related to financial concerns instead of solely struggling to cope with the flooding itself. After a major natural disaster, it is common to see increased unemployment or underemployment resulting in financial stress on families; a need for families to relocate resulting in changes in schools or peer groups for the children; temporary living situations that are suboptimal or causes of interpersonal conflict; or depression, substance use, or marital conflict among parents. Such an increase in marital stress, domestic violence, and parental mental health problems was demonstrated in the Gulf Coast region after Hurricane Katrina.[15,16] Child abuse has also been reported to increase after major disasters.[17] Pediatricians may see children and families dealing with such issues even if the children or adults in the family did not experience the disaster itself as traumatic but instead are reacting to secondary losses or stressors. Management of these concerns requires a different approach than trauma treatment; pediatricians need to adopt a more holistic approach to assessing adjustment and promoting coping and resiliency among children and families after a disaster. Assessments need not only to explore how children are adjusting with the disaster event itself, but also to seek information about their current life circumstances and how they are dealing with the challenges these circumstances may pose. Given that children may withhold voicing their concerns in the presence of their parents or other family members so as not to further burden the adults who may be in distress themselves, it is important to interview the children alone with the parents' permission and child's assent when trying to assess fully their level of coping.

Given that these secondary losses and stressors may continue for even several years after a major disaster, children's adjustment difficulties may persist for a similarly extended time. Children's adjustment should not be expected before the restoration and stabilization of the home, school, and community environments and supports for children, which may not return to being fully functional for several years.

If children experience the deaths of family members or friends as a result of the disaster, bereavement may emerge as their predominant concern. In most situations, bereavement in the context of a disaster is not dissimilar from bereavement occurring in other contexts; when children have observed a violent death of a loved one, grief may be compounded by trauma reactions requiring treatment of trauma in addition to bereavement support. Children, like adults, will struggle with understanding and accepting the death and the effect it has on them and their family and the challenge of a life devoid of someone they loved.[18] Parents, teachers, and other caring adults are often reluctant to talk with children who are grieving or even to raise the topic out of a fear of causing further distress by saying the "wrong thing." Yet, the distress is caused by the reaction to the death itself, rather than any question or invitation to talk. Talking may provide some relief if not coerced. Avoiding discussion is rarely helpful and often isolates children at a time when they are most in need of support and assistance.

Pediatricians and other pediatric health care providers can serve as a useful resource for children who have recently experienced the death of a close family member or friend by helping their caregivers understand the importance of inviting and answering their questions, providing information to help guide them in understanding and adjusting to the loss, and helping them identify strategies for coping with the associated distress. Timely information about how to involve children in the funeral or other memorialization activities, how to enlist the support of school personnel, and bereavement support services available within the community are helpful to provide, through in-person meetings, phone calls, or psychoeducational material. Practical and free resources are available for this purpose[19] (see www.aap.org/disasters/adjustment and www.achildingrief.com). A resource offering free multimedia training materials on how to support grieving children is available through the Coalition to Support Grieving Students at www.grievingstudents.org. Practical guidance on how to approach notification of children about the death of a family member or friend,[20] including within the unique context of a disaster,[21] can be found elsewhere.

RISK FACTORS FOR ADJUSTMENT DIFFICULTIES AND GUIDELINES FOR REFERRAL

In the immediate aftermath of a disaster, pediatricians need to assess both the physical and mental health of children. The primary focus is, of necessity, medical stabilization and evaluation, but a secondary mental health triage should follow shortly thereafter. Table 3 outlines the factors to be assessed during this mental health triage to identify children most in need of mental

health services or other immediate attention to their mental health needs. The following factors, in particular, suggest the need for immediate mental health services: (1) dissociative symptoms, such as detachment, derealization, or depersonalization, which may present in children as appearing confused, distant, daydreaming, or aloof (such dissociation at the time of exposure has been found to be the most significant predictor of later PTSD); (2) extreme confusion or inability to concentrate or make even simple decisions; (3) evidence of extreme cognitive impairment or intrusive thoughts; (4) intense fear, anxiety, panic, helplessness, or horror; (5) depression at the time of the event[13]; (6) uncontrollable and intense grief; (7) suicidal ideation or intent; and (8) marked physical complaints resulting from somatization.[22] When children's caregivers are struggling themselves to cope with the event, helping the caregivers access services for themselves and/or providing a referral to a mental health provider to assist with children's coping also may be indicated.

TABLE 3 Factors Associated With an Increased Risk of Adjustment Problems After a Disaster[24]

1. Preexisting factors
   - Previous psychopathology, significant losses, attachment disturbances, limited coping skills, or other traumatic events.
   - Socioeconomic differences that result in lower levels of postdisaster resources and support.
2. Nature of disaster experience
   - Injury of the child or death or injury of those close to the child.
   - Nature and extent of exposure, including number of deaths, physical proximity to disaster, and extent of personal loss. Human-made disasters, especially terrorist attacks that have a high degree of intentionality, generally create reactions that are more prevalent and long-lasting.
   - Extent of exposure to horrific scenes (including indirectly through the media).
   - Child's perception (at the time of the event) that his or her life was in jeopardy.
3. Subsequent factors
   - Personal identification with the disaster or victims.
   - Separation of child from parents or other important caregivers as result of event.
   - Loss of property or belongings; need to relocate or other disruption in daily routine or environment.
   - Parental difficulty in coping, substance abuse, mental illness.
   - Lack of supportive family communication style.
   - Lack of community resources and support.

Children's adjustment and resiliency depend on a number of factors that relate to the nature of the event itself (such as how much damage or death resulted from the event); the degree of personal effects on children or those close to them in terms of death, disability, injury, or loss of property or damage to housing; the level of exposure involving direct witnessing or viewing graphic coverage through the media or online; the degree and duration of secondary losses and stressors; the disruption caused to children's extended support system and the level of adaptation of caregivers and the degree to which they are able to create a safe and nurturing environment that promotes recovery for the children; and the nature of children's preexisting coping abilities.[23,24] Table 3 outlines the factors before, during, and after a disaster that are associated with an increased risk of difficulty adjusting after a disaster.

Separation from parents or other important caregivers is associated with increased difficulty adjusting to a disaster. Efforts to reunite children who are separated from their family by the event are a high priority.[25,26] In those situations in which children require medical treatment or observation before reunification is possible, individual volunteers can be assigned to provide consistent and ongoing support to individual children until reunification is achieved. When parents, guardians, or other family members are available, guidance by the health care team can help them serve an active and appropriate role in the evaluation and treatment process and can help to reduce their children's distress.[3]

BASIC SUPPORTIVE SERVICES AND PSYCHOLOGICAL FIRST AID

Attention to the basic needs of individuals affected by a disaster is a top priority for the immediate response. Basic needs include food, shelter, safety, supervision, communication, and reunification with loved ones. Ensuring that these basic needs are addressed is the first step to providing emotional support.

In addition, all individuals directly affected by a disaster should be provided psychological first aid, which involves psychoeducation and supportive services to accelerate the natural healing process and promote effective coping strategies. Psychological first aid includes providing timely and accurate information to promote an understanding that will facilitate adjustment, offering appropriate (but not false) reassurance that corrects misconceptions and misperceptions that might otherwise unnecessarily increase the appraisal of risk, supplying information about likely reactions and practical strategies to facilitate coping with distress, and helping people identify supports in their family and useful resources in their community.[27] One such model for psychological first aid that is readily accessible to those outside the mental health field is Listen, Protect, and Connect.[28] Pediatricians and other pediatric health care providers should ensure that all staff in their practice setting, including front office and support staff, are familiar with psychological first aid and ready to provide such support to children and adults in the aftermath of a disaster. Given that children and families who present to health care settings are often in distress, these are useful skills that can be used on a daily basis even outside the context of a disaster. In addition, having other adults who

care for children, such as staff within child care facilities and schools, also be familiar with these strategies is important to create resilient communities that are able to support children in the aftermath of a disaster.

NOTIFICATION AND MEDIA COVERAGE

Children should be informed about a disaster as soon as information becomes available. Children can sense when critical information is being withheld and when trusted adults are not being genuine; this, in turn, undermines their trust and sense of safety and compromises the ability of these adults to be later viewed as a source of support and assistance. Even very young children or those with developmental disabilities can sense the distress of trusted adults. Children also often overhear or otherwise learn information about the events, such as through the Internet or social media or from conversations with other children.

The amount of information to share with individual children may vary by the developmental level of the children or their typical coping strategies. In general, older children seek and benefit from more information. Irrespective of their age, children who generally cope by learning more and understanding more about a threat will often seek and benefit from a deeper understanding. But no matter the developmental level or usual coping style, it is best to start with simple and basic facts about the event and then take the lead from children's questions that follow about what further information or explanations will be helpful. If some time has passed since the event, children can be asked what they may have already heard or learned about the event and what questions they now have. In this way, misunderstandings and misconceptions can be identified and addressed. The goal is to help children feel they understand what is going on enough for them to know how best to deal with the situation.

Media coverage often contains graphic images and details, evocative pictures or stories, or strong emotional content that is not helpful for children or adults. Technological advances and changes in the mass media landscape now offer a stage unlike any in history, from which disaster events can reach an enormous audience in real-time. Continuous news coverage, broadcast over the ubiquitous presence of televisions, personal computers, the Internet, and smartphones, and an increasingly sophisticated technology for live broadcasts has resulted in the unprecedented coverage of disasters in real-time and exquisite detail, allowing viewers to experience the event almost as if they were physically present. This expanded media presence has led to a broader population of children and youth with either primary or secondary exposure to an event.[8,29,30]

Parents should, therefore, limit the amount of media coverage in the immediate aftermath of a disaster for children and all members of the family, including television, radio, Internet, and social media, and remember that children often overhear and pick up on media coverage being viewed by adults. If media coverage is going to be viewed by children, parents may want to record and view it first and/or watch along with children. In discussions, avoid graphic details and excessive information that is not helpful to understand what has happened or learn what to do to keep safe or to cope. If no further understanding is resulting from continued viewing of coverage of the event, then it is best for even adults to discontinue such viewing. Right after a disaster occurs is a good time to turn off electronic devices that are being used for entertainment and come together physically and emotionally as a family unit to provide support to one another.

PROMOTING EFFECTIVE COPING STRATEGIES

Advocating specific coping strategies for children after a disaster can be challenging because of the interaction among a number of factors, including a child's personal characteristics, preexisting functioning, and developmental level.[10] Research on stress management has demonstrated that directly facing a problem is associated with better outcomes, and avoiding the situation or only reacting emotionally can be more problematic, but outcomes may vary depending on the nature of the stressors. Problem-focused coping may be most beneficial when stressors can be controlled by the child. Avoidant or emotion-focused coping might be more productive when stressors cannot be removed.[31] The influence of a child's caregivers is also important to consider; parents and other caring adults may be so overwhelmed themselves after a disaster that they are unable to appreciate the distress in their children. Adults often hide their own distress to protect their children or provide them false reassurance; they may intentionally or unintentionally imply that children should not be upset. In reality, if children feel worried, then they are worried. Telling them that they should not be worried is usually ineffective and undermines the potential for children to own their feelings and learn strategies to deal with them.

Although it is important for children to be encouraged to express their feelings and concerns, it is equally important that adults help foster a range of coping skills in children so that they have strategies they can use to address distress and troubling feelings. If parents can communicate some of their own distress, with an

emphasis on sharing personal strategies they have used to cope effectively with that distress (that may be applicable to the children), they provide opportunities for children to learn coping strategies. For example, a parent can share that he was upset about the destruction of their home and loss of personal property and that this interfered with his sleep or caused some sadness, and then discuss how talking to another trusted adult, getting some exercise, meditating, helping others who were also affected, and so forth, helped him feel better. Pediatricians can support families by providing examples of a variety of coping strategies (eg, both problem focused and emotion focused, approach and avoidance) while modeling emotional regulation and a positive attitude. Suggesting that children contribute to a food or clothing drive for those who lost their homes or draw hopeful pictures for victims in hospitals can help children feel like they are contributing. Adolescents may wish to write positive comments in social media to encourage those who may be isolated and distressed after a disaster. Children may also benefit from the pediatrician sharing his or her own understanding of the disaster and recovery process which will help children better interpret all that is going on (eg, "The tornado created a big mess, but we are pulling together as a community," or "Living in a shelter with all the other children in the neighborhood must have been a real adventure"). Communicating with children in this manner after a disaster may help them begin to make sense of all that has occurred and increase their self-confidence because they have coped with an event that once appeared overwhelming.

Children may feel guilt or shame associated with the disaster, even when they have no objective reason to feel responsible. They may question what they did or failed to do that led to or contributed to the impact of the disaster; they may wonder what they could have done to have improved the outcome. It is often helpful to reassure children about their lack of responsibility. When children persist in beliefs that their inadvertent comments or actions were somehow contributory (eg, a child has an argument with a parent just before the parent is killed in a car accident during a severe storm), it may be helpful to clarify that their behavior or conversation was in no way intended to cause such harm and did not do so. Although such guilt and shame may be common in the aftermath of a disaster, if left unaddressed, these painful self-incriminating emotions may cause significant distress and long-term adjustment problems. Self-blame and survivor's guilt may remain with children and can lead to long-term difficulties.[32]

Children, just as do adults, often feel powerless in the aftermath of a disaster; this may be improved if they are able to help others. It is, therefore, beneficial to help children identify practical actions they can take to aid others, whether victims of the disaster or others in need in the family or broader community.

Psychotropic medications should generally be avoided in the management of children's distress after a disaster. Children need to develop an understanding of the event and learn to express and cope with their reactions. Medication should, therefore, not be used to suppress reactions such as crying or feelings such as sadness and should not be used to blunt children's awareness of the event. Referral to or consultation with a child mental health professional with expertise in the management of childhood trauma is recommended for primary care providers when considering use of psychotropic medications for persistent or severe posttraumatic reactions.[21]

CONSULTATION TO SCHOOLS

Pediatricians can work with local schools to assist in recovery efforts for students. After a disaster, schools are likely to see negative effects on learning among their students, and staff may find it difficult to teach or manage their classes unless adequate supports are put in place immediately after the disaster and maintained until recovery has been completed. Schools can serve as an effective means to reach the broad population of children and families affected by the disaster and a cost-effective and accessible site for the delivery of basic and supportive services by professionals already familiar to the students and trusted by the families. Schools are also sites that are amenable to psychoeducation, psychological first aid, and group supportive services. Schools are particularly well suited to monitoring children's adjustment over time and can be used to provide additional mental health services or referral to community services.

Schools should have well-established guidelines for crisis response and well-trained crisis response teams.[33,34] All school staff should have basic skills in psychological first aid[28] and basic bereavement support.[18,35] Resources for training and guidance for schools responding to crisis and loss can be found at the Web site for the National Center for School Crisis and Bereavement (www.schoolcrisiscenter.org) and the Coalition to Support Grieving Students (www.grievingstudents.org).

SHORT- AND LONG-TERM INTERVENTIONS

The goal of short-term intervention is to address immediate physical needs and to keep children safe and protected from additional harm; to help children understand and begin to accept the disaster; to identify, express, validate, and cope with their feelings and reactions; to reestablish a sense of safety through routines and

family connections; to start to regain a sense of mastery and control over their life; and to return to child care or school and other developmentally appropriate activities.[21,36] Children who are grieving the loss of a family member or friend may benefit from bereavement counseling or support. Those experiencing or at high-risk of developing PTSD should be offered referral to a mental health professional experienced in cognitive-behavioral therapy that addresses trauma. School-based group treatment using cognitive-behavioral treatment approaches, such as Cognitive-Behavioral Intervention for Trauma in Schools, also has been shown to be effective.[37] Children with multiple stressors and/or chronic and ongoing trauma and those with limited external supports within their family, school, and broader community are more likely to require counseling or other formal support.

In general, children are helped by returning to their routine, such as child care, school, organized activities, and sports, as soon as practical after a disaster, as long as the necessary support systems and accommodations (such as temporarily reducing or providing more time for homework assignments or tests) are in place. Expectations for children's classroom performance and behavior may need to be modified until their adjustment difficulties no longer interfere with their cognitive, emotional, and social functioning. Parents and educators may be falsely reassured, however, by a return to routine, misinterpreting that children are more resilient than they may be and are no longer in need of support or assistance once they have begun the process of recovery. Children often need ongoing support for months or longer after a major disaster, and some will require more intensive interventions. If supports and assistance are withdrawn before full recovery has occurred, some children will fail to return to their baseline level of adjustment and coping and may show continued impairment for an extended period of time.

In the immediate aftermath of a disaster, communities often become more cohesive for a time period, with members of the community providing and receiving support that had not been expressed before the disaster. This "honeymoon phase" is often characterized by some initial improvement in coping among members of the community but is often not sustained. Some vulnerable individuals, despite an initial improvement, may be challenged without ongoing support; they may come to feel hopeless about their ability to return to their baseline functioning or doubt they will ever recover fully. Depression and suicidality, especially among adults, may therefore be seen later, such as several months after the disaster event, despite initial improvement but before substantial recovery occurs. These observations have been noted among communities affected by major disasters and represent an important vulnerability.[38,39]

In contrast, if children and adults receive sufficient and sustained support, and have the internal resources to adjust to the event, they may emerge with new skills that they can use to cope with future adversity. In this way, disasters may result in posttraumatic growth among both children and adults. Such posttraumatic growth is more likely to occur when children are provided support of sufficient intensity and duration.[24]

Schools also can provide opportunities for students to help others as they and their communities recover from the event and its aftermath. Having the opportunity to help others often assists in the adjustment and coping of the students providing such assistance. Schools also can help students identify appropriate mechanisms for memorialization and commemoration. These activities provide a means for expressing grief and loss in a shared fashion, thereby decreasing isolation and promoting cohesion. When deaths have occurred as a result of the disaster, these means of remembrance can reaffirm the personal attachment to the individual(s) who died and reassure the bereaved that the loved one will be remembered. Any such activities should involve the active participation of children and adolescents both in the planning and implementation to ensure that they are developmentally appropriate and personally relevant for them. Simply put, a memorial planned by adults for children is most likely to be therapeutic for the adults.[18]

PROFESSIONAL SELF-CARE

Pediatricians, when they are members of the community affected by a disaster, also experience their own personal effects as well as the effects on family and friends. Despite this, they must contend with the increased needs of their patients during a time when conditions may be austere and the supports available for the practice of medicine may be significantly compromised. Physicians may find that they need to provide more direct mental health services and basic medical services while also helping families navigate the process to obtain social services. The "emotional labor" during disasters can be highly strenuous. In addition, it can be difficult to witness the distress of patients and their families (as well as that of other staff); vicarious traumatization can result from repeated exposure to the evocative stories of patients and their families. Reminding oneself that one is making a positive impact, when surrounded by enormous needs that seem beyond one's control, can be challenging. Establishment of flexible routines, monitoring oneself for negative thoughts, creating realistic

professional expectations, setting healthy boundaries between personal time and professional hours, practicing daily personal stress management, making a conscious attempt to reduce compassion fatigue, and use of both professional and social supports, including counseling, will increase the likelihood that pediatricians will remain able to attend to the needs and feelings of their patients as well as their own.[6]

Pediatricians, as a group, need to acknowledge that it is acceptable to be upset when situations are particularly distressing, need to become willing to ask for and accept assistance whenever it may be helpful (as opposed to only when it is "absolutely needed"), and need to actively take steps to care for their colleagues and themselves. The American Academy of Pediatrics has identified a range of resources that pediatric health care providers can use to promote the recovery of children, families, and communities (www.aap.org/disasters/adjustment). As a professional organization, the American Academy of Pediatrics has identified professional self-care as an important priority and has focused funding, strategic planning efforts, and continuing education initiatives in this area.

Most pediatricians enter the profession because of a heartfelt desire to help children and families most in need. If adequately prepared and supported, pediatricians who are able to draw on their skills to assist children, families, and communities to recover after a disaster will find the work to be particularly rewarding, although at times exhausting. There are few other opportunities to have such a dramatic effect on the lives of children, their families, and the community.

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ABBREVIATION

PTSD: posttraumatic stress disorder

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Responding to Children's Emotional Needs During Times of Crisis

Pediatricians are often the first responders for children and families suffering emotional and psychological reactions to disasters and other crisis events. As such, pediatricians have a unique opportunity to help parents and other caregivers communicate with children in ways that allow them to better understand and recover from traumatic events such as disasters. Pediatricians also can help facilitate timely referral to mental health services, as appropriate, for these children and their families.

Important tips that pediatricians can share with parents and other caregivers include:

- Take care of yourself first. Children depend on the adults around them to be and feel safe and secure. If you are very anxious or angry, children are likely to be more affected by your emotional state than by your words. Find someone you trust to help you address your personal concerns.
- Watch for unusual behavior that may suggest your child is having difficulty dealing with disturbing events. Stress-related symptoms to be aware of include:
    - Depressed or irritable moods
    - Sleep disturbances, including increased sleeping, difficulty falling asleep, nightmares or nighttime waking
    - Changes in appetite, either increased or decreased
    - Social withdrawal
    - Obsessive play, such as repetitively acting out the traumatic event, which interferes with normal activities
    - Hyperactivity that was not previously present
- Talk about the event with your child. To not talk about it makes the event even more threatening in your child's mind. Silence suggests that what has occurred is too horrible to even speak of. Silence may also imply to your child that you don't think their reactions are important or appropriate.
- Start by asking what your child has already heard about the events and what understanding he or she has reached. As your child explains, listen for misinformation, misconceptions, and underlying fears or concerns, and then address these.
- Explain - as simply and directly as possible - the events that occurred. The amount of information that will be helpful to a child depends on his or her age. For example, older children generally want and will benefit from more detailed information than younger children. Because every child is different, take cues from your own child as to how much information to provide.

- Encourage your child to ask questions, and answer those questions directly. Like adults, children are better able to cope with a crisis if they feel they understand it. Question-and-answer exchanges help to ensure ongoing support as your child begins to understand the crisis and the response to it.
- Limit television viewing of disasters and other crisis events, especially for younger children. Consider coverage on all media, including the internet and social media. When older children watch television, try to watch with them and use the opportunity to discuss what is being seen and how it makes you and your child feel.
- Don't force the issue with your child. Instead, extend multiple invitations for discussion and then provide an increased physical and emotional presence as you wait for him or her to be ready to accept those invitations.
- Recognize that your child may appear disinterested. In the aftermath of a crisis, younger children may not know or understand what has happened or its implications. Older children and adolescents, who are used to turning to their peers for advice, may initially resist invitations from parents and other caregivers to discuss events and their personal reactions. Or, they may simply not feel ready to discuss their concerns.
- Reassure children of the steps that are being taken to keep them safe. Disasters and other crises remind us that we are never completely safe from harm. Now more than ever it is important to reassure children that, in reality, they should feel safe in their schools, homes, and communities.
- Consider sharing your feelings about the event or crisis with your child. This is an opportunity for you to role model how to cope and how to plan for the future. Before you reach out, however, be sure that you are able to express a positive or hopeful plan.
- Help your child to identify concrete actions he or she can take to help those affected by recent events. Rather than focus on what could have been done to prevent a disaster or other crisis, concentrate on what can be done now to help those affected by the event.
- If you have concerns about your child's behavior, contact your child's pediatrician, other primary care provider, or a qualified mental health specialist for assistance.

In addition to helping parents and other caregivers communicate with their children effectively, pediatricians have the opportunity to serve an important role in their community by assisting schools and other community groups in planning how to best meet the needs of children in times of crisis and by providing consultation and support. For example, pediatricians can work with schools and local agencies to facilitate early identification of adjustment reactions and the provision of supportive services in community sites such as child care centers, after school programs and other congregate care sites. The web page **Helping Children Cope and Adjust After a Disaster** includes information, resources and materials on dealing with disasters and providing psychologic support for children

CLINICAL REPORT Guidance for the Clinician in Rendering Pediatric Care

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

Supporting the Grieving Child and Family

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Under Review

This policy automatically expired and is under review by the authorship team.

The death of someone close to a child often has a profound and lifelong effect on the child and results in a range of both short- and long-term reactions. Pediatricians, within a patient-centered medical home, are in an excellent position to provide anticipatory guidance to caregivers and to offer assistance and support to children and families who are grieving. This clinical report offers practical suggestions on how to talk with grieving children to help them better understand what has happened and its implications and to address any misinformation, misinterpretations, or misconceptions. An understanding of guilt, shame, and other common reactions, as well an appreciation of the role of secondary losses and the unique challenges facing children in communities characterized by chronic trauma and cumulative loss, will help the pediatrician to address factors that may impair grieving and children's adjustment and to identify complicated mourning and situations when professional counseling is indicated. Advice on how to support children's participation in funerals and other memorial services and to anticipate and address grief triggers and anniversary reactions is provided so that pediatricians are in a better position to advise caregivers and to offer consultation to schools, early education and child care facilities, and other child congregate care sites. Pediatricians often enter their profession out of a profound desire to minimize the suffering of children and may find it personally challenging when they find themselves in situations in which they are asked to bear witness to the distress of children who are acutely grieving. The importance of professional preparation and self-care is therefore emphasized, and resources are recommended.

INTRODUCTION

At some point in their childhood, the vast majority of children will experience the death of a close family member or friend[1,2]; approximately 1 in 20 children in the United States experiences the death of a parent by the age of 16.[3] Despite the high prevalence of bereavement among

abstract

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children, many pediatricians are uncomfortable talking with and supporting grieving children.[4]

Bereavement is a normative experience that is universal in nature, but this does not minimize the impact of a loss. The death of someone close to a child often has a profound and lifelong effect on the child and may result in a range of both short- and long-term reactions. Pediatricians, within a patient-centered medical home, are in an excellent position to provide anticipatory guidance to caregivers before, during, and after a loss and can provide assistance and support in a number of areas, including the following:

- exploring and confirming that children understand what has occurred and what death means;
- helping to identify reactions such as guilt, fear, worry, or depressive symptoms that suggest the need for further discussion or services;
- providing reassurance to children who become concerned about their own health or those of family members;
- offering support to grieving children and their families to minimize their distress and accelerate their adjustment;
- informing families about local resources that can provide additional assistance; and
- offering advice on funeral attendance of children.

Pediatricians also can play an important role in supporting parents and other caregivers after the death of a child, even in the absence of surviving siblings.[4–6] In addition, children may experience grief in response to a range of other losses, such as separation from parents because of deployment, incarceration, or divorce, which may be helped by similar caring strategies.

This clinical report is a revision of an earlier clinical report that introduced some of the key issues that pediatricians should consider in providing support to grieving children.[7] Guidance is available elsewhere regarding how to support families faced with the impending or recent death of their child,[4,8] including practical advice on how to approach notification of parents about the death of their child in a hospital setting[8,9] or in the unique context of a disaster.[10] Because traumatic events often involve loss, complementary information on providing psychosocial support in the aftermath of a crisis can be found in a recent clinical report,[11] which may be particularly relevant to pediatricians providing care in emergency departments and intensive care settings.

IDENTIFYING CHILDREN'S LOSS EXPERIENCES

In a busy pediatric practice, it is likely that a pediatrician interacts with a child who is grieving a death virtually every week, if not every day. But many children who are grieving show few outward signs during an office visit. From an early age, children learn that questions or discussion about death make many adults uncomfortable; they learn not to talk about death in public. In the context of a recent death, children may also be reluctant to further burden grieving family members with their own concerns.

Children's questions about the impact of a personal loss can be quite poignant and/or frame the experience in concrete and direct terms that underscore the immediacy and reality of the loss to adults (eg, "If Mommy died, does that mean that she won't be here even for my birthday? How can I live the rest of my life without her?"). Adolescents who are in a better position to appreciate the secondary losses and other implications of a significant loss may raise concerns that surviving adults may not have yet appreciated (eg, "I don't know if I ever will feel comfortable having my own children when I grow up, without Mom there to help me."). When children ask such questions or make similar comments, surviving family members may become tearful and/or obviously upset. Children may misinterpret these expressions of grief triggered by their questions as evidence that the questions themselves were hurtful or inappropriate. They subsequently may remain silent and grieve alone, without support. In addition, when children lose a parent or other close family member, they are often fearful that others they count on for support may also die and leave them all alone. Children may find it particularly unsettling to observe their surviving caregivers struggling and often respond to their surviving parent(s) demonstrations of grief by offering support or assistance (eg, "Don't worry Daddy, I can help do many of the things Mommy used to do; we are going to be okay."), rather than asking for help themselves, which may convince surviving caregiver(s) that the child is coping and has no need for assistance. For this reason, it is important for pediatricians to offer to speak with children privately after a family death to identify their understanding, concerns, and reactions without children feeling that they need to protect surviving caregivers.

Caregivers who are struggling with their own personal grief may be particularly reluctant, or even unable, to recognize or accept their children's grief. The reality is that many children in this situation are grieving alone, postponing expressing their grief until a time when it feels safer, or seeking support elsewhere, such as at school or after-school programs where they can talk about their feelings and concerns with adults who have personal distance from the loss.

Young children, in particular, may not yet understand the implications the death may have for them or their family. Children and their families may wish to seek advice but view death as a normative experience that does not warrant professional assistance and may not realize that their pediatrician may be interested in helping and able to assist them. During an incidental pediatric office visit, children may be reluctant to raise the topic because they worry that they will start crying or otherwise embarrass themselves. They may be afraid to start a discussion in the pediatric office or at school because they worry that once they start to cry, they will be unable to compose themselves by the end of an office visit or a conversation at school. Children may also express their grief indirectly through their behavior or attempt to address their feelings through play. Grief is, in many ways, a private experience. Older children, especially, may elect to keep their feelings and concerns to themselves unless caring adults invite and facilitate discussion. These are among the many reasons why pediatricians may be unaware of a death involving a close family member or friend of one of their patients.

Pediatricians can increase the likelihood that children and families will bring significant losses to their attention by directly informing families, often during the initial visit and periodically thereafter, that they are interested in hearing about major changes in the lives of patients and their families, such as deaths of family members or friends, financial or marital concerns of the family, planned or recent moves, traumatic events in the local community or neighborhood, or problems or concerns at school or with peer relationships. At subsequent visits, pediatricians can ask whether any major changes or potential stressors at home, at school, or within the community have occurred or are anticipated.[12] Practices that respond to these needs as they arise in families, by inviting conversations, expressing concern, and offering information and referral, create an atmosphere in which families are more likely to disclose their occurrence and actively seek assistance and support.

INITIATING THE CONVERSATION

Pediatricians and other caring adults often worry that asking children about the recent death of someone close to them may upset them. In the immediate aftermath of a major loss, the loss is almost always on survivors' minds. Although a question about the death may lead to an expression of sadness, it is the death itself, and not the question, that is the cause of the distress. Inviting children to express their feelings allows them to express their sadness; it does not cause it. In contrast, avoiding the subject may create more problems. Children may interpret the silence as evidence that adults are unaware of their loss, feel that their loss is trivial and unworthy of comment, are disinterested in their grief, are unwilling or unable to assist, or view the child as unable to cope even with support. Instead, the following steps can be used to initiate the conversation[13]:

- Express your concern. It is okay to be tearful or simply to let them know you feel sorry someone they care about has died.
- Be genuine; children can tell when adults are authentic. Do not tell the child you will miss her grandfather if you have never met him; instead, let the child know that you appreciate that he was important to her and you feel sorry she had to experience such a loss.
- Listen and observe; talk less. Simply being present while the child is expressing grief and tolerating the unpleasant affect can be very helpful.
- Invite discussion using open-ended questions such as "How are you doing since your mother died?" or "How is your family coping?"
- Limit the sharing of your personal experiences. Keep the focus on the child's loss and feelings.
- Offer practical advice, such as suggestions about how to answer questions that might be posed by peers or how to talk with teachers about learning challenges.
- Offer appropriate reassurance. Do not minimize children's concerns but let them know that over time you do expect that they will become better able to cope with their distress.
- Communicate your availability to provide support over time. Do not require children or families to reach out to you for such support, but rather, make the effort to schedule follow-up appointments and reach out by phone or e-mail periodically.

Adults are often worried that they will say the wrong thing and make matters worse. In the context of talking with a patient who has recently experienced a death, caregivers may wish to consider the following suggestions[13]:

- Although well intentioned, attempts to "cheer up" individuals who are grieving are usually neither effective nor appreciated. Anything that begins with "at least" should be reconsidered (eg, "at least he isn't in pain anymore," "at least you have another brother"). Such comments may minimize professionals' discomfort in being with a child who is grieving but do not help children express and cope with their feelings.
- Do not instruct children to hide their emotions (eg, "You need to be strong; you are the man of the

house now that your father has died.").

- Avoid communicating that you know how they feel (eg, "I know exactly what you are going through."). Instead, ask them to share their feelings.
- Do not tell them how they ought to feel ("You must feel angry.").
- Avoid comparisons with your own experiences. When adults share their own experiences in the context of recent loss, it shifts the focus away from the child. If your loss is perceived by the child as less important, the comparison can be insulting (eg, "I know what you are going through after the death of your father. My cat died this week."). If your experience appears worse (eg, "I understand your grandfather died. When I was your age, both my mother and father died in a car accident."), the child may feel compelled to comfort you and be reluctant to ask for help.

The use of expressive techniques, such as picture drawing or engaging children in an activity while talking with them, may be helpful in some situations in which children appear reluctant to address the topic in direct conversation. Pediatricians can also provide written information to families about how to support grieving children (eg, *After a Loved One Dies: How Children Grieve and How Parents and Other Adults Can Support Them*, which is freely available and can be accessed through the coping and adjustment Web page of the American Academy of Pediatrics at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/Children-and-Disasters/Pages/Promoting-Adjustment-and-Helping-Children-Cope.aspx).[14] Books written specifically for younger children that help them develop a better understanding of death or that help children and adolescents cope and adjust with a personal loss (eg, Guiding Your Child Through Grief is one such resource for older children[15]) can be found through recommendations of a children's librarian or at bookstores. Pediatricians can identify a few books to recommend and, ideally, may even choose to stock their offices with a couple of copies to lend to families.

CHILDREN'S DEVELOPMENTAL UNDERSTANDING OF DEATH

Before the development of object permanence, something out of view is felt to be literally "out of mind." Therefore, it is unlikely that infants in their first 6 months of life can truly grieve. But as children develop object permanence during the second half of the first year of life, they begin to acquire the ability to appreciate the possibility of true loss. It is therefore not coincidental that peek-a-boo emerges during this time period as a game played by children in all cultures, wherein the child shows heightened concern at separation and joy at reunion, as if "playing" with the idea of loss. Infants and toddlers play this game repeatedly as they try to understand and deal with the potentiality of loss. It has been suggested that peek-a-boo is one of many games that children play that might allude to loss or death. In fact, "peek-a-boo" is translated literally from Old English as "alive-or-dead." Parents who worry that it is too early to raise the topic of death with their preschool- or even school-aged children likely do not realize that they began communicating with their children about loss at an early age.

Research has shown that there are 4 concepts that children come to understand that help them make sense of, and ultimately cope with, death: irreversibility, finality (nonfunctionality), causality, and universality (inevitability).[14–19] On average, most children will develop an understanding of these concepts, outlined in Table 1, by 5 to 7 years of age. Personal loss or a terminal illness before this age has been associated with a precocious understanding of these concepts[19]; education has been shown to accelerate children's understanding as well.[20] The death of a pet in early childhood can be used as an opportunity to help young children both understand death and learn to express and cope with loss.

Understanding the concepts of death can be viewed as a necessary precondition, but not necessarily sufficient, for acceptance and adjustment. Children at a very young age can understand that death is irreversible; indeed, even toddlers come to learn "all-gone." But accepting that someone about whom you care deeply will never return is difficult even for adults. Pediatricians can counsel parents to help children understand these concepts and assess children's comprehension directly through simple questions. Parents can be encouraged to be patient with children's repetitive questions after a loss, which may occur over an extended period of time. For young children, such questions may reflect attempts to develop a more complete understanding over time as cognitive development progresses.

Misinformation or misconceptions can impair children's adjustment to loss. Literal misinterpretations are common among young children. For example, children may become resistant to attending a wake after being told that their parent's body will be placed in the casket; adults often assume this is because of a fear of dead bodies. But some children, when told that the "body" is placed in 1 location, may conclude that the head is placed elsewhere; their reluctance to attend the wake may be attributable to a fear of viewing their parent decapitated. It is best not to assume the reasons for children's worries or hesitation but instead ask what they are thinking about. Young

TABLE 1 Component Death Concepts and Implications of Incomplete Understanding for Adjustment to Loss

Irreversibility: death is a permanent phenomenon from which there is no recovery or return
• Example of incomplete understanding: the child expects the deceased to return, as if from a trip
• Implication of incomplete understanding: failure to comprehend this concept prevents the child from detaching personal ties to the deceased, a necessary first step in successful mourning
Finality (nonfunctionality): death is a state in which all life functions cease completely
• Example of incomplete understanding: the child worries about a buried relative being cold or in pain; the child wishes to bury food with the deceased
• Implication of incomplete understanding: may lead to preoccupation with physical suffering of the deceased and impair readjustment
Inevitability (universality): death is a natural phenomenon that no living being can escape indefinitely
• Example of incomplete understanding: the child views significant individuals (ie, self, parents) as immortal
• Implication of incomplete understanding: if the child does not view death as inevitable, he/she is likely to view death as punishment (either for actions or thoughts of the deceased or the child), leading to excessive guilt and shame
Causality: the child develops a realistic understanding of the causes of death
• Example of incomplete understanding: the child who relies on magical thinking is apt to assume responsibility for the death of a loved one by assuming that bad thoughts or unrelated actions were causative
• Implication of incomplete understanding: tends to lead to excessive guilt that is difficult for the child to resolve

Reprinted with permission from Schonfeld D. Crisis intervention for bereavement support: a model of intervention in the children's school. *Clin Pediatr (Phila).* 1989;28(1):29.

children also may have difficulty understanding why families would choose to cremate a loved one after death. Providing developmentally appropriate explanations for parents and other caregivers to use to address common questions can be helpful and reassuring (eg, explaining to preschool-aged children that once people die, their body stops working permanently and they no longer are able to move, think, or feel pain, which is why it is okay to cremate the body, or use high temperatures to turn the body into ashes).

To minimize misinterpretations, it is best to avoid euphemisms; especially with younger children, it is important to use the word "dead" or "died." For example, a young child told that a family member is in eternal sleep may become afraid of going to sleep himself. Religious explanations can be shared with children of any age according to the wishes of their caregivers. But because religious concepts tend to be abstract and therefore more likely to be misunderstood by young children, it is important to also share with children factual information based on the physical reality. For example, a young child told only that a brother died "because he was such a good baby God wanted him back at his side" may begin to fear attending church (if this is viewed as "God's home") and misbehave whenever brought to religious services.

Children with intellectual disabilities will generally benefit from explanations geared toward their level of cognitive functioning, followed by questions to assess the degree of comprehension and to probe for any misunderstandings. Children with neurodevelopmental disorders, such as autism spectrum disorder, may benefit from practical suggestions about communicating their feelings and needs, as well as additional support to promote coping. Children unable to communicate verbally may show their grief through nonspecific signs or behaviors, such as weight loss or head banging. To provide support after a death, parents and other caregivers can draw on the strategies and approaches that have worked with their children in the past to provide comfort when faced with other stressors and to explain challenging concepts.

ADOLESCENTS

Adolescents may have a mature conceptual understanding of death, but they still experience challenges adjusting to the death of a close family member or friend.[21] Although they are capable of rational thinking, adolescents, like adults, nonetheless benefit from additional explanation and discussion in addition to emotional support. Although they often turn to peers for support and assistance in many situations, after the death of a close family member or friend, they can benefit from the additional physical and emotional presence of adults. Unfortunately, many adolescents receive limited explanation or support after a death. Often, surviving caregivers rely on them to take on more adult responsibilities, such as contributing to the care of younger siblings and performing more chores within the home, and may count on them to serve the role of a confidante and source of emotional support for the caregivers themselves. Pediatricians may be able to assist in such cases by encouraging adult caregivers to identify their own support, such as through faith-based organizations, community-based support groups, or professional counseling.

Juniors or seniors in high school are at a point in their development when they may be particularly vulnerable to difficulties in coping with the death of a close family member or friend. This is a time of heightened academic demands, and the common short-term negative effect on academic productivity may be compounded by the high level of academic scrutiny characteristic of applying to college. Completing high school and leaving family to

pursue their own education or career is a challenging transition for adolescents and often involves stress and ambivalence. A recent death can exacerbate academic and personal challenges. Youth anticipating leaving home for school or career may feel guilty about leaving other family members who are grieving or worry that they will have difficulty coping when separated from their family, friends, and familiar supports. These young people may arrive in college to face peers who are unaware of their loss, unfamiliar with how best to provide them with support, and focused on pursuits and activities that seem incongruous with their grief. The food, people, and settings that normally provide them solace and comfort may be lacking at a time when they are most needed. Pediatricians can support these adolescents by staying connected with them during the transition and helping them and their families identify supports and resources at college and in their family's community.[13]

GUILT AND SHAME

Because of the egocentrism and magical thinking that are characteristic of young children's understanding of causality, children will often assume that there was something they did, did not do, or should have done that would have prevented the death of someone close to them and develop guilt over a death. Even older children, and indeed adults, often feel guilty when there is no logical, objective reason for them to feel responsible for a death. People may assume some responsibility because it helps them believe that, by taking actions they failed to take before, they can prevent the future deaths of others about whom they care deeply and feel more in control. For example, if a child assumes that the reason his father died was because he attended a friend's party rather than staying home to monitor his father, he can reassure himself that his mother will be okay as long as he never leaves the home at night again. The alternative to this kind of thinking is accepting that we have limited influence over tragic events, but that reality leaves many feeling helpless. It is frightening to realize someone else we care about could die at any time, no matter what we do. But assuming fault for a death in this manner does not prevent future loss, and the resulting guilt contributes to further distress. In situations in which children's actions clearly contributed to the cause of death (eg, a child who accidentally discharges a firearm that results in the death of someone) or when children persist in feeling responsible (whether such guilt is logical), pediatricians should consider referral for counseling. In the context of ongoing support, children can be helped to either dismiss illogical guilt or come to forgive themselves for unintended actions they believe have contributed in some way to the death.

Children are also more likely to feel guilty about a death when the preexisting relationship with the deceased was ambivalent or conflicted. The relationship between adolescents and their parents often has some element of such ambivalence or conflict as the adolescent strives for independence, and conflict is more likely to be present if the deceased had a chronic mental or physical illness or problem with substance abuse or had been abusive, neglectful, or absent (eg, incarcerated or deployed). Guilt of other family members may also lead to difficulties: for example, it can distort the relationships between parents and surviving children after the death of a sibling.[22]

It is helpful for pediatricians to approach children who have lost a loved one to presume that guilt may be present, even when there is no logical reason for it. Pediatricians can explain that they know there is nothing that the child did, failed to do, or could have done to change the outcome but wonder if the child ever believes that he or she somehow contributed to the death as many children do in similar situations. They can explain that feeling bad does not mean you did anything bad and feeling guilty does not mean you are guilty. When pediatricians help children express their guilt associated with a death, it allows children to begin to challenge their faulty assumptions about personal responsibility and promotes a refocusing on the child's feelings about the loss.

Children also may experience guilt over surviving after a sibling died or feeling relief after a death that followed a lengthy illness. In the setting of a protracted illness, family members and friends often experience anticipatory grieving. They can imagine the death and experience graduated feelings of loss, but when it becomes overwhelming they can reassure themselves that their loved one is still alive. Anticipating the death allows them to accomplish some of the "work" of grief before the death actually occurs. But this is a painful process, and at some point, many individuals in this situation will wish for the death to occur. Although they may couch this in terms of hoping for the person who is dying to be able to end his or her suffering, the death would also end some of their own emotional suffering as they anticipate the death of a loved one and free them of their responsibility to focus much of their time and efforts on the needs of the person who is critically ill. This situation can result in further guilt and complicate the grieving process.[8]

When children assume that the cause of the death was the result of the actions, inactions, or thoughts of the person who died, they may feel ashamed of the person who

died and/or the death and reluctant to talk with others about their loss. Shame is also likely to complicate bereavement when the death is somehow stigmatized, such as death from suicide or resulting from criminal activity or substance abuse. This shame further isolates grieving children from the support and assistance of concerned peers and adults.

Suicide is often complicated by both guilt and shame among survivors. As a result, discussion about the cause of death is often limited, and children may struggle to understand the cause or circumstances of the death. Open communication helps prevent suicide from becoming a "family secret," which may further disrupt the grieving process. If the explanations are too simplistic, concerns may be increased. For example, if children are told only, "Your uncle killed himself because he was very, very sad," they will likely notice that extended family members and friends, who are overwhelmed with grief, may look "very, very sad" and worry that they, too, will kill themselves. A preferable explanation might aim to convey that suicide is usually the result of underlying depression or other mental health problems; it may also be related to alcohol or other substance abuse. It is important to emphasize that suicide is not generally a logical "choice" made by someone who is thinking clearly and able to consider a range of solutions to problems. In addition, children should be encouraged to communicate when they are distressed or feeling depressed, informed about where they can go for advice and assistance, and instructed not to keep in confidence when peers or others communicate to them that they are considering self-harm.[23] Sample scripts and language for discussing suicide with children at different developmental levels, prepared by the National Center for School Crisis and Bereavement, can be used by schools to respond to a death by suicide of a student or member of the school staff (freely available at www.schoolcrisiscenter.org).

SECONDARY AND CUMULATIVE LOSSES

Although children generally show a remarkable resiliency and ability to adjust to the death of someone close to them, nonetheless, they do not "get over" a death in 6 months or a year. Rather, they spend the rest of their life accommodating the absence. In fact, many find the second year more difficult than the first. The first year after the death is filled with many anticipated challenges: the first holiday or birthday without a loved one or the first father-daughter dance after the father's death. Expectations typically are reduced (ie, the child expects to feel sad at the first special holiday without a loved one), and multiple supports are usually in place. But when these special occasions are still not joyful in the second year, children may wonder if they will ever be able to experience joy again. Unfortunately, by this point in time, the support they may have received from extended family, teachers, coaches, and others at school and in the community has probably already ended. However, the sense of loss is persistent, and without proper support it may be perceived as overwhelming. Maintaining support for children and families is important well beyond the initial period of grief.

When children experience a death of someone close to them, they lose not only the person who died (ie, the primary loss) but also everything that person had contributed or would have contributed to their life (ie, secondary losses). Common secondary losses include the following:

- change in lifestyle (eg, altered financial status of the family after the death of a parent);
- relocation resulting in a change in school and peer group;
- less interaction with friends or relatives of the person who died (eg, friends of a child's sister no longer visit after the sister dies);
- loss of shared memories;
- decreased special attention (eg, a child may no longer value participating in sports activities without his parent there to cheer for him);
- decreased availability of the surviving parent (who may need to work more hours or who becomes less available emotionally because of depression); and
- a decreased sense of safety and trust in the world.

Relationships that seemed incidental may take on new meaning after they are no longer available. For example, after the death of his sister, a younger brother may now miss the advice and guidance provided by his sister's boyfriend, who no longer visits. Other losses may not become apparent until years later. A 5-year-old girl experiencing the death of her grandmother who was her primary caregiver may not realize until many years later that she has lost her grandmother's advice and support as she faces puberty or her first date, or on the first night her newborn infant cries inconsolably. At each new milestone, the loss of someone for whom we care deeply is redefined and grief is revisited.

When children experience a death at a young age, they may also not fully understand the death or its implications. Each new developmental stage, as cognitive development advances and experience widens, may prompt a resurfacing of their grief and be accompanied by questions that permit the child to come to a more mature understanding of the death and its implications.

Subsequent losses and stressors also add to the challenge of adaptation. Children who have experienced traumatic events or significant losses in the context of sufficient support and internal capacity to cope may experience posttraumatic growth and emerge with increased resiliency and new skills to cope with future adversity. These children may shift their life goals to align more with public service; place a higher priority on family, friends, spirituality, and helping others; or become more empathic.[11,24] But in communities that are characterized by high rates of violence, poverty, and frequent deaths of peers and young family members, such supports are generally not present or are insufficient to meet the heightened need. Children in such environments do not somehow "get used to death" or become desensitized. Rather, these losses make them progressively more vulnerable to future stresses and loss. Children in these circumstances often come to appreciate that adults in their communities are unable to provide for their safety and are unwilling or unable to provide support and learn not to seek assistance from these adults because they know it is unlikely to be offered. One reason children and adolescents in these environments may instead turn to peers (and gangs) is to seek such support, which may contribute to high-risk behaviors that jeopardize their safety. They may engage in risky behaviors out of fear for their own mortality and the need to challenge these fears by engaging in the same behaviors they know to be dangerous. Only by surviving these risks can children and adolescents reassure themselves that they are safe, at least for the moment. In this context, it becomes critical that adults in our society take responsibility for ensuring that the environment is safe for children and adolescents, especially in communities characterized by violence, poverty, and frequent loss, and that we provide them with the support and assistance they need to cope with loss and crisis.

GRIEF TRIGGERS AND ANNIVERSARY REACTIONS

Grief triggers evoke sudden reminders of the person who died that can cause powerful emotional responses in children who are grieving. Although they are most common in the first few months after the death, they may happen months or years later, although the strength of the emotions generally lessens with time. Some triggers, such as a Mother's Day activity in class or a father-daughter dance at school, are easier to identify, but grief triggers can be ubiquitous and often difficult to anticipate. A child may pass by a stranger wearing the same perfume as her aunt or hear a song that her grandfather used to sing and be reminded of the loss. Parents can work with teachers to both minimize likely triggers in school settings and create a "safety" plan wherein students know they can leave the classroom if necessary. If children know that they can leave if they need to, they are less likely to feel overwhelmed or afraid they will cry in class. As a result, they will rarely need to exit and are more able to remain within the classroom and engaged in the classwork.[13]

Anniversaries of the death, birthdays of the deceased, holidays, special events, and major transitions (eg, changing schools, graduating high school, moving homes) are also times when a loved one's absence will be acutely felt. Pediatricians can help the family find ways to meaningfully honor these events. The medical home is uniquely well suited to provide ongoing periodic bereavement support. Pediatricians should invite children and their families to reach out for assistance and advice as children adjust to the loss over time. However, many individuals who are grieving may not anticipate the challenges posed by anniversaries or events or may feel uncomfortable imposing on the physician for advice for what they believe to be a normative and universal experience. Pediatricians can, instead, schedule follow-up appointments to coincide with such timed events (eg, just before the start of a new school year; just before the first-year anniversary of the death), when modest changes in the timing make it practical, or can call, write, or e-mail a patient/family periodically to check in and let the child and family know of their continued availability and interest. Pediatricians interested in providing significant direct bereavement support for children and families within their practice can explore coding by time for counseling and coordination of care to maximize reimbursement for these services. When the pediatrician lets the family know he or she is still concerned and available, it increases the chances that the child or family will seek advice and assistance when needed.

FUNERAL ATTENDANCE

Children, like adults, often benefit from participating in funerals, wakes, and other memorial or commemorative activities after the death of a close family member or friend. It provides them with an opportunity to grieve in the presence of family and friends while receiving their support and, as appropriate to the family, solace from their spiritual beliefs. Parents and other caregivers sometimes exclude children from funerals and wakes for fear that the experience may be upsetting or because they, themselves, are grieving and unsure whether they can provide appropriate support. Children who are excluded from memorial or funeral services often resent not being able to participate in a meaningful activity involving

someone they care deeply about and may wonder what is so terrible that is being done to the loved one that it is not suitable for them to view. What they imagine is likely to be far worse than the reality.

It is best to invite children to participate in wakes, funerals, or memorial services, to the extent they wish. Begin by providing basic information in simple terms about what children can expect from the experience. For example, include information about whether there will be an open casket and anticipated cultural and religious rituals (eg, guests may be invited to place some dirt on the coffin at the gravesite), as well as how people may be expected to behave (eg, some people may be crying and very upset; humorous stories and memories may be shared). Ask children what additional information they would like and what questions they might have. Children should not be forced or coerced to participate in particular rituals or to attend the funeral or wake. If older children who had a very close relationship with the deceased (eg, teenagers whose parent has died) indicate they do not want to attend the funeral, it is helpful to explore the reason for their not wishing to attend and ask them to describe what accommodations might be made in the plans to meet their needs (eg, they prefer not to attend the wake but will attend the funeral service). But, as with all true invitations, the decision is ultimately left to the child. Families can work with children to identify alternate ways for them to recognize the death, such as a private visit to the funeral home once the casket has been closed or a visit to the gravesite after the burial. All children can be invited to make meaningful but developmentally appropriate decisions about the service of an immediate family member; they may be permitted to select a flower arrangement or a picture of the parent to be displayed at the wake.

It can be helpful to assign an adult whom the child knows well but who is not personally grieving (eg, a teacher, babysitter, or relative who is close to the child but less familiar with the deceased) to accompany and monitor the child throughout the services. If the child is fidgeting or appears distressed, the adult can suggest they go for a walk and inquire about how the child is coping with the experience. If the child prefers to stand outside of the room and hand out prayer cards, that level of participation can be accommodated without disrupting the experience for other grieving family members (ie, the child would be less able to stay outside of the room if being watched by the mother who feels it important to stand by her husband's coffin throughout the wake). Older children and adolescents may wish to invite a close friend to sit with them during the service or assist with greeting guests as they approach the room. Suggestions on how to address the needs of children related to commemoration and memorialization involving a crisis, especially in a school setting, can be found elsewhere.[11,13]

CULTURAL SENSITIVITY

Different cultures have a range of traditional practices and rituals as well as expectations around how members of their culture typically mourn the death of a family member or close friend. Although it is helpful for pediatricians to know something about these cultural differences, it is important to remember that the fundamental experience of grief is universal.

Knowledge of the common practices of a particular culture may not accurately predict how a family or individual from that culture will behave. Many families have mixed backgrounds and/or have been exposed to different cultures through their communities or schools. Parents sometimes have different beliefs or practices from their children. Families or individuals may choose to follow practices of a different culture if they seem to align better with their current preferences. Assumptions about how someone ought to mourn in a particular culture may result in a stereotype that could cloud our perceptions and make us miss opportunities to be helpful. Pediatricians should therefore ask families what they feel would be most helpful for their family or for individuals within the family.

The best approach is to be present, authentic, and honest. Approach children and their families with an open mind and heart and be guided by what you see, hear, and feel. The following are questions that may assist in this process:

- "Can you tell me how your family and your culture recognize and cope with the death of a family member?"
- "How does this fit with your own preferences at this time?"
- "Can you help me understand how I can best be of help to you and your family?"

WORKING WITH SCHOOLS

Children typically experience at least temporary academic challenges after the death of a close friend or family member. The effect the loss has on learning may first appear weeks or even months later. Some children may even respond to a death by overachieving in school. Children with learning problems that predated the loss may experience a marked worsening.

In general, it is best for the family to anticipate at least brief difficulties in learning and concentration and to establish a proactive relationship with the school to coordinate

supports at school with those within the home. If schools wait for academic failure to become apparent, then school becomes a source of additional distress rather than a potential support. Instead, academic expectations should be modified as needed and supports put into place in anticipation of a possible need.

Caregivers and educators can work together to identify the level of academic work that feels appropriate and achievable at a particular point of time in the recovery process after a major loss. Some modifications that may be considered include the following:

- adapting assignments (eg, allow a student to prepare a written presentation if he feels uncomfortable with an oral presentation; substitute smaller projects for a large project that may feel overwhelming in scope);
- changing the focus or timing of a lesson (eg, excuse the student from a lesson on substance abuse if her sister recently died of a drug overdose or consider postponing it to later in the semester);
- reducing and coordinating homework and extracurricular activities so that the student is able to meet expectations for what is being required; or
- modifying or excusing the student from tests or placing more weight on grades achieved before the death.

The goal is to maintain reasonable expectations while providing the support and accommodations so that the student can achieve at that level and be prepared for successful advancement to the next grade level.[13]

Pediatricians can help provide training to schools about how best to support grieving students and provide consultation after a death has occurred involving a member of the school community.[11,13,25–27] The Coalition to Support Grieving Students was formed to develop a set of resources broadly approved by 10 of the leading professional organizations of school professionals to guide educators and other school personnel in supporting and caring for their grieving students. The resources are available at no charge to the public at www.grievingstudents.org. The video-training modules feature expert commentary, school professionals who share their observations and advice, and bereaved children and family members who offer their own perspective on living with loss. Handouts and reference materials oriented for classroom educators, principals/administrators, and student support personnel that summarize the training videos, as well as a range of additional resources, can be downloaded from the Web site. Although developed for use by educators, the materials are applicable for the professional development of pediatric health care providers as well. Many are also appropriate for other sites where child congregate care is provided, including early learning centers, preschools, and in-home day care settings. Those caring for children younger than school age similarly benefit from the support and training that can be provided by pediatricians.

COMPLICATED MOURNING AND INDICATIONS FOR REFERRAL

In the immediate aftermath of a death, the reactions of children and adults can be quite extreme and varied. It is best to avoid the tendency to judge or try to categorize such acute reactions as either "normal" or "abnormal." If children or adults appear to be at risk of harming themselves or others, action should be immediately taken to preserve safety. Pediatricians should be aware of community resources for bereavement support. These resources may include the following:

- bereavement support groups and camps (a listing of national and regional services and resources for grieving children can be found at http://www.newyorklife.com/nyl/v/index.jsp?contentId=143564&vgnextoid=755540bf8c442310VgnVCM100000ac841cacRCRD);
- school-based programs and services;
- counselors who are interested and qualified in counseling children who are grieving; and
- other mental health professionals trained to counsel grieving children who are also experiencing depression, anxiety, or trauma symptoms.

As noted previously, adults in the family may benefit from their own support so that they do not depend unduly on their children for emotional support and so they are better able to discern and address the needs of their grieving children.

Grief from the death of a close family member or friend can dominate children's lives in the immediate aftermath of the loss, causing disinterest in engaging in previously enjoyed activities, compromising peer relationships, interfering with the ability to concentrate and learn, causing regressive or risk-taking behavior, or creating a challenge to healthy social and emotional development. But with time and adequate support, grieving children learn that their lives in the absence of the deceased, although permanently altered, nonetheless can be meaningful and increasingly characterized by moments of satisfaction and joy. Children who instead experience complicated mourning may fail to show such adjustment over time.[28] They may experience difficulty with daily functioning at school or at home that persists months after the death. They may become preoccupied with thoughts about the deceased or develop nonadaptive

behaviors, such as tobacco, alcohol, or other substance use; promiscuous sexual behavior; or delinquent or other risky behaviors. Referral for counseling is particularly important in this context. More immediate or urgent referral is indicated if children show deep or sustained sadness or depression, especially if they are perceived to be at risk of suicidal behavior.

PROFESSIONAL PREPARATION AND SELF-CARE

Pediatricians often enter the profession because of a desire to help children grow, develop, and be healthy and happy. Understandably, pediatricians can find it difficult to witness children's distress as they grieve the death of someone about whom they care deeply. Many pediatricians have received limited training about how to support grieving children. It is difficult to believe you are helping people when they remain in such distress. You want to help people feel "better," but when they freely express their sorrow in the immediate aftermath of a death, it is difficult to know that you are helping them ultimately adjust and cope. Following up with children and their families over time and actively inquiring about how they are continuing to adjust will help the pediatrician support and observe the course of recovery and understand his or her role in that process. Professional preparation and education are helpful; resources are available on various professional Web sites (eg, the American Academy of Pediatrics at www.aap.org/disasters/adjustment; the Coalition to Support Grieving Students at www.grievingstudents.org; or the National Center for School Crisis and Bereavement at www.schoolcrisiscenter.org). Pediatricians can also seek out and request professional development training through professional meetings, through grand rounds, from other continuing medical education venues, and via retreats and psychosocial rounds in hospital settings.

Children's grief may also trigger reminders of loss and other reactions in pediatricians. It may remind adults of their own losses or raise thoughts or concerns about the well-being of those they love. Children's grief is often unfiltered and pure; their questions are direct and poignant. It is difficult to witness a child's grief and not feel an effect personally. In fact, not being affected should not even be an expectation or a goal. Nonetheless, pediatricians should monitor their reactions and feelings and limit their support to what they feel ready and able to provide to any particular family at that point in time. If the family is in need of additional supportive services, the pediatrician can seek the assistance of a professional colleague in the office or through referral to someone in the community.

It is important for pediatricians to examine and understand their personal feelings about death to be effective in providing support to children who have experienced a personal loss or who are faced with their own impending death. Often, this understanding will involve an awareness of the effects of deaths of patients on pediatricians' professional and personal lives. The culture in medicine needs to acknowledge that it is understandable to feel upset when bearing witness to something that is upsetting. As professionals, pediatricians should offer support to our colleagues and seek out and accept support for ourselves.

Pediatricians who do provide support to grieving children and families often have a meaningful and lasting impact. A relatively modest effort to provide compassion and support can have a dramatic effect. It can help reduce the amount of time grieving children feel confused, isolated, and overwhelmed. Pediatricians will not be able to take away the pain and sorrow (and should not see that as their goal), but they can significantly reduce the suffering and minimize the negative effects of loss on children's lives and developmental courses.

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FAQs: How To Talk to Kids About Grief

OVERVIEW

In the wake of tragic events, it can be difficult for caregivers to know how to talk to children and teenagers about processing their fear, grief, and trauma. It's totally understandable to be concerned about finding the right words, and it's important to take time to care for yourself, too. Here are some common questions you may have, and resources to guide you further.

FAQS

- **Q: What are some common reactions we can expect from kids when they learn about scary news close to home?**
  - A: In addition to verbalizing their emotions, you may notice changes in kids' sleep, eating, or conversation/engagement levels when they're processing scary news or traumatic events.
- **Q: As a parent, caregiver, or community adult, what are some ways I can help kids close to me process traumatic events? Is it okay for me to be emotional?**
  - A: Being present for kids close to you is the first step. It's okay to not have all the right words. It **is** okay, and even helpful, to express emotion yourself, but it's helpful to first take the time to make sure you are able to share your emotions in a way that doesn't seem out of control to the child, which could increase their sense of fear.
- **Q: How does this differ when we think about teens/adolescents?**
  - A: Teens are building their identities, which comes along with a sense of purpose. For teens, you may try looking at ways to get involved/help in addition to supporting them through conversation.
- **Q: If I or my family have questions or need support, what are some of the ways I can go about getting it?**
  - **A:** Organizations like the American Psychological Association and the American Psychiatric Association publish great resources for parents. If you think seeking care might be appropriate, a good place to start to look for options is by contacting your health insurance plan or local health authorities.
- **Q: Should I talk to my young child (3rd grade or lower) about these things at all?**
  - **A:** A good way to start this conversation is to ask the child what they've heard about a situation, and go from there. Realistically, in today's environment, even very young children are exposed to current events through media and conversations, and even very young children can sense when adults are acting differently, so it's a good idea to address things proactively to give them space to discuss with a trusted adult.

Additional Resources

01

BOOK

Something Bad Happened: A Kid's Guide to Coping With Events in the News
by Dawn Huebner

02

VIDEO

A Kid's Book About School Shootings
by Crystal Woodman Miller

03

WEBSITE

Helping Your Children Manage Stress in the Aftermath of a Shooting
American Psychological Association

04

BOOK

When the World Feels Like a Scary Place
Abigal Gerwitz, PhD

Information clinically reviewed by Divya Chhabra, MD

Preguntas Frecuentes: Cómo Hablar a los Niños Sobre el Duelo

VISIÓN GENERAL

A raíz de eventos trágicos, puede ser difícil para los cuidadores saber cómo hablar con los niños y adolescentes sobre cómo procesar su miedo, dolor y trauma. Es totalmente comprensible preocuparse por encontrar las palabras adecuadas y también es importante tomar tiempo para cuidarse a sí mismo. Aquí hay algunas preguntas comunes que usted puede tener y recursos para guiarlo más.

PREGUNTAS FRECUENTES

- **P: ¿Cuáles son algunas reacciones comunes que podemos esperar de los niños cuando aprenden sobre noticias aterradoras cerca de casa?**
  - R: Además de verbalizar sus emociones, es posible que los niños cambien el patrón del sueño, sus hábitos alimenticios, niveles de comunicación o compromiso cuando están procesando noticias aterradoras o eventos traumáticos.
- **P: Como padre, cuidador o adulto de la comunidad, ¿cuáles son algunas formas en que puedo ayudar a los niños acercarse a mi para procesar eventos traumáticos? ¿Está bien compartir mis emociones con ellos?**
  - R: Estar presente para los niños cercanos a usted es el primer paso. Está bien no tener todas las palabras correctas. Está **bien**, e incluso es útil, expresar sus emociones, pero es útil que primero tome el tiempo para asegurarse de que pueda compartir sus emociones de una manera que no parezca fuera de control para el niño, lo que podría aumentar su sensación de miedo.
- **P: ¿Cómo se diferencia esto cuando pensamos en adolescentes y jóvenes?**
  - R: Los adolescentes están construyendo sus identidades, lo que viene acompañado de un sentido de propósito. Para los adolescentes, usted puede tratar de buscar formas de participar y ayudar, además de apoyarlos a través de la conversación.
- **P: Si mi familia y yo tenemos preguntas o necesitamos apoyo, ¿cuáles son algunas de las formas en que puedo conseguirlo?**
  - R: Organizaciones como la Asociación Americana de Psicología y la Asociación de Psiquiatría, publica excelentes recursos para los padres. Si piensas que buscar atención puede ser lo apropiado, un buen lugar para comenzar a buscar opciones es comunicarse con su plan de seguro médico o las autoridades de salud locales.
- **P: ¿Debo hablar con mi hijo pequeño (tercer grado o menos) sobre estas cosas?**
  - R: Una buena manera de comenzar esta conversación es preguntarle al niño qué ha escuchado sobre una situación, e ir desde allí. Siendo realistas, en el entorno actual, incluso niños muy jóvenes están expuestos a los acontecimientos actuales a través de los medios de comunicación y conversaciones, e incluso los niños pequeños pueden sentir cuando los adultos actúan de manera diferente, así que es una buena idea abordar las cosas de manera proactiva para darles espacio y poder discutir con un adulto de confianza.

Recursos Adicionales

01 *Guía para los Padres Para Ayudar a los jóvenes después de un tiroteo reciente*

02 *Consejos para que los padres ayuden a los niños de edad escolar después de un desastre*

03 *Cómo ayudar a sus hijos tras los tiroteos en los centros de educación*

04 *Consejos para adultos*

Información revisada clínicamente por Divya Chhabra, MD y Massiel Perez, LMHC

THE ECUMENICAL CENTER FOR EDUCATION. COUNSELING. HEALTH.

Community Bereavement Support in San Antonio

This list of resources has been created for those who have experienced loss of a loved one. The support groups and resources found here are places where those who have experienced loss can come together.

If there are questions, suggestions, or corrections for this list, please call The Ecumenical Center at (210) 616-0885.

Loss of Infant/Child

PROGRAM	PROGAM DESCRIPTION	PLACE(S) TIME(S)	CONTACT	PHONE
Bridges of Support	Bereavement outreach services for families experiencing a loss of a child (0-24 years).	See website for meeting times and locations.	Emily Sanchez	www.bridgesofsupport.org
Children's Hospital of San Antonio	Angels Away Support Group for families whose babies have died due to neonatal perinatal loss: miscarriage, stillborn, ectopic pregnancy or infant death.	The 3rd Thursday of each month at 7 p.m.	Peggy Huber, Chaplain	(210) 704-2181
The Compassionate Friends	A self-help group offering friendship and understanding to bereaved parents who have lost children from any cause at any age.	Alzafar Shrine Auditorium Cabiri Conference Room 901 North Loop 1604 West San Antonio, TX 78232 The 1st Thursday of every month at 7:30 p.m.	Trish Willoughby	(210) 496-6281 twilloughby@satx.rr.com
The Ecumenical Center	Services include support groups, counseling and education for children, families and individuals of all ages. Also offering the Life After Loss bereavement support group program.	Please call for schedules, to make an appointment or for more information. And visit us at www.ecrh.org.	Lejla Cenanovic	(210) 616-0885, ext. 214
Parents of Murdered Children and General Loss/Support	Bereavement support group for families and friends of homicide victims.	Balcones Heights Community Center 107 Glenarm Place San Antonio, TX 78201 Meetings on the 2nd Monday of each month at 7 p.m., except for June and July	Mary Jane Peterson	(830) 981-9490 mjpadar@aol.com
Porter Loring Family Care Services "Forever Loved"	A very special group of parents who have lost a child of any age (child or adult).	Alamo Heights United Methodist Church Seminar Room 107 825 East Basse Road San Antonio, TX 78209 Tuesdays, 7-8:30 p.m.	Celeste Miller, Bereavement Coordinator	(210) 227-8221

Loss of Parent

PROGRAM	PROGRAM DESCRIPTION	PLACE(S) TIME(S)	CONTACT	PHONE
Children's Bereavement Center of South Texas	Grief support for children ages 3-24 and their families. Individual counseling for anyone experiencing a loss.	Please visit www.cbcst.org for more information. 205 West Olmos Drive San Antonio, TX 78212	Tammy Cochran	(210) 736-4847
The Ecumenical Center	Services include support groups, counseling and education for children, families and individuals of all ages. Also offering the Life After Loss bereavement support group program.	Please call for schedules, to make an appointment or for more information. And visit us at www.ecrh.org.	Lejla Cenanovic	(210) 616-0885, ext. 214
Porter Loring Family Care Services	Six-week classes are conducted at various locations throughout the community. These programs particularly help those who have lost parents, as well as other types of losses.	For more information about this program or to schedule one at your church, please call	Celeste Miller, Bereavement Coordinator	(210) 227-8221

Loss of Spouse

PROGRAM	PROGRAM DESCRIPTION	PLACE(S) TIME(S)	CONTACT	PHONE
The Ecumenical Center	Services include support groups, counseling and education for children, families and individuals of all ages. Also offering the Life After Loss bereavement support group program.	Please call for schedules, to make an appointment or for more information. And visit us at www.ecrh.org.	Lejla Cenanovic	(210) 616-0885, ext. 214
Porter Loring Family Care Services "Men's Grief Support Group"	This group of men 65 years and older, invite you to join them for lunch and fellowship as you grieve the loss of your wife.	Alamo Heights United Methodist Church 825 East Basse Road San Antonio, TX 78212 Thursdays from 12 p.m. – 1:30 p.m.	Celeste Miller, Bereavement Coordinator	(210) 227-8221
Porter Loring Family Care Services "Fellowship in Grief"	This is an ongoing support group for men 25-66 years old who are faced with challenges of living life without their wives.	Porter Loring Family Care Services 2119 Mannix Drive San Antonio, TX 78217 The 2nd and 4th Tuesdays of each month, 12 p.m. - 1:30 p.m.	Celeste Miller, Bereavement Coordinator	(210) 227-8221
Porter Loring Family Care Services "Grief Support for Women"	This group is open to women 60 and older who have lost a husband and would like to join with other women in a journey of sharing, comfort, and healing.	Alamo Heights United Methodist Church 825 East Basse Road San Antonio, TX 78212 Mondays from 10 a.m. - 11:30 am	Celeste Miller, Bereavement Coordinator	(210) 227-8221
Porter Loring Family Care Services "Younger Women's Grief Support"	This group is an ongoing support group for women 25-60 years old who face the special challenges of losing their husband early in life.	Porter Loring Family Care Services 2119 Mannix Drive San Antonio, TX 78217 Meetings on the 1st and 3rd Tuesday of each month from 11:00-12:30 p.m.	Celeste Miller, Bereavement Coordinator	(210) 227-8221

PROGRAM	PROGRAM DESCRIPTION	PLACE(S) TIME(S)	CONTACT	PHONE
San Antonio Area Widowed Persons' Service and the Widowed Persons' Travel Group	Services: referrals, resources, support groups, socials, trips. Widowed persons of all ages are welcome.	Location varies on the event. Please call for information or visit www.sa-widowed.com Meetings are on Fridays at 7:00 p.m. at 10911 West Ave., San Antonio, TX 78216	Susan Blumhorst, M.A.	(210) 745-5801
St. Matthew's Catholic Church	Widowed and Widowers Support Group	St. Matthew's Catholic Church 10703 Wurzbach Road San Antonio, TX 78230 The 1st and 3rd Tuesdays from 7-8:30 p.m.	Terri Nanez	(210) 478-5036

Loss of A Loved One by Suicide

PROGRAM	PROGRAM DESCRIPTION	PLACE(S) TIME(S)	CONTACT	PHONE
The Ecumenical Center	Services include support groups, counseling and education for children, families and individuals of all ages. Also offering the Life After Loss bereavement support group program.	Please call for schedules, to make an appointment or for more information. And visit us at www.ecrh.org.	Lejla Cenanovic	(210) 616-0885, ext. 214
S.O.L.O.S. (Survivors of Loved Ones' Suicide)	Support group designed to help families and friends of suicide victims cope with the sorrow of the tragedy and the pain of survival.	The Ecumenical Center 8310 Ewing Halsell Drive San Antonio, TX 78229 The 1st and 3rd Wednesday of each month, 7-8:30 p.m.	Tony Mata Angie Navarette	(210) 885-7069 (210) 722-9752

General Loss/Support

PROGRAM	PROGRAM DESCRIPTION	PLACE(S) TIME(S)	CONTACT	PHONE
Abode Contemplative Care for the Dying	Contemplative care for the dying and their loved ones. Physical, emotional, spiritual, and bereavement support to dying guests and their families, offered at no charge 24 hours a day.	In-services on various aspects of end of life care and the Art of Living and Dying. Guest eligibility: Please call (210) 967-9891. Interfaith Meditation Group: Mondays from 5:30 - 6:30 p.m. 8619 Post Oak Lane San Antonio, TX 78217 Tours: Weekdays from 9 a.m. - 5 p.m. Call for an appointment.	Mireyal Hinojosa	(210) 967-9891
Air Force Village Hospice	Twelve-week grief recovery program for any type of loss.	Air Force Village Hospice 12455 Freedom Way San Antonio, TX 78238	Chaplain Dr. Luis Carlos Sanchez	(210) 838-6340
A-Med Community Hospice and Home Health	Ongoing bereavement support	4903 Golden Quail, Ste. 110 San Antonio, TX 78240	Chaplain Charles Murray	(210) 734-6300
Alamo Hospice	Bereavement support	3201 Cherry Ridge San Antonio, TX 78230	Chris Sitton	(210) 444-2244
Alzheimer's Association	Alzheimer's Monthly Grief, Loss & Mourning Support Group	Brookdale Castle Hills 1207 Jackson Keller Road, Building 2 San Antonio, TX 78213	Taylor Smith	(210) 375-8132
Beginning Experience of San Antonio Ministry	A retreat for Widowed, Divorced & Separated to deal with grief after the loss of a marriage partner. Held at Shrine of Our Lady of Czestochowa in San Antonio.	Mailing address: P.O.BOX 235 Castroville, TX 78009 Physical Address: 138 Beethoven Avenue, San Antonio, TX 78210	Michelle Barrentine	(210) 478-0690

PROGRAM	PROGRAM DESCRIPTION	PLACE(S) TIME(S)	CONTACT	PHONE
Bereavement/Soul Care Provider	Providing bereavement services, individual and spiritual care for those who are facing terminal illness and for their survivors.	11703 Huebner Rd., Suite 106-505 San Antonio, TX 78230	Jan Davis, D.Min., Certified Spiritual Care Director	(210) 408-1841
Castle Ridge Mortuary	Bereavement Aftercare Program	Castle Ridge Mortuary 8008 Military Drive West San Antonio, TX 78227	Ana Campos	(210) 645-6000
Christus-VNA Hospice and Palliative Care	Life after Loss Bereavement. Support groups available in English and Spanish.	Christus Homecare 4241 Woodcock Drive, Ste. A-100 San Antonio, TX 78228 Monthly Grief Support 2nd Thursdays from 11:30 a.m. - 1 p.m. At 414 Wayside Drive San Antonio, TX 78213	Veronica Ibarra	(210) 785-5255
Sunset Memorial	Lift program for widows, Grief Guidance series.	Sunset Memorial 1701 Austin Highway San Antonio, TX 78218	John Segura	(210) 238-0050 (210) 828-2811
The Ecumenical Center	Services include support groups, counseling and education for children, families and individuals of all ages. Also offering the Life After Loss bereavement support group program.	Please call for schedules, to make an appointment or for more information. And visit us at www.ecrh.org.	Lejla Cenanovic	(210) 616-0885; ext. 214
Gentiva Hospice	Bereavement support	Odyssey Hospice 4440 South Piedras Drive, Ste. 125 San Antonio, TX 78228	Camille Torrez, Chaplain and Bereavement Coordinator	(210) 733-1212
Good Shepherd Hospice	Bereavement support	4241 East Piedras, Ste. 171 San Antonio, TX 78228	Cindy Magsis	(210)733-3939 cindy.magsig@goodshepherdhospice.com

PROGRAM	PROGRAM DESCRIPTION	PLACE(S) TIME(S)	CONTACT	PHONE
Harbour Hospice	Bereavement Support, Life After Loss classes twice a year (spring and fall)	12915 Jones Maltsberger, Ste. 501 San Antonio, TX 78247	Chaplain Cleo Kukeya	(210) 403-9911
Holy Spirit Catholic Church	Bereavement support group. Life After Loss clsses twice a year (spring and fall).	Holy Spirit Catholic Church 8134 Blanco Road San Antonio, TX 78216	Ann Hillestad Rose Cruz	(210) 492-3877 (210) 341-1395
Hope Hospice/New Braunfels	Bereavement Support, Family support groups, Newly bereaved groups, individual counseling for children and adults. Family camp in April – ages 5 and up. No charge for participants, open to the community, including San Antonio residents.	Hope Hospice 611 North Walnut Avenue New Braunfels, TX 78130	Oscar Olivares & Stephanie Shaw	(830) 258-5300
Hospice Compassus	Bereavement support	4204 Woodcock Drive, Ste. 240 San Antonio, TX 78228	Harry Miller	(210) 284-0149
New Century Hospice: "Knot Forgotten"	"Knot Forgotten" is a unique bereavement program emphasizing giving back to the community while offering support to one another.	New Century Hospice 8207 Callaghan Road, Ste. 353 San Antonio, TX 78230 The last Saturday of each month 10 a.m.- 12 p.m.	Elvia Obregos	(210) 520-7734
North Central Baptist: "Bridges Beyond Grief"	Bereavement support group	Holy Trinity Catholic Church 20423 Huebner Road San Antonio, TX 78258 Tuesdays 10 a.m. - 12p.m. Independence Hill Retirement Community Private Dining Room 20450 Huebner Road San Antonio, TX 78258 Tuesdays from 2 p.m. -3 p.m.	Emily Baril	(210) 497-8166 903 Hedgestone San Antonio, TX 78258

PROGRAM	PROGRAM DESCRIPTION	PLACE(S) TIME(S)	CONTACT	PHONE
Nurses in Touch Hospice	Bereavement support	Supporting provided in Floresville, Kenedy, and other San Antonio areas. Please call for more details.	Chaplain Philip Williams Rechelle Ehlert	(830) 216-7111 or 1 (800) 867-1668
Oak Hills Church: "Grief and Healing"	"Grief and Healing" classes offered twice per year.	Please call for schedule.	Mary K. Griffin, Care Ministry Martie Noll, Bereavement Ministry	(210) 698-4631
Outreach Health Service	Bereavement support	1111 Babcock Road San Antonio, TX 78201	Sister Rosa Sanchez, I.W.B.S.	(210) 736-1812
St. Bonaventure Catholic Church	Bereavement support	1918 Palo Alto Road San Antonio, TX 78211	Veronica Ibarra	(210) 785-5255 caregiver.support@christushealth.org
St. Luke's Catholic Church	Life After Loss support groups are offered twice a year in March and October. The group is offered in English, however, when requested, support for Spanish speakers is also available. Also Healing Hearts Bereavement support group.	4603 Manitou Drive San Antonio, TX 78228 Wednesdays from 10 a.m. - 12 p.m.	Deacon Robert Garza, Pastoral care Or call the parish office	(210) 313-1053 (210) 433-2777
St. Matthews Catholic Church	Bereavement support	10703 Wurzbach Road San Antonio, TX 78230 Thursdays from 7 p.m. - 8:30 p.m.	Bruce Orey	(210) 478-5036

PROGRAM	PROGRAM DESCRIPTION	PLACE(S) TIME(S)	CONTACT	PHONE
Summit Christian Center Grief Care Ministry	Pastoral care and spiritual support provided to those grieving the death of a loved one.	Summit Christian Center 2575 Marshall Road San Antonio, 78259 "Tear Soup" Support Group meets 1st Thursdays at 7 p.m.	Michelle Ramirez	(210) 683-8282 or (210) 402-0565, ext. 2171 griefcare@summitsa.com
UTHSC Allograft resources	Grief support on various topics. For more information, visit www.change100lives.com.	Westage Medical Building 5282 Medical Drive, Ste. 605 San Antonio, TX 78229 Monthly grief support workshops on 2nd Tuesdays at 6:30 p.m.	Michelle Ramirez	(210) 567-0528
Vitas Innovative Hospice	Bereavement support group	Monthly Bereavement Support Group, 1st Saturday of each month Meets at Morningside Manor Chapel 602 Babcock Road San Antonio, TX 78229		(210) 348-4305 VITAS Healthcare 8401 Data Point Drive, Ste. 300 San Antonio, TX 78229