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Children of Trauma and Loss: Their Treatment in Group Psychotherapy

JANIS L. KEYSER
KATHY SEELAUS
GLORIA BATKIN KAHN

Jason's father routinely comes home drunk and beats up his mother. The last time, he used kitchen knives to threaten her. Many times during the day now, when Jason's mother goes to look for him, she finds her 5-year-old lying under his bed, eyes wide open.

David's mother does not take him to visit his father in jail. His mother tells him that his father doesn't want to see him. She also tells him he's worthless like his father. David broke two chairs in fourth grade last week by throwing them against the wall.

Nine-year-old Kia's parents are divorced. Kia and her little brother, 4, were formerly living with their mother, who takes drugs. Some nights she wouldn't come home at all, leaving the children by themselves. Her father hadn't shown up for visits for a while, and his whereabouts are currently unknown. Now they have been placed in foster care. Kia, usually well behaved and a good student, has just cut up her favorite poetry book.

A year ago, when Michael was 6, he was a passenger in the car his mother was driving. An accident ensued, and his mother was killed. He is now living with his grandmother, and nobody talks about his

mother's death. They "shush" him when he mentions her name. Michael refuses to eat because his tummy hurts; his head hurts, too.

WHAT IS TRAUMA FOR CHILDREN?

Something powerful and hurtful has occurred in the lives of the children described above. Their normal development has been impaired by traumatic events, and there is a real risk of their situations' remaining unchanged or deteriorating unless some intervention occurs.

In our consideration of the nature of trauma in the lives of children as opposed to trauma in the life of adults, one reality is apparent and of the utmost concern: Children are *still growing*, and they need to put their attention and energy into the developmental tasks of growing. This is hard to do at best. When a "curve ball" occurs in a young life, the growing process receives an assault, and development is arrested unless some therapeutic intervention occurs. Something needs to be done.

What is traumatic for children? A basic working definition of "trauma" for children is any experience or event that threatens a child's sense of safety and security to such an extent that it is perceived by the child to be unmanageable. There is a continuum from extreme trauma, "distinctly unusual and deemed abnormal" (Apfel & Simon, 1996, p. 6) in quality and requiring intense intervention, to relatively uncomplicated grief, which by its nature may require minimal intervention in order for satisfactory recovery to occur. A trauma may be acute or chronic. Although all trauma inherently includes a multitude of losses, not all loss is traumatic. In the case of children, though, it is harder to maintain a distinction between trauma and loss. For instance, a child's loss of a parent—whether to death, incarceration, substance misuse, or mental illness—is a traumatic loss.

Some children's view of the world is one of "reasonable stability and sanity," while others may in fact live in a world that in their view is always "predictably violent and cruel" (Apfel & Simon, 1996, p. 6). A trauma creates a sensation of overwhelming arousal, to which children are particularly susceptible. They take in and record the blunt, raw impact of the experience (Young, 1996). Research has indicated that traumatic experiences in childhood can alter brain development and chemistry in such a way that learning and concentration are affected (DeBellis, 1999). With their coping skills and sense of who they are still in the process of development, they end up feeling frighteningly helpless and out of control. They can feel as though their world has been cracked open and turned upside down. Over time, there is a strenuous struggle to make sense of their experiences, to search for meaning or meanings (Garbarino & Kostelny, 1996; Webb, 1991). In the process, there is often a battle with the contradiction between feeling powerless and feeling that the traumatic events were their fault. The

self-blame, and the shame that accompanies it, are hard for a child to speak of.

There are many disruptive happenings in the lives of children: poverty, illness, parental drug/alcohol addiction, parental incarceration, or death of a family member. These things are not just aspects of the inner-city environment; they are the "monsters" of the suburbs as well. When further significant traumatic experiences are added to the mix—for instance, murder, separation from family, AIDS, a mass disaster (e.g., the Oklahoma City bombing), or a natural disaster (e.g., a hurricane)—children's sense of the world's order and safety may be shattered (Garbarino & Kostelny, 1996). The boundaries around their safe haven are destroyed as the world becomes much bigger and more fearful. Their response to this crisis is often played out in destructive or violent acting out of the craziness of their inner turmoil, for lack of any other sense of how to handle it (Wolfelt, 1996).

CHILDREN'S RESPONSES TO TRAUMA

For children as well as for adults, grief is a normal reaction to loss. Grief reactions are evident in even very young children as responses to separation from their mothers (Bowlby, 1960). Even when a loss is temporary, a child can respond with intense distress. Webb (1993, pp. 8–10) makes a distinction between "grief" and "mourning," with mourning being dependent upon an understanding of the permanence and irreversibility of the loss. Although young children may be unable to understand these concepts, they experience the grief process, which is accompanied by many thoughts, feelings, and behaviors (Wolfelt, 1983).

Grief is undeniably psychologically, socially, behaviorally, and physically challenging, but it may or may not be traumatic, depending on the circumstances. A traumatic reaction may be experienced after a loss that is sudden, unexpected, and/or violent, or after a loss that disrupts a child's whole life, such as the death of a parent. For children as compared to adults, there is a greater overlap between grief and traumatic loss reactions. A loss that may cause a grief reaction in an adult may precipitate a more profound traumatic reaction in a child. When, just as children are developing a capacity to understand the world, that world is turned upside down by a loss, they can be left feeling threatened, anxious, helpless, guilty, dissociated, and distrustful (Rando, 1993).

Webb (1991) notes six factors that play a part in a child's reaction and that should be part of the assessment process after a child has been through a crisis: age and developmental factors; precrisis adjustment; coping style and ego adjustment; past experience with crisis; Global Assessment of Functioning score (Axis V of the DSM diagnostic system); and the specific

meaning of the crisis to the child. This concept of meaning is of particular interest. Janoff-Bulman (1985, 1992) has studied the assault upon the assumptive world that comes with grief and trauma. She emphasizes the differences in this assumptive world for a child versus an adult: The child is more open to new input and more able to accommodate new stimuli. Janoff-Bulman adds that this capacity is a two-edged sword, allowing for both psychological protection and destruction.

While growing up, a child has to have an idealistic understanding of his or her world. Children who have dealt with trauma in the past or who are dealing with ongoing trauma have been robbed of their innocence prematurely. Their suffering has shown them that life is not easy or fair—that it has not conformed to the ideal they had hoped for or that they see their peers still holding as valid. For a while, they cling to and yearn for the lost assumptive world to be restored and for their cherished ideals to be reinstated.

The work of processing grief or trauma can be interrupted by current needs and happenings in a child's life; conversely, psychological development can be interrupted by grief and trauma. A disruption or derailment during a critical period of development results in a more rocky path for the resolution of that particular period of growth. Certain tragedies, such as a child's own life-threatening illness or that of a loved one, can lead to much earlier refinement of death- and trauma-related concepts.

Children can demonstrate amazing resilience, even in the face of trauma, if the key element of social support from significant adults in their environment is in place. A fundamental requirement for the healthy growth of children is the presence of loving, caring adults who are there on a consistent basis for them. Children, due to their dependence, are particularly reliant upon family resources (i.e., parents or guardians) and their extended support network (e.g., teachers, club leaders, members of the clergy) for help and guidance, especially after a traumatic event. In a classic study of children during the London Blitz of World War II (Freud & Dann, 1951), it was demonstrated that children who stayed with their parents in the bombed area fared better than those who were moved to a safe area but separated from their parents. The nurturing that parental presence provided was invaluable in reducing the impact of the traumatic events. The value of a child's healthy attachment to adults in the family and in the extended support network when a traumatic event occurs is to "reframe and transform the event" (Janoff-Bulman, 1992, p. 86)—to help the child obtain a perspective on it that makes it less overwhelming to the child's inner schema, and/or to help the child do the work of revising his or her inner world to obtain a degree of resolution.

In the event that an adult who would have filled this role is missing (due to death, substance abuse, incarceration, etc.), other adults must become reliable sources of support and caring. Many adults, however, are not prepared for this role. When these important people react with panic and despair in response to the child's need, the child's adaptation may be com-

promised (Garbarino & Kostelny, 1996). In addition, a whole different set of implications results when children are the recipients of "victimization by the very people who are looked to for protection and safety" (Janoff-Bulman, 1992, p. 86). A more hopeful view of this subject comes from studies by Young-Eisendrath (1996), who suggests that in some cases it may take one particular adult in an at-risk child's life to precipitate a turn toward resilience. A counselor, a teacher, or other adult may fill this role by providing valuable mentoring for even a short duration of time. The way in which such an adult is present to the child in offering guidance and support can help the child summon up the strength he or she needs to move through challenging situations.

THE ROLE OF GROUP THERAPY FOR TRAUMATIZED CHILDREN

The group therapy experience provides a setting in which a child's psychic and developmental wounds can receive some healing. Family members are often unable to deal with the trauma constructively, and they give either direct or indirect cues that talking about the painful event is unacceptable. Thus the wounds continue to fester and development is blocked. The group offers a model for the restoration of an ideal—a caring "family" consisting of empathic adults and other children who are accepting and understanding. This "family group" creates for the children a caring circle of people who will walk with them through the suffering, allowing them to verbalize the stories of their experiences.

Children's Response to Group Therapy

Therapeutic support in the group setting can be as helpful for children as for adults facing trauma. Most children find groups to be a natural environment in which to play, grow, and express their physicality. In the Freud and Dann (1951) study of children during the London Blitz, it was found that some of the children who were separated from their parents spontaneously developed a peer group that provided some of the nurturing they needed. Unfortunately, there is a paucity of literature on the subject of group therapy with traumatized children.

Short-Term Trauma-Focused Groups

Children who have experienced trauma benefit from belonging to short-term groups focused on their specific trauma. Children's communication styles and patterns are different from those of adults. Pynoos and Nader (1988) have observed that school-age children often do not make direct statements about their emotional status, so that it is easy to underestimate the strength of their

feelings. Since these children may not typically look to words for expression of fears, the therapist uses the children's play, artistic expression, and peer encounters in the group as clues to their inner thoughts, feelings, and fantasies. Schamess (1993) notes, "A capacity for and an interest in verbalizing feelings should be viewed as a desired outcome of treatment, rather than as a prerequisite for participation" (p. 565). He adds,

> Trauma-focused groups work because their psychoeducational structure contains anxiety and reduces the likelihood of regression and decompensation, even in the face of highly stimulating material. Those groups are effective in ameliorating particular aspects of the pain and the dysfunction caused by repeated trauma, and they help prevent retraumatization. (p. 561)

Healing in the Telling of Children's Stories

When children get the opportunity to tell their stories in the group, they can share as much or as little as they choose. They are telling these stories to others within whom there is a place in which the stories can resonate, because these "others" are their peers who have also been traumatized. Each child not only is validated by peers (e.g., "Yeah, I thought I was going crazy, too, when that happened to me"), but gets the chance to hear his or her own story spoken aloud. Paradoxically, by hearing themselves in the company of listening peers, who are being compassionate toward their own experience—validating its reality and the accompanying feelings, thoughts, and sensations—the children also become more objective about it, slowly gaining distance from it. They move beyond that first horror of being helpless children in an out-of-control world, to being bearers of stories, narrators in the midst of peers. This also gives the children the beginning of a sense of control: They determine when and how much they will tell of their tales. They can choose a *Reader's Digest* version, compressed and edited to meet their needs, or they can take one aspect and explore it more fully. They learn over time in the supportive atmosphere of the group that, as Fred Rogers (1979) of public television's *Mister Rogers' Neighborhood* has said, what is mentionable can be manageable. The restoration of self-esteem and mastery is an important outcome.

The therapist starts by accepting that each child's initial story (though it may include many fantasies and misconceptions, from the helper's point of view) is the child's reality at the moment. At least it is where he or she is willing to begin, and a place from which the full story can unfold. Over time, with the help of the therapist and peers, fantasies and misconceptions can begin to fall away. Within the safety of the group, the child begins to process the nuggets within the story—to get to the heart of the trauma and its assault upon the child's world.

For children this process has a different flavor than for adults, in that

it can be a huge breakthrough for children even to know they have stories to tell. Children, putting their entire beings into who they are, may not distinguish their experiences from the core of who they are. For example, if they feel shameful about elements of their traumatic events, their shame can become the reality that they accept without question. They may not reason or rationalize any differently, and consequently may not gain any distance from the events to examine them more objectively. Their propensity toward magical thinking, in which they believe the power of their thoughts and wishes can cause things to happen, may further reinforce their feeling. When they share in the group or hear other children share a similar feeling, their view of themselves as the sole containers of that feeling can crack, if even just a little—enough to let in the light of day. That is a start. A connection is made to another; a link is forged; identification with the group has begun. Healing becomes a possibility.

Often children may have the opportunity to reenact their stories in the group. For instance, the therapist's use of group activities to help the children identify bodily states of anger or fear may allow a child to demonstrate how he or she reacted when angry or afraid as a result of the traumatic event. At other times, certain triggers may spontaneously lift to awareness particular feelings or events related to the trauma, offering an impromptu opportunity for a child to play out his or her story in the group. The therapist's guidance in identifying and naming of this reenactment process can help it to be a safe experience for the child. With the support of the group, positive changes and adaptations can be learned.

Through attention to children's stories, they can be reassured that they are not alone and will not be left alone in their grief and trauma. As others are compassionate toward the children, they can learn to be compassionate toward themselves. As the children receive support, they can begin to give support to others. These empowering interactions help the children begin to trust once again, in what has otherwise become a scary world. In the group, the meaning of and the feelings connected to the trauma are recognized on many levels. Thus addressing the trauma within the group creates a curative experience.

The Development of Children's Groups

Grounding in group development theory is necessary for the successful facilitation of a group for traumatized children through its many vicissitudes. It is essential for the therapist to have a model to use as a lens through which to view group process, and to keep in mind that group development theories are based on research with groups of adults. They are not specific to children's groups, nor are they specific to children's traumatic loss groups. Still, they can be helpful in informing the therapist's work with groups of children.

The view that we find particularly useful in working with children's

groups is Johnson and Johnson's (1987) life cycle model. This model builds upon Tuckman's (1965) linear-progressive theory. Tuckman's scheme includes (1) "forming" a group through a stage of testing and dependence; (2) "storming" through intragroup conflict and emotional expression; (3) "norming," through which cohesion and commitment is built in the group; and (4) "performing" the group task. In applying Tuckman's model to cooperative learning groups, Johnson and Johnson propose a seven-stage model that includes a terminal phase; they liken the period of a group's existence to a life cycle that includes decline and death. Groups, including those with children, can move rapidly through the first five stages, which are (1) defining and structuring procedures and becoming oriented; (2) conforming to procedures and getting acquainted; (3) recognizing mutuality and building trust; (4) rebelling and differentiating; and (5) committing to and taking ownership for the goals, procedures, and other members. The next stage is (6) functioning maturely and productively. The group may remain in this stage for a number of sessions. The last phase is (7) terminating. The termination phase acknowledges the finiteness of the group and the feelings of separation and loss that can accompany its ending. In a group designed to help children deal with traumatic loss, attention to how this termination phase is handled is particularly important. The more cohesive the group has become, the stronger the emotional attachments will have become. It can be painful to leave the security of the "ideal family" that the group has become for the children over many weeks. Through the therapist's skill and intentionality, this stage provides important learning for the children. It can offer some sense of closure, which may not be possible in regard to many of the losses with which they are dealing.

Through attention to group processes and roles, the therapist can encourage children to stretch into new, positive, healing behaviors. Children may demonstrate a natural proclivity toward certain roles in groups, and the therapist may need to actively "run interference" to a child's repeated enactment of certain roles to the exclusion of others. The therapist may also need to work toward keeping a balance so that no one member contains a particular function or emotion for the entire group, and so that children have the freedom to try on roles that they haven't played before. For instance, a previous harmonizer can be guided to take the risk of being a gatekeeper or an opinion giver. If a child tends to enact the role of parent in the group, the therapist may encourage him or her to try the role of follower or information seeker. Behavioral disruptions in the group can result from a child's denial of his or her pain. Those who bully others, who get the group to laugh at their antics through their clowning, or who hold out from participating by sulking or clinging are children who cannot easily let themselves go on a path of discovery that they know will be painful. Depending on the developmental level of the group, children may or may not benefit from the therapist's attempt to interpret these maladaptive roles to

them. For latency-age and younger children, it is often more effective for the therapist to maintain enough structure in the group that the roles do not have a negative impact upon the group process. Through attention to group process and roles, the therapist can prevent scapegoating, subgrouping, and other potential problems that can proliferate in groupings of children.

In addition, a knowledge of children's developmental stages is important. For example, Piaget's stages of development are helpful. However, as Webb (1993) notes, research on children's conceptualizations of death suggest that children may have a realistic perception of the finality and irreversibility of death at age 9 or 10, which is earlier than would be suggested by Piaget's stage of formal-operational thought. It is important for the therapist to be mindful of individual differences among children in their conceptualizations of death and trauma.

The ways in which successful groups for children are run may vary as a function of the children's age. The value of group psychotherapy for traumatic loss has been demonstrated for preschoolers through adolescents, though each age level brings its own challenges. Preschoolers are less verbal and tend to focus greatly on play materials and activities. Progress is rather slow, and much patience is required on the part of the therapist, but an important grounding in terms of trust building and familiarity can be established for future group and individual work. Groups for latency-age children require the therapist to develop structured plans and utilize varied materials for projects and crafts, honoring their proclivity toward concrete thinking. Groups for preadolescents and adolescents require the therapist to work with resistance issues that come from a more defended stance toward group participation.

In establishing a group, the therapist has to consider many factors. These include demographic issues, such as potential differences between the needs of inner-city children and those of children from suburban neighborhoods. Whether the group is held in a neighborhood school, a local hospital, a psychology clinic, or another location in the community can influence children's participation and perceptions about the group. Consideration should also be given to the duration of the group (i.e., time-limited or ongoing). Younger children can benefit from a shorter series of time-limited groups, with the potential opportunity to participate in a future series, whereas teens may benefit from ongoing groups over months or years.

The Therapist: Role and Person

In order to understand how the group serves to deliver a curative effect, we must first look at the therapist. The therapist is the pivotal person in creating the environment for healing to occur. The therapist needs to have attributes that make him or her, in a way, the ideal parent. These attributes

include a genuine love for children and a recognition and respect for their unique personhood, as well as the ability to give and receive affectionate responses. The therapist must be able to tolerate frustration, chaos, and aggression, while possessing his or her own sense of wonder at and hope for the world, even when children's assumptions about it have been shattered. The therapist must understand what it means to play, and must cherish the qualities of joy, creativity, and curiosity that accompany play, while also being able to assert limits. In embracing these contradictions, the therapist becomes the ideal and protecting parent—providing unconditional acceptance of each child, though not always accepting as constructive the ways in which the symptoms of the child's traumatization are acted out in the world. That the children in the group come to depend on the therapist is a healthy and appropriate development, given that they *are* children; this makes such a group different from an adult psychotherapy group (Siepker, Lewis, & Kandaras, 1985).

It is important for the therapist to have the clinical training to pace the therapy to meet each child's needs and to start from the place where the child is. The therapist needs to understand a child's tempo, particularly a traumatized child's tempo. Often these children are highly defended, withdrawn, or hostile; they need time to settle into the group and to trust that this is in reality a safe and a consistently caring place. The therapist needs to be a patient person who can give each child the time to begin to trust and let down the barriers.

Group work with traumatized and bereaved children requires particular openness to the examination of the therapist's own processes, including coming face to face with his or her own childhood experiences of trauma and grief (Schamess, Streider, & Connors, 1997). In fact, without this examination, the therapist's effectiveness is likely to be limited. The children's stories and personalities will inevitably stir feelings within the therapist. It is important to understand this so that the therapist does not "react" out of his or her own needs and feelings. It is essential for the therapist to know him- or herself as much as possible before beginning this challenging work with groups of traumatized children; then it is necessary to remain continually alert to the countertransference reactions that may arise. It is helpful for the therapist to have a cotherapist and/or supervision to help keep a perspective on the process.

A CLINICAL EXAMPLE

The Context and Setting

There is no better way to make real the concepts of group practice that we have been discussing than to illustrate them with an extended clinical example. We give an overview of the 6-week life of a children's traumatic loss

group, in order to convey the reality of the experience both for the children and for the group therapists. In pursuing this approach, we identify specific guidelines for the cotherapists and share with the reader their path—sometimes discouraging, and sometimes richly gratifying. It is important to note that not all goes well even for experienced practitioners, who realize that any group represents many unknowns, and who are excited and challenged by that fact. In working with groups of children, our knowledge gained has been great; our progress has often been moderate; and our hopes remain firm.

The group we describe here included seven children, aged 7–9, who had each experienced one or more traumatic losses (e.g., incarceration of a parent, the witnessing of the murder of a sibling, movement among multiple foster homes, or death of a close family member). The sessions were conducted after school in the school library.

The Therapists

The two therapists who led the group brought both similarities and differences to the group experience. One therapist had been the bereavement coordinator at a children's hospital in the city, and in that role had dealt with hundreds of bereaved family members over many years. The other therapist had begun grief work unexpectedly, working with families who had lost an infant to sudden infant death syndrome; she then went on to work with child and adult survivors of trauma (especially homicide), and from there to work with children who had experienced any severe kind of loss. Both therapists felt qualified by experience and supervision for this particular activity; more importantly, they had a personal commitment to the work, especially in this neighborhood, which was known to both of them as bleak and often fearful for children. They had each, however, experienced the hidden richness of survival qualities in these families, and they longed for the community to be able to "turn a corner" and see the possibility of change. In addition, they each genuinely loved children and enjoyed them. Both were mothers; indeed, they were mothers who each had suffered the loss of a child. They had known the heartbreak of untoward death many years ago, and had come to hold in high regard everything about the process of grief work.

Factors Considered in Setting Up the Group

Previous experience led the therapists to recognize certain factors that were very important to consider in setting up the group. These included attention to the selection of group members and the degree of traumatic loss suffered, as well as the recency of each child's loss and its relevancy to the child; the meeting time and setting of the session; and the inclusion of refreshments.

Selection of the Children

Careful screening of the children was of utmost importance. The children needed to be selected most specifically on the basis of a very common trauma, which for this group was bereavement. The therapists decided that the traumatic loss must be recent and/or must still be causing a child significant pain. For example, a child whose grandparent had died several years ago would not be appropriate for the group if he or she were not in current distress. Although there might be some residual feelings of loss, the child might easily be distracted into playing that strayed away from the group task. The therapists would not exclude those children whose suffering resulted in extreme behavioral problems, because they believed that the need of these children was possibly greater. They would either deal with a child's difficult behavior in the group or invite that child to meet with one of the therapists separately from the group.

The Meeting Place and Time

The therapists knew that the group needed to be held at the conclusion of the school day and planned as one of the after-school clubs. During a school day, norms exist that are counterproductive to the purpose of a traumatic loss group. A child in school is programmed to adhere to a "get it right" approach; this is different from the approach needed in trauma-related grief work, where the only "skills" required are openness and acceptance of all feelings, as well as a consistent, respectful availability. Placement of group sessions in the middle of the school day does not allow children to integrate the experience fully, as they may be required to shift gears rapidly to adjust to the demands of the next class, and this leaves them no place to go with affect. Schedules can also be disrupted by fire drills and other demands. In addition, it is more obvious that the children are involved in a "different" activity from that of their classmates.

Finally, the meetings of a children's traumatic loss group need to take place in a space that allows a warm setting for circle time and conversation. A typical classroom is not ideal for these purposes. The school library was chosen for this particular group, since meeting in the library allowed ample space for movement, play, and writing activities.

Refreshments

For children, the inclusion of food in a group experience is a necessity (Schleidlinger, 1982). Food is of great importance to children, and in groups it is a time-honored initiator of talk. As Rachman (1995) mentions, providing refreshments is seen as an integral part of a group therapy program, regardless of members' age, sex, education, or socioeconomic status,

or of the therapeutic setting. Schleidlinger (1982) states, "In work with latency age children the group climate needs to be planfully structured toward constancy, nurturing, and feeding" (p. 138), and he includes actual feeding in the form of a snack or even a full-fledged meal. He adds, "The actual experiencing of gratification in this approach is most valuable" (p. 138). In this group, as the children came in for each session, they were greeted with a spread of refreshments consisting of juice, fruit, and pretzels at the low children's library table. The therapists soon also came to realize how valuable it was for some children to be associated with the preparation of the food, no matter how simple their tasks were. On succeeding weeks, young faces shone as the children were asked to wash grapes or count pretzels. And as the weeks progressed, the insides of the children began to shine as well.

Development of the Group

In early October, a flyer from the principal went home with each child at the local inner-city elementary school (which included kindergarten through fifth grade), inviting parents and guardians to consider their children's participation in a children's grief support group, to meet once a week for an hour for 6 weeks. The group would meet immediately after school, and was meant to be helpful to those children who had experienced a recent loss of a loved one due to death or separation and were in distress (of whatever kind) because of that loss. When the tear-off responses came in, there were 12 potential group members who fit the specific criteria of recent experience of loss of a loved one due to death or separation. Of these 12, 7 children attended regularly throughout the sessions, with no dropouts. Five others who had been selected and signed up didn't attend because of either reluctance on a child's part or transportation difficulties.

At the beginning, the children came in one by one; some of them were quiet, others were nonchalant, but all of them were somewhat tentative. As they gathered into a circle on the rug for beginning conversation, the children found a variety of comfortable positions. All of the children were in a mood of anticipation, even the nonchalant ones. When invited to do so, they introduced themselves in turn, and then the children were asked to share the reason that brought them to the group. It was mentioned that anyone could feel free to "pass," and one group member, Joey, 7, did. As noted above, each of the group therapists had suffered the loss of a child, and they spoke about this briefly. The children were very much interested in their stories. It was important for them to see the therapists as models who had experienced losses and had learned to deal constructively with their feelings about these. The children were able to see that it was appropriate to put their feelings about the experience of loss into words, and that this was a safe place for them to try to do the same.

The Children

Thomas, 8, had a father who was in prison for the third time. Thomas lived with his mother and grandmother. His father had been absent for most of his life, but on a few occasions he had taken Thomas to car races. At other times, the father's promises had usually gone unfulfilled. Thomas would become known to the therapists for his erratic moods and occasional aggressive behaviors.

Tameeka, 7, had witnessed the murder of her beloved older brother by her mother's boyfriend. She was badly traumatized, and she and her mother were now living temporarily with relatives. Her teacher reported that Tameeka clung to her and appeared withdrawn in the classroom, although she had had two angry outbursts with classmates, one of which involved a physical attack.

Marny, 9, had lived in three different foster homes since she was 4. Her grandmother had recently died in a fire in her home. The story was on television, but Marny did not acknowledge it to her classmates, although she had been very close to her grandmother and often spent weekends with her. Her demeanor was cool and in control. The therapists learned later that she would periodically explode in angry bouts of crying.

John, 8, had lived in a multifamily household with many changes in occupants, until his mother died of a drug overdose when he was 6. He now lived with his aunt, who had a disabling disease and had little patience with him. John told group members that his aunt worried about who would take care of him when she was no longer able to do so. He had a strong need for control and often picked fights.

Joey, 7, did not know that he was HIV-positive. He had been in foster care with the Patrick family since the age of 2. His mother, whom he never knew, died of AIDS when Joey was 3, and his father died when he was 7. He spoke of his father's many unkept promises, one of which was to bring him home. The Patricks took Joey to his father's funeral, where he met several cousins for the first time. He seemed pleased to be connected with an extended family. The Patricks' adoption of Joey would be complete 3 months after the start of the group.

Jamelle, 9, a winsome, talkative child who was overly eager to please, had spent her early years with extended family members; her teenage mother had left her at birth to live with a boyfriend (not Jamelle's father) out of state. At age 6, Jamelle was placed in foster care with the Demmy family, where there were three other foster children and one natural child. Mrs. Demmy was quiet and steady, with strong religious beliefs. Jamelle liked her religious training and spoke eloquently of the love of God, as well as God's judgment. She remarked often and bitterly about her mother's abandoning her. In spite of her religious inclinations, and her need to please, she had been seen to act in mean ways to the other children.

Rosie, 9, had often seen her father beat her mother. Once, in a drunken rage, he turned on the children, and they all had to run to their aunt's house. A month prior to Rosie's starting in the group, he died from complications of alcohol and drug use. The family had peace in the house now, but Rosie said that her mother cried a lot and didn't seem to know how to do anything.

Session 1: Getting Started

Not all of these stories were told in much detail during the first introductory circle. For the most part, the children were succinct in their description of their losses: "My mother died from drugs," or "My father is in jail," or "I'm in a foster home—I don't know where my mother is." It was yet too early for emotions; the children were probably defended against their own pain, or had been taught in a number of ways to "shut up," "be strong," or "move on." How many grieving children grow to adulthood with such unprocessed grief and trauma, only to suffer more severely and in multiple ways? There is a point at which children stop reaching out for support and comfort if it is not there. This amounts to a second loss for them and a most serious one.

Ground Rules

The therapists spoke of rules next, and the children were able to come up with some themselves: "Don't interrupt," "Don't call names," "Don't tease or make trouble," "Clean up after group." The therapists discussed what it might be like as the group members shared more and more. They stated, "Sometimes stories are not easy to tell, and everyone needs to remember that whatever happened, their feelings about it are theirs—not right or wrong but theirs, and okay, because they're real. And those who listen need to be serious about each person's feelings, no matter what they are." It was also important for the children to know that they were allowed to "pass" whenever they did not feel like talking. The therapists then talked about confidentiality and what it meant—that whatever the group talked about, it must remain "in the room." The therapists spoke of how adults and children alike can be very careless about this rule.

The therapists were concerned about how well the children observed this rule of confidentiality. The therapists did not learn much about confidentiality within the family setting, but they learned that within the school, because group members were not actually asked a lot of questions by their peers about the group, private material was probably not divulged. Based on feedback from the children's teachers, the therapists were fairly certain that those in the group did not initiate any talk about group content. This was a sign that group boundaries were being respected and that group cohesion was developing.

The Value of Talking

The children were curious about a colorfully decorated tree branch in a bag. John wanted to hold it, and the facilitators let him take it out to show the group. "This is a talking stick," they told the children. "It is just like those which were used by Native Americans when they got in a circle to talk. Whoever is holding it has the attention and respect of everyone else, because what is being said is very important to that person. For us, it means that no one else talks at the same time. It's a pretty serious idea, and we thought it would be good for our group. What do you think?" The group's interested response and quick "Yes" probably had as much to do with wanting to hold the "talking stick" as anything else about it. The therapists described how they would use it next week as they sat in the circle and had "check-in time"; for now, however, the children wanted to pass it around for inspection, and the therapists did.

The therapists then initiated a discussion about loss of all kinds and how it affects people, both young and old. They asked the children, "What are some of the things that can happen after the loss of someone we love?" There was a long silence, and then John asked, "What do you mean? Like the funeral?" "Well, yes, the funeral; but what about after the funeral?" John replied, "My aunt just said, 'Well, that's that' [making a rubbing motion with his hands], 'now let's get back to normal.' " "Is that how you felt too?" one therapist asked. "No, but when I began talking about the funeral and my mom, my aunt told me, 'Cut it out; nobody needs that talk.' " The therapists felt fortunate: John had helped them to get into just what they had planned. The therapists then guided the discussion into looking at how easy it seems to "put pain away" and *not* look at it. This discussion brought some stark observations from the children: "Yeah, who needs to be stabbed in the heart again?"; "Why talk about it? It doesn't help"; "When I cry, I upset my mother." There were some children who disagreed. Thomas said, "But I'm *so* mad! It stinks when you're told to 'stop talking like that'!" Jamelle said, "My foster mom says when I'm angry, it's the devil in me. Is that true?" Rather than responding to each comment, the leaders showed how impressed they were by the thinking of all the children—by the honest and sensible thoughts they expressed. The therapists went on to describe how the group would be a place to do some really good talking about those things. It was a safe place; the children would not be "put down" for anything they said; they could ask some really weird questions; they could share what hurt them and what helped them, even if it sounded strange.

The therapists had to remain aware that real help would lie not in their being "answer persons," but in listening. Especially with children, it is so easy to give a facile answer, which may even be correct but which becomes dangerously close to being didactic—a sure way to lose a group.

This does not mean that a therapist cannot bring up ideas that are helpful, but a group should do the exploring together, wondering and speculating about things as a group. A rather moving development is likely to result from this: The children find that it becomes possible to help one another. When this happens in a group, it is more than bonding—it is the beginning of caring and development of the capacity for concern about one another. The group becomes more cohesive as empathy for one another grows.

The Use of Activities

After this serious talk, the therapists planned a break for the group, which was an exercise involving movement and imagination: "How do we get our stuck feet out of this cement?" It was great fun. The children were free and un-self-conscious as they moved about and followed the silly scenario.

They then sat/fell into their chairs around the table. They were asked this question: "Would you like to make something next week that will be a way of remembering this group—and your lost loved one—and *yourselves*?" "Why us?" one child wondered. The therapists answered, "Well, you're the ones who are going to be doing all this thinking, and remembering, and wondering—and you ought to be able to include yourselves."

The therapists knew how important it was to help the children see that they were bigger than their pain, bigger than their loss. Every bereaved child has a self—a many-sided self—that went on in the world daily before the loss. That self still goes on after the loss, and the different "pieces" of it can be tapped into as the child moves toward healing: "Who am I as I make this box?"; "What do I think is beautiful?"; "What is my style?" These questions are not asked consciously by the child as he or she works, but they form an unconscious matrix for self-knowledge and growth—growth out of desolation and loss.

The therapists put it to the children: Would they like to make a piece of art, or a "Memory Box," or a special book—a journal or a scrapbook? The children were impassive (were they getting tired?—it had been 45 minutes). Then Marny said, "I would like to make a scrapbook if I could decorate it a certain way." This started a flurry of responses: "Can we use real photos?" "What would a Memory Box look like?" In the end, the group decided that each child would make a Memory Book, which would include photos, drawings, writing of all kinds, and any other creative ideas that the children might think of. Working on the books would be part of each meeting, but the group would be doing other things also.

The Closing

As they all entered the circle again for closing, the therapists invited the children to bring photographs of their lost family members (if they wanted

to) or of their families, so everyone could get to know one another better. They reminded them to take good care of themselves, because they were so important! The therapists then suggested singing a song for ending and asked for suggestions. The children were quiet, or giggled, looking restless. Then Jamelle said, "Can we sing 'Amazing Grace'?" They all knew it; as they sang, holding hands, their restlessness subsided, and there was a perceptible feeling of calm and quiet. They passed around a handshake and parted until next week. The therapists had a sense of a good start.

Session 2: Continuing to Build Connections

Check-In

The second group session the following week had a pleasant feel of familiarity about it, as the children came in with questions such as "What are we going to do today?"; "Can I help with the snacks?"; "Where is the talking stick?" The therapists knew they would be doing something new—having "check-in" time—and the thought occurred to them that it seemed natural to do it at the table with snacks, because talk had begun to flow. They decided against it, however, because they suspected that one real risk would be that of abandoning structure when things "felt good." This did not mean that the role of intuition should be abandoned in any way; intuition is so important in working with children, especially in tuning in to "where they're at" emotionally at any given time. The therapists decided that "check-in" would be part of regular group routine, and that it would occur at circle time.

As the therapists explained this step to the children, now assembled on the rug in a circle, they told them that it mattered to them just how the week had gone for everyone, and that's why they wanted to "check in" with them. They asked each child in turn, "How was your week?" This was nonproblematic for all; in fact, the challenge was to keep updates short enough. The children enjoyed holding the "talking stick" as they recounted their news, and all members listening observed the silence rule quite well (so far!). The therapists made a modification: If one child had a question about another's "news," he or she could raise a hand to ask it. This occurred when Thomas described how he watched *Star Wars* two times at home while his mother went to visit his father in jail, and John wanted to know whether Thomas ever went with his mother on those visits. In a low voice, Thomas answered, "No, he said he doesn't want to see me." "Do you want to see him?" asked John. "Yes." There was pain in the answer as Thomas lowered his head. "That's tough!" someone was heard to say. The therapists wondered about some sort of helpful/comforting phrase, but sometimes (as in this case), silence itself speaks and honors the hurt.

Talking about Death

As the circle ended, the group went back to the library table once again. "What are we going to talk about?" asked Marny. "Death," was the one-word answer from one of the leaders. The therapists felt lucky that these children (like most children) could deal with straightforward answers. They would not "tiptoe" around difficult concepts with the children. They knew that they wanted to be sources of correct information if nothing else (of course, they wanted so much more!). As therapists, they knew they wanted to give consistent respect to the children, both in their attention to the children and in their presumption that they could deal with hard things. The children should never feel that the therapists were protecting them from harsh reality. This would actually be collusion in denial. Rather, as therapists, they would "walk with them" through whatever was likely to be hard.

The therapists embarked on a discussion of death by looking at the concept of "change" and its many forms in their experience. What changes were the children familiar with? Their answers included the seasons, their own growing up, and the difference between life and death in plants, insects, animals. "What does 'slow death' mean?" asked John. "My aunt says that's what she has." The therapists talked about the changes that disease brings—the many losses of physical ability—and how sad that is for sick people. They then talked of the permanence of actual death, and how many children growing up have a hard time realizing that there is absolutely no coming back from death. Jamelle said, "Mrs. Demmy says, 'Dead people fall asleep in the Lord.' " "Yeah, but they don't wake up," added John. "Well, then, why do they say 'fell asleep'?" asked Rosie. "It's kinda dumb." The group was able to talk then about some of the words people use for death, and about why they don't like to use the word "death" itself. "I always thought when people 'passed,' they were getting ahead of other people," said Tameeka. "Yeah, right," cut in John, "right ahead to the graveyard!" "My father," said Rosie, "he was a lot of times 'dead drunk,' said my mom. And guess what? He is really dead because he was drunk so much."

"So death is actually a pretty big change," the therapists observed, "from living to not living." "Forever and ever," said Joey quietly. He had not said anything so far, and both weeks he had looked very solemn and absorbed in his own thoughts. "That's saying it like it is, Joey," said one of the therapists, "and it's hard to say it that way, but we need to." "No big deal," he said, surprisingly. "My mother was 'forever and ever' away from me. I *never* saw her. So it was no big deal when she died." The children were quiet in the wake of this statement from the youngest member of the group. Their thoughts could almost be felt. "What must it be like to *never* have seen your mother?" Tameeka asked that question. Joey almost said

again, "No big deal," but stopped and said, "Not great." "Man," commented John, "that's like *worse* than death." "Cut it out," snapped Thomas, "*you're* makin' it worse." "Thomas," the therapist intervened, "can you guess why John said that?" John jumped in: "I was trying to show *respect,* man!"

The therapists went on, in that heightened mood, to speak of what matters most when someone is in great pain from a loss. They wanted to bring out the importance of acknowledging that person in his or her sadness and pain. "We know we can't bring a dead person back, or make an absent person present, so what can we do when we're with someone who's had that happen?" "Shut up and not say something stupid," muttered Thomas. "Pretty smart, Thomas, but how do we show we care?" asked the facilitator. Thomas was at a loss. Other answers came: "Invite them somewhere" (Marny); "Say 'tough break, man'" (John); "Pray for them" (Jamelle). The therapists invited the children to do just that—literally say something to Joey—but he broke in and said quickly, "That's okay, I get it."

An Exercise Break and Work on the Memory Book Activity

This circle was longer and "heavier" than the therapists had anticipated. It was time for a break. It seemed a good idea to do the "cement shoes" routine again; it was so silly that it would do everyone good. When the children sat down to do the Memory Book activity, the therapists felt it would be helpful for them to have a rough structure to follow. Each child would do a title page naming him- or herself and giving some personal facts, especially about the loss and the loved one(s) the child wanted to keep in memory. (Titles chosen by the children included "The Book about Me and My Story," "Me and Mom," "My Memory Book about Tyrone" [Tameeka's brother]). Besides a title page, there would be a cover, and the facilitators knew that each child would decorate it carefully and elaborately. As the children defined what they wanted, they were focused on their own creativity—a strength, and a counterpoint to loss. They would remember that they were good and interesting persons in addition to bereaved persons—and that they could go on in life with sadness, with memories, *and* with self-awareness and strength.

The Closing

As the group drew to a close that day and the therapists asked for a song to sing, Marny said, "What about 'He's Got the Whole World in His Hands'?" It seemed very fitting; it also seemed as if everyone was helped by singing it. Enough verses were used to name each child, and then they named the therapists! A pretty good two-way support street!

Session 3: Sharing Painful Memories

The third meeting continued with a mix of circle talk (checking in); physical activity (this time, "Follow the Leader"); table talk (serious again; it seemed as if a climate of safety and acceptance had been reached early—the therapists felt so lucky); work on the Memory Books; and a farewell song and handshake (once again, "He's Got the Whole World in His Hands"—everyone liked it).

Circle talk on this day focused on memories, all kinds of memories: those of special times with the lost loved ones; those of the death and/or the funeral, in cases where loved ones had died; those about the rest of the family; or memories of anything else. They talked of good memories: "My father wasn't drinking and he was all dressed up nice when he came to my First Communion" (Rosie); "I used to go to the store for my grandmother, and she would say, 'Take 50 cents for yourself and get a candy bar'; she was *so* kind!" (Marny). They also talked of memories that weren't so good. Jamelle said, "I saw my foster mother on her knees praying once, and I asked her who she was praying for, and she said, 'Your mother.' " "That's an all-right memory," said John. "No, it isn't," responded Jamelle, "she said it wouldn't count probably, because she'll burn in hell. I kind of hate her [the mother] for leaving me, but I don't want her to burn in hell!" Tameeka then said, "I remember screaming at Richard to stop shooting my brother. It's an awful picture in my mind—I *hate* it!" "Wow," said Joey in disbelief, "I remember something bad, but it's not like a shooting. I remember the funeral of my father—I *hate* funerals." This raised a flurry of questions and observations: "Was the casket open?" "Were you told to kiss him?" "People say silly things to kids at funerals, like 'Have big shoulders for your mom.' Why do they talk about shoulders?" "My grandmother's casket had to be closed. She was so burned up." This from Joey: "Something *was* okay for me; I met some cousins who are neat, kinda cool. I didn't even know I had them for cousins!" He had a look of wonderment on his face.

All of this provided such a good opportunity for talking about ways of mourning—not only funeral practices, but the role of memory in people's lives. What was more heartening, though, was the openness with which these remarkable children expressed themselves, and the interest and caring they showed toward one another's stories.

By this session, the therapists observed the assuming of certain roles by group members. Marny, Thomas, and John emerged with a certain sense of authority—a responsibility, as it were, for the quality of the group and the well-being of its members. They filled roles as nurturers and expediters. Was this a function of personality or age? They were among the older members. Or had the path of their healing experience been one that had "toughened" them? The therapists felt thankful that these qualities had not

been accompanied by denial; all three appeared to be looking at their feelings honestly.

Session 4: Feeling and Expressing Painful Feelings

At the fourth meeting, the therapists and children worked with feelings—it seemed a good time for it, and the children had already encountered some of their deeper levels of feeling. The activity chosen was a game of charades about feelings. The therapists had prepared a basket with several paper strips in it, each one identifying a feeling. On a flip chart, they had placed a large red cardboard heart—nothing else. Each child would take one strip and try to act out the feeling represented without using words. When the word was guessed, the strip would be pinned to the heart. The therapists hoped for some spontaneous talk about feelings as the guessing took place. Some of the words for guessing, and the exchanges that occurred, were as follows:

"Sad": Tameeka wiped her eyes and heaved her shoulders to show deep sadness. The other children guessed "crying," then "sad." Someone asked why she was sad. Tameeka paused as if not knowing how to say what she felt. Her face tightened and she said in a low voice, "I miss Tyrone; I want him back." She cried. Marny went to her, and together they sat down. John needed to say, "I'd be sad, but I'd be rippin' angry too—at Richard. I would be wantin' to get him." "Well, you're probably angry a lot," said Thomas, "because of what happened to you." "Yeah," replied John, "but you can't say to people, 'I'm so mad at my mother'—but I am." "Well, guess what? I'm mad at my father and I'll tell anybody, even him, especially him!" exploded Thomas. "He doesn't care about me; he doesn't even want to see me."

"Angry": It was so fitting that Thomas went next. He stomped around and punched the air. He made grimaces full of rage. He banged his fists on empty desks. "C'mon," he called to John, "you're angry too!" John followed and kicked some desks. He then got down on his knees and pounded the floor. He just stayed there, pounding the floor. It felt right to get down on the floor with him, so the therapists did. The children followed, and the group continued that way. Before leaving "anger," the therapists asked for some other words for it. Words came fast: "explode," "powerful," "hate," "want to scream," "scary," "head hurts." When the therapists brought up the question of how to express anger in ways that wouldn't hurt, the children gave all the right answers: "Use a punching bag," "Take a walk," "Count to 10," "Get in a private place." So often children can articulate correct responses, but how often can they do the pounding and kicking and be understood for the validity of that feeling, let alone do it together and *share* each other's feeling? In this case, as they all (therapists and children) knelt and pounded the floor, they were one.

"Grateful": Jamelle tried hard, but the group had a hard time figuring out the word. "Sorry," "praying," and "happy" were all guessed. She finally showed the word: "I was trying to show a fixed-up heart." "Do you have something to be grateful for, Jamelle?" the therapists asked. "Well," she paused, "I heard something awful the other day, and I'm glad—uh, grateful— she [my mother] didn't do it. I'm glad she didn't flush me down the toilet. But I still hate her for leaving me." "Why did she do that?" asked Joey, his eyes wide. "Mrs. Demmy says she didn't have good sense. She said she was scared to be a mother." "Well, I guess I'm grateful she didn't do it, too," exclaimed Rosie, who hadn't said much. The others each said something similar. Jamelle smiled.

"Empty": Tameeka wanted to add this word. She placed her hands in a circle over her heart. When the children didn't guess, she said, "It's a hole. I feel like I have a hole in me." Everyone understood and agreed with this.

The children added other words, and the acting out took most of the hour. They ended with *their* song: "He's Got the Whole World in His Hands." "Who wants a hug?" the therapists asked. No surprise: Everybody did!

This exercise was remarkable in many ways. Not only did it draw on the children's creativity and self-possession, but it was an opportunity for that important double task of *feeling* their feelings and of *expressing* their feelings. Because it was done in the community of their group, there was understanding and respect for each other's reality. The therapists knew that their plan to deal with feelings this week would include a certain degree of risk. The story of loss for each one of these children was so severe that touching those feelings could be too powerful, too harsh. Should they let this happen? What about their belief in the importance of "walking through the pain, not around it"? Did the therapists truly believe they could be with these children in the dark places, the broken places? Yes. If a reenactment of the original wounding was to happen, the therapists felt that the group was a strong enough holding vessel for that experience. They also knew that if revisiting the pain was too hard for some of the children, as revealed in their behaviors, the therapists would interpret this to the group. If the message from deep within was "Hey, I can't go there! Look at my silly behavior instead!," they could work on it together. Naming what was happening could be part of the healing process.

Session 5: Getting Back a Life

The next group session occurred right before Thanksgiving, and there was the benefit of three volunteers—a real luxury. The idea of giving thanks is more fitting than is often supposed for a traumatic loss group (as seen in Session 4, when the group worked on "grateful" with Jamelle). The chil-

dren had absolutely no problem switching to the excitement associated with a holiday, especially one that is so connected with home and a very special meal. The children made some minibooklets of all the things they were grateful for. As they worked, each volunteer sat by the side of two of the children, while one therapist sat with Joey (who had gotten a slow start) and the other therapist "floated." The adults asked questions about the pictures that emerged. What happened in this process was felt by the therapists to be remarkable: As the children realized that there was genuine curiosity and interest in the particular practices of their *own* households, they became, as it were, spokespersons for the traditions of their families. The talk was quiet but nonstop, as just the right questions were asked: "You ate *how many* pieces of pie?"; "How does your mother ever get a turkey in the oven by 9 in the morning!?"; "How did you fit all those people around the table?" The children wanted to do intricate drawings of Thanksgiving scenes, including most rooms of their houses, along with family "portraits" of all (including extended family members). There were some lovely ways of portraying the lost loved ones (in a cloud over the house, in a heart-shaped picture frame on the wall of the dining room). The feeling was one of contentment, pride, and ownership—all as a counterpoint to loss. This was a rich and powerful step toward the goal of "getting back a life" (i.e., a child's knowing ways to be in the world that still surrounds him or her, and putting a value on whatever helps that to happen).

Session 6: Ending the Group

The sixth and last meeting meant that the children would finish their Memory Books and have some talk about ending. The therapists also planned to have a special guest—a musician, who came with her instruments, which were many and intriguing. At check-in time, the children gave their updates without much change to record. However, there was, if not behavior change, in fact some very clear change in viewpoints. Thomas said, "I have a feeling I'll have something to be grateful for soon—I think my father might want to see me on his birthday." He was smiling. Joey said, "On Thanksgiving, I said out loud at grace that I was glad to have my new cousins."

The children's Memory Books were remarkable collections of writings, drawings, photos, collages, and in one case an actual pop-up picture (Marny portrayed her grandmother in heavy colored paper in a rocking chair, which not only popped up but rocked!). Thomas cast himself as a Power Ranger who tore open his father's prison bars and brought him home. In the next picture, he gave a stark warning (complete with skull and crossbones): "NO MORE JAIL!" In the next picture, Thomas and his father were fishing.

The special guest, Melanie, came into the circle with her guitar, and the group sang a few songs together—some with motions, such as: "Did You See My Cow?" and "All God's Critters Got a Place in the Choir." She then brought in other instruments (tambourines, blocks, bell, triangles, drums, etc.) and did some wonderful African and Australian songs. The group members marched to "When the Saints Go Marching In." It was glorious to watch the children forget themselves and their burdens. As they sat down again, the leaders talked about ending. They urged all the children to feel okay about taking care of themselves. John began a "wise old man" act: "Now listen up, you all, remember you are bigger than 'it,' and you are gonna be okay, and if you forget how to take care of *you,* just come to me, and I'll give you my special help!!" Everybody laughed, and Rosie asked, "Do we have to make an appointment?" When they sang their farewell, it consisted of both "Amazing Grace" and "He's Got the Whole World in His Hands," this time with many, many verses: All of the people in the group, *and* all of their lost loved ones, were included. Needless to say, hugs were exchanged all around.

As the therapists watched the children leave together, they asked each other: "What, exactly, did the children learn? How did they change?" John's last words contained one of the biggest lessons: "You are bigger than 'it.' " How could he say that? How could the others laugh so knowingly, as if acknowledging common wisdom? It became clear to the therapists that one of the most important outcomes of group work with traumatized children is helping them find those other pieces of themselves—the pieces that are strong. In this case, the other children laughed affectionately at John's "wise old man" act only because they had all internalized the same wisdom. They could be "wise young people" to each other.

DISCUSSION

Summary of Group Sessions

What began as a collection of individual children suffering from grief and trauma, tentatively coming together, became a therapeutic work group in which the children helped one another heal their hurts. Some very important elements were put into place by the therapists to influence this outcome. Circle time was a crucial ritual that symbolically created the safe space needed to begin the group work each week. It set this time and place aside as different from the children's everyday environment. The ground rules laid the foundation for ways of communicating that were also qualitatively different from those in their daily world. The process of norm setting helped to define the group, giving it a structure in which trust could be built, especially around the respect that is essential for really hearing one another and holding that sacred sharing in confidence. This began tenta-