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Supporting children with traumatic grief: What educators need to know

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Abstract
Following traumatic deaths children may develop Childhood Traumatic Grief (CTG), a condition in which trauma symptoms interfere with adaptive child grieving. Educators have an important role in supporting children who have CTG. Key contributions that educators can make are to (a) recognize CTG symptoms in school settings; (b) refer children for mental health evaluations when appropriate; (c) recognize reminders that trigger trauma symptoms and identify ways to manage these triggers and responses in school settings; (d) support CTG treatments in school by reinforcing children's use of stress-management strategies; (e) respect confidentiality; (f) recognize the importance of cultural issues in CTG; and (g) maintain good communication with parents and other helping professionals.

Keywords
adolescents, bereavement, childhood traumatic grief, children, educators, evidence-based treatment schools, trauma

Many children experience the death of a parent, sibling or other important person during childhood. Most children are able to negotiate the grieving process without lasting scars. However, some children experience the traumatic death of a parent, sibling, or other loved one, and develop a condition known as Childhood Traumatic Grief (CTG), in which trauma symptoms

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impinge on children's optimal adaptive grieving process. These children often benefit from trauma-focused treatment in which they learn skills to regulate feelings, thoughts and behaviors, and receive assistance in mastering the most upsetting aspects of the traumatic death (Heath, Nickerson, Annandale, Kemple, & Dean, 2009).

Educators are critical sources of support to children who receive trauma-focused treatment for CTG. This article describes a variety of ways that educators can provide collaborative support to such children during the healing process.

The adaptive child grieving process

Children grieve deeply. Grief is an ongoing process that does not have a statute of limitations. Children do not 'get over' their grief but like adults, learn to live with and adapt to the loss of a parent, sibling, or other loved one. Adaptive childhood grief includes the following characteristics: (a) children are able to experience the deep pain associated with losing someone they loved; (b) older children are able to understand the permanency of death. Very young children may repeatedly ask when the person is coming back and need to be reminded that the person is dead and is not able to return; (c) children are able to tolerate memories of the deceased person, and to remember the totality of the person, not only good things. Children often find comfort in talking or thinking about the deceased person; (d) over time the relationship changes from one in which children see, speak to, and do things with the person on a regular basis to one of memory—that is, one in which children can only talk to the person in their thoughts or mind; (e) children are able to slowly commit themselves to new relationships, even though the person who died cannot be replaced; (f) children move ahead in a healthy developmental trajectory instead of getting stuck at a certain developmental level or regressing to a previous level (Wolfelt, 1996; Worden, 1996).

Most children will display these characteristics after a relatively brief period of time. However, it is critical to stress that adaptive grieving is very individual. Even children who experience adaptive grief grieve in their own time frame, in their own individual ways, and often return to previous points in this process at different times, with intermittent periods of great sadness and pain even after many months of seeming to be 'back to normal'. Since grief is so individual, adults should not expect children to follow a preconceived time frame for grieving nor expect them to 'get over' grief within a certain period of time. Children who do not show the above characteristics may be experiencing a different condition, CTG.

Recognizing childhood traumatic grief in school settings

Childhood traumatic grief arises after a death that a child experiences as traumatic (i.e. one that causes intense fear, helplessness, or horror; American Psychiatric Association [APA], 2000, p. 463). It is important that professionals understand that CTG can occur not only after deaths that adults judge to be

traumatic (e.g. a shooting or disaster-related death) but also may occur after deaths that adults may have anticipated (e.g. those from chronic illness) or deaths that adults may view as 'sad but normal' (e.g. an elderly relative who lived a long life). For example, CTG may occur if the child did not believe the person was going to die, if the child witnessed the deceased person suffer before death, and/or if the child saw, heard, or smelled gory death-related details. CTG is currently defined as the interference or impingement of trauma symptoms on the above tasks of childhood bereavement (Cohen & Mannarino, 2004). Typical trauma symptoms include the following:

With *re-experiencing*, the child has frightening or otherwise distressing memories. These memories include thoughts or dreams of the person, how the person died, and with younger children, scary thoughts or dreams that may seem unrelated to the death. These memories and fears may interfere with the child's ability or desire to remember happy times with the deceased person. At other times the child may seem perfectly normal. The child may become very angry, upset, or physically ill when faced with trauma, loss, or change reminders (including idiosyncratic ones), described below. At school these symptoms may look like daydreaming, not paying attention, or seeming distracted due to having intrusive thoughts about the death or the deceased person.

With *avoidance*, the child attempts to avoid memories of the deceased person, even happy memories, because these may segue into thoughts about the traumatic nature of the person's death. This may lead to the child not wanting to celebrate holidays that remind him or her of the person; not wanting to visit the cemetery; not wanting the family to reminisce about the person; and becoming angry when other family members or peers derive comfort or happiness from such activities. In a school classroom this may take the form of withdrawing from activities (e.g. not wanting to engage in holiday, birthday or other celebratory activities, not wanting to talk about certain topics), getting angry or changing the subject when certain subjects are raised. These topics may have little apparent relationship to the deceased or the way the person died and it may take some detective work on the teacher's part to make a connection.

With *hyperarousal*, the child may have difficulty sleeping, increased anger, physical symptoms or increased jumpiness, e.g. in response to loud noises. Again, these symptoms may be interspersed with periods of the child seeming perfectly normal. At school hyperarousal may take the form of frequent headaches, stomachaches, asking to go to the nurse's office, decreased ability to concentrate or pay attention, or angry outbursts.

With *emotional, behavioral de-regulation, or maladaptive cognitions*, the child may have trouble modulating feelings and/or behaviors, especially when reminded of the death or the person who died. For example, children may have new fears or more difficulty with anger, be more irritable, moody, bored, inattentive, or seem to 'go from zero to sixty' in terms of escalating emotional and behavioral outbursts. The child may also make statements of

self-blame or of omen formation prior to the traumatic death. For example, 'I should have known my mother would get killed' or 'I should have warned my brother not to walk home from school that way', etc. These changes may be readily apparent in school or may only occur outside of class.

With *learning problems,* the child may have trouble with concentration, memory, comprehension, paying attention in class, and/or or falling asleep in class. Any of these or other changes that significantly and negatively impact school performance and learning over an extended period of time may be signs of childhood trauma and warrant a psychological evaluation to determine the need for educational support (Individuals with Disabilities Education Act, IDEA-2004).

Referring children for mental health evaluations

Educators will recognize that many of the above symptoms (e.g. behavior problems; anger; somatic symptoms; learning problems) are commonly displayed in the classroom by children who have not experienced the death of an important person. This presents several challenges to teachers who are trying to understand the cause of these problems and how to address them. For example, how can teachers know whether or not the problems are related to a recent death? How long after a death should such symptoms be attributed to the death rather than typical behavioral problems? Regardless of their origin, how should educators manage such children when these behaviors become highly disruptive?

These are legitimate concerns, and highlight the need to refer children who present with any of the above trauma symptoms—even if they appear to be 'garden variety' behavior problems—to a school counselor or to a school psychologist for a mental health evaluation. More than two-thirds of American children have experienced trauma exposure (Copeland, Keeler, Angold, & Costello, 2007); a significant proportion of these children have symptoms of Post-traumatic Stress Disorder (PTSD) or other trauma symptoms that are rarely recognized or treated. It is highly likely that several children in each classroom have undetected trauma symptoms that educators are treating as routine behavioral or learning problems. Death of a significant person accounts for a substantial number of PTSD cases (Copeland et al., 2007). Left untreated, PTSD is associated with potentially long lasting and serious psychological and medical problems.

Educators may be the first and only adult to recognize children's significant PTSD symptoms. Thus it is important for teachers to consult with school-based mental health professionals regarding children's symptoms. Teachers may also alert parents about the child's specific behaviors and invite the parent to make an appointment with schools professionals to consider the need for supportive school-based counseling. Taking these precautions may prevent serious long term problems for these children. Recognizing that trauma may be causing

these problems is a critical first step that educators can take towards addressing these problems.

Recognizing and managing trauma, loss and change reminders

Trauma symptoms can be triggered by the presence of three types of reminders or cues. These cues include (a) trauma reminders; (b) loss reminders; and (c) change reminders [www.nctsn.org].

Trauma reminders are cues that remind the child of the traumatic death itself, for example, if the person died in a car accident, trauma reminders might be cars, sirens, or loud noises. It is important to remember that trauma reminders are idiosyncratic to the individual child and situation. For example, one child whose mother died in a car accident became extremely upset when her teacher sang the child's favorite song in school. It turned out that the child's mother sang this song right before leaving for work: Mother was subsequently hit by a drunk driver on her way to the bus stop and never returned home. Unbeknownst to the teacher, this song was the child's last memory of her mother, and the child associated this song with her mother's traumatic death.

Loss reminders are cues that remind the child of the person who died, for example, pictures of the deceased person, discussions about the person, or even family members. These too may be idiosyncratic to the individual child and situation. For example, one child suddenly withdrew from her favorite male teacher who resembled her favorite uncle, recently deceased. Both men had a beard and red hair. Another child whose father died in the military became very upset during a certain class because the classroom directly overlooked the cemetery in which his father was buried. The teacher refused to make accommodations because she thought he should 'be over' his father's death.

Change reminders are cues that remind the child of how the death has changed the child's or family's living situation. For example, the death of a mother may change the family's child care dynamics, resulting in the family moving close to nurturing grandparents, the child changing schools and losing contact with friends. Another example, a previously stay-at-home parent may now have to work. For example, one child seemed to be coping very well with her father's death until the day she began attending a new school the following September (necessitated by the loss of the family's home after the death). She broke down sobbing during the first day of class and told the guidance counselor that she wanted to die so she could be with her father and not have to deal with all the stress. For this child the change reminder of starting a new school triggered the onset of her symptoms.

In a school setting, educators may provide support in a variety of ways: They can (a) increase their awareness of the potential for these different types of loss and change reminders to trigger trauma symptoms; (b) collaborate with school-based mental health professionals to identify potential

reminders; (c) if feasible, develop a plan to remove reminders (e.g. the teacher in the first scenario would not sing the song that triggers the child's traumatic memories); and (d) if not feasible to remove the reminders (e.g. the cemetery will remain across the street from the boy's school), develop a plan with the child, parent, and mental health professional, identifying strategies to strengthen the child's adaptive coping skills, helping them function in the presence of loss and change reminders. Educators should carefully consider mental health professionals' recommendations and the needs of other students in the class. Be aware that it may take several weeks for children to develop the ability to cope with painful or frightening reminders. Be patient and do not expect this to occur overnight.

CTG treatment: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)

Several related treatment models have been developed and evaluated for CTG or traumatic death (e.g. diverse causes of CTG, Cohen, Mannarion, & Knudsen, 2004; Cohen, Mannarino, & Staron, 2006; survivors of war, Layne et al., 2008; survivors of suicide, Pfeffer, Jaing, Kakuma, Hwang, & Metsch, 2002; survivors of violent death, Salloum, 2004). A prototypical CTG treatment is Trauma-Focused Cognitive Behavioral Therapy (TF-CBT [www.musc.edu/tfcbt; www.musc/edu/ctg], Cohen, Mannarino, & Deblinger, 2006). This model has been used for children who were traumatically bereaved by a variety of causes, including terrorism, disasters, community and domestic violence, suicide, accidents, medical causes, and military deaths (Cohen et al., 2004, 2006) and has also been used cross-culturally (Murray, 2006). TF-CBT includes the following features.

Gradual exposure is incorporated throughout all of the TF-CBT components. This means that children are gradually assisted in mastering the frightening aspects of the death by incorporating discussion of some aspects of death, dying, and/or the manner of death into each session, but doing so very slowly and carefully calibrating the child's ability to tolerate such discussion.

Resilience-building stress management skills are included at the beginning of TF-CBT treatment to help children re-regulate feelings, behaviors and thoughts related to the traumatic death. Parents learn effective behavior management skills similar to those used by effective teachers such as the use of praise, positive attention and positive incentives for desired behaviors, encouragement, and selective attention (i.e. not attending to undesired behaviors). Relaxation skills such as focused breathing, the use of recreation, and muscle relaxation are taught to children and parents and practiced between treatment sessions in order to help children reverse physical manifestations of stress.

Affective expression skills encourage children and parents to accurately label and express different feelings without judgement of 'negative' feeling states. Instead of discouraging children's affective expression with such statements as 'don't feel sad', 'don't cry', encouragement of affective expression gives the message that it's okay to express these feelings in appropriate ways. Children often feel better after sharing their feelings with a caring friend or adult (Balk, Zaengle, & Corr, 2011). *Affect modulation skills* help children and parents to regulate difficult feeling states through strategies such as seeking support, negotiating, using humor, positive thinking, faith (Jerome, 2011), patience, and problem solving.

Cognitive coping skills help children and parents to understand connections among thoughts, feelings, and behaviors, and to examine whether negative feelings are caused by thoughts that are inaccurate or unhelpful. If this is the case, children are helped to replace these thoughts with more accurate and/or more helpful thoughts.

Trauma-specific interventions include developing a trauma narrative of the person's traumatic death and cognitive processing of maladaptive cognitions related to the death; in vivo mastery of trauma reminders; and enhancing safety and future development related to the death. The trauma narrative is started after the child and parent have gained some mastery over using resilience-building skills described above, since the child may need to rely on these skills when talking directly about details describing the important person's traumatic death. This narrative is typically developed in the form of a written book, a poem, a series of pictures, a song, or other creative effort in which the child shares the story with the parent. After cognitive processing, and if necessary, addressing feared reminders through in vivo exposure (*directly confronting the feared reminders*), safety issues are addressed (for example if the deceased person died through community or domestic violence, or through suicide, safety issues may be especially important to address with the child and parent).

Grief focused interventions help the child begin a more adaptive grieving process. These interventions include learning about death and grief; grieving what has been lost through the death ('what I miss'); addressing ambivalent feelings about the deceased person that may not have been resolved prior to the death ('what I don't miss'); preserving positive memories; redefining the relationship from one of interaction to one of memory; committing to new relationships; and planning for future reminders and loss issues.

Supporting CTG treatments in school settings

Educators can support children who are receiving TF-CBT or other CTG treatments by helping them to implement resilience-building stress management skills in school settings. Educational professionals can particularly reinforce the use of relaxation, affective modulation and cognitive coping skills, since

these are skills that children use to manage physiological, behavioral, affective and cognitive dysregulation, respectively.

Teachers, school psychologists, guidance counselors, and other educational professionals can implement and support relaxation, affective and cognitive coping skills in school settings. It is critically important to work as a *team*, in close collaboration with the child, child's parent, school psychologist, and community-based therapist. This will assure that school personnel are providing interventions that coincide with what therapists and parents are providing in therapy and home, respectively, rather than confusing children with potentially contradictory strategies or messages. The following descriptions provide examples of how educators might support CTG treatment in classroom settings.

Example 1: Supporting relaxation skills

Maria is an 11-year-old girl whose 13-year-old brother died in a car accident in which her mother was seriously injured. Maria was fearful during school, had trouble concentrating and complained of stomach aches, prompting her to ask to go to the nurse's office and from there, to go home to mother. This was occurring on an almost daily basis. Maria and mother were receiving TF-CBT at school. The school psychologist and mother met with Maria and her teacher to discuss a plan for how to manage Maria's stomach aches and fearfulness in class so that she would not need to go to the nurse's office and miss additional school. Maria agreed to use the following relaxation strategies when her stomach started to hurt: deep breathing (inhale slowly and deeply, then exhale slowly); visualizing the ocean and butterflies (two comforting images selected by Maria); signaling the teacher if the first two strategies did not work, she would give the teacher a discrete signal (putting her hair into a pony tail) and the teacher would come to Maria's desk and help her take some deep relaxing breaths.

Maria's teacher practiced these strategies with Maria and her school psychologist (Ms Rachel). Maria reported that these strategies helped her feel safe and comfortable with her teacher. The following week Maria tried the outlined strategies but had some difficulty initiating relaxation. Her teacher came to Maria's desk and helped Maria take some relaxing breaths. However, Maria was still anxious and asked to go to the nurse's office. To give Maria individualized attention, the teacher directed the class to work on an assignment at their desks.

As the students started the assignment, the teacher knelt down next to Maria's desk and quietly said to Maria, 'I know we can do this if we try just one more time' (*use of positive thinking; encouragement*). 'I would like you to try to do that visualization exercise that I saw you do with Ms Rachel. You are so good at doing that' (*use of praise*). 'Can you draw a butterfly or the ocean for me, just like you did for Ms Rachel? If you can do that

for me I would like to put your picture up on the wall right next to my desk' (*use of positive incentive*). 'Won't you try for me? I would love to see the picture you draw while you are doing your relaxation now' (*use of positive attention*). Maria smiled and drew the picture. Demonstrating the effectiveness of the teacher's support, Maria was able to stay in the classroom for the rest of the class period.

Example 2: Supporting affective expression and modulation skills

Billy is a 7-year-old boy whose infant brother died of natural causes two months previously. Billy is having angry outbursts in school since his brother's death. He is pulling girls' hair and fighting during recess. When another child's parent brought a baby sibling to school Billy became very agitated and tried to kick the child's mother saying, 'Get him out of here right now!'

Recognizing Billy's traumatic grief, the teacher consulted with the school psychologist, then shared concerns with the parents. With a private therapist Billy started treatment for CTG. In counseling sessions Billy started talking about his feelings. With the parent's consent, the school psychologist and therapist discussed strategies for supporting Billy in the classroom. They suggested to Billy's teacher that it would be helpful to encourage Billy to talk about feelings in class as well.

When another child told the class that her dog died, Billy's teacher used this as an opportunity to talk about death. She initiated a class discussion, saying 'It is very hard when animals or people die. I have had people in my family die and I had all kinds of different feelings' (normalizing a variety of feelings). 'Kids may have lots of different feelings when this happens. Would you children like to help me make a list on the blackboard of different feelings that kids have when an animal or a person that they love dies?'

The child whose dog died said she felt 'sad' and the teacher wrote 'sad' on the board. Another child volunteered that she felt 'scared'. Other children suggested a few additional feelings. Billy then said that he felt 'mad, really mad'. The teacher said, 'I'm so glad that you said that, Billy, because lots of kids feel really mad when someone they love dies' (normalizing; encouraging expression of 'bad' feelings). Billy smiled, obviously pleased with his teacher's supportive comment.

Later, Billy came up to his teacher and said that his brother died and that he was really mad. His teacher thanked him for talking to her about that and said that she was very sorry about his brother (expressing empathy). She told him that she hoped he would come and talk to her about this whenever he wanted to (inviting future affect expression; providing social support). Again, evidencing the positive impact of teacher's supportive strategies, Billy had fewer angry outbursts in class. The teacher also felt an increased confidence in saying and reacting in ways recommended by the therapist and school psychologist. When the school psychologist checked in with the teacher a few

days later, the teacher gave a positive report. When Billy's angry outbursts occurred, the teacher felt confident in her ability to respond in a manner that supported Billy's grief.

Example 3: Supporting cognitive coping skills

Thomas is a 15-year-old whose father completed suicide six months after returning from two deployments in Iraq. To the school's knowledge, no other students in Thomas' school have military parents. Prior to the suicide, the school was not aware that Thomas' father served with the National Guard or that he had been deployed. His father's military background and the cause of his death have been sensationalized in the newspapers and Thomas has been embarrassed and ashamed about how his father died. Many teachers and other school personnel seem uncomfortable talking about it as well. School personnel are unsure about how to respond to peers' rude comments (e.g. 'Your old man took the lead pipe'). Thomas has become increasingly withdrawn and disinterested in his school work. He is receiving TF-CBT at a community mental health center. The school psychologist obtained parental permission to speak with the therapist and learned that Thomas struggled with guilt, blaming himself for not preventing his father's suicide.

Ms Johnston, the school psychologist, arranged a staff in-service to share information with school personnel regarding causes underlying military suicide and how to support survivors. She requested information from the National Military Family Association [www.nmfa.org] and the Tragedy Assistance Program for Survivors [www.taps.org]. Both organizations provided information and one provided a speaker for the presentation.

The in-service was very well attended. After this presentation the school staff felt much better prepared to support Thomas and effectively respond to students' inappropriate comments. As part of their training the faculty learned the importance of providing teen suicide preventive education and made plans to prepare classroom discussions on this topic. Following the inservice, the faculty decided to plan classroom discussions on teen suicide prevention and invited Thomas to participate in planning, if he was comfortable doing so (*acknowledge; inquire*).

Ms Johnston met with Thomas and told him about the faculty's recent in-service on two important topics, military suicide and teen suicide prevention. Thomas was surprised to hear that the school was interested in these topics and wanted to include him in planning classroom discussions. He agreed to help prepare material with the school psychologist but was uncertain about attending his classroom's discussion. Ms Johnston said it was his choice, but she hoped he would attend because he was an expert on suicide's impact on survivors. Thomas asked, 'You mean, what it's like not to stop it in time?'. Ms Johnston replied, 'How could you have possibly stopped it? Did your father tell you that he planned to kill himself?'. Thomas replied, 'Of course not'.

Ms Johnston then stated, 'Well, unless you're a mind reader I don't know how you could have known what he was planning' (*support of accurate cognitions*). Thomas said, 'That's what my therapist says. I just think I should have known. He was my dad. We were close. How could I not have known?'. Ms Johnston said, 'I'm sure you wish more than anything you could have known. You really loved your dad. I wish he hadn't made this decision too' (*accurate empathy; reinforce a helpful cognition*). Thomas said, 'I do wish that'. Ms Johnston said, 'It's so hard to accept that what others do isn't in our power. But I'm sure your father wouldn't have done this if he had been thinking clearly. He must have been very depressed and his thoughts were greatly affected by that depression. I hope you can hold on to how much you loved each other' (*support accurate and helpful cognitions*). Thomas asked if Ms Johnston really believed this. She said that she did. Thomas thanked her for talking to him and seemed relieved to be able to talk with someone at school about his father. Rather than avoiding the uncomfortable topic of suicide, other teachers and school staff also told Thomas how sorry they were about his father's death. They also noted appreciation for his father's service in defending their country.

Additionally, teachers intervened when peers made inappropriate remarks, redirecting their focus to supportive comments and empathizing with the difficulty of Thomas' situation. This resulted in Thomas feeling much more supported at school. He decided to attend and participate in the planned classroom discussions. Afterwards several peers thanked him for helping them understand the experience of suicide from a survivor's perspective. His therapist called the school psychologist to thank her for talking to Thomas and organizing school support. The therapist said that these school-based efforts marked an important turning point for Thomas' therapy.

The importance of confidentiality

The above sections support the importance of open collaboration with parents, therapists, school psychologists, and teachers. These cases emphasize the importance of key stakeholders having access to certain aspects of children's confidential health information such as the death of an important person, how the person died, and maintaining an open link of communication with mental health professionals. Unfortunately, many students and parents do not want educators to have access to this type of information. Unlike mental health and medical providers, educators may not understand the laws and regulations guiding how and when children's or family's personal information should be shared. Although families and professionals outside the school system typically expect this information to be kept strictly confidential, unless they give specific permission to share it, it is not uncommon for educators to share such information with other school staff. In particular, without careful consideration of who will learn about the student's confidential information,

teachers may overlook the legal and ethical aspects of confidentiality. Unfortunately, if this personal information is included in permanent educational records, unbeknownst to the parent, this information may follow the child through high school. Although educators may have good intentions when sharing such information, violations of privacy jeopardize family trust in school personnel and negatively impact the educator's ability to help the child.

In order to prevent this from happening, educators should treat every piece of information as if it is completely confidential (i.e. as the teacher would wish his or her own child's information to be treated). Unless the teacher has written consent from the parents to include a specific piece of information in the child's educational record, he or she should not do so. If the teacher does not have permission to share specific information with others in the school, the teacher should not do so. This is the best way to build confidence and enhance trust between the teacher and the parent or child. The only exception to these guidelines would be if the student is a danger to self or others. In these situations confidentiality is overridden by the teacher's responsibility to notify parents and the school's principal (Williams, Armistead, & Jacob, 2008, p. 33). Child protective services may also need to be notified if the child or others' safety is in jeopardy.

Cultural issues

The mourning rituals associated with grief are implicitly connected to culture and family. In order to optimally support children and families after a death, particularly a traumatic death, it is important for educators to understand the family's culture. Just because an educator knows that the family is from a certain cultural or ethnic group, does not assure an understanding of the family's personal culture, cultural values, or how the family integrates those cultural values around mourning rituals and bereavement (Jerome, 2011). There may be complete alignment, some connection, or a complete lack of connection among the child's, the parents', and the broader community's cultural values. Additionally, each individual family member's level of acculturation must be considered. Family members vary in the level to which their dominant culture impacts personal beliefs and expressions of grief. Educators must consider the degree to which students and parents have retained a separate cultural identity, language and rituals, and to what degree these beliefs and traditions are integrated into mourning the death of an important person.

Given the growing diversity of American culture it is not feasible for educators to be familiar with all cultures represented by their students. Even if this were possible, because each family has their own unique culture it is critical for educators to learn about each child's and family's culture anew. Become a student: Ask for the family's assistance in educating school professionals. The student and family are the experts about their own cultural practices and mourning rituals. By asking the family for information, professionals not only learn about diverse cultural practices, they also open the door to understanding and trust.

Table 1. Resources for Educators Supporting Students' Traumatic Grief

It's OK to remember: Understanding childhood traumatic grief (35 minute video)
Retrieved from http://www.nctsn.org/nctsn_assets/acp/ctg/nctsnnew3.htm
Presents general information: overviews causes, consequences, and treatment of CTG.

National Child Traumatic Stress Network Child Traumatic Grief Committee. (2009). Coping with unconfirmed death: Tips for caregivers of children and teens. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress. Retrieved from http://www.nctsn.org/nctsn_assets/pdfs/Coping_with_Unconfirmed_Death.pdf
Four page handout offers tips for caregivers to support children coping with trauma of an unconfirmed death, includes one page of additional resources.

National Child Traumatic Stress Network. (2008). Traumatic grief in military children: Information for educators. Los Angeles, CA & Durham, NC: National Center for Child Traumatic Stress. Retrieved from http://www.nctsn.org/nctsn_assets/pdfs/military_grief_educators.pdf
Resource for educators taken from NCTSN Traumatic Grief in Military Children Information Series (2008); Twelve page booklet listing student's traumatic grief responses, how to create a supportive school environment (peer-to-peer, classroom, and school), and additional support including information on organizations, internet sites, & community-based resources.

Childhood Traumatic Grief Educational Materials for School Personnel. (2004).
http://www.nctsn.org/nctsn_assets/pdfs/reports/schools_package.pdf
Twelve page NCTSN booklet adapted specifically for schools, provides information on children's traumatic grief & PTSD; last two pages provide a summary of basic essential information.

Childhood Traumatic Grief Educational Materials for Parents. (2004).
English (15 pages): http://www.nctsn.org/nctsn_assets/pdfs/reports/parents_package1-15-04.pdf
Spanish (20 pages): http://www.nctsn.org/nctsn_assets/pdfs/edu_materials/GriefSpanishComplete.pdf
Information adapted specifically for parents, NCTSN booklet provides information on children's traumatic grief and PTSD. Last two pages of booklet (last three pages of Spanish version) provide summary of basic essential information.

The Dougy Center for Grieving Children and Families. (n.d.). *When death impacts your school*. Portland, OR: Author. Retrieved from http://www.dougy.org/grief-resources/death-impacts-your-school/
Information geared for adults (teachers and school administrators). Identifies basics of what to say and how to support grieving students.

Maintaining communication with parents and professionals

It should go without saying that in order to achieve the above goals it is crucial to maintain open and optimal communication with parents and caregivers; teachers; school-based mental health professionals; and when appropriate, community-based mental health therapists. Additionally, the school's principal should be advised of collaborative arrangements and accommodations to assist the impacted student. This should be done within the limits of confidentiality as previously described.

Prior to securing parental consent for open communication, school personnel and mental health professionals should explain the benefits and parameters of confidential communication with the child's community-based therapist and other participating professionals. This open dialogue will often help parents agree to such communication and will increase their confidence in supporting the child across settings. For example, the teacher, school psychologist, and parent might discuss the steps described in this article for supporting children struggling with CTG, extending the discussion to include how these strategies might be implemented in collaboration with the child's therapist and parent. If the parent asks the teacher to participate without direct teacher-therapist communication, the school psychologist might be involved to assist the teacher in implementing stress management skills in collaboration with the child and parent. If this is helpful for the child in the classroom setting, the parent may agree to continued communication between educators and the student's community-based therapist.

Summary

Educators can provide critical support for children impacted by CTG. Educators can help children cope with the traumatic death of a loved one by recognizing and referring children with CTG, helping children cope with traumatic reminders, supporting CTG therapy in classroom settings, maintaining confidentiality, understanding the importance of culture and family beliefs, and maintaining communication with parents and professionals. Additional resources for educators are listed in Table 1.

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