A CHILD'S JOURNEY THROUGH TRAUMATIC GRIEF: A CASE STUDY

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Submitted in fulfilment of the requirements for the degree of

MAGISTER ARTIUM IN CLINICAL PSYCHOLOGY

in the

Department of Psychology,

Faculty of Health Sciences

at the Nelson Mandela Metropolitan University

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February 2015
Dedication

This treatise is dedicated to:

Linda, for changing me and inspiring me through her resilience following the violent death of her mother.

and

To my mother, Frieda who passed away when I was 5 years old from a sudden illness.
Acknowledgments

I wish to express my sincere gratitude to the following:

- My supervisors, Mrs Lisa Currin and Prof Diane Elkonin for their input, guidance, patience, unfailing support and understanding throughout this process.

- My family for their love, unwavering support and encouragement as well as their understanding for the sacrifice of not being able to spend much time with them throughout this process.

- My boyfriend, Daveril, for his unrelenting support and belief in my abilities, for constantly encouraging me and for his patience during this process. I especially would like to thank him for all the sacrifices he made.

- My close friend, Thulani for being a sounding board and a support system and for always being available throughout the process.

- My friends, Greg and Sherry for their words of encouragement and motivation.

- Linda, for allowing me to share her journey and to tell her story. I would especially like to thank her for her strength and inspiration.

- To Almighty God, without whom, nothing is possible.
Declaration

I, Chantal Debra Goliath, student number 205053165, hereby declare that this treatise for the degree Magister Artium in Clinical Psychology is my own work and that it has not previously been submitted for assessment or completion of any postgraduate qualification to another university or for another qualification.

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Chantal Debra Goliath                  Date
# Table of Contents

Dedication.........................................................................................................................................................ii

Acknowledgments................................................................................................................................................iii

Declaration........................................................................................................................................................iv

Table of Contents..................................................................................................................................................v

Abstract .............................................................................................................................................................xi

## CHAPTER ONE: INTRODUCTION AND MOTIVATION FOR THE STUDY… 1

Introduction........................................................................................................................................................1

Motivation for the Study....................................................................................................................................1

Overview of Chapters.........................................................................................................................................1

## CHAPTER TWO: DOMESTIC VIOLENCE ................................................................. 3

Introduction........................................................................................................................................................3

Domestic Violence in South Africa ...................................................................................................................3

Children’s Exposure to Domestic Violence .......................................................................................................5

Intimate Partner Homicide ..................................................................................................................................9

Children’s Exposure to Intimate Partner Homicide .........................................................................................11

Conclusion.........................................................................................................................................................14

## CHAPTER THREE: THEORETICAL OVERVIEW OF CHILDHOOD

TRAUMATIC GRIEF (CTG)......................................................................................................................... 15

Introduction......................................................................................................................................................15

Interaction of Trauma and Grief in Childhood....................................................................................................15
Differentiating Normal Bereavement from CTG ........................................16

Core Features of CTG ...........................................................................20

Associated Features of CTG .................................................................22

Conclusion ............................................................................................25

CHAPTER FOUR: TRAUMA-FOCUSED COGNITIVE BEHAVIOURAL THERAPY (TF-CBT) ..............................................................26

Introduction ..........................................................................................26

Development of the Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) for CTG model .................................................................26

Core Values of the TF-CBT model ..........................................................28

Overview of the TF-CBT model ...............................................................29

TF-CBT Components ............................................................................31

Trauma-focused components ...............................................................31

*Psycho-education* .............................................................................31

*Parenting skills* .................................................................................32

*Relaxation and breathing techniques* ..................................................32

*Affective expression and modulation* .................................................33

*Cognitive coping and processing* .......................................................33

*Trauma narrative* ...............................................................................34

*In-vivo mastery of trauma reminders* .................................................35
Conjoint parent-child sessions ................................................................. 35

Enhancing future safety and development .............................................. 36

Grief-focused components ..................................................................... 36

Grief psycho-education ......................................................................... 36

Grieving the loss and resolving ambivalent feelings about the deceased

“What I miss” and “What I don’t miss” ...................................................... 37

Preserving positive memories of the deceased ........................................... 38

Redefining the relationship with the deceased and committing to present

relationships .......................................................................................... 38

Conclusion .............................................................................................. 39

CHAPTER FIVE: METHODOLOGY ............................................................... 41

Introduction ............................................................................................ 41

Research Design ...................................................................................... 41

Qualitative studies .................................................................................. 42

Case study research ................................................................................ 42

Definition of a case study ....................................................................... 42

Principles of case study research ............................................................ 43

Descriptive case studies ......................................................................... 43

Participants and Sampling ...................................................................... 44

Procedure ............................................................................................... 44
CHAPTER SIX: CLINICAL PICTURE AND PRESENTATION OF THERAPY

CASE ..................................................................................................................52

Introduction .........................................................................................................52

Linda’s Biographical Information .......................................................................52
Abstract

The death of a parent is one of the most serious stressors that can occur in a child’s life. The aim of this study was to describe an 11-year-old child’s journey through traumatic grief after the violent death of her mother. The conceptual framework utilised was Trauma-Focused Cognitive Behavioural Therapy (TF-CBT). The case study approach was applied as it provided a suitable research design in which to give an account of the subject in a therapeutic situation. A purposive sampling technique was utilised to select the research subject in the study. The following three principles of data collection were adhered to: a) using multiple sources of information, b) creating a case study database, and c) maintaining a chain of evidence. Irving Alexander’s content-analysis technique in conjunction with Guba’s model of trustworthiness was employed for data analysis. The finding that emerged from the study was the resilience shown by Linda in relation to her adaptive functioning following the trauma of witnessing the violent death of her mother. Conclusions and recommendations were made following the findings based on the information obtained during the therapy sessions.

Key words: Parental death; Traumatic Grief; Trauma-Focused Cognitive Behavioural Therapy (TF-CBT).
CHAPTER ONE
INTRODUCTION AND MOTIVATION FOR THE STUDY

“Safety and security don't just happen; they are the result of collective consensus and public investment. We owe our children, the most vulnerable citizens in our society, a life free of violence and fear.”

Nelson Mandela, former President of South Africa

Introduction

Many South African children are affected by trauma because of the high levels of violence prevailing in this country, both within the home and in the wider community. The focus of this case study is a specific story of a young girl age 11 years, who witnessed her father murdering her mother. This study arose out of issues of domestic violence which resulted in a muti murder, experienced within the research subject’s home. The research subject’s father decapitated and dismembered her mother’s body parts for muti. The research subject witnessed the traumatic event and was exposed to the horrifying image of her mother’s decapitated body parts. Thus the child came to therapy as a result of witnessing the violent death of her mother.

Motivation for the Study

The researcher worked with the client who showed great resilience in the face of trauma. The motivation of the study was to further psychotherapy for clients presenting with similar traumatic experiences.

Overview of Chapters

The presentation of this treatise includes eight chapters. In Chapter Two a detailed review is given on domestic violence. Chapter Three provides a detailed review of theory on Childhood Traumatic Grief (CTG), the interaction of trauma and grief in childhood is discussed, followed by differentiating normal bereavement from CTG, core features of CTG
and lastly the associated features of CTG. Chapter Four provides a detailed description of the therapeutic approach utilized, namely Trauma-Focused Cognitive Behavioural Therapy (TF-CBT), with the methodology of the study as well as ethical considerations taken into account being discussed in Chapter Five. The client is introduced in Chapter Six with a description of the seven therapy sessions conducted. In Chapter Seven the findings of the study are discussed. In Chapter Eight, the conclusions, limitations of the research, as well as the recommendations for future research studies are presented. The following chapter provides an in depth discussion on domestic violence.
CHAPTER TWO
DOMESTIC VIOLENCE

“Childhood should be carefree, playing in the sun; not living a nightmare in the darkness of the soul.”

Dave Pelzer

Introduction

South Africa is a violent society, characterised by a history of brutal crimes (Makhubela, 2012). While South African men are most likely to be the victims of criminal violence, South African women and girls are at high risk of experiencing intimate partner and sexual violence or coercion (Kaminer & Eagle, 2010). Violence in South Africa is one of the main causes of trauma in the lives of children (Kaminer & Eagle, 2010). The current chapter discusses domestic violence and its prevalence in South Africa, as well as children’s exposure to domestic violence and how they are affected. Furthermore, the concept of intimate partner homicide is discussed with a focus on how children are affected by witnessing the murder of one parent by another parent. A specific focus on the phenomenon of muti murders is described, which provides the context, together with domestic violence for this research case study.

Domestic Violence in South Africa

An often underreported form of violence is that of domestic violence, also referred to as intimate partner violence, characterised by physical, sexual, psychological/emotional and economic abuse (Makhubela, 2012). Physical abuse involves hurting or trying to hurt someone by hitting, slapping, kicking, punching, hitting with objects, stabbing or shooting them. Sexual abuse is forced (unconsenting) sexual contact, for instance rape and beating of the sexual parts of the body as well as forced unprotected sex. Sexual abuse may also include undermining a person’s sexuality with insults and unsupported accusations of infidelity.
Psychological/emotional abuse refers to the abuser frightening the victim by intimidation, threatening harm or harm to others, and threatening death or harassment. The abuser undermines the victim’s sense of self-worth by constant criticism, belittling, name calling and undermining the parent-child relationship and so forth. Economic abuse refers to the abuser’s efforts in trying to make the victim financially dependent—for instance by maintaining control over the victim’s income, withholding money or access to money, keeping the victim from engaging in outside activities such as school or employment and requiring the victim to justify all money spent (Kaminer & Eagle, 2010).

The Department of Justice estimates that 1 in every 4 South African women are assaulted by their boyfriend/partner or husband (People Opposing Women Abuse [POWA], 2010). In South Africa, reliable statistics on the prevalence of gender-based violence are difficult to obtain because in many cases violence against women remains unreported. This occurs for many reasons, including women’s emotional and economic dependency on the abuser, fear of further punishment by the abuser, lack of confidence in the police and fear of being further victimised by the criminal justice system, the absence of any nearby police stations, feelings of shame and self-blame, or an acceptance of the abuse as normal, deserved or a private matter that should not be disclosed. Furthermore, police statistics tend to classify reported acts of gender-based violence under more general categories such as assault or attempted murder, which do not reflect the gender of the victim (Kaminer & Eagle, 2010). According to the Parliament of South Africa, domestic violence statistics are almost impossible to access because domestic violence is not in itself a crime category. However according to the National Instructions 7/1999 relating to the implementation of the Domestic Violence Act 116 of 1998, in police stations, all domestic violence incidents must be recorded in a domestic violence register. Effectively what this means is that it should be possible to access domestic violence statistics from the South African Police Service monthly, however, the
domestic violence register reports are not available online, nor are they referenced in the police statistics (Parliament of the Republic of South Africa, 2013). In addition, estimated statistics on the prevalence of intimate partner violence do not necessarily reflect the severity of violence against women in South Africa. However, according to Kaminer and Eagle (2010), the degree of intimate partner violence in South Africa appears to be particularly extreme. A number of factors are proposed to contribute to this form of violence. According to Gelles (1993), conflicting interests, tensions in family interactions, age and generational differences, finances and lack of privacy are among the contributing factors. Another factor contributing to intimate partner violence is substance abuse. Overindulgence in alcohol or drugs, is often the symptom of other emotional problems, for example, feelings of inadequacy triggered by unemployment or underemployment may cause a spouse to vent frustration in undesirable ways (Meadows, 2007).

**Children’s Exposure to Domestic Violence**

Violence takes place in the presence of children living with their parents or caregivers. In the last 30 years studies have become more focussed on the scope and impact of children’s exposure to domestic violence, resulting in a depth of empirical knowledge about the prevalence of domestic violence and the impact on the young victims (Idemudia & Makhubela, 2011). Previously children were thought of as being detached from the violence between parents, and frequently labelled as “silent witnesses” (Holt, Buckley & Whelan, 2008, p. 798). However more recent qualitative research has disputed this opinion, finding that children are active in their efforts to make sense of their experiences, while finding their way around the complication and fear intrinsic to domestic violence (Holt et al., 2008). Living with the abuse of their mother can be considered a form of emotional abuse for children, at its most basic level, as it may negatively implicate their emotional and mental health and future relationships (Brandon & Lewis, 1995). Many authors agree that children
can be witnesses in many ways beyond direct observation, such as overhearing arguments or
observing its aftermath, for example seeing bruises and cuts and broken furniture
(Cunningham & Baker, 2004; Mullender et al., 2002).

The effects of exposure to violence committed against one parent by another vary widely,
which often depends on the developmental stage of children (Makhubela, 2012). Research
indicates that children growing up in violent and aggressive families are at a higher risk for
an extensive range of psychological, cognitive, behavioural and social problems, whether the
witnessing of abuse was direct or indirect. Children may suffer negative outcomes such as
increased internalising and externalising behaviours, depression and anxiety and may be more
prone to physical aggression and higher levels of general behaviour problems when reported
by parents and teachers (Holt et al., 2008). Domestic violence may also lead to Posttraumatic
Stress Disorder (PTSD) (see Appendix A for diagnostic criteria) symptoms in the form of
intrusive re-experiencing of the events in dreams or flashbacks, hyper-arousal or an
exaggerated startle response, and emotional withdrawal (American Psychiatric Association
[APA], 2013). The essential feature of PTSD are characteristic symptoms following exposure
to an extreme traumatic stressor which may involve direct personal experience of an event
such as actual or threatened death or serious injury, or threat to one’s physical integrity or
witnessing an event that involves death, injury or a threat to the physical integrity of a family
member (APA, 2013).

Literature reviewed on gender suggests that boys and girls generally respond differently to
exposure to domestic violence. Evidence suggests that boys’ display externalised problems
more frequently such as hostility and aggression, while girls display more internalised
difficulties such as depression and somatic complaints (Buckner et al., 2004; Edleson, 1999;
Martin, 2002). McIntosh (2003) explains that boys’ externalising behaviours are associated
with their experiences of a high level of threat from violence exposure, while girls’ internalising responses are indicative of them experiencing a higher level of self-blame.

Empirical evidence suggests that growing up in an abusive home environment can critically jeopardise children’s developmental progress and personal abilities (Martin, 2002; McIntosh, 2002), the increasing effect of which may be carried into adulthood and can contribute significantly to the cycle of adversity and violence (Cunningham & Baker, 2004). For the purpose of this study, and given the age of the child who is the focus of this study, the focus will be on school-age children between the ages of 6-12 years. According to Daniel, Wassell and Gilligan (1999), school age children are involved in developing more sophisticated emotional awareness of themselves and others, and in the case of domestic violence, in particular of how the abuse is affecting their mothers. They are also able to think in more intricate ways about the reasons for the violence, and may try to predict and prevent the abuse based on this reasoning. Younger children in this developmental stage still think ego-centrically and may blame themselves for their mother’s abuse, which may result in guilt and self-blame. In attempting to work things out, they will try to rationalise their father’s behaviour, by justifying it on the basis of alcohol, stress, or bad behaviour on theirs or their mother’s behalf, as this helps them cope with the unacceptable idea that their father is bad or imperfect in any way. If inappropriate or inaccurate attitudes and beliefs are not addressed, children are potentially at risk of adopting anti-social justifications for their own abusive behaviour, where this occurs (Cunningham & Baker, 2004).

English, Marshall, and Stewart (2003) found significant negative effects of domestic violence on family functioning, including negative effects on the health and well-being of parents and caregivers and the quality of caregiver-child interactions. In turn, less than adequate family functioning has been associated with a harmful impact on children’s behaviour and health. In addition, less sibling and parental warmth has been found in families
marked by aggression. Even when warmth is present in the family, family social support fails to protect children from the harmful effects of domestic violence. Overall, according to Cummings (1998), children who are exposed to domestic violence tend to experience poorer parental discipline, intimidating family interactions, and negative parental emotional and psychological unavailability.

Furthermore, exposure to domestic violence during childhood may predispose children to becoming a perpetrator towards a partner, or conversely, to becoming a victim of abuse from their partner in adulthood (Levendosky et al., 2002). According to relationship theories, children internalise the violent patterns that they witness their parents engaging in and re-enact them in their own relationships (Graham-Berman & Levendosky, 1998). Thus, domestic violence may become part of an intergenerational cycle of violence (Osofsky, 1999). For example, a father who abuses his partner may provide male children with a violent role model that children may identify with and imitate. In contrast, witnessing a mother figure being abused may demonstrate to female children that violence toward women is normal. Such exposure may promote the development of expectations for violent intimate adult relationships (Graham-Berman & Levendosky, 1998).

Empirical evidence highlights the complex relationships that children who grow up with domestic violence have with both their parents (Holden, 2003; Levendosky et al., 2003). Peled (2000) indicates that, children view their abusive fathers in two contradictory ways-as the “good, loved father” and as the “bad, abusive father” (p. 802), however, they seldom maintain both views simultaneously. Peled (2000) found that children applied strategies to both minimise the negative view of their fathers, and to find ways to see their fathers in a positive way, with both of these strategies creating complex emotions when it came to making choices involving their parents. Children describe paternal experiences that are tainted with sadness, fear, confusion and disappointment (Mullender et al., 2002) and
ambivalent attitudes towards both their parents, including fear and empathy towards their father, and compassion coupled with a sense of obligation to protect their mother (Goldblatt, 2003). While acknowledging that parenting cannot prevent children from ever experiencing conflict or stress, McIntosh (2002) suggests that parenting is however about clarifying those experiences in ways that can be thought about and integrated by the child. McIntosh (2002) argues that the presence of domestic violence results in the failure of the parental functions of protection and thought. While the man has detached himself from the experiences of those around him, the woman’s survival may require her to create a state of dissociation from aggression that in itself maintains a cycle of fear and victimisation (McIntosh, 2002). Both aspects of parental dissociation results in a lack of empathy with children’s experiences, where children are not assisted to deal with and assimilate the impact of family violence in order to recover from the trauma they have experienced (Holt et al., 2008).

Children’s risk levels and reactions to domestic violence exist on a continuum where some children demonstrate enormous resilience while others show signs of significant maladaptive adjustment (Child Welfare Information Gateway, 2009). Resilience is defined as not simply the absence of pathology but competence in the face of crisis or adversity (Kitzman, Gaylord, Holt & Kenny, 2003). Protective factors such as social competence, intelligence, high self-esteem, outgoing temperament, strong sibling and peer relationships, and a supportive relationship with an adult, can help protect children from the adverse effects of exposure to domestic violence (Child Welfare Information Gateway, 2009).

**Intimate Partner Homicide**

Intimate partner violence has unfortunately seen a rise in cases, with an increase in the number of women being murdered by their intimate male partners, referred to as intimate partner homicide. A lack of statistical information on this form of murder makes it very hard to measure the extent of the scourge (POWA, 2010). According to Kaminer and Eagle
(2010), South African women are killed by their intimate male partners six times more often than the international average. Meadows (2007) states that the strongest risk factor for intimate partner homicide is an abuser’s lack of employment, as unemployment increases the risk of intimate partner homicide fourfold.

Although intimate partner homicide typically occurs as a result of violence, abuse and aggression, this form of violence may also cause victims of abuse to become targets for muti murders perpetrated by their intimate partners. The research subject’s mother in this case study was murdered by the research subject’s father as part of a muti murder ritual. Further detail regarding the murder event will be discussed in Chapter Six.

Since 2010, South Africa has seen a rise in muti killings. However no statistics are available to measure the extent of this scourge as crime statistics in South Africa record muti murder within the general category of murder (Behrens, 2013). While muti murders have occurred throughout history in South African culture, little research exists on the phenomenon (Behrens, 2013). The word muti is a Zulu word meaning medicine. Muti murder may be loosely defined as a murder where the intention is to gather human body parts for use in traditional African medicine (Minnaar, 2001). The purpose is usually to improve an individual’s circumstances. Motives vary however economic prosperity; sexual potency and success in romantic matters are by far the most commonly recurrent themes (Flanagan, 2002). A sangoma (traditional healer) usually advocates the muti murder after having been consulted by a client. The reason for using human body parts is that they are considered to be more powerful than the usual ingredients or methods used by the sangoma as they contain the person’s ‘life essence’ (Labuschagne, 2004, p. 193). The death of the victim usually occurs after the injuries have been inflicted whilst removing the body parts. Traditionally, the victim must be alive when the body parts are removed as this increases the ‘power’ of the muti because body parts then retain the person’s life essence (Labuschagne, 2004, p. 193). Muti
made from human body parts is considered to be exceptionally powerful. Which body parts are used will be guided by the aims of the client who approaches the traditional healer. The traditional healer will then determine which specific body parts are necessary and the very specific manner in which they are collected (Flanagan, 2002). Harvested body parts are usually mixed with other medicinal plant matter and cooked. The product is sometimes consumed, but may also be carried about by the person who aims to benefit from its powers or secretly smeared onto the body, clothing or included in the food of the person who is its target, such as a reluctant or abusive lover (Matshikiza, 2004). The mutilation that occurs in muti murder, which may include dismemberment or decapitation, is not done with the intention of delaying identification, nor is the mutilation brought about by a fit of rage, as the murder is carefully planned and a victim selected, nor is there any sexual activity or fantasy involved in the mutilation (Labuschagne, 2004). Strangers or enemies are seldom the target of muti murders. On the contrary, victims are often blood relatives or family members of those responsible for their murder (Scholtz et al., 1997).

**Children’s Exposure to Intimate Partner Homicide**

As discussed previously, domestic violence has seen a rise in cases of intimate partner homicide in South Africa. The types of violence children are exposed to differ, which vary from less severe forms of battery to the most extreme forms, such as homicide and in some instances, children may witness the murder of one of their parents (Kaminer & Eagle, 2010). These children are at risk for negative psychological and behavioural problems as a result of the trauma associated with experiencing the murder of their parent. This is an extremely horrific, traumatic and emotionally draining experience for a child. When the death is the consequence of a murder committed by another significant other and in the presence of children, the extent of trauma is likely to be intensified. The psychological effects are simultaneously numbing and debilitating, creating emotional scars of far-reaching
proportions (Burman & Allen-Meares, 1994). Children who witnesses the murder of a parent
(usually their mother) at the hands of the other parent (usually the father) experience not only
the trauma related to the high threat, sensory inputs (sights, sounds etc.), and outcome of the
event but also numerous types of losses. These children loses both parents suddenly and
simultaneously; their mother the murder victim, and their father being imprisoned or on the
run (Lewandowski, McFarlane, Campbell, Gary & Berenski, 2004). Children may be placed
in foster care or with relatives which may result in them being separated from siblings, move
home, change schools and lose friends and personal belongings. Family routines may also be
disrupted (Lewis, 1999). Later, they may have to re-live the murder and experience additional
trauma if they are called upon to testify in court (Pynoos & Eth, 1983). Children may also
face a loyalty dilemma as the fact of the killing is hard for them to understand, particularly as
they may have loved both parents. After a family murder, children may initially be in a state
of shock and their quietness and lack of emotion may be misinterpreted to mean that they are
unaffected. Children may also hide their feelings for fear of being a burden (Lewis, 1999).

Many studies have described regressive responses that accompany these horrifying events,
such as enuresis, sleep disturbances, temper tantrums, flashbacks, dissociation, anxiety and
psychosomatic disorders, and passive and aggressive behaviours (Burman & Allen-Meares,
1994). Shocking images, thoughts and memories-immediately following the violence may be
manifested as children are haunted by the mutilation of the parent, and the helplessness and
powerlessness of both victim and witnesses. Feelings related to depression, anger and guilt
are pervasive and inclusive (Burman & Allen-Meares, 1994).

In their study of children who witnessed the murder of one of their parents, Pynoos and
Eth (1985) found that even very young children were able to provide detailed accounts of the
traumatic experience. Furthermore, the children remembered essential details better than
peripheral details. Children who have been interviewed after having witnessed the murder of
a parent do not show any tendencies to misbelieve what they have witnessed and do not show forgetfulness due to trauma. Instead, most children are well aware of their experiences and are able to differentiate real experiences from fantasies (Pynoos & Eth, 1985). Other studies have shown that children who have witnessed a family murder have, in addition to visual memories, bodily and auditory memories as well, and that auditory memories are perceived as extra unbearable (Overlien & Hyden, 2007). A recent study investigating children’s memories and reports of homicidal violence further revealed that children remember their experiences well (Christianson, Azad, Leander & Selenius, 2013). The majority of the children showed little or no hesitancy to report on the severe violence they had witnessed and provided a great amount of details concerning the important features of the violence (i.e. forensically relevant information such as details about the assault and the perpetrator-how the violence was executed, possible weapon used, and victim’s and perpetrator’s verbalisations) (Christianson, et al, 2013). Research findings by Azad, Christianson and Selenius (2013), indicate that children with previous experiences of repeated violence exposure provide detailed accounts of the homicidal event. One possible explanation for this finding is that the homicidal event differed from the previous acts of violence they had witnessed, in the sense that the homicidal event was more significant and brutal, and deviated from the previous experiences. Therefore with unique experience it is likely that children tend to remember the most salient details.

Children who witness a violent death face a dual process of coping; dealing with trauma mastery and grief work (Nader, 1997; Nader, Pynoos, Fairbanks, & Frederick, 1990; Pynoos & Eth, 1985). That is, normal grief is often hampered by the presence of trauma symptoms, which may lead to children developing a condition known as Childhood Traumatic Grief (Eth & Pynoos, 1994; Pynoos & Eth, 1985). Further detail regarding this condition is discussed in Chapter Three.
Conclusion

Domestic violence often occurs in the presence of children. The effects of witnessing this form of violence may be negative, causing children to develop psychological, behavioural and social problems. Domestic violence may lead to intimate partner homicide, where one partner (usually the father) kills the other (usually the mother). The witnessing of one parent being murdered by the other is a traumatic, horrific and emotionally draining experience for a child. Children are faced with coping with a violent trauma as well as the instantaneous loss of both parents. This combination of trauma and grief work causes them to develop a condition known as Childhood Traumatic Grief, which is discussed in further detail in the following chapter.
CHAPTER THREE
THEORETICAL OVERVIEW OF CHILDHOOD TRAUMATIC GRIEF

“Tears are the silent language of grief.”
Voltaire

Introduction

The current chapter is grounded in Judith Cohen and Anthony Mannarino’s (2004) theory on Childhood Traumatic Grief. Children who lose a family member, loved one, or significant other through traumatic circumstances face unique challenges. In addition to dealing with the traumatic event, children are also confronted with the sadness, grief and loss associated with no longer having their loved one in their life. Therefore, it is this combination of traumatic stress and loss that uniquely characterises Childhood Traumatic Grief (CTG) (Cohen & Mannarino, 2004). The chapter focuses on the interaction of trauma and grief in childhood, differentiating normal bereavement from CTG, core features of CTG as well as associated features of CTG. Each of these aspects is discussed in further detail in the chapter.

Interaction of Trauma and Grief in Childhood

Some authors have observed that a parent’s death during childhood is, per se, a trauma. As noted in the previous chapter, the American Psychological Association [APA] (2013) defines a trauma as the outcome of an individual directly experiencing the traumatic event that involves actual or threatened death or serious injury, or threat to one’s physical integrity, or witnessing an event that involves death, injury or threat to the physical integrity of another person. Black (1978), in her review of the literature on the bereaved child, concludes that an immature ego, which cannot sustain the grief process without suffering injury, results in a parent’s death usually constituting a massive psychic trauma. As a result, she does not distinguish among modes of death except that parental suicide is associated with a worse outcome for the child. However, the child observing a sudden murder is in a very different
predicament from the child whose parent dies in a hospital from a chronic illness. For Worden (1982), “The loss of a parent through death is obviously a trauma” (p. 102). Krueger (1983), comments that: “The real rather than the symbolic or fantasised loss of a parent during development imposes an actual trauma, with implications for intra-psychic organisation during development” (p. 582). According to Cohen and Mannarino (2011), many children experience the death of a parent, during childhood. Most children are able to negotiate the grieving process without lasting scars. However, some children experience the traumatic death of a parent and develop a condition known as Childhood Traumatic Grief (CTG). Typically, loss by traumatic means (e.g. homicide) is conceptualised as a traumatic stressor event that can lead to Posttraumatic Stress Disorder (PTSD). However grief is a distinct individual, social and relational experience (Neria & Litz, 2003).

**Differentiating Normal Bereavement from CTG**

The terms grief and bereavement are used continuously when referring to the loss of a loved one. Bereavement refers to the internal process of having lost a loved one. Grief is the personal response to the loss, such as thought and feelings associated with the loss (Kirwin & Vanya-Hamrin, 2005). Grief in children following the death of a parent is displayed in a very similar way as grief in adults. Children report initial shock, confusion and disbelief, sadness, a longing for the deceased person to return, concentration difficulties, sleeping and eating difficulties, and anger. Children’s understanding of death as well as their developmental level influences their expressions of grief (Dowdney, 2008). Children may display episodic expressions of grief, which stems from their ability to distract themselves through normative childhood activities such as play. Young children’s inability to verbalise their feelings may lead to their caregivers questioning whether or not they are truly grieving (Dowdney, 2008).

Uncomplicated bereavement involves a process referred to as reconciliation, which is defined as “the process that occurs as the bereaved individual works to integrate the new
reality of moving forward in life without the physical presence of the person who died” (Cohen, Mannarino, Greenberg & Shipley, 2002, p. 309). Reconciliation is achieved through specific tasks that take place during bereavement. Wolfelt (1996) and Worden (1991) indicate that adaptation to loss involves moving through specific tasks that include (1) acceptance of the reality of the loss; (2) working through and experiencing the negative emotions associated with the loss; (3) adjusting to an environment in which the deceased is no longer physically present; and (4) establishing continuing bonds with the deceased. Similarly, Cohen, Mannarino, and Knudsen (2004) refer to these tasks as (1) accepting the reality of the death; (2) fully experiencing the pain associated with the loss; (3) adjusting to life without the loved one; (4) integrating aspects of the loved one into one’s own self-identity; (5) converting the relationship from one of ongoing interactions to one of memory; (6) finding meaning in the loved one’s death; and (7) recommitting to new relationships with other adults.

According to Boelen, van den Hout and de Keijser (2003) and Bonanno (2004) most people are able to cope with and pass through the normal grieving process without complications; however some may experience difficulty in doing so successfully. When the normal bereavement process is interrupted, individuals experience difficulty in moving through the tasks adequately and grief reactions become more painful, resulting in the likelihood of the development of complicated grief (Boelen et al., 2003; Bonanno, 2004). In the literature, the term complicated grief is also used to describe the condition of Childhood Traumatic Grief (CTG) (Howarth, 2011).

CTG has been described by Cohen, Mannarino, Greenberg, Padlo and Shipley (2002) and Layne et al. (2001) as “a condition that results from the loss of a loved one in traumatic circumstances and is characterized by the encroachment of trauma-related symptoms on the child’s ability to negotiate the normal bereavement process” (Cohen et al., 2002; Layne et al., 2001). Eth and Pynoos (1985) were early advocates of this condition. Their initial
conceptualizations of the condition were based on the existence of PTSD symptoms in children who had witnessed the murder of a parent.

Cohen and Mannarino (2004), explain that:

These children get stuck on the traumatic aspects of their loved one’s death such that when they start to remember their loved one, including happy memories, their memories tend to segue into thoughts about theterrifying or horrific manner in which the person died. When this process occurs, children begin to avoid reminiscing about the loved one and may avoid any reminders about the deceased because of the tendency of these reminders to stimulate the children’s painful trauma memories (Cohen & Mannarino, 2004, p. 24).

CTG differs from uncomplicated bereavement in several ways, as the nature of the death is often different. These forms of death usually result from sudden, unexpected, tragic, and/or violent causes such as suicide, homicide, accidents, war, terrorism, and disasters. Chronic medical conditions may also result in CTG as the child’s loved one may die suddenly and unexpectedly and therefore the child may not have anticipated or comprehended that their loved one was going to die (Mannarino & Cohen, 2011). Deaths occurring from anticipated causes can be extremely disturbing to children if they witness frightening events such as their loved one gasping for air, attempts at resuscitation, or severe bodily deterioration. Thus, according to Cohen and Mannarino (2010), any cause of death can lead to the development of CTG provided that the child subjectively experiences the death as traumatic. Dickens (2013) states that the type and suddenness of the death, whether or not the child witnessed the death, self-blame, and emotional attachment to the deceased are risk factors which may contribute to the development of CTG. Brown and Goodman (2005) add that the death of a loved one, in conjunction with its occurrence under traumatic circumstances, places children at risk for developing severe and persisting mental health problems.
Furthermore, in CTG, the child is unable to complete the tasks of uncomplicated bereavement as a result of the intrusion of trauma symptoms. PTSD symptoms such as sleep difficulties, loss of interest in peer and social activities, and trouble concentrating, can normally be expected in bereaved children. However, core PTSD symptoms which are more characteristic of CTG than of uncomplicated bereavement include: the intrusive re-experiencing of the deceased’s death, persistent avoidance of death reminders or reminders of the loved one, and hyper-arousal expressed through angry outbursts or hyper-vigilance (Cohen & Mannarino, 2010).

Cohen and Mannarino (2004), emphasise that developing CTG is not the norm for children who lose loved ones, even if the cause of death is objectively traumatic. The non-normative nature of CTG can be described by the following examples of studies conducted. Pfefferbaum and colleagues (1999) conducted a study on children who were directly affected by the bombing of the federal office building in Oklahoma City in 1995. The results of the study indicated that although PTSD was significantly associated with the loss of a loved one and the closeness of the relationship, seven weeks after the bombing the majority of children who lost loved ones did not report increased PTSD symptoms or impairment in functioning (Pfefferbaum et al., 1999). Brent et al. (1995) conducted a study on siblings of adolescents who had committed suicide. The results of this study indicated that the siblings who were affected by the suicide did not demonstrate increased PTSD symptoms as compared to a control group who had not been exposed to suicide, despite the former group experiencing continued grief symptoms (Brent et al., 1995). The same researchers’ conducted a study of adolescents who lost friends as a result of suicide and reported that the findings of the study indicated that only 5% of the adolescents reported persistent PTSD symptoms (Brent et al., 1995; Brent, Perper & Moritz, 1993). Therefore, Cohen and Mannarino (2004) conclude that it is likely that the majority of children whose loved ones die under traumatic circumstances
do not develop CTG, and therefore persistent PTSD symptoms that intrude on children’s ability to grieve are not typical responses for such children.

**Core Features of CTG**

Numerous types of mental health problems, such as PTSD symptoms, anxiety problems, depression, and ongoing behavioural difficulties may be evident with many childhood traumas such as sexual abuse, physical abuse, or domestic violence even in the event that no death has occurred (Cohen & Mannarino, 2011). CTG however is characterised by the presence of PTSD-like symptoms which interfere with the child’s ability to fully grieve the loss of a loved one (Howarth, 2011). PTSD symptoms associated with CTG may include recurrent upsetting and intrusive thoughts or dreams of the traumatic event that led to the loved one’s death or a sense of the event re-occurring (Howarth, 2011). Research shows that many children react to traumatic events with resilience, and develop no or few PTSD symptoms, while other children however, may develop only temporary PTSD symptoms lasting only several weeks and may remit suddenly (Cohen & Mannarino, 2004). According to Cohen and Mannarino (2010), children who suffer from CTG may also display some degree of functional impairment. This may be evident in declining academic performance, difficulty in relating to peers or family members, or general struggles with everyday tasks such as homework and routine chores.

Pynoos, Steinberg and Piacentini (1999) state that the child may experience additional stressful and traumatising events following the sudden or violent death of a parent, such as efforts to assist the injured parent, the grief reactions of other witnesses, and the child’s separation from the parent’s body. These traumas also referred to as secondary traumas become intrusive memories that interfere with the child’s ability to mourn, because the child experiences difficulty in remembering the parent without becoming distressed by the specific manner of the parent’s death (Pynoos et al., 1999). According to Lieberman, Compton, Van
Horn and Ghosh-Ippen (2003), the child’s ability to cope with the fear, powerlessness, and helplessness which may have been experienced at the time of witnessing the parent’s violent death, further complicates the process of mourning. Disturbing sensory experiences such as horrific visual images, overwhelming auditory stimuli, autonomic arousal, and other sensory experiences may trigger fear and disorganisation and thus overpower the child’s coping resources. Therefore, intense fear and distress may be evoked by the sight of the injured or dead parent which may cause the child to become overwhelmed by images of how the parent looked at the time of death whenever they remember the parent when he or she was alive (Lieberman et al., 2003).

Pynoos (1992) described three types of reminders which may trigger intrusive and disturbing trauma-related thoughts, images, and memories. Trauma reminders refer to situations, people, places, sights, smells, or sounds that remind the child of the traumatic nature of the parent’s death. Loss reminders refer to places, objects, thoughts, or memories that remind the child of the deceased loved one. Change reminders are situations, people, places, or things that remind the child of the changes in their living circumstances as a result of the parent’s traumatic death. Howarth (2011), states that these trauma-related thoughts may cause the child to experience physiological reactions and psychological distress, similar to the reactions experienced at the time of the parent’s death. Thus, children may attempt to avoid exposure to these reminders in order to minimise stress. According to Nader (1997), these reminders are usually impossible to totally avoid. Howarth (2011) states that children may use avoidance and emotional numbing to protect themselves against the unpleasant feelings associated with the death, which accompany these trauma-related reminders as well as to cope with the unavoidable reminders. Avoidance may include children’s efforts to avoid thoughts or conversations about death and places or situations which serve as reminders of the traumatic nature of the loves one’s death (Mannarino & Cohen, 2011). Emotional
numbing may take the form of extreme detachment or estrangement in which children feel different and isolated from others, as well as their own family who may have experienced the same traumatic loss (Nader, 1997).

Thoughts, memories and emotions related to the traumatic nature of the loved one’s death, may also be triggered by children’s thoughts of happy times shared with the loved one. Reminiscing about the loved one leads to thoughts of the horrible way in which they died which then results in PTSD symptoms (re-experiencing, hyper-arousal, physiological hyper-reactivity, and intense psychological distress) (Cohen & Mannarino, 2004; 2011). This further enhances children’s inability or unwillingness to reminisce, to feel the pain of the lost relationship, or to alter the relationship with the deceased loved one into one of memory, as these tasks require the child to tolerate loss and change reminders without attempting to engage in avoidance or emotional numbing behaviours (Cohen & Mannarino, 2004; 2011).

According to Brown and Goodman (2005), children may use avoidant strategies in order to escape the experiences which trigger distressing thoughts or images of the traumatic cause of the loved one’s death or horrifying injury and mutilation, which interferes with the normal healing process of reminiscing. As Pynoos (1992) stated, “It is difficult to reminisce when a mutilated image is what first comes to mind” (p.7). As a result, children become overwhelmed and therefore experience difficulty in reconciling to the loss (Howarth, 2011).

**Associated Features of CTG**

Additional characteristic features of CTG, includes children’s avoidance of identification with the deceased parent as a result of their fear that any resemblance to the deceased might cause them to also die in a tragic and horrific manner (Howarth, 2011). This fear interferes with children’s ability to incorporate positive aspects of the deceased into their own self-concept, which is a key task of reconciliation (Nader, 1997). Thus, children who are afraid of any identification with the deceased may not be able to successfully reconcile themselves to
the loss of this person (Cohen et al., 2002). On the other hand, over-identification with the
deceased may also occur, which consists of the child adopting characteristics or behaviours of
the deceased, or changing their name to that of the deceased in an attempt to avoid accepting
the reality of the loss and thereby prolonging the pain associated with grief (Cohen et al.,
2002).

Following a traumatic death, children often ask why it happened to a loved one and not to
themselves (Cohen et al., 2002). This can result in survivor guilt, which is characterised by
children’s feelings of guilt for being alive and safe when their loved one has died (Cohen et
al., 2002). Some children may also unrealistically blame themselves for not being able to
rescue the deceased loved one which may lead to them to developing revenge fantasies in
which they do so (Cohen & Mannarino, 2004; 2011). In addition to grief and traumatic stress,
children may also experience feelings of embarrassment and shame if there is perceived
stigma surrounding their loved one’s death, as may be the case in suicide, or homicide
(Cohen & Mannarino, 2011).

Children may also experience secondary adversities following the death of a parent. These
adversities may include the loss of the family’s home and if the family has to relocate,
children may be required to change schools and be faced with the loss of close friends, new
peer groups, different places of worship, and unfamiliar social support systems. These
adjustments may cause further distress as they are added burdens after a parent has died
(Lewis, 1999). Furthermore, children may have to deal with legal procedures following the
violent death of a parent (Lewis, 1999). These adversities may increase children’s likelihood
of developing CTG (Cohen & Mannarino, 2004).

According to Howarth (2011), parental response to death may impact upon the
development and intensity of traumatic grief in children. When one parent has died, the
surviving parent or caregiver’s caretaking responsibilities may increase which can result in
high levels of distress as well as irritability and fatigue. These symptoms can reduce the parent’s emotional availability and affect their caretaking abilities (Brown & Goodman, 2005). Furthermore, a parent or caregiver’s avoidance of speaking about death can make it difficult to tolerate the child’s own expression of grief. Thus, this combination of parental distress and avoidance can increase the likelihood of a child developing traumatic grief (Howarth, 2011).

Mannarino and Cohen (2011), state that “the ability to comprehend death and master the tasks associated with grief and trauma depends on children’s cognitive and emotional development, at least in part” (p. 27). Some authors have also suggested that traumatic grief may be expressed by children in various ways and at different developmental levels. However, there is a lack of empirical research to support the concept of developmental variation in the clinical presentation of CTG (Mannarino & Cohen, 2011).

Little, Akin-Little and Somerville (2011) state that while many children exposed to trauma are resilient, that is, they are able to quickly return to prior functioning, and others may display improvement in functioning, many children however who are exposed to traumatic experiences develop psychological difficulties. Without intervention, traumatic death may have potentially long-term effects on children (Cohen & Mannarino, 2004). Thus, researchers have examined effective treatments specifically for bereaved children. According to Stubenbort and Cohen (2006), treating children with CTG requires the treatment of both trauma and grief symptoms. Thus, a trauma-and grief-focused Cognitive Behavioural treatment model referred to as Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) for CTG was developed (Cohen, Mannarino & Deblinger, 2006). This treatment model will be discussed in further detail in the following chapter.
Conclusion

The current study is grounded in Cohen and Mannarino’s (2004) theory on Childhood Traumatic Grief (CTG). The chapter provided an overview of important aspects relevant to understanding the particular reaction in children that may follow the death of a loved one during a traumatic event. Without intervention, traumatic death appears to have the potential for long-term effects on children. Therefore, evidence suggests that a cognitive behavioural approach to treatment- one providing both trauma-and grief-focused modules to children and their caregivers-may be an effective means of reducing CTG symptoms. In the subsequent chapter the therapeutic approach utilised in the study, namely Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is discussed.
CHAPTER FOUR
TRAJAUMA-FOCUSED COGNITIVE BEHAVIOURAL THERAPY

“Listening to the voices of grieving children, it is important to see their complete pictures by observing their positive moments, happy times, and resilience while attending to their emotions such as sadness and fear.”

Eppler (2008)

Introduction

The current chapter focuses on Judith Cohen, Anthony Mannarino and Esther Deblinger’s Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) model (Cohen, Mannarino & Deblinger, 2006). The development and core values of the model, a theoretical overview and finally the TF-CBT model components are discussed. Each aspect is discussed in further detail below.

Development of the Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) for Childhood Traumatic Grief (CTG) model

Trauma-Focused Cognitive Behavioural Therapy (TF-CBT) is a treatment model developed by Judith Cohen, Anthony Mannarino and Esther Deblinger (Cohen et al., 2006). According to Copeland, Keeler, Angold and Costello (2007), children throughout the world experience traumatising events and if left untreated, their vulnerability to developing a variety of mental health problems may increase. Studies have identified an association between trauma exposure and increases in anxiety and mood disorders as well as severe behavioural problems. However, according to Saigh, Yasyk, Oberfield, Halamandaris and McHugh (2002), the most frequently reported symptoms of psychological distress are posttraumatic stress symptoms. In the aftermath of traumatic experiences, such as violence, significant PTSD levels have been reported (Kilpatrick et al., 2003). Professionals treating CTG have emphasised the importance of including both trauma-focused and grief-focused
treatment components and that trauma-specific interventions should be provided first. In this way, resolving PTSD symptoms allows children to be able to tolerate memories of the deceased and to proceed through the process of grieving (Cohen et al., 2002, Layne et al., 2001). Thus the TF-CBT model for CTG was developed.

The model was originally developed for treating children exposed to sexual abuse (Deblinger, Lippman & Steer, 1996; King et al., 2000; Cohen, Deblinger, Mannarino & Steer, 2004) and based on the success of TF-CBT interventions in decreasing PTSD symptoms and other mental health problems, researchers later incorporated TF-CBT interventions into the early stages of an individual-treatment model for CTG with the presumption that children with CTG would need to resolve their trauma symptoms first in order to address their grief. Included in the model were grief-focused interventions, which had gathered preliminary empirical support in children who had lost a parent to homicide (Salloum, Avery & McClain, 2001). Two pilot studies have demonstrated the effective use of TF-CBT in treating CTG (Cohen, Mannarino & Knudsen, 2004; Cohen, Mannarino & Staron, 2006). Follow up studies have also shown that the positive treatment gains are maintained (Deblinger, Mannarino, Cohen & Steer, 2006). One recent study has demonstrated the use of TF-CBT in children exposed to domestic violence (Cohen, Mannarino & Iyengar, 2011). Literature related to the treatment of CTG focuses on the use of either play therapy or Cognitive Behavioural Therapy (CBT) (Brown, Pearlman, & Goodman, 2004; Cohen & Mannarino, 2004; Salloum & Overstreet, 2008; Webb, 2003). However, research indicates that CBT, specifically, TF-CBT, is considered to be the most effective, validated approach to treating trauma and CTG (Cohen, Mannarino & Deblinger, 2006). The CBT model attends to a variety of symptoms such as cognitive, physiological, and behavioural responses to various emotions, including sadness and fear (Brown et al., 2004). CBT assists traumatically bereaved children in identifying and changing distorted cognitions and behaviour patterns, which researchers
indicate are the core of traumatic grief (Matthews & Marwit, 2004). The skills taught during CBT provide a means to address impairment in school, family, and social functioning. Although some children may be asymptomatic immediately following a trauma or death, they may develop symptoms over time, and teaching CBT skills may help to prevent later mental health problems (Brown et al., 2004).

According to Silverman et al. (2008), TF-CBT met the well-established criteria for evidence-based practices, which was concluded by a review examining the evidence on treatments for children and adolescents exposed to traumatic events. Furthermore, TF-CBT has also been tested in numerous randomised controlled trials, which have all demonstrated the model’s efficacy in reducing PTSD as well as emotional problems in children (Cohen & Mannarino, 2008; Silverman et al., 2008).

**Core Values of the TF-CBT Model**

Cohen et al. (2006) summarise the core values of the TF-CBT model by using the acronym CRAFTS which consists of the core values of Components-based treatment, Respect, Adaptability, Family Involvement, Therapeutic Relationships and Self-Efficacy. Components-based treatment emphasizes a set of critical skills that gradually build on previously learned skills. TF-CBT describes interrelated components, instead of a rigid session-by-session approach, which should be provided in a manner that meets the needs of the child and the family. Respect for individual, family, religious, community, and cultural values is essential in the TF-CBT model as therapists work together with both the child and parent in deciding on the most effective way of implementing the core components, and taking into account that treatment occurs in harmony with the family’s community and cultural context. Adaptability refers to the therapist’s creativity and flexibility in implementing the core components of the model. The therapist’s clinical judgment and creativity are highly valued and respected and ultimately determine the use of the TF-CBT
components to help each child and family. Family involvement is an important aspect of the TF-CBT model. Parents are included in the child’s treatment, and a primary emphasis of treatment focuses on improving parent–child interactions, communication, and closeness.

Therapeutic relationships are central to the TF-CBT approach. The researchers believe that in order for traumatised children to restore their trust, optimism and self-esteem, it is essential to develop and maintain trusting, accepting, and empathic therapeutic relationships with their therapist. Crenshaw (2007) elaborates and explains this in terms of creating a sense of safety through establishing a safe and secure therapeutic space and a strong therapeutic relationship which is embedded in a genuine connection with the child. Self-efficacy, which refers to self-regulation of affect, behaviour, and cognitions, forms part of a long-term goal of the TF-CBT model. The aim of the TF-CBT model is to provide life skills and enhance strengths in order for children and their families to continue to thrive after the termination of therapy (Cohen et al., 2006).

**Overview of the TF-CBT Model**

Although the TF-CBT model is grounded in cognitive-behavioural theory, it also incorporates principles from attachment theory, family systems theory, and humanistic perspectives. The primary principles of TF-CBT include respect for the clients’ culture and system of beliefs, focussing on the quality of the therapeutic relationship, and utilizing a strengths-based approach in order to promote family self-efficacy (Cohen, Mannarino, & Deblinger, 2006; Cohen, Deblinger, Mannarino, & De Arellano, 2001). TF-CBT treatment for children is brief and strategic, averaging 10 to 18 sessions, and is appropriate for children and adolescents aged 6 to 18 years (Cohen et al., 2006). The specific components of this model are divided into trauma-focused and grief-focused segments. The trauma-focused segment includes nine components, described using the acronym, PRACTICE. These components include Psycho-education, Parenting skills, Relaxation skills, Affective
Modulation skills, Cognitive Coping skills, Trauma Narrative, In Vivo Exposure, Conjoint Child-Parent Sessions, and Enhancing Safety (Cohen et al., 2006). The goal of each component is to help the child and the parent achieve mastery over avoidance of trauma-related thoughts, feelings, reminders, and memories. The grief-focused segment of the model includes the following components: Grief-psycho-education, Grieving the Loss and Resolving Ambivalent Feelings about the Deceased, Preserving Positive Memories of the Deceased and Redefining the Relationship with the Deceased and Committing to Present Relationships (Cohen et al., 2006).

In TF-CBT, the therapist works with both the child and the child’s parent or caregiver (Cohen & Mannarino, 2010). Research indicates that the inclusion of a caregiver enhances the effectiveness of treatment (Feeny, Foa, Treadwell, & March, 2004) and that parental support facilitates the child’s outcome (Cohen & Mannarino, 2010). For example, in a randomized clinical trial, Deblinger, Lippman, and Steer (1996) found that the addition of a caregiver component resulted in the reduction of children’s symptoms more than the provision of caregiver or child-only treatment. However, according to the National Child Traumatic Stress Network ([NCTSN], 2008), TF-CBT can work for children who do not have a parent available to participate in treatment, and therefore, children should not be excluded from receiving treatment for this reason.

Cohen et al., (2006) indicate that although the treatment is manualised, the therapist’s creativity and flexibility are crucial in determining how the treatment is implemented in order to address the needs of the child. Thus the therapist can address the components with variable techniques. Edgar-Bailey and Kress (2010) indicate that interventions using creative techniques are helpful as they assist children in expressing their feelings or experiences through creative mediums such as poems, drawings, paintings and songs in a way that they may not be able to express verbally. Children with CTG often struggle with connecting to an
extensive range of painful and complicated feelings. Therefore creative modalities assist them in connecting with these experiences (Edgar-Bailey & Kress, 2010). Cohen and Mannarino (2004) add that creative interventions provide opportunities for children to create alternatives to disturbing images. Cohen et al. (2006), state that by incorporating pleasurable creative activities in the therapy process, children’s avoidant behaviours which are associated with triggers of the traumatic event, may decrease.

**TF-CBT Components**

Cohen et al. (2006) state that in practice, therapy often flows between trauma and grief segments depending on the child’s needs as well as any external influences which may impact on their symptoms, although the model is divided into trauma-focused and grief-focused segments which build on each other. Therefore, certain components may be more relevant than others to a child or their family, depending on their individual needs. Thus, the therapist’s clinical judgment is important in deciding which component to introduce at which times during the therapeutic process, as well as the amount of time spent on a specific component before progressing to another (Cohen et al., 2006). According to Cohen and Mannarino (2010), a particular component may be revisited at later points in the therapy process, once it has been introduced. Furthermore, several components may be blended together in a single session in order to provide optimal intervention and the therapist’s clinical judgment will determine how, and when, to blend the various components (Cohen & Mannarino, 2010). In this particular therapy case, not all components were applied due to time limits, as discussed further in Chapter Eight under limitations of the study. The subsequent section focuses on describing each of the components individually.

**Trauma-focused components. Psycho-education.** Cohen et al. (2006) refer to psycho-education as one of the major components of TF-CBT which is applied throughout the therapy process. The primary goals of psycho-education are to normalize children’s responses
to traumatic events and to reinforce accurate cognitions about the event. These goals are crucial in addressing the painful and confusing feelings that children may experience following trauma exposure (Cohen et al., 2006). Psycho-education involves providing information to the child and the parent; about how frequently the specific trauma occurs, who is exposed to this type of trauma as well as common emotional and behavioural reactions to the type of trauma (Cohen, Berliner & Mannarino, 2000; Cohen & Mannarino, 2008).

**Parenting skills.** Parents’ may experience challenges in their parenting abilities following a child’s exposure to a traumatic event. Cohen et al. (2006) state that these challenges may create barriers to the child’s healing process as parents’ may struggle to maintain normal routines and consistency in rules due to adaptive functioning as a result of stress. Parenting skills include the use of praise, reinforcement schedules, time-out procedures, and selective attention, and are useful when children respond to traumatization with negative behaviours such as aggression and angry outbursts (American Association of Child and Adolescent Psychiatry [AACAP], 1998). According to Cohen et al. (2004), despite the parenting skills being basic, they have been found to have a positive impact on parenting abilities in parents of children who experience behavioural problems as a response to trauma exposure.

**Relaxation and breathing techniques.** Children who have been traumatized find it difficult to relax either physically or emotionally and are often hyper-vigilant and anxious (Cohen and Mannarino, 2004). According to Westbrook, Kennerly and Kirk (2011), relaxation and breathing techniques assist in the reduction of physiological manifestations of stress and PTSD, which include hyper-vigilance, agitation, anger or rage reactions, increased startle response, difficulty sleeping, restlessness and irritability. Breathing techniques include focused breathing in which children are taught the use of abdominal breathing, that is, the abdomen rises during inhalation and falls during exhalation) as well as focused concentration on the sensations related to breathing (Kabat-Zinn, 1990). Cohen et al. (2006), suggest that
the therapist allows the child to practice these techniques during therapy sessions and to encourage the child to apply these techniques at times when they experience physical or emotional tension or difficulty falling asleep at night.

**Affective expression and modulation.** Children, who lose loved ones under traumatic circumstances such as homicide, may require assistance in dealing with particular emotions. They may experience painful, difficult feelings as well as dysregulation of affect and often fear that they will be overwhelmed by the intensity of their feelings (Cohen & Mannarino, 2004). Therefore, affective expression and modulation skills assist children to express and manage their feelings effectively. These skills include feeling identification, thought stopping, positive self-talk and enhancing safety (Cohen & Mannarino, 2004). Nader (1997), states that children may have less need to use avoidant strategies if they are assisted in improving their abilities to express and modulate their frightening feelings. Cohen et al. (2000) define thought stopping as an affective modulation skill in which the child’s attention is diverted from the traumatic or upsetting thought and is replaced with a positive thought. Deblinger and Heflin (1996) describe the use of positive self-talk as a useful method for children who require the repetition of self-empowering statements. Cohen et al. (2006) add that encouraging children to practice positive self-statements may enhance their ability to cope with stressful life events after termination of the therapy process.

**Cognitive coping and processing.** Cognitive coping encourages children to explore their thoughts in order to challenge and correct unhelpful or inaccurate cognitions (Beck, 1995; Seligman, Reivich, Jaycox, & Gillham, 1995). Children may be prone to dysfunctional or inaccurate thoughts about traumatic experiences as a result of their limited knowledge base. These thoughts can influence their developing views and belief systems in a negative way. Many children are unaware that by choosing to change their own thoughts, they are better able to change their feelings and behaviours. This forms the basis of the cognitive triangle.
Children’s understanding of the cognitive triangle, or the interrelated relationships between thoughts, feelings, and behaviours, is an important part of resolving traumatic grief (Cohen & Mannarino, 2004). It is important for children to specifically understand how their negative or problematic feelings and behaviours may be related to unhelpful or inaccurate cognitions about the trauma. Thus when children are aware of these relationships, the opportunity to modify their distorted cognitions is enhanced (Cohen & Mannarino, 2004).

**Trauma narrative.** The trauma narrative provides an opportunity for the child to gradually face increasingly painful and frightening aspects of the traumatic event which led to the death of their loved one. This component allows the child to 1) gradually become desensitised to thoughts and reminders of the traumatic aspects of the event 2) to decrease avoidant behaviours associated with the horrifying aspects of the event 3) to aid the child’s understanding of traumatic events in terms of his or her own life and the and 4) to identify any cognitive distortions about the traumatic death of their loved one (Cohen & Mannarino, 2004). Eppler and Carolan (2005) explain that by using narratives or allowing the child to talk about their traumatic experiences, assist therapists in assessing and gaining a better understanding of the child’s relationship to the experience and can therefore facilitate any meaningful cognitive shifts. According to Cohen and Mannarino (2004), the therapist should at some point encourage the child to include the “worst moment” (p.164) of the traumatic experience in their narrative. After the child describes the worst moment, the therapist reviews any unhelpful or inaccurate thoughts that the child may have. It is important that the child understand how these distorted thoughts may have influenced his or her behaviour and feelings in that situation (Cohen & Mannarino, 2004). Through repetition and gradually including more painful or avoided aspects to the narrative, children become more comfortable with talking and thinking about the whole experience, which in turn may result in less need to avoid such thoughts or conversations. The therapist may assist the process by
not becoming emotionally distraught or fearful when hearing the child’s story. By demonstrating competent coping, the therapist reassures the child that hearing their story is not unbearable (Cohen et al., 2006).

**In vivo mastery of trauma reminders.** Wolpe (1990) described In vivo exposure as an intervention designed to gradually assist the child to overcome avoidance and allow them to reach a state of normal functioning. Thus the goal is to help the child gradually get used to the feared situation in order to increase their tolerance at each step (Wolpe, 1990). Similarly, Cohen, Mannarino, Berliner and Deblinger (2000) explain that through the process of repeated exposure, thoughts about the trauma as well as trauma reminders become less overwhelming, resulting in a decrease in negative emotions such as anger and fear. This in turn leads to the decrease in intensity of intrusive traumatic thoughts thus reducing the need to use avoidant behaviour which has value for children’s adaptive functioning. According to Cohen et al. (2000), when children learn that they have the ability to overcome terrifying memories and fears, they are able to gain self-efficacy which may lead to positive outcomes in their lives. Cohen et al. (2006), however, believe that the most important outcome of this intervention is that children reclaim a sense of competence and mastery.

**Conjoint child–parent sessions.** Conjoint sessions include meetings with both the child and parent to review educational information, read the child’s trauma narrative, and improve open communication between the child and parent. The aim of the sessions are to enhance the child’s ability to reach a level of comfort which allows them to speak directly with the parent about the traumatic nature of the loved one’s death as well as any other issues that the child or parent may wish to address (Cohen et al., 2006). The child will likely not have been able to communicate their thoughts and feelings previously, as a result of avoidance being a significant factor in CTG, and therefore may not have felt comfortable in asking parents questions about the traumatic event. Thus, both the child and parent are encouraged to ask
and answer such questions in the sessions, in order to address any concerns they may have (Cohen et al., 2006).

**Enhancing future safety and development.** Children who have experienced trauma may become anxious and concerned about their safety. Fears related to harmless trauma reminders can most often be resolved through cognitive processing, the trauma narrative or through in vivo exposure. However, realistic safety concerns are better addressed through education and training in safety skills. It is important to teach children these skills due to the heightened level of vulnerability they may experience (Cohen et al., 2006). Evidence suggests that children are more likely to engage in self-protection strategies and find it easier to disclose information about victimisation attempts when they are taught safety skills (Finkelhor, Omrod, Turner & Hamby, 2005). Thus, according to Cohen et al. (2006), in order to reduce the risk of children being victimised, it is important to incorporate safety skills exercises into treatment as this may enhance children’s feelings of self-efficacy in order to deal with potential future life stressors.

**Grief-focused components. Grief psycho-education.** Children may experience difficulty in speaking about death even after they have talked about the traumatic aspects of their loved one’s death. This inability may also be demonstrated by adults who often “do not know what to say” (Cohen et al., 2006, p. 171) when a loved one dies, and may either say nothing at all, or entirely avoid speaking about death. Therefore grief psycho-education assists children in learning about and understanding the process of grief (Cohen & Mannarino, 2011). It may be helpful for children to begin the grief-focused segment of therapy by reading a developmentally appropriate book about death. This approach referred to as bibliotherapy, may provide assistance to children in speaking about grief and loss (Edgar-Bailey & Kress, 2010). These authors state that when children are able to connect with a character’s feelings of grief and loss, in a story, it may assist them in expressing similar emotions. Furthermore,
bibliotherapy may assist in reducing children’s trauma symptoms of feeling estranged or disconnected from others and experiencing a restricted range of affect (Edgar-Bailey & Kress, 2010). According to Heath et al. (2008), reading such books is an initial, gradual form of exposure to death and grief.

**Grieving the loss and resolving ambivalent feelings about the deceased: “What I miss and what I don’t miss”**. Grieving the loss (“what I miss”) refers to children grieving the loss of both the relationship with the deceased at present such as basic caregiving, joyful aspects of the relationship, as well as the loss of things, such as important rites of passage, which may have occurred in the future, including graduation, weddings etc., however will now never be shared with the deceased (Cohen et al., 2006). These two dimensions are often intermingled in therapy. Grieving the loss of the relationship requires children to remember and identify things shared with the loved one such as what they did with and for each other (Cohen et al., 2006). Children may start to anticipate loss reminders and develop positive coping responses in order to address these two aspects (Layne et al., 2001). The goal is to reduce children’s susceptibility to being overwhelmed when these reminders occur in future (Cohen et al., 2006).

Addressing ambivalent feelings (“what I don’t miss”) about the loved one requires children to acknowledge their imperfections, which is often difficult. If the loved one’s death occurred in a sudden, unexpected and traumatic manner, this may intensify the difficulty as children may have viewed the loved one as a hero. However, there may also be unfinished business such as unresolved conflicts or words said between the child and the deceased, which they may regret (Cohen et al., 2006). This lack of resolution often results in children experiencing feelings of guilt. On the other hand, as a result of their family’s expectations to “not speak ill of the dead”, they may experience unresolved anger or resentment as this may remain unspoken (Cohen et al., 2006, p. 180). Once children have discussed their issues and feelings,
these are normalised by explaining to them that children often have conflicts with their parents, however these are worked out over time. Edgar-Bailey and Kress (2010) suggest writing letters to the deceased, a creative technique which can assist children in resolving these feelings.

**Preserving positive memories of the deceased.** Children may be able to move on and focus on positive aspects of the relationship shared with the loved one, once they have begun the process of grieving their loss, and have addressed unfinished business with the deceased (Cohen et al., 2006). According to Worden (1996), children may create a memory book or box, collage, or any other memorial which may include photographs, hand-drawn pictures, keepsakes and/or poems about the loved one. Children will experience sad and painful feelings while recording and preserving tangible positive memories, however this also allows them to re-experience the joy and happiness they once shared with the loved one (Cohen et al., 2006).

**Redefining the relationship with the deceased and committing to present relationships.** Children often have mental conversations with the loved one’s death. Although this behaviour is perceived to be normal, ultimately the hope is that over time, children will begin the process of accepting that the relationship with the loved one is no longer an interactive one but rather one of memory (Wolfelt, 1991). When children begin to adjust to a future without the deceased, they may feel guilty, as it may seem that they are betraying the loved one. However, Cohen et al. (2006) emphasise the importance of children beginning the process of adjustment, as this will assist them in re-investing in present relationships. The authors further add that this is an important step in enhancing the child’s adaptive functioning. As is the case in traumatic grief, much of the child’s energy is consumed by intense reminders of the traumatic event and attempts to avoid them (Cohen et al., 2006). However, once they have begun to accept the loved one’s death, an important aspect of the
healing process is that of reconnecting with other significant individuals in their lives. Therefore, allowing them to reinvest in existing and new relationships (Rando, 1993; Worden, 1996). Crenshaw (2007), warns of obstacles which may hinder the process of reinvesting, which therapists must take cognisance of. He states that children may guard themselves against strong attachments in fear of additional losses. Therefore, it is important to assist children in understanding how their need to protect themselves from pain and loss may also prevent them from experiencing love and friendships.

Cohen et al. (2006), emphasise that it is important to recognise that grief is a process that can be long lasting and, and therefore it should not be expected that children’s grief will be “resolved” (p. 169) at the end of treatment. However, Cohen and Mannarino, et al. (2004) and Cohen et al. (2006) have also found that once children receive help to become unstuck from the traumatic aspects of their loved one’s death, their CTG symptoms subside, thus allowing their adaptive functioning to improve.

**Conclusion**

This chapter outlined the development of the TF-CBT for CTG model as well as its efficacy as a well-validated and evidence-based treatment approach to treating CTG. The core values of the treatment model were described in detail. An overview of the model provided an understanding of how children with CTG need to work through their trauma symptoms first in order to be able to focus on their grief. However, although the model is divided into trauma-focused and grief-focused segments, in practice, therapy often flows between the two elements depending on the child’s needs. Furthermore, clinical judgment is important in deciding which component to introduce or focus on at which times in the therapeutic process. Thus the therapist’s creativity and flexibility are highly valued. Finally, grief is a process that can be long lasting and, as such, it is not expected that children’s grief will be resolved at the conclusion of the treatment model. The findings of the application of
the model to the current study are discussed in greater detail in Chapter Seven. The subsequent chapter covers the methodology of the current study.
CHAPTER FIVE
METHODOLOGY

Introduction

This chapter provides an overview and description of the case study research design employed in this study. The chapter explores the methodology applied by looking at the research design, sampling methods, procedures, ethical considerations and data analysis methods that were employed.

Aim of the Study

As a result of the increasing rate of domestic violence and muti murders in South Africa and children being witnesses thereof, the motivation of the research case study was to contribute towards the literature on childhood trauma. This was achieved by integrating theory as part of the therapeutic process in an attempt to elicit relevant information which may support an existing body of knowledge.

The aim of the study was to describe *Linda’s journey through traumatic grief after the violent death of her mother.1

Research Design

A research design refers to the structure of research that is designed to answer the research question and includes the planning of the research procedure as well as the procedure for data analysis and collection (Allison, 2000). A qualitative descriptive case study method was employed. The case study approach was selected as it provides a suitable research design in which to give an account of the subject in a therapeutic situation (De Vos, Strydom, Fouche & Delport, 2005; Fouche & De Vos, 1998). Each of these concepts is discussed further in the chapter.

1 “Linda” is a pseudonym used for the research subject for the purposes of anonymity. The symbol * as given here indicates the first use of a pseudonym for any individual mentioned.
**Qualitative studies.** Denzin and Lincoln (1994), state that qualitative research emphasizes processes and meanings that are not rigorously examined and measured in terms of quantity, intensity or frequency. Qualitative researchers are interested in insight, discovery and interpretation rather than hypothesis testing. An advantage of qualitative studies is that they provide detailed descriptions and analyses of quality or substance of human experience (Marvasti, 2004). Qualitative research, however, does not provide the researcher with certainty, in that alternative interpretations of the data are always possible (Willig, 2001). Therefore, it is to allow for space for the practice of reflexivity. This concept is discussed later in the chapter. As the qualitative method takes into account the individual characteristics and experiences of human experiences, it was selected for the present study.

**Case study research.** The objective of case study research is the development of an accurate description of a single case which leads to the development of theory and general principles and therefore case studies often generate hypotheses that could be tested by other research methods (Edwards, 1990). Yin (2003) states that case studies continue to be a relevant method of research and are the strategy of choice when there is little control over events by the researcher and when the research focuses upon a contemporary phenomenon within a real-life context. Furthermore, it provides a suitable research design in which to give an account of the research subject in a therapeutic situation (De Vos et al., 2005; Fouche & De Vos, 1998 as cited in De Vos, 1998).

**Definition of a case study.** Bromley (1986) described a case study as any singular case, example or incident that, when described and analysed, is thought to contribute to and enhance understanding of an area of enquiry. While Lindegger (1999), defined case study research as ideographic research whereby individuals are studied as individuals and not as members of a population. Case studies therefore are thorough investigations of individuals, single families, units, organisations, communities or social policies (Lindegger, 1999). Yin
43

(2003) further defined a case study as an “empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (p.13).

In order for case study methods to retain their value as a scientific endeavour, certain principles need to be adhered to which are discussed in the following section.

**The principles of case study research.** As the case study method is generally utilized in qualitative research, statistical inference is not utilized (Yin, 2003). Rather, validity is established by a logical process namely analytic generalization, analytic induction or content analysis (Yin, 2003). The case study researcher aims to develop a conceptualisation in order to reveal the important qualities of the investigated case. The conceptualisation will make assumptions regarding the constructs or theoretical perspectives utilised to frame it as well as the relationship assumed to exist between them (Edwards, 1990).

**Descriptive case studies.** Descriptive case studies strive to describe, analyse and interpret a particular phenomenon and the real-life context in which it occurred (Yin, 2003). Extreme or unique cases may occur that justify a study in its own right. In this regard an intensive study of one instance or a small number of instances is undertaken in order to produce detailed descriptions of these cases. The purpose is not to understand a broad social issue, but merely to describe the case being studied (De Vos, Strydom, Fouche & Delport, 2011). The descriptive case study was employed as the researcher described the condition of Childhood Traumatic Grief as well as evidence of resilience as observed in Linda’s case. These findings are reflected in Chapter Six. The researcher further aimed to provide an accurate representation of Linda’s case without generalizing her case to other cases but rather to generalize her case to existing theory.
Participants and Sampling

A non-probability purposive sampling technique was utilised for the selection of the participant in the study. In purposive sampling, the researcher uses her judgment to select the membership of the research subject based on the specific goals of the research. The current research relied on retrospective therapeutic work with a child who had been in therapy for trauma and grief.

An advantage of this type of sampling is that the researcher can use it to select unique cases that are especially informative (Neuman, 2003). The researcher’s judgment is very prominent in this type of sampling (De Vos et al., 2011). However, in this type of sampling, the chances of selection bias are high, which result in difficulties related to the generalization of results to the population (Cozby, 1997; Neuman, 2003). The researcher of this study however did not attempt to generalize the case to the population but rather to existing theory.

A purposive sampling technique was employed for the selection of the research subject in the study as she demonstrated evidence of resilience during the therapeutic process, which will be discussed in further detail in the Chapter Seven.

Procedure

Permission to conduct the study was gained from the Faculty Research, Technology and Innovation Committee (FRTI), and the Research Ethics Committee-Human (REC-H) at the Nelson Mandela Metropolitan University. Upon termination of the therapeutic process, written informed consent was obtained from the research subject’s aunt and legal guardian, *Susan, in order to conduct the research case study. Assent was gained from Linda. The data sources for the study included case material from the client file which was stored at the University Psychology Clinic situated in the Department of Psychology at the Nelson Mandela Metropolitan University. Detailed records in the form of process notes were obtained from the therapy sessions. Permission to utilise the case material in the client file for
the purpose of conducting the research, was obtained from the NMMU Psychology Clinic manager.

**Ethical considerations.** Prior to the study commencing, permission to conduct the study was obtained from the Faculty Research, Technology and Innovation Committee (FRTI) as well as the Research Ethics Committee-Human (REC-H) in order to ensure that the proposed study met all ethical requirements. Specific ethical considerations which were considered are highlighted below.

**Informed consent.** Due to Linda being a minor, verbal assent was gained from her in order to gain permission to conduct the study. Written informed consent was obtained from Susan. This included a full description of the nature of the study, potential risks and benefits, the knowledge that the family could withdraw at any stage and finally, knowing who will have access to the case information once the study was completed.

**Non-maleficence and beneficence.** The notion of doing no harm as well as promoting human welfare is paramount within the field of psychotherapy as well as research. While the process of undergoing psychotherapy can be difficult, no foreseeable risk of harm was anticipated in the proposed study. The research subject and her family were free to end the research process at any stage they deemed necessary. Therefore, benefits for the individual included being able to grieve the loss of a parent during the therapeutic process as well as to learn how to cope with the loss of a parent. Possible benefits for the legal guardian included obtaining a greater understanding of the child’s ability to process traumatic grief. Benefits toward the community could not readily be anticipated due to the lack of generalizability of case studies. However, benefit to the community was by virtue of increasing therapeutic knowledge around Childhood Traumatic Grief.

**Anonymity and confidentiality.** In order to protect the research subject and her family from identification, all recognisable details were changed through use of pseudonyms.
Confidentiality was maintained by the researcher and her supervisors as part of professional conduct and as a means of adhering to ethical guidelines established by the Professional Board of Psychology.

The NMMU Psychology Clinic stores and keeps record of the client’s file, which includes therapy process notes and informed consent to therapy. The client’s identifying details are available in the clinic file however access to the file is strictly prohibited in order to protect the client’s anonymity and confidentiality. This file is safely stored within an access controlled storage space for a period of five years, after which time it will be shredded. No duplicates of this file were made in order to limit the amount of information available in multiple forms and therefore ensure greater control of access to the information.

Data Collection

For the purpose of this study, the three principles of data collection as proposed by Yin (2003) were adhered to. The three principles are: a) using multiple sources of information, b) creating a case study database, and c) maintaining a chain of evidence.

Using multiple sources of information. The use of multiple sources of evidence allows the researcher to address a broader range of historical, attitudinal and behavioural issues (Yin, 2003). Cozby (1997) states that depending on the purpose of the research, the individual’s history, symptoms, characteristic behaviours, reactions to situations and responses to treatment may be presented in the case study. The greatest advantage of using multiple sources of evidence is that any finding in the case study is likely to be more accurate as it is based on several different sources of information (Yin, 2003). Upon termination of the therapeutic process, the data sources for the study included case material from the therapy sessions, more specifically, detailed records in the form of process notes as well collateral information obtained from Susan.
Creating a case study database. A case study database is the practice of developing a formal and presentable database including the researcher’s case study notes (Yin, 2003). The case study database for the present study included process notes from the therapy sessions, as well as collateral information obtained from Susan.

Maintaining a chain of evidence. The importance of maintaining a chain of evidence is that it enables the readers of the case study to move from one part of the case study process to another, following the source of evidence from initial research question to conclusions (Yin, 2003). The researcher ensured that a chain of evidence was adhered to throughout the study by dating the evidence as it was collected. For example, each therapy session was dated.

Data Analysis

The data was analysed utilizing content analysis. Content analysis is a method for analysing communication after it has been produced. There are no boundaries to the form of communication and can be applied to behaviour as it has a communicative dimension (Haslam & McGarty, 2003). Irving Alexander’s (1988) content analysis technique was employed, where core identifying units, in the form of “themes”, were extracted. In Alexander’s (1988) model the data is approached in accordance with two routes, namely, a) letting the data reveal itself, and b) asking the data questions.

Letting the data reveal itself. This involves the researcher sorting through the raw data and identifying what in the material demands further scrutiny due to its importance. The sorting through the data serves two purposes namely reducing the data into manageable proportions and to break the conscious communicational intent of the content (Alexander, 1988). When breaking the conscious communicational intent of the content, the researcher must be directed away from the judgement of the content and rather focus on the awareness of what in the content signals importance to the individual in what has been communicated
Alexander (1988) proposed nine guidelines for the extraction of salient data which includes the following:

1) Primacy. This refers to the association that is made between the concepts of first and importance. According to Alexander (1988) people tend to speak or write first about what is most on their minds.

2) Frequency. This refers to speech or writing that occurs often and frequently (Alexander, 1988). Certainty and importance is attributed to the frequency with which information is reported.

3) Uniqueness. This refers to that which is singular or odd (Alexander, 1988). As an indicator of importance, uniqueness is related to a variety of normative assumptions and the various baselines that the examined material is being compared with must be kept in mind. Uniqueness not only refers to verbal expression but also the content of what is being expressed. Alexander (1988) advises that the therapist should look for unique verbal as well as nonverbal cues from the client.

4) Negation. Negation statements are statements which are denied or turned into its opposite (Alexander, 1988) and are indicators of possibly repressed or unconscious material (Fouche’, 1998).

5) Emphasis. That which is overemphasized, underemphasized or mistakenly emphasized should be noted by the researcher. Overemphasis is usually noted when something which is widely held to be commonplace, receives excessive attention (Alexander, 1988). Under-emphasis is noted when something that seems important receives little attention, while misplaced emphasis occurs when an apparently irrelevant aspect of a crucial event is emphasised (Elms, 1994).
6) Omission. This refers to what is missing. Alexander (1988) stated that a therapist should pay special attention to affect which is commonly omitted while description of actions and events abound.

7) Error or Distortion. This is that which is a mistake or error. Mistakes can occur in a variety of forms, for example, they can be related to general facts about the case or to facts about the individual (Alexander, 1988).

8) Isolation. This refers to that which is alone or does not fit (Alexander, 1988). If this leaves one asking the question “Does this really make sense?” or “Where did that come from?” it is highly likely that important material is contained in this isolated communication (Alexander, 1988).

9) Incompletion. This refers to that which is not finished (Alexander, 1988). This may happen when an individual’s story may follow a course but then ends before closure is reached. Alexander (1988) points out that the individual may sometimes be aware of what is happening and may abruptly stop with her story, which may indicate that it is too painful to continue. Other forms of incompletion may include subtle changes, where distraction serves to interrupt the narrative flow and there is no return to the original story line (Alexander, 1988).

Asking the data questions. The researcher extracted relevant information from the data by categorizing the information into “core identifying units” also known as themes.

Guba’s model of trustworthiness was utilised in order to make every effort to remain objective whilst analysing the data. The model outlines credibility, transferability, dependability, and confirmability as the criteria for assessing qualitative research.

Credibility. Credibility refers to whether the researcher has established confidence in the truth of the findings. This can be achieved by presenting accurate descriptions of human
experience that people, who are familiar with the experience, would instantly recognize the
description (Willig, 2001). Credibility is enhanced through the process of reflexivity.

According to Rule and John (2011), if one is an active participant in the case that is being
studied, recordings about feelings and self-reflection becomes invaluable data. Qualitative
research makes allowance for this process and is considered under the concept of reflexivity.
Reflexivity can be broadly described as a qualitative researcher’s engagement with or
continuous examination and explanation of how they have influenced a research project.
Reflexivity provides a space for the potential influence of the researcher particularly in case
study research which acknowledges the place of the researcher in the process, rather than
trying to hide her (McGloin, 2008). The extent to which researchers engage in reflexivity
depends on the methodological approach they have adopted for their study (Given, 2008).
Reflexivity is considered essential, potentially facilitating understanding of both the
phenomenon under study and the research process itself (Watt, 2007). Achieving reflexivity
is not a straightforward endeavour. Current discussions on reflexivity reflect the need for
qualitative researchers to be explicit in their actual practice of reflexivity so as to make a
qualitative study more rigorous in its approach (Given, 2008). The concept of reflexivity was
particularly relevant for the current study as the researcher had formed part of the therapeutic
process. In this way, the researcher was both a participant and an observer.

**Transferability.** Transferability refers to the degree of which the findings can be
generalized to other contexts. Research meets this criterion when the findings from a study fit
into contexts outside of the study situation (Krefting, 1991).

**Dependability.** Dependability addresses the issue of whether the findings would be
consistent if the study were replicated (Krefting, 1991).

**Confirmability.** Confirmability refers to freedom from bias in the research procedures and
results (Krefting, 1991).
Conclusion

The methodology of the research was discussed including the research design, sampling method, data collection method as well as the data analysis method. Furthermore, methodological considerations as well as ethical considerations were discussed. In the following chapter, the clinical material will be discussed and the therapy case will be presented.
CHAPTER SIX
CLINICAL PICTURE AND PRESENTATION OF THERAPY CASE

“Inside each child there is a story that needs to be told - a story that no-one else has yet had
the time to listen to.”

Winnicott

Introduction

The current chapter describes the process of Trauma-Focused Cognitive Behavioural
Therapy (TF-CBT) which took place between a female child and a trainee therapist. A
description of the child in the current case, which includes her background information and
reason for referral are discussed. Finally a session by session account of the therapy process
is described. All session data, including personal reflections were recorded in the process
notes in the clinic file. The layout of the sessions in the current chapter was considered for
providing a clear understanding of the case. It is important to reiterate that pseudonyms have
been used when referring to the child participant and her caregiver. The chosen pseudonyms
are Linda and Susan, respectively. Susan is Linda’s mother’s cousin, however it should be
noted that during the therapy process, as described later in the chapter, Linda refers to Susan
as ‘aunty’. Furthermore, Linda’s mother’s twin sister will be referred to as her maternal aunt.

Linda’s Biographical Information

Linda is an 11-year-old girl who was very well-mannered, friendly and polite. She is
intelligent and displayed greater maturity in her cognitive and emotional development than
the average child her age. She had short brown hair, brown eyes and always wore a smile on
her face. Linda was always neatly dressed and took pride in her appearance. She had two
siblings- an older brother, aged 15 and a younger sister aged 6 years. She and her siblings had
been living with Susan for one month at the start of therapy. After Linda’s mother’s funeral,
Susan had taken Linda and her siblings into her care which resulted in them relocating to Port
Elizabeth, thus Susan is their legal guardian. After termination of therapy, Linda and her siblings however relocated to live with their maternal aunt in a different town in the Eastern Cape where they are currently residing, although Susan still remained their legal guardian.

**Developmental History**

Information pertaining to Linda’s developmental history could not be obtained from Susan as she did not have access to this information.

**Background Information**

Linda was exposed to ongoing domestic violence at home, by witnessing her father physically and emotionally abusing her mother. She lost both her parents on the same day when her father murdered her mother as part of a muti murder ritual, which led to his arrest and later to imprisonment. Susan explained that Linda’s father had belonged to a church, which was believed to be an ‘evil’ church. He was informed by the leader of the church, who was speculated to have been a witchdoctor (according to Susan), that in order for him to win the lottery, he was required to harvest a human’s body parts, someone close to him, in accordance with instructions given by the witchdoctor. Linda’s father carried out this act by decapitating and dismembering her mother’s body while she was alive, using an axe and a saw. The murder had taken place in her parents’ bedroom. Linda and her siblings had witnessed the murder as they lived in a RDP house which had no ceiling and were in the room next door to their parents’. This resulted in them being exposed to the horrific auditory and visual sensory aspects of their mother’s death. Furthermore, Linda was exposed to her mother’s decapitated body parts thrown by her father in a hole he dug in the front area of the house. The motive for the muti murder was as a result of her father being unemployed and struggling financially.
Reason for Referral

After being removed from the small hometown in rural Gauteng, Linda and her siblings were removed to the care of their mother’s cousin and enrolled in a school in Port Elizabeth. The school principal had been informed about the traumatic death of her mother by Susan and felt that it was important that Linda (and her siblings) be referred for therapy in order to get help in dealing with the trauma. Furthermore, the school principal was concerned that they may have had difficulty in socialising with other children as well as adjusting to the new school environment. Thus the school principal contacted the Nelson Mandela Metropolitan University Psychology Clinic on Susan’s behalf and made referrals for therapy for Linda and her siblings. They were then seen soon after the referral had been made.

The Therapeutic Journey

The therapeutic journey that Linda and I followed relied a great deal on the strong therapeutic relationship that was formed between us, as this assisted Linda in feeling safe and comfortable in sharing her story with me and allowing herself to confront and express her feelings and emotions as well as to process her grief. Furthermore, therapy was mostly based on Linda telling me her story, as it was evident that it this was a great need for her. The therapist felt that in order to work through the crux of Linda’s needs, Linda needed to guide the therapist as to what was most troubling for her. Thus not all TF-CBT components were applied during the therapy process, only those which were relevant to addressing Linda’s needs. The components were often blended together in therapy sessions, as a result of limited time due to transport difficulties on Linda’s part and the uncertainty of whether Linda would attend weekly scheduled therapy sessions. Therapy sessions flowed between trauma and grief elements and thus did not follow a rigid component approach.

Session one. The first 30 minutes of the session began with a meeting with Susan, in order to conduct an intake interview and to gain a better understanding of Linda’s reason for
referral as well as Susan’s concerns. Susan provided information regarding the traumatic
event as well as the reason for Linda and her siblings relocating to Port Elizabeth to live with
her. After our meeting, I met with Linda for the remaining 30 minutes of the session in order
to introduce myself to her and get to know her a bit better. The reason for splitting the session
was due to transport difficulties on Susan’s behalf, and there was no guarantee as to whether
Linda would have attended a scheduled “first session” the following week. When I met Linda
in the waiting area, she appeared shy. However upon entering the therapy room, she engaged
well, smiled a lot and was very polite. The session began with me introducing myself and
explaining my role to her. I then asked her whether she knew the reason why she was referred
for therapy. She replied “Yes, my aunt brought us here because of what happened to us, I
think it is because she is worried about us.” I asked how she felt about coming to therapy and
she replied “I’m happy because I have not been able to talk to anyone about the way I am
feeling. I did see a social worker twice after what had happened, but she did not really care
about my feelings and did not allow me to speak much, she just asked me a lot of questions
and she was only interested in hearing about how my mother was murdered.” Without being
prompted, she then began to tell me that she had a problem. She explained that she had often
found herself crying a lot because she missed her mother and in the session, she began to cry.
I provided grief psycho-education to her and normalised her feelings for her. She apologised
for crying and then asked if she could draw a picture. She drew a picture of her home that she
had shared with her family, but made it beautiful with a fixed ceiling and colourful plants and
flowers surrounding the house. She stated that when she grows older and earns money, her
wish is to go back to her home and fix it up according to the way it looked in the picture, as it
was her mother’s dream to fix the house and make it beautiful. She spoke about her mother
and explained that she was a good person and felt sorry for her for the bad things her father
did to her. She explained that her little sister cried a lot for her mother and asked questions
about where she was. Linda stated that she comforted her and explained that their mother is with Jesus which is why they were living with Susan. She also stated that she was worried about her brother as he did not eat and always ‘stared into space’. At the end of the session, she thanked me for allowing her to speak and said that she looked forward to her next session.

**Session two.** Linda missed the next therapy sessions due to transport difficulties but arrived the following week. She appeared more relaxed during this session and spontaneously volunteered more information. Upon catching up from the previous session, she stated that she was doing a bit better, and that she did not cry much during the week. Although she still thought a lot about her mother. The aim of the session was to provide psycho-education to Linda about traumatic/upsetting events. Linda requested to paint and while doing so, she spontaneously began to speak about her mother and the traumatic event, without being prompted. She stated the following:

The way my mother died was very painful. She did not deserve to die that way; she was a very good person. It was also not her time. I will always think of her and miss her a lot. Before she died, she burnt her hand badly on the gas stove. She struggled to cook and clean, but she tried anyway. I wished that I could cook so that I could help her because she was struggling. After my father killed her, there was blood all over the house. I had to leave most of my clothes there when I left because most had blood stains on them. My favourite pair of white takkies, turned red because they were covered in blood, so I had to leave them behind because I couldn’t wear them anymore and they also reminded me of my mother’s death. At my mother’s funeral, I felt numb and I was shaking, but I knew that she was safe where she was. She had been through a lot in her life, especially with my father who treated her so badly. Before he killed her, he used to hit her a lot, sometimes in front of us. I always felt sorry for her.
After Linda told her story, I processed her feelings and provided both trauma and grief psycho-education to her in order to normalise her feelings of loss, sadness and disbelief. She painted a picture of a tree and birds in the sky.

**Session three.** The session began with a 10 minute meeting with Susan in order to follow up on any concerns that she might have had regarding Linda’s progress as well as to enquire how Linda was coping since being in therapy. Susan explained that she had no concerns and was surprised that Linda was coping well. Furthermore she explained that Linda was domesticated and assisted with house chores and was very nurturing towards her siblings, particularly towards her younger sister. The aim of the session was to create Linda’s trauma narrative. She was informed that she could decide how she would like to tell her story. She stated that she preferred to tell me her story verbally instead of writing it down. She requested to paint while telling her story and painted a picture of herself. She told her story as follows:

This whole thing happened because my father started attending a certain church in our area, I don’t know what type of church it was but ever since he started attending it, he changed and would disappear from home for days. People said that it was an evil church. He also started drinking a lot. He stopped giving us money and buying us clothes and didn’t care about us anymore. He was dirty and wore the same dirty clothes all the time. He was told at the church that if he wanted to get rich, he must cut off someone’s body parts, that was close to him and he would win the lotto. He used to be a very loving father and took care of us, but I don’t know what happened. Everything changed when he started attending that church. It was on a Thursday night when he killed my mother. He came home early that morning from the streets carrying an axe and a saw and locked himself in the bathroom. We were on our way to school. When we came home, he was still locked in there and my mother said that he had been there all day. We begged him to come out because we wanted to use the bathroom but we weren’t able to use it the whole day. After
we ate supper, we sat with my mother and made jokes and we were laughing and playing. Then my father came out of the bathroom with the axe and the saw and grabbed my mother and dragged her to the bedroom and told us to close ourselves in our bedroom which was next door to theirs. We lived in a RDP house which had no ceiling so we could hear everything that happened in my parents’ bedroom. I heard my mom crying and begging my dad to stop hitting her. It was quiet for a little while and then my mom started begging my dad again. I just heard my mom scream and after a while it was quiet again, this time for good. I knew then that she was dead. I heard while he was cutting her up and I could tell the difference when he was using the axe and when he was using the saw. I was very scared that my father would kill us too. I blocked my sister’s ears and tried to make her sleep so that she didn’t hear what was happening. I was really scared that my father was going to also kill us. I heard my father walk in and out of the house. So when it was quiet, I snuck out of the bedroom to see what had happened. There was blood everywhere. I bumped into my father in the passage. He got a fright and stopped while he was on his way out carrying one of my mother’s arms to bury outside. I looked into his eyes, and at that moment when he looked back at me, I could tell that he knew that what he did was wrong because he then looked down and didn’t want to look at me again. My brother escaped to try and find help. He found two policemen in the street but by the time they got to the house it was already too late. I am grateful to him though because he saved us. When the policemen arrived, I went outside to see what was happening. I saw that my father dug a hole and was throwing all my mother’s body parts in it. I remember looking at her cut off head and breasts that were just lying there. People from the community also came to see what happened. My father wasn’t even afraid of the policemen and ignored them, because while they were standing there he was going in and out of the house to fetch the body parts. I have many questions that I would like to ask my father. I want to ask him whether
he ever thought that what he did would affect us so much and also why he would take away our mother from us. I felt that I lost all trust in him. What broke my heart even more was that one of the policemen took pictures of my mother’s body parts and sent them to his friends and also put them on Facebook. My mother’s breasts and head were cut off and exposed and people were joking about it. This made me very sad because that was still our mother lying there. But at least we found out that the policeman was fired from work. I felt guilty because I kept on thinking that if we tried to call an ambulance, or tried to get her to the hospital somehow, maybe she would still be alive today, even if she was missing some body parts. Sometimes, when I sit alone, I think about what happened and find myself crying. I’ve been experiencing painful headaches since last week. I think it’s because I think about what happened, while I’m at school but then I try hard to block the thoughts out of my mind and think of something else so that I can focus on my schoolwork instead.

At the end of her story, I processed Linda’s thoughts and feelings with her. I then introduced her to a relaxation and breathing exercise (refer to Appendix B and Appendix C) in the session in order for her to practice during times when she felt overwhelmed. Thereafter I provided trauma and grief psycho-education to her. I further introduced Linda to the cognitive triangle, particularly to address her feeling of guilt by explaining that her unhelpful thought causes her negative feelings of guilt and leads to the negative behaviour of blaming herself. This helped her realise that her mother’s death was not her fault. Thought stopping was reinforced, related to diverting her thoughts of the traumatic event to positive thoughts. Although she had already been enforcing this technique on her own, she was encouraged to continue practising. Susan was informed about the headaches Linda was experiencing and stated that she would monitor the occurrence and severity. Grief psycho-education was provided to address her feelings of sadness and heartbreak regarding the jokes made about her mother’s decapitated body parts as well as the distribution of pictures. Furthermore, to
address her feelings of sadness related to trying and restoring her mother’s dignity while her body parts were scattered and exposed by her stating “That was still our mother lying there.” At the end of the session Linda thanked me for allowing her to speak so much, and for listening to her story, by stating: “Sorry that I spoke so much, but I haven’t been able to tell anyone the full story before because I know my brother and aunt are also hurting.”

Session four. Prior to the session beginning, Susan had informed me of the possibility of the following week’s session being Linda’s last as Susan had obtained a job in a different province which meant that Linda and her siblings would have to relocate again. However, Linda and her brother would not have relocated with Susan, but instead would have relocated to a different town to live with their maternal grandmother, thus only her little sister would have relocated with Susan.

Upon fetching Linda from the waiting area, she expressed to me how happy she was to attend therapy. While probing further, she stated that therapy helped her to ‘speak out’. She also reported that she had been practicing the relaxation and breathing exercises that she had learned in the previous session, when she felt a bit overwhelmed thinking about the traumatic event and stated “It makes me feel calm.” The aim of today’s session was to engage Linda in bibliotherapy to psycho-educate her about the process of grieving. Thereafter, she was able to paint a picture of her choice. Linda asked to read “When I am feeling sad”, “When I am feeling scared” and “When I am feeling angry”. She requested that I read along with her. After reading “When I am feeling sad”, she stated that she felt sad about her mother’s death and not having her around anymore because she missed her a lot. After reading “When I am feeling scared”, she explained that she felt scared on the day of her mother’s death as she was afraid that her father would kill her and her siblings as well. After reading “When I am feeling angry”, she explained that she is angry at her father for what he did, as his actions have caused them a lot of pain. Thereafter, Linda painted a picture of her family which included
herself and her siblings in the centre of the painting, and her parents on either side. She painted her and her siblings in the centre of the page, holding a big red heart and inside the heart stood the words “Love Your Family”. I asked her to describe her painting to me to which she explained that she wished things could go back to the way they were when they were a normal, happy family. She expressed to me that although she is angry at her father for murdering her mother, she feels that in order for her to move on and live a happy life with peace in her heart, she needs to forgive him. Linda’s painting indicated that she grieved the loss of her family, particularly in happier times. Her feelings of loss and sadness were processed and normalised. Furthermore, her decision to consider forgiving her father was also processed with her.

**Session five.** Linda missed her therapy session the previous week once again due to transport difficulties. The aim of the session was for Linda to engage in effective expression by exploring the sandtray in order to create an “image/collage” of her choice in order to allow her to express her feelings and emotions that she may have been struggling to express verbally. At the beginning of the session, Linda stated that there was something that she needed to tell me by saying:

After our last therapy session, I’ve been thinking a lot about what happened and my feelings and I’ve made a choice to forgive my father, because it is the right thing to do. I want to feel peace in my heart. I would also like for us to get a chance to see him and speak to him and tell him that he does still have children who love him and that we will always be his children. We all make mistakes. I am happy living with my aunt and appreciate that she is trying her best to be like a mother to us. I would like for us to go back home during the June holidays to see our friends and the people in our community because we left there suddenly and it was a painful time. They will be happy to see us.
Linda’s feelings were processed regarding her decision to forgive her father. It was evident that this was an important decision for her to make. She was praised for being a brave girl. Her feelings related the secondary losses of her friendships and relationships with community members processed and normalised.

In the sandtray, Linda arranged 9 dolls sitting in a circle, under umbrellas and trees as well as farm animals in the one corner of the sandtray. When asked to explain her image, she stated:

This family is close and the people are all sitting together. If you have a problem, you must speak about it. There is also a paramedic to check how things are going in the people’s lives. Every family should live happily and if you have problems, you should solve them. I am the type of person who enjoys making others grow. I wish I could live like this one day; I liked staying with my family because I never got bored. I wish as a family, we could have been a happy one and lived nicely. If there was a problem, it should have been discussed, in order for us to have been able to live happy and smile all the time. I miss my mom and dad a lot. I still don’t know why and how my father could have done something like this, but I’ve decided to forgive him. I did not realise that when someone you love dies, it hurts so much because it is very painful.

Linda was able to express her feeling and emotions through the sandtray. It was evident that she grieved the loss of her family as a unit. Linda’s feelings of loss and sadness were processed related to the loss of her mother and her father as well as the loss of her family as a whole. Grief psycho-education was provided to address the painful feelings she expressed of losing a loved one. These emotions were normalised. Trauma-psycho-education was provided to address her feelings of confusion and disbelief towards her father being capable of murdering their mother.
Session six. Linda had not yet relocated and was able to attend her therapy session. The aim of the session was to continue to focus on affective expression by engaging Linda in a feelings exercise called the Colour Your Life exercise. This exercise would allow her to focus on processing and expressing her feelings and emotions related to her life before, during and after the traumatic event. The task required her to write down her feelings and to assign a colour to each feeling written down and then to explain why she chose the specific colour for each feeling.

Linda expressed enthusiasm at the task and completed it successfully. She wrote down the following feelings, in the following order:

1. In blue: “I was scared”

   She explained that “I was scared that my father was going to kill us. I chose to write it in blue because blue is slightly better than black, meaning that I am no longer scared and I no longer feel like I am in a dark place.”

2. In black:
   
   “I felt like I just wanted to die.”
   “I didn’t want to eat food and didn’t want to sleep.”
   “No parents”
   “It was like I was dreaming”
   “I was just thinking that I no longer want to live”
   “But now I have a family and my aunt to look after us”
   “I love my mother and father”

Linda explained that “I chose black because I was in a dark place. After my mother died I felt hopeless and nothing made sense to me. I also felt numb and had thoughts of wanting to be knocked over by a car or to drink poison just to end my life. I also felt heartbroken when I realised that both my parents are gone. Although I still have my brother and sister, which I
am grateful for, I still wish that both my parents were here.” When asked to explain why she wrote “I love my mother and father” in black, she stated “I was my mother’s child and did not really share a very close relationship with my father. I am also confused as to what he did and the pain that he has caused us. This also makes me very sad and heartbroken. But I know that I will see my mother again someday when I go to heaven.”

3. In red: “But now I am happy”

Linda explained that “Red is the colour of love and happiness, and I am now feeling better and happy.”

Psycho-education was provided to address both trauma and grief elements and to normalise her thoughts and feelings. Trauma psycho-education was provided to address her feelings of fear of being killed during the traumatic event. Grief psycho-education was provided to address and normalise her thoughts and feelings of wanting to die, having no appetite and sleep disturbances, numbness, thoughts and feelings of disbelief and hopelessness, all associated with her feelings of being in a dark place following her mother’s death. Her positive feelings were also acknowledged and processed, specifically regarding her feelings of happiness and feeling better as well as the gratitude shown, for Susan taking care of them. It appeared that despite all the negative feelings, Linda had been able to cope, by holding on to her belief that she would see her mother again someday when she goes to heaven.

**Session seven.** Linda missed one month of therapy prior to this session (4 sessions), due to transport difficulties. Susan contacted me a week prior to this session, to inform me that this would be Linda’s last session as she and her siblings would be relocating to a different town the following week to live with their maternal aunt. This news was all very sudden and surprising as I had hoped to continue therapy with Linda. Therefore this was our termination session.
The aim of the session, being our last, was for us to create a personalised journal for Linda by decorating an A5 sized blank book using colourful materials such as colourful paper, stickers, glitter and different colour pens. The purpose of the journal was to serve as an end product of therapy and a transitional object for Linda always to remember how far she had progressed. More specifically, for her to continue to express and process her thoughts and feelings as she had learned in therapy, by writing in her journal. The journal was created as we had not had more time to focus on processing her thoughts and feelings due to her having to terminate therapy suddenly and unexpectedly.

As I fetched Linda from the waiting area, she was not her usual happy self. As we entered the office and sat down, I followed up on how she was doing as a result of not seeing each other for one month. She stated the following:

I’m feeling much better because I’m not that sad anymore and I don’t cry as much as I used to. I’m a bit sad though that we are leaving because we started to form a bond with aunty (Susan) and she looked after us well. I’ll always be grateful. I’m also a bit sad about leaving school because I made friends there. But I’m also excited that I’m going to be with my other family members as well, and my cousins because they are all part of my mother’s family. I feel okay about living with my aunt, my mother’s twin sister although I get sad when I look at her because she looks just like my mother, but it’s fine, at least I know that I will be with family.

Grief psycho-education was provided to Linda, explaining that grief was a life-long process and that there may be times in her life when she feels better and other times when she feels sad about losing her mother. She was able to understand this by stating “I know that I will always miss her and I’ll never forget her.” Despite the added secondary losses and her feelings of sadness related to these losses, she is however content at just being surrounded by her siblings and her mother’s family, throughout the therapy process, it had been evident that
this was important to her, as she valued being with her mother’s family. As we created the journal, I processed Linda’s feelings regarding how she felt about the session being our last, to which she responded:

I’m sad that today is our last session because I learned a lot in therapy. By speaking to you, I was able to accept that my mother has passed on and I am not very emotional anymore. When I look at the stars and the moon, I know that my mother is guarding and protecting us. I know that she is very proud of us. I still forgive my father for what he has done because I want peace in my heart. I know that he deserves to be punished for what he did, but at the same time, I feel sorry for him because I see on tv what happens to people in jail. When I see him one day, I want to give him a bible and photos of all of us, as memories. What he did has brought a lot of pain, not only to us, but to the family and to the community. The community wanted to kill him because they all liked my mother very much. She had a very big funeral, almost the whole community attended, people were very sad. When I die one day, I also want people to remember me like that and have a big funeral. I also want people to say what a good person I was. I want to be like her and be remembered like her. She raised us and taught us very well. She is going to be missed. I will always think about her.

Linda’s feelings of sadness were processed; regarding the termination of therapy. The positive memories she preserved of her mother and her wanting to be like her mother were embraced in the session, and it was evident that this made Linda happy. Her feelings of empathy towards her father were also processed. Despite all the pain and suffering he had caused them, Linda was still willing to forgive him and to maintain a relationship with him. Linda was encouraged to create a memory box or book of all the things that reminded her about her mother and to keep these as momentos.
At the end of the session, Linda got up off her chair and hugged me tightly. She whispered: “I don’t want to let go, I wish that I did not have to leave. Thank you for being there for me and helping me.” Together we processed her feelings, and I explained to her that although it was a sad day, I was proud of her for how well she had progressed in therapy and for being a brave girl. As we departed, Linda thanked me for the journal as she held onto it tightly. She stated “I’m going to write down my feelings in my journal, as you taught me and I am always going to remember you when I look at it and how you’ve helped me.”

Conclusion

This chapter introduced the client, Linda. It included the biographical information, developmental history as well as Linda’s background information. This was followed by the reason for referral. Finally the seven therapy sessions were described in detail. In the following chapter the results of the study will be discussed.
CHAPTER SEVEN
FINDINGS AND DISCUSSION

“Everyone copes differently, some cry for the loss of a loved one; others smile because they
know they’ll see them again.”

Author unknown

Introduction

The results of this study are presented in this chapter. The seven therapy sessions were
contextualized utilizing the theoretical frameworks of Cohen and Mannarino’s theory on
Childhood Traumatic Grief and Cohen, Mannarino and Deblinger’s Trauma-Focused
Cognitive Behavioural Therapy (TF-CBT) model. The results are presented according to the
TF-CBT components which were applied in therapy. Certain TF-CBT components were
applied, as therapy was short-term, thus only those relevant to addressing Linda’s needs were
applied. The following emerged from the therapeutic process.

Psycho-education

Psycho-education was provided to Linda and continued throughout the therapy process, in
order to normalise her responses and cognitions to the traumatic event. PTSD symptoms
associated with CTG may include recurrent upsetting and intrusive thoughts or dreams of the
traumatic event that led to the loved one’s death or even a sense of the event re-occurring
(Pynoos, 1992). Additionally, children may also experience sleep difficulties, loss of interest
in peer and other social activities, and trouble concentrating (Cohen & Mannarino, 2004). At
the beginning of therapy, Linda reported the following PTSD symptoms which she had
experienced immediately following the traumatic event: upsetting and intrusive thoughts of
the traumatic event, fear, helplessness, overpowering auditory and visual sensory
experiences, shock and sleep difficulties. However, she stated that “I no longer feel scared”
and that she no longer experienced sleep difficulties. Although she had experienced difficulty
concentrating at school, she had been practising thought stopping on her own, prior to beginning therapy, and stated that this technique allowed her to focus on her schoolwork instead of intrusive thoughts of the traumatic event. Psycho-education assisted in educating Linda that these were normal responses to a traumatic event. Research indicates that many children react to traumatic events with resilience, and develop no or few PTSD symptoms, while other children develop only temporary PTSD symptoms which remit suddenly over several weeks (Cohen & Mannarino, 2004).

**Relaxation and Breathing**

Linda was introduced to relaxation and breathing techniques, to practice at times when she experienced emotional tension or difficulty falling asleep at night as well as if she experienced disturbing thoughts related to the traumatic event. She was able to practice these techniques successfully in therapy and reported that she had been practicing outside of therapy when she felt slightly overwhelmed thinking about the traumatic event, and reported that “It helps to calm me down.”

**Affective Expression**

Linda displayed maturity regarding her emotional development and awareness. At the beginning of therapy, when Linda was asked how she felt about attending therapy, she replied “I’m happy because I have not been able to talk to anyone about the way I am feeling.” Affective expression allowed Linda to be able to identify and express her feelings. She was able to describe painful and confusing feelings associated with the pain that her father had caused her and her siblings by stating “I’d like to ask him whether he ever thought that what he did was going to cause so much pain and how he could take our mother away from us.”

She also expressed anger towards her father and stated that she had lost all trust in him for what he had done. However, despite feeling this way towards him, she made a decision to forgive him as she stated “I still don’t know why and how my father could have done
something like this, but I’ve decided to forgive him in order for me to have peace in my heart and to live a happy life.” Linda felt that this was the right thing to do, instead of harbouring resentment towards her father. Making this decision had significantly influenced her ability to adapt to her life-altering circumstances and to move past the trauma. According to Radford and Hester (2006), resilient children take a proactive rather than a passive approach to problem solving. This means that they tend to take charge of their life situations and are also able to interpret their experiences in positive and constructive ways, even when those experiences are negative or painful (Radford & Hester, 2006). Although Linda was also able to express empathy towards him, by indicating that “We all make mistakes”, and that she felt sorry for him as she had seen on television what had happened to people in jail, she did not however condone his behaviour and had the ability to understand and express that he deserved to be punished for what he did. Although she did not share a close relationship with him, she still felt it in her heart to reassure him that he had children who loved him. Thus she was willing to still maintain a relationship with her father. Research has indicated that individual characteristics such as intelligence, communication skills, the ability to show empathy for others, and positive self-esteem, enhance children’s ability to thrive in difficult circumstances (Baldwin et al., 1990; Carver, 1998; Howard et al., 1999)

The Colour Your Life exercise assisted Linda in identifying her feelings before, during and after the traumatic event by associating colours with her feelings. She had the ability to understand and associate the colour black to express that “I chose black because I was in a dark place” following her mother’s death. She was also able to identify and express that choosing the colour blue indicated “I no longer feel like I am in a dark place” and that “Red is the colour of love and happiness, and I am now feeling better and happy.” Thus Linda was able to associate colours to her feelings during the traumatic event and how she felt at present. The use of the sandtray further assisted Linda in expressing her feelings and
emotions. The image that she had created in her sandtray depicted that of a happy home environment, thus indicating her grief for the loss of her family and her yearning for a happy family. At the end of the therapy process, she was able to state that: “I’m feeling much better because I’m not that sad anymore and I don’t cry as much as I used to.” Linda was also able to understand the purpose of the journal by stating “I’m going to write down my feelings in my journal, as you taught me and I am always going to remember you when I look at it and how you’ve helped me.” Linda’s paintings and drawing further provided mediums for her to express herself as they were symbolic of her feelings and emotions related to the losses she had experienced.

**Cognitive Coping and Processing**

Linda displayed maturity in her cognitive processing and reasoning abilities. Cognitive coping was introduced to Linda to challenge and correct her cognitions that were inaccurate or unhelpful. An unhelpful cognition that she had experienced was her feeling of guilt for not being able to rescue her mother. Cohen, Mannarino, Greenberg, Padlo and Shipley (2002) state that following a traumatic death, children may experience survivor guilt and may unrealistically blame themselves for not being able to rescue their deceased loved one. Therefore, by explaining the cognitive triangle to her, she was able to understand that this negative thought, led to negative feelings of guilt, which resulted in blame for her mother no longer being alive. She realised that she need not feel guilty as there was nothing that she was able to do in that situation as she too was fearful for her own life and took comfort in realising that at least her brother had tried. Linda had practised thought stopping on her own prior to beginning therapy, thus this technique was reinforced and encouraged for her to practice at times when she experienced negative intrusive thoughts of the traumatic event.
Trauma Narrative

The trauma narrative allowed Linda to tell her story. In CTG, trauma reminders, loss reminders, and change reminders may trigger memories, thoughts, and images of the traumatic nature of the loved one’s death and may be accompanied by physiological symptoms of hyper-arousal. Thus the distress that children experience on exposure to these reminders may lead them to try to avoid such exposure in order to minimise stress (Cohen & Mannarino, 2004). Linda, however, did not avoid speaking either about the traumatic event or about her mother’s death and told bits of her story in each session. This gradually desensitised her thoughts and reminders of the traumatic aspects of her mother’s death and decreased her avoidance of the horrifying aspects of the death. Through repetition from session to session, she was able to add more painful aspects to her narrative until she became more comfortable in talking and thinking about the totality of her experience. Linda was able to discuss the ‘worst moments’ in her narrative, associated with the disturbing auditory sensory experience of being able to tell the difference from when her father was using the axe and the saw. Also, the visual sensory experiences of the large amount of blood in the house and being exposed to her mother’s body parts scattered in a hole outside the house. Telling her story was important for her as she stated: “Thank you for allowing me to tell my story, I’m sorry that I spoke so much, but I’ve never had the chance to talk about what happened.” Thus, the trauma narrative assisted her in cognitively processing the traumatic event and being able to identify her feelings related to the event and the loss of her mother. The therapeutic space allowed her to feel safe and comfortable in sharing her story. Furthermore, the therapist modelling competent coping and not becoming emotionally distraught or fearful, reassured Linda that hearing her story was not unbearable.
**Grief Psycho-education**

At the beginning of therapy, Linda expressed that she cried a lot when she thought about her mother as she missed her a lot. Bibliotherapy assisted in educating her about death and normalised her responses to her mother’s death. Particularly her feelings of numbness, shaking, decreased appetite, sleep difficulties, hopelessness and thoughts of wanting to die. She explained that she had experienced these symptoms immediately after her mother’s death, but no longer did. According to Cohen and Mannarino (2004), children with CTG may experience less interest in normal activities, a feeling of emotional distance or detachment from others, or a sense of a foreshortened future. Linda was able to engage in normal activities and was praised by Susan for being domesticated and fulfilling house chores. Linda did not feel estranged or disconnected from others, on the contrary, she embraced the relationship she shared with her siblings and did not want to be detached from them as she stated “I’m grateful to still have them because at least I still have a family.” She displayed hope by referring to her goals for the future.

**Grieving the Loss**

CTG has been described as “a condition in which children get stuck on the traumatic aspects of their loved one’s death which impinges on their ability to progress through typical grief processes” (Cohen et al., 2002, p.24; Layne et al., 2001). Although Linda was initially stuck on the traumatic aspects of her mother’s death, she was able to grieve the loss of her mother throughout the therapy process. According to Cohen and Mannarino (2004), grief is the intense emotion and pain that one feels following the death of a loved one (Cohen & Mannarino, 2004). Linda was able to express the emotional distress she experienced by stating “I didn’t know that when someone close to you dies, it is so painful. It really is painful. I think a lot about her and miss her a lot.” She was also able to grieve the loss of the relationship she shared with her mother by stating “We were close, I was my mother’s child.”
I’m going to miss her a lot”. Although Linda stated that she did not share a close relationship with her father, she was able to express that she missed him a lot as well. She grieved the loss of her family as a unit, although she was grateful to still have her siblings. The painting she created with her and her siblings in the centre holding a red heart stating “Love Your Family” and both parents on either side, demonstrated her grief for the loss of her family.

Linda further grieved the secondary losses she encountered when relocating, such as changing schools, and the loss of her friendships. According to Cohen and Mannarino (2004), after the death of a family member, children may experience secondary adversities such as the loss of the family’s home, and if the family has to relocate, children may also be required to change schools and be faced with the loss of close friends, a new peer group, and a completely unfamiliar social support system (Cohen & Mannarino, 2004). These adjustments can be extremely stressful even in the absence of losing a loved one but are added burdens after a family member has died. Despite experiencing these losses and the associated stressors, Linda was however able to adapt well to her new home environment and was able to adjust well to her new school environment, form new friendships and also develop a relationship with Susan.

**Preserving Positive Memories of the Deceased**

According to Cohen and Mannarino (2011), when children with CTG begin to remember their loved one, their memories tend to trigger thoughts of the horrific manner in which the person died. When this process occurs, children begin to avoid reminiscing about the loved one which may lead them to avoid any reminders about the deceased because of the tendency of these reminders to stimulate painful trauma memories. Linda, however, was able to speak fondly of her mother by preserving positive memories of her. She was able to reminisce about her and speak about her without avoidance. She often expressed in therapy that she was a “Good, loving person.” According to Brewer and Sparkes (2008), as children grow,
memories that are nurtured and cherished will enable them to build and maintain a secure attachment to a dead parent and, which in turn will enhance their resilience. Furthermore, a key resilience building-block is the capacity to talk about the person who has died in a way that brings comfort and worth to the relationship (Brewer & Sparkes, 2008). Linda adopted a nurturing role, specifically towards her sister. This may have been influenced by her trying to model her mother’s behaviour and wanting her mother to be proud of her, which could have been related to the close relationship they had shared. Thus, further allowing her to maintain a secure relationship to her mother.

After a death, children are confronted with the reality of going forward with their lives without their loved one. Wolfelt (1996) describes this process as reconciliation. Wolfelt (1996) and Worden (1996), have identified a number of tasks as significant in the reconciliation process, including accepting the reality of the loss; fully experiencing the emotional distress of the loss; adjusting to one’s environment and sense of self without the loved one; finding meaning in the loved one’s death; and becoming engaged with other adults who can provide ongoing comfort, security, and nurturance. These tasks require children to tolerate continued thoughts about the deceased loved one and their relationship with the deceased and to face and bear the pain associated with their loss (Wolfelt, 1996; Worden, 1996). Although Linda had expressed emotional distress toward the loss of her mother, she was however able to accept the reality of her mother’s death as she mentioned during the termination session: “Thank you for helping me accept that she’s gone.” “When I look at the stars and the moon, I know she’s in a safe place, looking down on us and protecting us.” “I will always think of her and miss her. I know that I will see my mother again someday when I go to heaven.” Bowlby (1969), in his work on separation and attachment, writes that a child can resolve loss successfully if the child shared a reasonably secure relationship with the parent before the loss. Linda had also found meaning in her mother’s death by aspiring to be
a like her and idealised her by stating “As I grow up, I also want to be a good person like my mother. When I die, I also want people to remember me like that.” “I’m the type of person who likes to make others grow.” According to Cohen, Mannarino and Knudsen (2004), integrating positive aspects of the deceased into one’s own self-identity is a key task of reconciliation.

According to Anderson and Alexander (2005), resilient children are good-natured and easy to deal with and as a result, they gain people’s positive attention. These children usually establish a close bond with one caregiver during infancy and early childhood. Linda was also able to adjust to a new environment without her mother and was able to form a relationship with Susan who provided comfort and nurturance. Therefore, she was able to reach reconciliation.

**Redefining the Relationship with the Deceased and Committing to Present**

**Relationships**

This component is an important step in enhancing a child’s adaptive functioning. Family is very important to Linda. She expressed gratitude at still having her siblings with her as this reassured her that she still had a family. She was able to commit to new relationships and valued the relationship she shared with Susan by stating “I’m grateful to her for taking care of us, I appreciate that she is trying her best to be like a mother to us.” Linda did not have any objections to relocating to live with her maternal aunt. Although she stated that she experienced sadness when she looked at her maternal aunt, she however expressed gratitude towards being able to live with her as it meant that she would still have the opportunity to be connected to her mother’s family. Living with her mother’s family enabled her to still have a secure attachment to her mother as well. According to Brooks and Goldstein (2001), children who are bereaved of a parent generally tend to experience a better outcome when they: have resilient personalities, shared a secure attachment and positive relationship with the deceased,
maintain a healthy connection to the dead parent, and engage well with siblings and caregivers. Thus, committing to these relationships appeared to enhance Linda’s adaptive functioning.

Linda was able to master the tasks of trauma and grief outside of therapy on her own, without much intervention and within a short period of time. Thus therapy facilitated this process for her. Mannarino and Cohen (2011), state that children’s ability to comprehend death and master the tasks of trauma and grief, partially depends on their cognitive and emotional development.

Linda did not speak much about the domestic violence, except that she always felt sorry for her mother when her father would abuse her. According to the Child Welfare Information Gateway (2009), children’s risk levels and reactions to domestic violence exist on a continuum where some children demonstrate enormous resilience while others show signs of significant maladaptive adjustment. However, protective factors such as intelligence, high self-esteem, strong sibling and peer relationships, and a supportive relationship with an adult, can help protect children from the adverse effects of exposure to domestic violence (Child Welfare Information Gateway, 2009). Thus, sharing a close relationship with her siblings as well as with her mother, in conjunction with her personal characteristics, may have fostered her resilience towards the negative effects of the domestic violence.

According to Stokes (2009), resilient children possess qualities and ways of viewing themselves and the world that are not apparent in children who have not been successful in meeting difficult challenges. Furthermore, a resilient mind-set requires children to have hope for the future as well as to have the capacity to trust others and risk forming secure attachments. Above all, children will need to find a way of creating an overall meaning for life that allows future growth.
Conclusion

In this chapter, the results of the study were discussed according to the TF-CBT model components which were applied during the therapeutic process. The conclusion, limitations and recommendations of the study are discussed in the following chapter.
CHAPTER EIGHT

CONCLUSION, LIMITATIONS AND RECOMMENDATIONS

“Every end is a new beginning.”

Proverb

Introduction

In this chapter, the final chapter of the study, a summary of Linda’s progress is presented followed by the limitations of the study. Finally, recommendations for future research are outlined.

Conclusions Arising from the Research

South Africa is a violent society and children are exposed to significant trauma in a variety of contexts, not least of which is domestic violence. This could result in negative outcomes for these children, however not all children experience negative outcomes and some demonstrate remarkable resilience. This was evident in Linda’s case as she displayed resilience in coming to terms with the trauma she had experienced of witnessing her father murder her mother. Linda was able to overcome her feelings of fear related to the traumatic event, which she had previously experienced. She displayed maturity regarding her emotional development and awareness and was therefore able to identify and express her feelings and emotions related to the aftermath of the trauma as well as the significant losses in her life. Linda’s ability to speak about the traumatic event, allowed her to gradually become desensitised to the thoughts and reminders of the trauma until she became comfortable enough to speak about the totality of her experience. Although she was initially stuck on the traumatic aspects of her mother’s death, she was however able to grieve her loss throughout the therapy process and accept the reality of her mother’s death. Furthermore, she was able to speak fondly of her mother by preserving positive memories of her and was able to reminisce about her without avoidance. Significant progress was made by Linda during the course of
her seven therapy sessions. She was able to ‘bounce back’ from her traumatic experience and learned to adapt to a new life and new circumstances within a very short period of time. She was able to master the tasks of trauma and grief. Thus the finding that emerged from the study was the resilience that Linda displayed in relation to her adaptive functioning following the traumatic event. Factors that fostered her resilience were her resilient personality, the strong secure attachment relationship she shared with her mother as well as her decision to forgive her father in order to have peace in her heart and to move on with her life. Furthermore, having her siblings with her and being able to form relationships with her mother’s family further fostered her resilience. Therefore Linda’s story turned from one of tragedy to one of hope.

**Limitations**

As a result of transport difficulties, Linda was often unable to attend weekly scheduled therapy sessions and therefore missed a number of sessions. Therefore, as a result of time limitations, not all TF-CBT components could be applied in therapy. Furthermore, the unexpected news about Linda relocating to a different town resulted in the sudden termination of the therapy process.

**Recommendations**

In South Africa, children are faced with ongoing violence and exposure to trauma on a daily basis within the home as well as within their communities. A recommendation for future research might be to explore what fosters resilience in traumatised children that allows them to adapt to life circumstances immediately following a trauma, within the South African context.
Conclusion

The aim of the study was to describe an 11-year-old child’s journey through traumatic grief after the violent death of her mother. The researcher is of the opinion that the aim of the study was accomplished.
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APPENDIX A

Diagnostic Criteria for Posttraumatic Stress Disorder

**Note:** The following criteria apply to adults, adolescents, and children older than 6 years. For children 6 years and younger, see corresponding criteria below.

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
   1. Directly experiencing the traumatic event(s).
   2. Witnessing, in person, the event(s) as it occurred to others.
   3. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
   4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains; police officers repeatedly exposed to details of child abuse).

**Note:** Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work related.

B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
   1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).

**Note:** In children older than 6 years, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.

   2. Recurrent distressing dreams in which the content and/or effect of the dream are related to the traumatic event(s).

**Note:** In children, there may be frightening dreams without recognisable content.
3. Dissociative reactions (e.g. flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)

**Note:** In children, trauma-specific re-enactment may occur in play.

4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event(s).

5. Marked physiological reactions to internal or external cues that symbolise or resemble an aspect of the traumatic event(s).

C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

2. Avoidance of or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs).

2. Persistent or exaggerated negative beliefs or expectations about oneself, others, or the world (e.g. “I am bad,” “No one can be trusted,” “The world is completely dangerous,” “My whole nervous system is permanently ruined”).
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.

4. Persistent negative emotional state (e.g. fear, horror, anger, guilt, or shame).

5. Markedly diminished interest or participation in significant activities.

6. Feelings of detachment or estrangement from others.

7. Persistent inability to experience positive emotions (e.g. inability to experience happiness, satisfaction, or loving feelings).

E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behaviour and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.

2. Reckless or self-destructive behaviour.

3. Hypervigilance.

4. Exaggerated startle response.

5. Problems with concentration.

6. Sleep disturbance (e.g. difficulty falling or staying asleep or restless sleep).

F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.
Specify whether:

**With dissociative symptoms:** The individual’s symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalisation:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one’s mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).

2. **Derealisation:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

**Note:** To use this subtype, the dissociative symptoms must not be attributable to physiological effects of a substance (e.g., blackouts, behaviour during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

Specify if:

**With delayed expression:** If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

(APA, 2013)
What is Relaxation?

Relaxation is about feeling calm and peaceful. After upsetting/confusing events happen, we often feel tense, jumpy, and worried. We feel better when we learn to relax our bodies and minds. Many kids have trouble calming down or falling asleep at night. If this ever happens to you, practice this activity at home.

Lie down or sit comfortably somewhere quiet and cozy (your bed, a couch). Breathe in slowly and out even more slowly. Close your eyes and imagine you are floating on a soft, fluffy cloud. You feel very safe on your cloud. Your whole body feels very relaxed and heavy. Notice your feet. Your feet feel very relaxed. Your feet feel so heavy that it would be hard to lift them if you tried. Now notice your legs. Your legs feel very relaxed. Your legs feel so comfortable all snuggled into your cloud. That nice, warm, relaxed feeling is slowly moving up your body, filling it with peace. Notice your stomach. It feels very calm and filled with nice warmth. Now be aware of your chest. Your chest feels relaxed as it moves up and down slowly with each breath. Notice your neck and shoulders. They feel so relaxed and heavy. Feel the backs of your shoulders touching the cloud below you, sinking in gently. Feel how relaxed your head is right now. It feels very warm, pleasant, and heavy. Your head and face are very relaxed. Your mouth and eyes are free of stress. Allow your thoughts to come and go without worrying about anything. Everything is okay, and you are feeling very calm and good. Enjoy the warm, calming feeling as it travels all around your body, filling you with peace and relaxation (Cohen, Mannarino & Deblinger, 2006).
APPENDIX C

Belly Breathing

Sometimes when we are upset, we forget to breathe! Or we take short, shallow breaths that don’t give our bodies the oxygen we need. To help ourselves feel relaxed and calm, we can practice belly breathing. Belly breathing is when you breathe in slowly and deeply (counting to 5 in your head) as your belly and lungs fill up with air (you can watch your belly stick out as you breathe in!). Then you let the air out, EVEN SLOWER (count to 6) and watch your belly go back in as the air is slowly pushed out. Pay attention to the air as it moves in and out of your body as you count (Cohen, Mannarino & Deblinger, 2006).