Combating Secondary Traumatization:

Using Bibliotherapy with Children and Adolescents of Military Families

Chaplain Trainer's Manual

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Introduction

These training materials were developed concerning the effects of secondary trauma on children and adolescents in military families. Through the use of supporting research based on a survey of the literature, three training modules were created to help ameliorate the negative effects of secondary trauma through the use of bibliotherapy on children and adolescents of military personnel.

Training materials concerning the effects of secondary trauma[1] are to be presented to parents of military children and adolescents in both individual and group settings. These training materials are divided into three modules (45 minutes each) for military service members, mental health professionals or other interested personnel.

The first module is an overview of Post-traumatic Stress (PTS)/ Posttraumatic Stress Disorder (PTSD) The effects of PTS and PTSD on returning service members is substantial.[2, 3] Current studies suggest that 0.6% to 31% of returning soldiers from Operation Enduring Freedom (OEF) and Operation Iraqi

1. Training materials were developed from research journals, books and articles (see page 1 on supporting research). They are presented in a military briefing format. Training slides (PPT) with a script that includes ideas, suggestions, and strategies for instruction are included in this manual.
2. Charles Hoge, et al., "Mild Traumatic Brain Injury in U.S. Soldiers Returning from Iraq," *The New England Journal of Medicine* 358 no. 5 (January 2008): 454-456.
3. Rhonda Cornum, Michael D. Matthews, and Martine E.P. Seligman, "Comprehensive Solider Fitness: Building Resilience in a Challenging Institutional Context," *American Psychologist* 66, no. 1 (January 2011): 4.

Freedom (OIF) are more likely to suffer from it effects.[4] The second module concerns the effects of secondary traumatization on military children and adolescents caused by parental primary trauma. Secondary traumatization has been defined as the process through which primary trauma is transferred to another and becomes secondary trauma. This can manifest itself on military children/adolescents who can experience the same symptoms and effects of the parent's primary trauma, e.g., arousal, avoidance, trust, and hypervigilance.[5] The final training module offers helpful suggestions on how to lessen the effects of secondary trauma on children/adolescents through the use of bibliotherapy.[6]

Also, these materials can be used to assist Armed Forces chaplains to brief a family support group before, during re-integration and throughout deployment cycle training. Therefore, information presented in these seminars can help prepare and empower those briefed with current information to assist them to better understand the negative effects of secondary traumatization.

Audience

These materials can be presented to parents and other care-

4. Brian C. Kok et al., "Posttraumatic Stress Disorder Associated with Combat Service in Iraq or Afghanistan: Reconciling prevalence Differences Between Studies," *Journal of Nervous and Mental Disease* 200, no. 5 (May 2012): 446-448.

5. "Secondary Traumatic Stress," *National Child Traumatic Stress Network*, accessed October 10, 2015, http://www.nctsn.org/resources/topics/secondary-traumatic-stress.

6. See supporting research for explanation of latent coping skills and how to use bibliotherapy to help lessen the effects to secondary trauma on military children and adolescents.

givers before, during and after deployments. They can be used for information briefings at family support groups, in a school setting, and for training seminars. They can also be adapted for many other uses, groups and environments.

Instructions for Use

Primarily, these materials were developed to be taught by military chaplains. Chaplains are not mental health professionals though they often have greater access and familiarity with the military service members and their families. As such, it may be worthwhile to have the mental health officers made aware of the chaplain's briefings so as both the chaplain and the mental health professionals are mindful on how to engage with military families concerning the effects on secondary trauma on military children and adolescents.

This training is organized into three modules: (1) An Overview of Posttraumatic Stress Disorder (PTSD), (2) Understanding Secondary Traumatization, and (3) Bibliotherapy. Each training module is intended to last for about 40-45 minutes, leaving 5-10 minutes for questions. The training is designed to be presented in a non-threatening manner, but chaplains should be aware that those present for the brief may experience their own anxiety, worry, or other concerns because of the topics covered. You may want to invite other chaplains or a chaplain assistant to be present to assist you to be aware of those who may be troubled by the presented material for follow-up or pastoral counseling.

This manual contains a link to all training materials that are stored on line (Google drive). Each slide contains talking points

and suggestions for presentations that are related to reviewed research. Presenters who are unfamiliar with the subject could still read the text and be effective instructors. Presenters who are more conversant with secondary traumatization and bibliotherapy should feel free to adapt the text and slides as they see fit.

Supporting Research

This review of the research literature will offer academic support for the training materials included in this manual. This brief literature review is designed to help chaplains who are unfamiliar with the subject matter to familiarize themselves while also serving as a refresher for chaplains more experienced with secondary traumatization.

The effects of war extend far beyond the initial and direct impact of those that experience the trauma of combat. War and combat changes soldiers, which in turn, affects military families.[7] Pamela Alexander suggests that the effects of war are not limited to service members alone.

> The negative impact of war is not limited to the soldier, given that 56% of 1.5 million military service members are married and 2 million American children have at least one military parent. In fact, three of five deployed soldiers have spouses and/or children. These family members are themselves subject to the short-term, long-term, and potentially

7. PBS Frontline, "Interview: Dr. Matthew Friedman", Conducted on Oct. 7, 2004, accessed June 1, 2015, http://www.pbs.org/wgbh/pages/frontline/shows/heart/themes/shellshock.html.

intergenerational effects of war.[8]

In conjunction to this, the Veteran's Administration (VA) clearly states that changes in military personnel due to primary trauma also effect the families of military members.[9] Though these families do not experience the traumatic material of combat directly, they can experience the effects of secondary trauma. According to the VA, the effects that family members might experience include: anger, avoidance, depression, and drug dependence. Military personnel (soldiers, sailors, marines and airmen) who experience primary trauma may transfer the effects of their experiences to their family members. In turn, family members may feel a vast range of emotions and experience a wide spectrum of challenges beyond that of 'normal' deployment stresses and concerns.[10]

In recent years, with the continued involvement of the United States (US) military in combat operations, the number of US military personnel who experience primary trauma is significant. The VA estimates that:

> Since the start of operations in the Middle East in October 2001 approximately 1.8 million US military personnel have deployed to areas in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). The VA estimates that

8. Pamela C. Alexander, *Intergenerational Cycles of Trauma and Violence: An Attachment and Family Systems Perspective* (New York: W.W. Norton & Company, Inc., 2015), 180.
9. United States Veteran's Administration, "Effects of PTSD on Family," accessed June 1, 2015, http://www.ptsd.va.gov/public/family/effects-ptsd-family.asp.
10. Veteran's Administration, "Effects of PTSD on Family."

10-18% of this deployed population has PTSD.[11]

Charles Hoge, et.al, estimates the rate of primary trauma to be 15.6-17.1% of those returning from service in OEF (Operation Enduring Freedom) and 11.2% for those who served in OIF (Operation Iraqi Freedom).[12] Currently there is no information or data regarding veterans of Operation New Dawn (OND) concerning the effects primary trauma.

Because of the potential effects of secondary trauma on military families, this project seeks to develop training for US Military Chaplains that can be used to help parents and other care takers understand the effects of secondary trauma that military children and/or adolescents may experience.

Primary Trauma

Primary Trauma and Primary Traumatic Stress

Primary trauma is what an individual an individual experiences or witnesses firsthand (e.g., combat, rape, robbery). According to the DSM-5 exposure to trauma via electronic media, television, movies, etc. is not considered to meet the criteria for PTSD, unless such exposure occurs as a matter of one's employment."[13] In other words, primary trauma does not stem from watching the news, social media, etc. unless you repeatedly en-

11. "PTSD in Service Members and New Veterans of the Iraq and Afghanistan Wars: A Bibliography and Critique," Veteran's Affairs, accessed July 14, 2015, http://www.ptsd.va.gov/professional/newsletters/research- quarterly/V20N1.pdf.
12. Charles Hoge, et al., "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *The New England Journal of Medicine* 351, no. 1 (July 2004): 7.
13. DSM-5.

gage in such media as part of your occupation.

An additional exception to the PTSD criteria of experiencing/witnessing trauma firsthand is "learning that the traumatic event(s) occurred to a close family member or close friends. [And] in cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental." This means that a spouse or child of a service member could potentially be diagnosed with PTSD after learning of their service member's traumatic event(s). However, just as experiencing/witnessing traumatic events firsthand may not lead an individual to be diagnosed with PTSD, learning of a loved one's traumatic experience does not necessarily lead to a diagnosis of PTSD.[14] As such, and for the purposes of this literature review, this exception will be handled in Understanding Secondary Traumatization of Military Children and Adolescents, as a potential secondary effect of PTSD. In summary, primary trauma herein is defined as directly experiencing or witnessing, in person, a traumatic event(s).

Posttraumatic Stress Disorder

Rhonda Cornum reports that "up to 70% of our soldiers are exposed to traumatic incidents in Operation Iraqi Freedom and in Operation Enduring Freedom in Afghanistan. [As such] it is not surprising… that soldiers experience high rates of posttraumatic stress disorder."[15] Regarding PTSD, the DSM-5 mentions four groups of symptoms that individuals experience for at least one month following a traumatic event(s). These groups of

14. Suozzi and Motta. "The Relationship between Combat Exposure," 18.
15. Rhonda Cornum, Michael Matthews, and Martine Seligman, "Comprehensive Solider Fitness: Building Resilience in a Challenging Institutional Context," *American Psychologist* 66, no. 1 (January 2011): 4.

symptoms are: (1) Reliving/Re-experiencing, (2) Avoidance, (3) Negative changes in beliefs and feelings, and (4) Hyperarousal.[16]

The reliving or the re-experience of event(s) can be manifested in nightmares and flashbacks. These experiences are associated and triggered by a smell, a sound, or a sight that reminds the service member of the event. While reliving/re-experiencing a traumatic event, it is as if the service member is again living and experiencing the event for the first time. According to Dr. Bremner, this vivid memory is caused in part because the service member's brain has trained itself to associate triggers and reflexes in such a way that causes the service member to relive/re-experience the traumatic event.[17] In other words, as a service member with PTS/PTSD hears a car backfire or smells a certain scent at a certain time of day, the service member is taken back to the traumatic event in mind, body, time, and again sees, hears, and smells the traumatic event.

Avoidance is when a service member strives to elude external reminders of an event. In other words service members with PTSD will avoid certain "people, places, conversations, activities, objects, situations [that are] closely associated with the traumatic event(s)."[18]

Additionally, avoidance can exhibit itself as emotional numbness and a "reduced involvement of the traumatized vet-

16. DSM-5.
17. Bremner, *Does Stress Damage the Brain?*, 94-97.
18. DSM-5.

eran in his offspring's life."[19] For example, a service member whose convoy was bombed may avoid driving or riding in an automobile, or the service member may spend long hours at work so as to avoid having to talk or reflect on the event(s). Also, once perceived as close to his/her children, the service-member can become distant because of traumatic events.

Negative changes in beliefs and feelings refers to the changes in which a service member with PTSD views themselves and others because of the traumatic event(s). An example of these mistaken beliefs is when a service member lives in persistent adverse emotional state such as always having "fear, horror, anger, guilt, or shame."[20] Conversely, the service member may be unable to feel or experience joy, fulfillment, or loving feelings.[21] The service member also may have extravagant and continual negative thoughts such as "'I am bad,' 'No one can be trusted,' [or] 'The world is completely dangerous.'"[22] These mistaken beliefs in the service member's beliefs and feelings, like avoidance, could be a reaction to help keep themselves safe from further physical/emotional harm and injury.

Hyperarousal is a response to traumatic events when an individual may always be on guard for danger (i.e., hypervigilance, being on edge) and may unexpectedly become angry. Because of being constantly on the lookout for danger and being worried about becoming angry many service members with PTSD may

19. Estee Cohen, Gadi Zerach, and Zahava Solomon, "The Implication of Combat-Induced Stress Reaction, PTSD, and Attachment in Parenting Among War Veterans," *Journal of Family Psychology* 25, no. 5 (October 2011): 695.
20. DSM-5.
21. DSM-5.
22. DSM-5.

have difficulty sleeping or concentrating.[23]

The signs and symptoms of PTSD can be divided into the four broad categories of reliving/re-experiencing, avoidance, negative changes in beliefs and feelings, and hyper-arousal. Though each individual who is diagnosed with PTSD will exhibit different combinations and manifestations of the symptoms and signs described in this section each of these individuals will experience some type of all four categories of symptoms.[24]

Though only a brief introduction to primary trauma and PTSD, this section has offered a basic insight into how PTSD can affect service members. This section on PTSD is important to help understand and to place in proper context, secondary traumatization of children and adolescents in military families.

Understanding Secondary Traumatization

The effects of war and military service are not felt by service members alone, but rather these effects extend to the service members' families as well. Lester and Flake state that "when a military father or mother volunteers to serve our country, their children do so as well."[25] Holmes, Rauch, and Cozza further argue that in each phase of deployment, injury, and recovery that military "children and families face emotional and practical dif-

23. DSM-5.

24. According to the DSM-5 to be diagnosed with PTSD an individual only needs to exhibit 1 or 2 of the 4 to 6 types of each symptoms/sign in order to receive the diagnosis.

25. Patricia Lester and Eric Flake, "How Wartime Military Service Affects Children and Families," *The Future of Children* 23 no. 3 (Fall 2013): 121.

ficulties."[26] These arguments seem to be refer to Murray Bowen's family systems theory.

Bowen's family systems theory submits that as an individual of a family unit is affected by an outside influence, the whole family unit is affected as a system. Bowen's theory would suggest that as a military parent experiences primary trauma there exists the potentiality for the primary trauma to have an effect throughout the family unit, i.e., secondary traumatization.[27] Indeed,

> Human beings do not live in a vacuum. They are surrounded by others. And those others will be confronted with the traumatic event… These people hear about the event, they perceive the suffering of the victims, and they have to cope with the changes caused by the event and suffering.[28]

As children and adolescents live and interact with a traumatized parent, it follows that the child/adolescent would also feel the effects of the traumatic event, i.e., secondary traumatization.

As previously defined, secondary traumatization is the process through which primary trauma is transferred to another and becomes secondary trauma. Secondary traumatization in children/adolescents can occur when a child/adolescent hears

26. Allison Holmes, Paula Rauch and Stephen Cozza, "When a Parent is Injured or Killed in Combat", *The Future of Children*, 23, no. 3 (Fall 2013): 143.
27. Peter Titelman, "The Concept of Differentiation of Self in Bowen Theory," in *Differentiation of Self: Bowen Family Systems theory Perspectives*, ed. Peter Titleman (New York: Routledge, 2014), 2-11.
28. Charles Figley and Rolf Kleber, "Beyond the 'Victim': Secondary Traumatic Stress," in *Beyond Trauma*, ed. Rolf Kleber, Charles Figley and Berthold Gersons (New York: Plenum Publishing Corporation, 1995), 77.

or learns about the personal trauma of their parent(s). Another avenue through which secondary traumatization can occur is by the child/adolescent being exposed to their parent's reaction to PTSD (e.g., parental drinking, abuse, flashbacks, avoidance, hypervigilance). When a child/adolescent experiences secondary traumatization they may mimic the symptoms of PTSD such as hypervigilance and avoidance.[29] The mimicking of a parent is due in part because "children commonly express what they're feeling through behavior."[30] When a child is afraid of a parent's action/reaction the child may mimic their parent's pattern of avoidance.

Causes of Secondary Traumatization in Children and Adolescents

Secondary traumatization of a child or adolescent is largely caused by what that child/adolescent sees their traumatized parent do, say, etc. Dr. Benjamin Spock states that beyond a formal education children are also "educated by identifying with and imitating their parents."[31] One such example that Dr. Spock offers is how "a two-year-old who picks up several new words each day by listening to his parents and a toddler who takes his first steps after he experiments by holding on his parents."[32] In less academic, but common language terms, children learn by

29. Jessica Lambert, Jessica Holzer, and Amber Hasbun, "Association Between Parents' PTSD Severity and Children's Psychological Distress: A Meta-Analysis," *Journal of Traumatic Stress*, 27 (February 2014): 9.
30. Holmes, Rauch and. Cozza, "When a Parent is Injured or Killed in Combat," 143.
31. Benjamin Spock, "Children Learn Through Imitating Behavior of Parents," *Journal of Education Thought* 91, no. 24 (May 1997): 22.
32. Spock, "Children learn through imitating behavior of parents," 22.

"monkey see, monkey do."[33] Thus, it is not surprising that children begin to mimic the symptoms they see expressed by their parent who suffers from PTSD.[34] In short, children who have a parent who struggles with PTSD may exhibit higher levels of anger, anxiety, avoidance, depression, drug use, etc. Additionally, many parents who struggle with PTSD have lower levels of parental function. Meaning, parents with PTSD are more likely to be "detached, emotionally unavailable, and [show] a lack of interest [in family activities]."[35] As such the non-PTSD parent may have to expend greater efforts to maintain peace and offer a sense of 'normalcy' for the children/adolescents of the family.

All children and adolescents experience stress, however not all children experience the same stress, nor do they react the same to similar stressors. Shonkoff and Garner put stress of children into three types: positive, tolerable, and toxic.[36]

According to Shonkoff and Garner examples of positive stress include the first day of school, getting shots, and day-to-day frustrations. Positive stress isBrief and mild to moderate in magnitude. Central to the notion of positive stress is the availability of a caring and responsive adult who helps the child cope

33. Michael Franks, "Monkey See-Monkey Do," *The Art of Tea*, (Reprise Records: New York City, 1976), Side 1, Track 3.
34. Tara Galovski and Judith Lyons, "Psychological Sequelae of Combat Violence: A Review of the Impact of PTSD on the Veteran's Family and Possible Interventions," *Aggression and Violent Behavior* 9, no. 5 (August 2004): 489.
35. Zahava Solomon, et al., "Marital Adjustment, Parental Functioning, and Emotional Sharing in War Veterans," *Journal of Family Issues* 32, no. 1 (January 2010): 140.
36. Jack Shonkoff and Andrew Garner, "The Lifelong Effects of Early Childhood Adversity and Toxic Stress," *Pediatrics* 129, no. 1 (January 2012): 235.

with the stressor, thereby providing a protective effect that facilitates the return of the stress response systems back to baseline status.[37]

When a child experiences a normal/common developmental stressor and they are able to receive support from a caring/loving adult the child is able to quickly return to their normal self, i.e., baseline status. This type of stress and response is a vital part of normal life and normal development and offers "important opportunities to observe, learn, and practice healthy adaptive responses to adverse experiences."[38]

Conversely, tolerable stress stems from stressors that are non-normative. Examples include "the death of a family member, a serious illness or injury, a contentious divorce, a natural disaster, or an act of terrorism."[39] Shonkoff and Garner argue that

> when [tolerable stress is] experienced in the context of buffering protection provided by supportive adults, the risk that such circumstances will produce excessive activation of the stress response systems that leads to physiologic harm and long-term consequences for health and learning is greatly reduced.[40]

In other words, when children do not receive support in these non-normal stressful situations the stressors are more likely to cause long-term physiological, health, and developmental harm However, even with heightened levels of stress, when children

37. Shonkoff and Garner, "The Lifelong Effects," 235.
38. Shonkoff and Garner, "The Lifelong Effects," 235.
39. Shonkoff and Garner, "The Lifelong Effects," 235.
40. Shonkoff and Garner, "The Lifelong Effects," 235-236.

are supported by caring/loving adults the children are less likely to experience the long-term effects of stress.

The last type of stress that Shonkoff and Garner describe is toxic stress. Toxic stress is hazardous to a child or adolescent's mental health.[41] Examples of toxic stress include "recurrent physical and/or emotional abuse, chronic neglect, severe maternal depression, parental substance abuse, and family violence."[42] Toxic stress can be severe in terms of duration, intensity, and/or frequency and is also characterized as lacking adult support.[43] Because symptoms of PTSD can lead to parental neglect, anger outbursts, etc., without proper support, watching a parent deal with the symptoms PTSD (e.g. reliving the experience, avoidance, etc.) can be a form of toxic stress for a child/adolescent. Chronic toxic stress in a child can lead to a number of long-term symptoms. The following discusses a few of these symptoms.

Symptoms of Secondary Traumatization in Children and Adolescents

Dekel and Goldblatt state that regardless of how a child or adolescent experiences secondary traumatization that the "PTSD symptoms [of a parent] impact or shape the child's distress, based on the evidence that children who grow up in a violent and/or stressful family atmosphere might experience negative

41. Shonkoff and Garner, "The Lifelong Effects," 236.
42. Jack Shonkoff, W. Thomas Boyce, and Bruce McEwen, "Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities: Building a New Framework for Health Promotion and Disease Prevention," *The Journal of the American Medical Association* 301, no. 21 (June 2009): 2256.
43. Shonkoff, Boyce, McEwen, "Neuroscience, Molecular Biology, and the Childhood Roots of Health Disparities," 2256.

implications."[44] This suggests that the symptoms of secondary traumatization are some of the ways in which a child or adolescent of a combat veteran may be impacted or shaped because of their parent(s)' primary trauma.

There are two ways in which the symptoms of secondary traumatization are expressed (1) through internalizing behaviors and (2) by externalizing behaviors. Externalizing behaviors include actions that are taken against others by means of aggression, defiance, etc. Examples include hitting, yelling, and smoking. Internalizing behaviors are in many ways the opposite in that the harm is against one's self. Examples include depression, anxiety, suicidal ideation, or mistaken beliefs regarding the world. Both internalizing and externalizing are methods of coping with stress. These can be dangerous to a child or an adolescent's mental well-being and health.[45]

The following symptoms of secondary traumatization have been divided to reflect their externalizing or internalizing manifestations. Within each grouping is an alphabetic listing of the symptoms that children and adolescents who are exposed to secondary trauma may experience. Each symptom listed will be briefly defined and discussed as it pertains to a child/adolescent.

Internalizing Symptoms

Anxiety

44. Rachel Dekel and Hadass Goldblatt, "Is There Intergenerational Transmission of Trauma? The Case of Combat Veterans' Children," *American Journal of Orthopsychiatry* 78 no. 3 (July 2008): 284.
45. Jonathan Perle, Allison Levine, Anthony Odland, et al., "The Association Between Internalizing Symptomology and Risky Behaviors," *Journal of Child and Adolescent Substance Abuse* 22, no. 1 (December 2013).

Anxiety has been defined as the "anticipation of future threat."[46] The DSM states that when an individual experiences anxiety they may feel restless, be easily fatigued, have difficulty concentrating, express irritability, have muscle tension, and experience sleep disturbances.[47] Anxiety in and of itself appears with a litany of its own symptoms that could affect a child or an adolescent. The DSM also notes that children who are abnormally anxious may be "overly conforming, perfectionist, and unsure of themselves."[48] Additionally, anxiety could also express itself as a fear or avoidance of social situations.[49] According to Ahmadzadeh and Malekian, children and adolescents of combat veterans are 10% more likely to score higher on the Cattle's Anxiety Scale, a test that measures anxiety, than the children of non-veterans.[50] This means that children of combat veterans are 10% more likely to exhibit anxious moods and thoughts when compared to their non-military family peers. Similarly, Daud, Skoglund, and Yrdelius, in their research study, show that when compared with the children of non-traumatized parents, the children of traumatized parents "show more anxiety symptoms."[51]

In summary, as a child/adolescent experiences secondary trauma, they are more likely to experience the symptoms of anx-

46. DSM-5, 189.
47. DSM-5, 222.
48. DMS-5, 222.
49. DSM-5, 203-204.
50. Gh. Ahmadzadeh and A. Malekian, "Aggression, Anxiety, and Social Development in Adolescent Children of War Veterans with PTSD Versus those of Non-Veterans," *Journal of Research in Medical Sciences* 5, no. 4 (January 2004): 233.
51. Atia Daud, Erling Skoglund, Per-Anders. Pydelius, "Children in Families of Torture Victims: Transgenerational Transmission of Parents' Traumatic Experiences to Their Children," *International Journal of Social Work* 14, no. 1 (January 2005): 29.

iety. Experiencing anxiety, whether said anxiety is diagnosable or not, can lead a child/adolescent to express abnormally higher levels of restlessness, fatigue, irritability, muscle tension, and sleep disturbances.[52]

Attachment

Bowlby, in his attachment theory, studied how children build emotional bonds.[53] Regarding Bowlby's theory, Doinita and Maria believe that parenting availability and responsiveness, in large part, determines how secure or insecure a child will become.[54] Thus, children who develop healthy relationships with their parents are more likely to grow into secure individuals. In summarizing Bowlby and Ainsworth's attachment theory, Jeffry Simpson and Steven Rholes in *Attachment Theory and Research: New Direction and Emerging Themes*, explain that attachment theory is a model "explaining the conditions under which parents and children, romantic partners, and close friends form, build, maintain, and sometimes dissolve attachment bonds."[55] The attachment theory suggests that one's circumstances, environment, and personality affect the way in which relationships are formed and the healthiness of these relationships.

Regarding attachment in the relationships of traumatized parents and their children Klaric et al., argue that "the attachment

52. DSM-5, 222.

53. Nanu Elena Doinita and Nijloveanu Dorina Maria, "Attachment and Parenting Styles," *Procedia – Social and Behavioral Sciences 203* (August 2015): 200.

54. Doinita and Maria, "Attachment and Parenting Styles," 200.

55. Jeffry Simpson and W. Steven Rholes, eds. *Attachment Theory and Research: New Directions and Emerging Themes* (New York, NY, USA: The Guilford Press, 2015), 1.

that children of PTSD parents receive and develop, certainly leaves an imprint in the emotional memory of the children."[56] This emotional memory is left in part because the "avoidance, detachment and numbing symptoms [of PTSD] impair veterans' ability to engage in normal interactions with their children, which is necessary for the development of a meaningful relationships."[57] Marsanic also argues that "because of veterans' unresolved sadness and fear of another loss, he may have difficulties in establishing and maintaining attachment, especially with children."[58] Because of military parents' potential diminished parenting abilities, they and their children may have difficulty forming healthy, normal developmentally critical bonds and relationships. van Ee, Kleber, and Jongmans, further argue that "the attachment of children of parents with unresolved trauma often becomes disorganized because the children are placed in the paradoxical situation of being attached to parents who sometimes behave in a fear-provoking way."[59]

The research explicitly suggests that children who experience secondary traumatization may have difficulty forming healthy, lasting relationships with their parent who experienced primary trauma. Nevertheless, the research seems to implicitly suggest that if the traumatized parent can resolve their own trau-

56. Miro Klaric, et al., "Secondary Traumatization and Systemic Traumatic Stress," *Medicina Academica Mostariensia* 25, Suppl. 1 (June 2013): 32.
57. Miro Klaric, et al., "Secondary Traumatization and Systemic Traumatic Stress," 32.
58. Vlatka Marsanic, et al., "Self-reported Emotional and Behavioral Symptoms, Parent-adolescent Bonding and Family Functioning in Clinically Referred Adolescent Offspring of Croatian PTSD War Veterans," *Early Child Adolescent Psychiatry* 23, no. 5 (May 2014): 302.
59. Elisa van Ee, Rolf J. Kleber, and Marian J. Jongmans, "Relational Patterns between Caregivers with PTSD and Their Nonexposed Children: A Review," *Trauma Violence and Abuse* (May 2015): 9.

ma the parent-child relationships will be less affected.

Avoidance

As mentioned earlier, avoidance is a common symptom of PTSD. It is defined as when an individual puts forth effort (consciously or not) to avoid reminders of the traumatic event, e.g., conversations, news, sounds, crowds[60]. Though avoidance can be simply defined; however, the effects of avoidance are complex within secondary traumatization. Although a child may initially mimic a primary traumatized parent's avoidance, this avoidance may become ingrained such that the child also avoids similar venues, conversation topics, movies, etc. as their traumatized parent. Additionally, a child or adolescent may begin to avoid other family members as a coping mechanism to suppress the emotions of experiencing secondary trauma.

For example, Scheeringa and Zeanah suggests that "if a traumatized parent (i.e., a secondarily traumatized parent) repeatedly asks questions or discusses the traumatic event (the secondary traumatization of the child), this unwelcome preoccupation from the parent may re- traumatize a young child."[61] Similarly, "a parent may be so intensely preoccupied as to be unable to censor his/her own statements or behavior to shield the child."[62] A child or adolescent that has a parent who experienced primary trauma may struggle if the non-primary traumatized parent is being too invasive, which in turn may exacerbate the child/adolescent's

60. Cohen, Zerach, and Solomon, "The Implication of Combat-Induced Stress Reaction," 695.

61. Michael Scheeringa and Charles Zeanah, "A Relational Perspective on PTSD in Early Childhood," *Journal of Traumatic Stress* 14, no. 4 (October 2001): 811.

62. Scheeringa and Zeanah, "A Relational Perspective on PTSD in Early Childhood," 811.

own avoidance. This in turn suggests that a child/adolescent may avoid all conversations, places or people that remind the child/adolescent of the experiences related to their secondary traumatization, to include the non-primary traumatized parent.

> Furthermore, Leen-Feldner, et al., argues that exposure to secondary traumatization may take the form of chronic or periodic experiences with alterations in parental behavior, affect, and/or cognitions. For instance, offspring may be exposed to cognitive distortions characteristic of PTSD (e.g., exaggerated beliefs regarding environmental threat). Similarly, parents may model avoidance of traumatic event cues or more directly influence offspring avoidance behaviors via prohibition of discourse about, or contact with, stimuli linked to the traumatic event.[63]

In this manner children and adolescents again may have ingrained into themselves a learning of avoiding certain behaviors, conversation topics, etc. that are related to their parent's primary trauma.

Avoiding of parent's, locations, or topics can be partly related to attachment issues, which in turn can lead a child or adolescent to also avoid seeking comfort when distressed and express a limited positive affect.[64] Thus avoidance and attachment, though different symptoms of secondary traumatization, are related and can intensify the symptoms of the other.

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63. Ellen Leen-Feldner, et al., "Offspring Psychological and Biological Correlates of Parental Posttraumatic Stress: Review of the Literature and Research Agenda," *Clinical Psychology Review* 33, no. 8 (December 2013): 1126.
64. DSM-5, 265.

Depression

Though the word depression is a clinical term used in defining a set of mental disorders, depression is also a lay term to describe someone who has "the presence of [a] sad, empty, or irritable mood."[65] The symptoms of depression are also typically "accompanied by somatic and cognitive changes that significantly affect the individuals' capacity to function."[66]

van Ee, et al., argues that "parental symptoms of PTSD predicted child internalizing behavior problems such as depression."[67] Supporting this increase of depression, Marsanic, et al., suggests "that adolescent offspring of PTSD veterans may experience significantly higher rates of depression than their non-PTSD veteran peers."[68] In conjunction, Dinshtein, Dekel, and Polliack show through their statistical research that the children of traumatized parents are statistically more likely to exhibit depressive symptoms.[69] Additionally, Leen-Feldner, et al., further suggests that "elevated parental [posttraumatic stress symptoms]/PTSD appears to be related to… negative offspring outcomes, including… depression."[70] This sampling of the research reports a correlation between parental PTSD and child/

65. DSM-5, 155.
66. DSM-5, 155.
67. van Ee, Kleber, and Jongmsn, "Relational Patterns Between Caregivers," 8.
68. Marsanic, et al., "Self-reported emotional and behavioral symptoms," 301.
69. Yula Dinshtein, Rachel Dekel, and Miki Polliack, "Secondary Traumatization Among Adult Children of PTSD Veterans: The Role of Mother-Child Relationships," *Journal of Family Social Work* 13, no. 2 (2011): 116.
70. Ellen Leen-Feldner, et al., "Offspring Psychological and Biological Correlates of Parental Posttraumatic Stress: Review of the Literature and Research Agenda," *Clinical Psychology Review* 33, no. 8 (December 2013): 1123.

adolescent depression levels. Thus, a parent who experiences and expresses the symptoms of PTSD as a result may have a child who exhibits symptoms of depression.

In review, the literature submits that children of traumatized parents are more likely to experience depression and depression like symptoms. Though little statistical analysis was offered in the literature reviewed, it appears that higher levels of parental PTSD are closely correlated with higher levels of child and adolescent depression. Furthermore, Smith, Perrin, Yule, and Rabe-Hesketh, argue that it is a "mothers'… depression scores that predicted child depression scores."[71] This is to suggest that a non-traumatized mother's own mental health may have a greater impact on a child or adolescent's ability to cope with the traumatized parent's symptoms. This also suggests that the children of combat women may be at a greater risk for developing depression.

Suicidal Ideation, Suicidal Attempts, and Suicidal Completion

For purposes herein "suicidal ideation" is defined commonly as suicidal thoughts. Suicidal ideation ranges from an individual having detailed plans, to momentary contemplations, regarding killing one's self, and do not include the act of attempting to kill one's self. "Suicidal attempts" are simply defined as an attempt to end one's own life, whereas "suicidal completion" is when an individual carries out their plans of suicide to fulfillment.[72]

71. Patrick Smith, et al., "War Exposure and Maternal Reactions in the Psychological Adjustment of Children from Bosnia-Hercegovina," *Journal of Child Psychology and Psychiatry* 42, no. 3 (March 2001): 402.
72. Lisa Cook and Jo Borrill, "Identifying Suicide Risk in a Metropolitan Probation Trust: Risk Factors and Staff Decision Making," *Legal and Criminological Psychology* 20, no. 2 (December 2015): 255-256.

In 2013 suicide was the tenth leading cause of death in the United States.[73] Within the military community the VA reports an increase of suicide risk for both veterans who had deployed (41% higher) and veterans who had never deployed (61% higher) when compared to the risk for suicide among the general US population.[74] The VA also reports that non-deployed veterans remain at a higher risk for suicide than deployed veterans for up to nine years after discharge from the service.[75] Surprisingly, Zivin reports that "veterans who received a PTSD diagnosis had a lower rate of suicide than did veterans without PTSD."[76, 77] Understanding the risk of suicide among veterans and PTSD veterans in particular is important because having a family member complete suicide is one of the leading risk factors for suicidal

73. Jiaquan Xu, et al., "Deaths: Final Data for 2013," *National Vital Statistics Report* 64, no. 2 (February 2013): 1.

74. United States Department of Veterans Affairs, "Suicide Risk and Risk of Death Among Recent Veterans," accessed 18 February 2016, http://www.publichealth.va.gov/epidemiology/studies/suicide-risk-death- risk-recent-veterans.asp.

75. VA, "Suicide Risk and Risk of Death among Recent Veterans."

76. Kara Zivin, H. Myra Kim, John F. McCarthy, et al., "Suicide Mortality Among Individuals Receiving Treatment for Depression in the Veterans Affairs Health System: Associations with Patient and Treatment Setting Characteristics," *American Journal of Public Health* 97, no. 12 (December 2007): 2195.

77. The difference between lower risk of suicide of veterans who are diagnosed with PTSD and those that are not diagnosed could be in part due to their diagnosis of PTSD. Those with a diagnosis are in the process of receiving help and thus have access to support (e.g., therapists, doctors, groups). While veterans who are not diagnosed may still suffer from the same symptoms of PTSD, but are not receiving the same support. Indeed, these veterans could be avoiding the support, which is line with the symptomology of PTSD. Thus, the veterans without support are left to figure out how to solve their trauma on their own. However, there is no research to support this opinion.

ideation and attempts.[78]

Other risk factors of suicide and suicidal ideation that children and adolescents of traumatized parents may be exposed to include: depression, anxiety, substance use, and PTSD.[79] However, though suicide is a real and dynamic challenge there is little research regarding the interplay between secondary traumatization and suicidal ideation, attempts, and completion.

Nevertheless, in one research study, Marsˇanic´, et al., reported that "inpatient adolescent offspring of PTSD veterans have high rates of suicide attempts."[80] Marsˇanic´, et al., suggests that this increase of suicide attempts are in part because

> an adolescent who is raised by a father with a combat related PTSD can be at risk for suicidal behaviors because of the transmission of suicidality and psychiatric conditions to offspring but also continuous exposure to varying degrees of impairment and instability within the home environment.[81]

Though this research done by Marsˇanic´, et al., is interesting it is limited to inpatient adolescents. No literature was found

78. Alexandra Pitman, et al., "Bereavement by Suicide as a Risk Factor for Suicide Attempt: A Cross- Sectional National UK-Wide Study of 3432 Young Bereaved Adults," *BMJ* Open, (Dec 2015), accessed 18 February 2016, http://bmjopen.bmj.com/content/6/1/e009948.full.pdf+html.
79. DSM-5, 945-946.
80. Vlatka Boricˇevic´ Marsˇanic´, et al., "The Prevalence and Psychosocial Correlates of Suicide Attempts Among Inpatient Adolescents Offspring of Croatian PTSD Male War Veterans," *Journal of Child Psychiatry and Human Development* 45, no. 5 (October 2014): 581.
81. Marsˇanic´, et al., "The Prevalence and Psychosocial Correlates of Suicide Attempts Among Inpatient Adolescents Offspring of Croatian PTSD Male War Veterans," 582.

that dealt with outpatient adolescents or adolescents who were not receiving professional help for their personal challenges. As such it is beyond the scope of the literature available to show exact prevalence of suicidal ideation, suicidal attempts, and suicidal completion among children and adolescents who have experienced secondary traumatization. However, it is not beyond the research available to suggest that the children and adolescents of traumatized parents could be at a higher risk for suicidal ideation and attempts.

Externalizing Symptoms

Behavioral Problems

Jordan, et al., argues that according to the Child Behavior Checklist (CBCL), "Children of veterans with PTSD are more likely to have behavioral problems than children of veterans without PTSD, and more than one third of male veterans with PTSD have a child with problems in the clinically significant range."[82] However, Jordan, et al., are also quick to point out that their "findings, do not suggest that all of the families of veterans with PTSD are extremely chaotic, desperately unhappy, and severely disturbed."[83] Though the children of veterans with PTSD are almost twice as likely to express behavioral problems, the severity and impact of these challenges will vary greatly from family to family. Additionally, Leen-Feldner et al., as well as Lambert, Holzer and Hasbun show that parental PTSD is correlated with general child behavioral problems but not with child behavioral

82. B. Kathleen Jordan, et. al., "Problems in Families of Male Vietnam Veterans with Posttraumatic Stress Disorder," *Journal of Consulting and Clinical Psychology*, 60 no. 6 (1992): 923-924.
83. Jordan, et al., "Problems in Families," 924.

disorders.[84, 85]

Though none of the aforementioned authors make specific mention of what behavioral problems children of parents with PTSD exhibited the CBCL measures for social functioning (e.g., activities and social interaction), mood and anxiety symptoms (e.g., depression/withdrawnness, and somatic complaints), and externalizing symptoms (e.g., rule- breaking and aggressive behavior).[86] The CBCL is also used by clinicians to measure the symptoms of Conduct Disorder and Oppositional Defiant Disorder.[87] It is important to note that an increase of some symptoms of Conduct Disorder or Oppositional Defiant Disorder does not automatically mean a child/adolescent has, or will, develop either disorder. Such diagnoses will not be handled in this project.

In summary, the literature suggests that children of a parent with PTSD may exhibit higher levels of behavioral problems as measured by the CBCL (aggressiveness, somatic complaints, truancy at school, sulkiness, vandalism, bed wetting).[88]

Substance Use

Acion, Ramirez, Jorge and Arndt show through their re-

84. Ellen Leen-Feldner, et al., "Associations Between Parental Posttraumatic Stress Disorder and Both Offspring Internalizing Problems and Parental Aggression Within the National Comorbidity Survey-Replication," *Journal of Anxiety Disorders* 25, no. 2 (March 2011).
85. Lambert, Holzer and Hasbun, "Association between Parents' PTSD."
86. T. Achenback, *Child Behavior Checklist for Ages 6-18*, accessed 5 February 2016, http://www.aseba.org/forms/schoolagecbcl.pdf.
87. T. Achenback and L Rescorla, *Manual for the ASEBA School-Age Forms and Profiles* (Burlington, VT: University of Vermont, Research Center for Children, Youth, and Families, 2001).
88. Achenback, *Child Behavior Checklist*.

search that children and adolescents of deployed military families are at a higher risk for substance use, misuse, and abuse.[89] However, Acion, et al., do not make any distinctions between children of non- traumatized parents and children of traumatized parents. Beckham, et al., nearly 20 years ago reported that 40% of children of Vietnam veterans with PTSD use illegal drugs.[90] But again, Beckham's research, as good as it was, is not recent, and therefore may only suggest similar substance use among returning OEF/OIF/OND veteran's families. However, there is no recent research how many military children/adolescents use, misuse or abuse substances solely because of secondary traumatization.

Because there is research showing that children of substance users are more likely to use themselves, it was expected that drug use/abuse would show up more in the research as a symptom of secondary traumatization. However, it did not. Nonetheless, most of the studies dealing with secondary traumatization either did not include drug use, or excluded drug use on grounds that there was no statically significant difference between offspring of traumatized parents and non-traumatized parents. Though there is research indicating an increase of use of substances among the offspring of traumatized parents, it is limited. Hopefully, more research regarding this topic will be forth coming.

PTSD

89. Laura Acion, et al., "Increased Risk of Alcohol and Drug Use among Children from Deployed Military Families," *Addiction* 108 (August 2013): 1421.

90. Jean Beckham, et al., "Minnesota Multiphasic Personality Inventory Profiles of Vietnam Combat Veterans with Posttraumatic Stress Disorder and Their Children," *Journal of Clinical Psychology* 53, no. 8 (December 1997): 850.

PTSD as a symptom of secondary traumatization is unique from the other symptoms of secondary traumatization. When the child/adolescent is no longer mimicking PTSD symptoms or developing secondary symptoms, but have become traumatized through primary trauma they themselves develop PTSD. As discussed and defined previously, PTSD is "an anxiety disorder that develops in some individuals after exposure to an extremely traumatic [terrifying] event(s)."[91] The first criteria for PTSD, Criteria A exposure to the traumatic event, is sometimes referred to as the gatekeeper of PTSD. Meaning that even with the other symptoms of PTSD, if an individual is not exposed to a traumatic event an individual cannot be diagnosed with PTSD. According to the DSM-5 there are two ways in which an individual can meet the criteria for PTSD, direct and indirect exposure.[92] Direct exposure is defined as when an individual has personally experienced or witnessed, a traumatic event.[93] Indirect exposure is defined as when an individual learns "that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend the event(s) must have been violent or accidental."[94] In other words, as a child or adolescent learns the details of the traumatic event(s) that their parent(s) experienced the child/adolescent passes the gatekeeping criteria for PTSD. However, unless the child or adolescent also develops the remaining criteria symptoms the child cannot be diagnosed with PTSD.

Neria, Olfson, Gameroff, et al., show that 43.3% of adults who had a loved one killed in the 9/11 attacks met criteria for

91. Fruesh, "Posttraumatic Stress Disorder," 249.
92. DSM-5, 271. See Criteria A1 and A2 of PTSD.
93. DSM-5, 271.
94. DSM-5, 271. See Criteria A3.

PTSD.[95] Furthermore, McCarrol, et al.,'s research points out that Gulf war soldiers who worked in mortuary affairs had higher levels of PTSD.[96] Additionally, troops who were exposed to human remains on assigned graves registration duties had a 65% prevalence of PTSD.[97] Moreover, Klaric et al., shows that of the women married to a PTSD veteran, 40.3% were diagnosed with PTSD themselves, while 58.4% of these spouses expressed PTSD like-symptoms without being diagnosed with PTSD, leaving only 1.3% experiencing no symptoms of PTSD.[98] This research supports the DSM-5 diagnostic criteria that though none of these individuals had primary exposure to the traumatic event(s) (e.g., 9/11 attacks, witnessing death of family and friends) that these individuals met the all the criteria of PTSD via indirect, or secondary exposure (i.e., secondary traumatization).

In terms of secondary traumatization in children and adolescents leading to the child/adolescent developing PTSD themselves, Yehuda, Halligan, and Bierer argue that, the most

95. Yuval Neria, et al., "Prevalence and Psychological Correlates of Complicated Grief Among Bereaved Adults 2.5–3.5 Years After September 11th Attack," *Journal of Traumatic Stress* 20, no. 3 (June 2007), 259.
96. James McCarroll, et al., "Effect of Exposure to Death in a War Mortuary on Posttraumatic Stress Symptoms." *Journal Nervous and Mental Disease* 189, no. 1 (January 2001): 44–48.
97. Patricia Sutker, et al., "Psychopathology in War-Zone Deployed and Nondeployed Operation Desert Storm Troops Assigned Graves Registration Duties," *Journal of Abnormal Psychology* 103, no. 2 (May 1994): 386.
98. Miro Klarić, et al., "Psychiatric and Health Impact of Primary and Secondary Traumatization in Wives of Veterans With Posttraumatic Stress Disorder," *Psychiatria Danubina* 24, no. 3 (June 2012), 284.

significant predictor of offspring PTSD, is parental PTSD.[99] Furthermore, Yehuda and her colleagues discuss "that vulnerability to PTSD is 'transmitted' across generations."[100] In conjunction, Yehuda and Bierer further stated that "parental posttraumatic stress disorder appears to be a relevant risk factor for the development of PTSD."[101] In this regard, Yehuda and Halligan, and Grossman note that the adverse experiences that children of PTSD parents endure "constitute important risk factors for PTSD and may set the stage for biologic alterations that are compatible with the subsequent development of PTSD."[102] This means that as a child or adolescent experience secondary traumatization their brains experience alterations that can lead the child/adolescent to develop PTSD.

Yehuda, Halligan, and Bierer report that when compared with non-traumatized parents' offspring, a child/adolescent of a father who suffers from PTSD are 10% more likely to be diagnosed with PTSD. Interestingly, these same researches report that when the mother is the traumatized parent, the children are nearly 40% more likely to be diagnosed with PTSD sometime in the child's life.[103] To clarify, maternal PTSD is more predictive than paternal PTSD as to whether or not a child/adolescent will

99. Rachel Yehuda, Sarah Halligan, and Linda Bierer, "Relationship of Parental Trauma Exposure and PTSD to PTSD, Depressive and Anxiety Disorders in Offspring," *Journal of Psychiatric Research* 35, no.5 (July 2001): 265.
100. Yehuda, Halligan, and Bierer, "Relationship of Parental Trauma," 267.
101. Rachel Yehuda and Linda Bierer, "Transgenerational Transmission of Cortisol and PTSD Risk," Progress in Brain Research 167 (2008): 121.
102. Rachel Yehuda, Sarah Halligan, and Robert Grossman, "Childhood Trauma and Risk for PTSD: Relationship to Intergenerational Effects of Trauma, Parental PTSD, and Cortisol Excretion," *Development and Psychopathology* 13, no. 3 (Summer 2001): 750.
103. Yehuda, Halligan and Bierer, "Relationship of Parental Trauma Exposure," 266.

be diagnosed with PTSD. By extension female service members' families are in need of greater support, etc. especially when the female service member is a single parent. Additionally, children and adolescents who develop PTSD from secondary traumatization, will like their parent(s) who experienced primary trauma, relive or re- experience their trauma or their parent(s)' trauma, e.g., avoidance, hyper-arousal, and play re- enactment.

In conclusion, though there is little research specifically dealing with the prevalence of children and adolescents developing PTSD through indirect exposure (secondary traumatization) the research clearly shows that "learning [of] traumatic event(s) occur[ing] to a parent or caregiving figure" can pass the child/adolescent through the gatekeeping criteria of PTSD and on to development of their own PTSD.[104]

Summary

The symptoms of secondary traumatization vary in nature and impact each child or adolescent differently. Though a child may not be affected to the point that they qualify for a diagnoses of a mental illness, the research is clear that the effects of trauma can influence the children and adolescents of traumatized parents. According to the research presented in this literature review, this effect is likely to cause children and adolescents of traumatized parents to experience higher levels of anxiety, attachment confusion, behavioral problems, depression, PTSD, and suicidal ideation. In other words, as a child or adolescent experiences secondary traumatization the stress they experience

104. Andrew Levin, Stuart Kleinman, and John Adler, "DSM-5 and Posttraumatic Stress Disorder," *Journal of American Academy of Psychiatry and Law* 42, no. 2 (2014) 148-150.

may be elevated from tolerable to toxic.[105] However, though the research clearly suggests that children/adolescents who experience secondary traumatization may be affected by these symptoms the research also clearly shows that the children and adolescents of military families are resilient.

The lessons of resiliency are taught to the children and adolescents of military families through learning to cope not only with deployments, but also with the changes to their parent(s) who suffers from the effects of primary trauma while learning to cope with their own secondary trauma. To help a children adolescents build resiliency with regard to the symptoms of secondary traumatization, the following survey of the literature concerning biobliotherapy will discuss the use of books as a tool to help ameliorate the effects of secondary trauma.

Bibliotherapy

Lambert, Holzer, and Hasbun state that "for children who live in a two-parent household, it is possible that a nontraumatized parent can help to moderate the effects of the other parent's PTSD. Further, when both parents are distressed, child functioning could be more problematic."[106] This suggests that children who live in a single parent home, or where both parents are distressed may need the intervention of the community and extended family members.

One way that a non-traumatized parent can help the children and adolescents of traumatized parents is by building up the child/adolescent's latent coping skills and abilities. One method

105. Shonkoff and Garner, "The Lifelong Effects," 235-236.
106. Lambert and Holzer and Hasbun, "Association Between Parents' PTSD," 14.

of helping children and adolescents develop their latent coping skills is through bibliotherapy. This part of the literature review will briefly discuss some of the latent coping skills that children in military families may already have, the literature review will then turn to bibliotherapy, its use and offer suggestions on a number of books that parents may read to or with their child/adolescents to help prepare and protect them against the effects of secondary traumatization.

Latent Coping Skills

It can be, and is rightly argued that not all military children/adolescents will be greatly affected by the effects of secondary traumatization. This is partly because of the life lessons children and adolescents learn through military family life. Lynn K. Hall argues that "military brats grow up in a world very different from the world in which most civilian kids grow up in the United States, but that experience has given them amazing resiliency and strengths."[107, 108] Hall notes that children of military families are very capable and responsible. Some of the strengths that Hall delineates in military children include: taking responsibility seriously, getting along with everyone, being resilient and flexible, being loyal and self-sacrificing, having a 'bring on the challenges' attitude, being productive and efficient, living their diversity, and talking care of the world.[109] Each of these strengths can be fundamentally vital while helping a family deal with primary or secondary effects of trauma.

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107. Lynn K. Hall, Counseling Military Families, (New York: Taylor & Francis Group, 2008), 110.
108. In this context, military brats are defined as children of service members. However, it should be noted that some view it as pejorative term.
109. Hall, *Counseling Military Families*, 101-128.

Nonetheless, Hall also recognizes that children of military families face major problems. One major challenge is the *permanent change of station* (PCS) where children nor their parents have much, if any control, on the location or timing in their moves.[110] By being moved time and time and time again children and adolescents of military families adapt and "tend to get along well with almost everyone, with perhaps one exceptions: the more authoritarian personality."[111] However, one down side of such adaptation is that military brats often "wear numerous masks to protect themselves against the loss of friendship or attachments, which they consider inevitable."[112] Additionally, due to the military environment, e.g., deployments, military children and adolescents learn "excellent coping skills necessary to deal with almost anything."[113] However, Hall warns that while "this resiliency for many leads to healthy and productive lifestyles… [other military brats] become ambivalent and lose sight of their personal values, what they really care about, or what they are willing to stand for."[114] These examples show that though military children often have amazing abilities to manage anything that life throws at them, it seems that when unchecked or untutored the same coping skills can become a hindrance to the long-term social and mental health of the adult life of military brats.

In terms of secondary traumatization, it is apparent that the coping skills mentioned by Hall can help with the holistic health of the child. Nonetheless, it seems that Hall is suggesting that the same skills may compound the negative effects of secondary trauma. Consequently, it becomes incumbent upon parents

110. Hall, *Counseling Military Families*, 113.
111. Hall, *Counseling Military Families*, 110.
112. Hall, *Counseling Military Families*, 110.
113. Hall, *Counseling Military Families*, 111.
114. Hall, *Counseling Military Families*, 111.

to intentionally model and teach health balances of these coping skills, which may require an alteration in parenting style.[115]

The development of many coping skills are often only self-taught. However, with intentional parenting children and adolescents are more likely to develop healthy coping skills. To help children build up their coping skills and improve their coping strategies Heath and collegues suggests that, "Historically, ideas from literature have assisted individuals in coping with the world around them."[116] With literature in mind, the literature review will now turn to bibliotherapy.

Understanding Bibliotherapy

Since the days of the Alexandrian Library, books have been recognized as "medicine for the mind."[117] In this vein, bibliotherapy has been defined as the "sharing [of] books or stories with the intent of helping an individual or group gain insight into personal problems."[118]

Bibliotherapy is a way of using books to help an individual build and learn coping skills. Lowe suggests that "story-telling is a timeless teaching tool. Expression through text offers readers of all ages the opportunity to find solutions through the characters and conflicts within a story, and thus within themselves."[119]

115. Hall, *Counseling Military Families*, 120.
116. Melissa Heath, et al., "Bibliotherapy: A Resource to Facilitate Emotional Healing and Growth," *School Psychology International*, SAGE Publications 26, no. 5 (November 2005): 563.
117. *Chamber's Encyclopedia: A Dictionary of Universal Knowledge for the People*, Volume 6, (New York, NY: American Book Exchange, 1879), 114.
118. Health, et al., "Bibliotherapy: A Resource," 564.
119. Danielle Lowe, "Helping Children Cope Through Literature," *Forum of Public Policy* 2009, no. 1 (March 2009): 1.

Roberts and Crawford also argue that "knowing what might happen in situations surrounding deployment, separation or divorce, moving, illness, or death demystifies children's fears associated with these difficult times."[120] Roberts and Crawford summarize their arguments stating that "quality children's books… model ways to cope."[121] Lowe further states that "bibliotherapy, or therapeutic reading helps children relate to characters and cope with their own emotions."[122] Lowe concludes that "appropriate books will enable a conversation."[123] In short, bibliotherapy is used when a parent intentionally reads a book or story with a child/adolescent in order to help elicit healing conversations, create dialogue, and teach coping skills. It gives parents the opportunity to open dialogue with their children in a non- threatening manner.

With this in mind, Grinder, Stratton, and McKenna state three assumptions for bibliotherapy to work. These assumptions are:

1. A need, problem, or issue must be identified by the [child] and/or [parent];
2. The reader must be able to identify with or relate to the character who shares the same problem, issue, or need…; and
3. The [child] must experience new insight, knowledge, or

120. Sherron Robert and Patricia Crawford, "Literature to Help Children Cope with Family Stressors," *Young Children* 53, no. 5 (September 2008): 14.
121. Roberts and Crawford, "Literature to Help Children Cope with Family Stressors," 4.
122. Lowe, "Helping Children Cope," 2.
123. Lowe, "Helping Children Cope," 12.

understanding after having read a selection.[124]

Bibliotherapy is more than merely a passive reading of a book with a child or adolescent. Rather bibliotherapy is a way of reading a book so as to inform the reader about a particular challenge or problem that the reader could be facing.

Edwards, believes that bibliotherapy, done within a parent-child/adolescent setting, can greatly help the parent-child/adolescent relationship by "open[ing] lines of communication between parent and [child]/adolescent."[125] Reading an appropriate book with a particular challenge in mind can help children/adolescents and parents communicate with one another regarding the challenges they face.

In order for bibliotherapy to be successful Roberts and Crawford offer that "children should be introduced to a book's content beforehand so as not to be caught off guard by sensitive issues presented."[126] Grinder, Stratton, and McKenna further suggest that bibliotherapy is successful when three things happen: (1) "When the reader sees similarities between his life and that of the book character;"[127] (2) "At the peak of identification and empathy, [with the book's character], the reader is able to release pent-up emotions and feelings;"[128] And (3), "once personal

124. Martha Grindeler, Beverly Stratton, and Michael McKenna, *The Right Book, The Right Time: Helping Children Cope* (Needham Heights, MA: Allyn & Bacon, A Viacom Company, 1997), 3.
125. Patricia Edwards and Linda Simpson, "Bibliotherapy: A Strategy for Communication between Parents and Their Children," *Journal of Reading* 30, no. 2 (Nov 1986): 115.
126. Roberts and Crawford, "Literature to Help Children Cope with Family Stressors," 5.
127. Edwards and Simpson, "Bibliotherapy: A Strategy," 111.
128. Edwards and Simpson, "Bibliotherapy: A Strategy," 112.

solutions are identified, the reader can mentally gather data on what suggestions might be integrated into her options for solutions. Insight occurs when the reader realized she is identifying with the characters."[129] In summary, for bibliotherapy to be successful in the home parents must prepare themselves and their children before reading the book. If needed the parent should help the child identify with the book's characters and assist the child to experience a cathartic release of emotions, feelings, and thoughts to help the child gain insight.

However, Edwards warns that,

> Like teachers and counselors, not every parent is qualified to conduct bibliotherapy. They need certain personal qualities, including emotional stability, a genuine interest in working with others, the ability to listen and to empathize without moralizing, threatening, or commanding the other person.[130]

In other words, parents need to be healthy (emotional/physical) in order to be helpful to the children they are assisting.

As has been mentioned, bibliotherapy is not a passive reading of a book with a child. Rather bibliotherapy is intentional reading. Beyond book selection, effective bibliotherapy requires preparation on the part of the parent.

Reading Preparation

Though bibliotherapy was originally implemented by clinical health professionals, the research literature clearly shows the bibliotherapy can be used by teachers, community leaders, as

129. Edwards and Simpson, "Bibliotherapy: A Strategy," 112.
130. Edwards and Simpson, "Bibliotherapy: A Strategy," 115.

well as parents and family members.[131] As previously discussed, effective bibliotherapy requires parental preparation so they can feel ready to discuss their child's emotions, fears, and challenges. A parent also needs to ask themselves if they are personally healthy enough to offer the needed support to their child. If not, then the parent may not want to engage in bibliotherapy. Parents must also determine, if they will simply allow the child or adolescent make their own connections or if the parent will assist in making these connections.[132]

After choosing an appropriate book (challenge relates to the issue, age appropriate, etc.) parents should prepare themselves in at least three areas: (1) How they will introduce the book to the child; (2) How they will read the book; and (3) What post-reading conversation questions or activities will be pursued.

Introducing the book may be as simple as suggesting the book to be read at bed time.However, before reading the book the parent needs to decide how they will talk about the general ideas from the book. Reading the book, may be the most straight forward piece of bibliotherapy. However, it remains important for the parent to remain cognizant of how they themselves and the child are reacting to the story. This attention is important as it will better enable the parent to have a honest conversation with their child/adolescent regarding the contents of the book.[133]

Post-reading is where much of the work will take place. As bibliotherapy will help open the lines of communication, a child

131. Edwards and Simpson, "Bibliotherapy: A Strategy."
132. Roberts and Crawford, "Literature to Help Children Cope with Family Stressors," 5.
133. Melissa Heath and Dawn Sheen. *School-Based Crisis Intervention* (New York: The Guilford Press, 2005): 70-71.

may simply start talking about the book. Other children, at other times, may require parental assistance to begin the conversation. Because of this, it is important that a parent be prepared to ask questions such as: What was your favorite picture?; How did you feel when you saw that picture?; Why do you think we feel stress?; What makes you feel stressed?; How do you handle stress? etc. In some cases, an activity may be appropriate to help stimulate conversation about how the book made the child feel. Regardless of the question or the activity, it is important that the child make a personal connection between their challenge and the challenge of the book's character.[134]

It is imperative, that parents adapt instructions and suggestions of how they will do bibliotherapy with their children and adolescents. As no two children, even in the same family, are the same, parents must be aware of how their child and adolescent may respond to various questions and suggestions for activities.

Book Suggestions for Bibliotherapy

What follows is a list of 13 books that are a sampling of children and adolescent literature. These books were chosen because of their quality and their content. Many of these books deal directly with military life and PTSD, while other address more general difficulties. These books can help parents to create dialogue with their children/adolescents who may be suffering from the effects of secondary trauma. A brief overview of each book will be given with its strengths and weaknesses, and suggestions on how it could be used as a vehicle to lessen the stresses associated with secondary trauma in military families.

134. Heath and Sheen, *School-Based Crisis Intervention*, 65-67.

A Terrible Thing Happened.[135] In *A Terrible Thing Happened* the reader learns how Sherman Smith, a raccoon, is affected by his terrible experience. Though the reader never finds out what Sherman's terrible experience is, it is clear that Sherman recognizes his experience as terrible and is troubled by it. As such *A Terrible Thing Happened* is universal in that it allows the reader to connect with Sherman regardless of the child's own terrible experience. At first Sherman tries to avoid thinking about or remembering the terrible thing. Next Sherman tries other outlets to forget the terrible thing. However, none of his coping mechanisms are working, and Sherman becomes angry and bitter. Sherman eventually meets Ms. Maple who helps Sherman think and talk about Sherman's feelings. Though meeting with Ms. Maple is hard for Sherman, he continues to talk with Ms. Maple and starts feeling stronger and less angry.

A Terrible Thing Happened is 31 pages long and is well suited for children from 1st to 5th grade. *A Terrible Thing Happened* offers inviting and warm pictures and simple storytelling. Because the reader never finds out what caused Sherman to be scared and upset, *A Terrible Thing Happened* is well suited for parents who may not know how, or are afraid themselves to start talking about some the challenges of secondary traumatization with their child. *A Terrible Thing Happened* may be a good starting point for many parents and child/adolescents to begin the conversations about secondary traumatization.

Some of the key concepts that are addressed in *A Terrible Thing Happened* include counselling, talking about one's feelings, and how one's response to bad things are normal, e.g. nightmares, avoidance, anger, etc.

135. Margaret M. Holmes, *A Terrible Thing Happened* (Washington, DC: Magination Press, 2000).

A Terrible Thing Happened may help a child begin discussing their reactions to seeing their traumatized parent's symptoms. Additionally, this book helps normalize the idea of talking to trusted adults, such as teachers, counselors, or therapists.

Alexander and the Terrible, Horrible, No Good, Very Bad Day.[136] Many children may know the story of *Alexander and the Terrible, Horrible, No Good, Very Bad Day* because of the movie that is based off this book. In this lighthearted book, Alexander has a day where nothing goes his way and that for him seems worse than all others. In response Alexander wants to leave his problems behind and move to Australia. However, his mom teaches him that even those who live in Australia have days that are terrible, horrible, no good, and very bad.

Alexander and the Terrible, Horrible, No Good, Very Bad Day teaches about avoidance and blaming. This book takes a serious look at helping children understand that all the terrible, horrible, no good, very bad things that happen cannot be avoided forever and it is better face and resolve challenges instead of running away.

Alexander and the Terrible, Horrible, No Good, Very Bad Day is suitable for children in the 1st to 6th grades and is 28 pages long. Some of the key concepts discussed in *Alexander and the Terrible, Horrible, No Good, Very Bad Day* include, avoidance, bad days, parental support, and self-determination. This book can help children understand that challenges are not to be avoided, but that there is also great peace in being heard.

136. Judith Viorst, *Alexander and the Terrible, Horrible, No Good, Very Bad Day* (New York, NY: Atheneum Books for Young Children, 1972).

Cool Cats, Calm Kids.[137] *Cool Cats, Calm Kids* is a simple book that helps teach, or remind, child and adolescents that in the face of stress, self-care is critical. In *Cool Cats, Calm Kids* the reader learns the nine secrets to the long lives of cats. These nine secrets are also good latent coping skills that most children have, but may need reminding of. Some of the examples of these skills or secrets include physical self-care, standing up for one's self, honesty, and endurance.

Though geared towards younger children *Cool Cats, Calm Kids* can also be used by adolescents to learn some coping strategies in the face of secondary traumatization. However, because of the simple text and simple black and white pictures, some readers may become disengaged before a complete reading.

Cool Cats, Calm Kids is 27 pages in length and is well suited for readers in 1st grade and older. The key terms and concepts discussed in *Cool Cats, Calm Kids* include, self-care, coping strategies, and self-esteem. *Cool Cats, Calm Kids* may help kids refocus on their self-care practices and reiterate the importance of moderation.

Daddy's Home.[138] *Daddy's Home* is a 29 page children's book about a young boy who has his routine interrupted when his father returns from a combat deployment. At first the boy is happy that his father has returned, but as time passes the boy is confused and angry that his father has upset the balance of his routine and home life. The boy gets scared as his father struggles with the effects of the war (primary trauma). The boy also struggles as he thinks that his father's flashbacks, nightmares, etc. are

137. Mary L. Williams, *Cool Cats, Calm Kids* (Atascadero, CA: Impact Publishers, 1999).
138. Carolina Nadel, *Daddy's Home* (Arlington, VA: Mookind Press, 2011).

his fault. The boy's mother reassures her son that his father's problems are not his fault and that his father still loves him.

Daddy's Home is a good book to help younger and older children understand some of the hidden or unseen effects that war can have on a loved one. The pictures are engaging and the writing is simple. Although *Daddy's Home* can be used as a conversation starter for parents it should be noted that the book may not be well suited for children/adolescents who think calling their father "daddy" or their mother "mommy" is childish. However, *Daddy's Home* uses simple language and pictures that can help explain PTSD in such a way that younger children can understand.

Daddy's Home may offer a wonderful starting point to help open the lines of communication with the child/adolescent regarding primary trauma and the effects that primary trauma can have on the child/adolescent.

Finding My Way: A Teen's Guild to Living with a Parent Who Has Experienced Trauma.[139] *Finding My Way* is a 130 page, 14-chapter workbook that is designed to help adolescents understand their "traumatized parent, [which] suggests ways to cope during the tough times, help [them] identify people who can support [them], and give [the adolescent] hope because there are things that [they] can do to make things better." *Finding My Way* is a book written to be used in conjunction with professional therapy or stand alone as a book for reading by the adolescent. The book is well written and addresses questions that adolescents may be interested in, but are unsure as how to ask,

139. Michelle Sherman and DeAnne Sherman, *Finding My Way: A Teen's Guide to Living with a Parent Who Has Experienced Trauma* (Edina MN: Seed of Hope Books, 2005).

such as, what happened to my parent? or how can I talk to my friends about my parent's experience? *Finding My Way* can help adolescents find their voice as they struggle with secondary traumatization.

Because the book is a "workbook" and is considerably long, many adolescents may be put off by it. As such, it is imperative that parents help the adolescent see that though *Finding My Way* may look like a "homework book" it is not. Because the book might deal with more than the adolescents wants or needs to delve into, individual chapters can be selected based on the adolescent's needs. In summary, *Finding My Way* may work well for many adolescents; however, it is not for all adolescents. This book may work very well with adolescents who enjoy structure but may not be appropriate for teens who struggle with seeing *Finding My Way* as homework.

The key concepts in *Finding My Way* are: understanding PTSD the traumatized parent, understanding secondary traumatization and self, and interacting with non-traumatized families.

Hope is An Open Heart.[140] Hope is An Open Heart offers simple suggestions on what hope is. The text is overset a series of live action pictures. Hope is An Open Heart offers a number of reframes about how tears, angry words, etc. are things that leave our bodies to make room for better things. The pictures show children from different ethnicities, cultures, and economic status, which feeds the book's message that hope is for everyone, even those who struggle.

Hope is An Open Heart is simple enough for young chil-

140. Lauren Thompson, *Hope is An Open Heart* (New York, NY: Scholastic Press, 2008).

dren to understand, but reflective enough for older adolescents to connect with. *Hope is An Open Heart* is a good book when a child or adolescent may be feeling hopeless. This book offers 32 pages that in addition to hope discuss the ideas of love, finding good in the world, and suggests that better days are to come.

Hope is An Open Heart may help children and adolescents connect their emotions with nature and other activities, which in turn may elicit meaningful conversations.

How Are you Peeling?[141] *How Are You Peeling?* presents to children a number of emotions expressed through the art of photographed fruit and vegetables. In conjunction with the pictures of fruits and vegetables expressing emotions, *How Are You Peeling*? asks children how they are feeling.

How Are You Peeling? is a good, fun book that can be used by parents who are unsure as to how their child is being is feeling about the return of their traumatized parent. The main themes of the book revolve around the core emotions of glad, mad, sad, and afraid. The book can be used with young children or with adolescents who struggle expressing their emotions.

Sparrow.[142] *Sparrow* is the story of a bird named "Sparrow" who enjoys flying with his father. One-day Sparrow's father flies by himself on a long journey. When Sparrow's father returns, the father is injured and can no longer fly. Seeing how injured his father is Sparrow goes off by himself. After some time passes, Sparrow and his father are reconciled. They again express their

141. Saxton Freymann and Joost Elffers, *How Are You Peeling?* (New York, NY: Scholastic Press, 1999).
142. Dorinda Silver Williams, *Sparrow* (Washington, DC: Zero to Three, 2012).

love for one another, and return home for dinner.

Sparrow is unique as it is written and geared for toddlers and very young children. The pictures and words are simple and engaging for the targeted age range. The story is simple, which allows the child to recognize the emotions that *Sparrow* conveys. This story shows the effect that a secure base has on a child. Because the book is a "cardboard book" and may be viewed as "childish," *Sparrow* may not be suitable for many older children and younger adolescents. However, because of the simplicity of the story middle and older aged adolescents may find the story relatable.

Sparrow is 29 pages in length and addresses the concepts of love, security, sadness, and the power of family traditions. *Sparrow* is most suitable and helpful for younger children because there is no traumatic material specifically discussed in the book. *Sparrow* comes in both a "papa" and "mama" version for parents who have deployed.

Tear Soup.[143] *Tear Soup* follows the grieving process of Grandy. Though the reader is never made aware of what the loss is, Grandy's process of grieving loss (life, lifestyle) is allegorized to the making of a pot of soup. Though Grandy's husband, Pops, does make a couple of cameo appearances, the book is mainly about Grandy and her journey.

In *Tear Soup*, Grandy goes through the traditional stages/steps of grief (denial, anger, bargaining, depression, and accep-

143. Pat Schwibert and Churck Deklen, *Tear Soup* (Portland, OR: Greif Watch, 2005).

tance).[144] The story of *Tear Soup* can affirm a bereaved child or adolescent who is suffering the loss of their pre-deployed parent or who has experienced secondary traumatization.

The artwork and writing makes *Tear Soup* easy to read with an older child (4th grade or older). Furthermore, because of the layers of understanding, *Tear Soup* is also very suitable for adolescents as well as adults.

Within its 32 pages, *Tear Soup* is packed with conversation topics. Most of the book revolves around the ideas and concepts of individualized grief/individuated healing, support from family and friends, and self-care. *Tear Soup* can help adolescents and older children.

That Makes Me Mad![145] In *That Makes Me Mad!* Nini, a young girl, tells her parents a number of the things that make her upset and angry. Nini gets mad when life doesn't go her way, or when Nini is blamed for things that are not her fault. Nini ends by telling her parents that she feels better when she can talk about her feelings.

That Makes Me Mad uses comic book style artwork to present situations that give an example of the times when Nini gets mad. The pictures and message of *That Makes Me Mad* can help a parent begin a conversation with their child about what makes the child mad, upset, or angry towards a parent who recently returned from deployments. As such *That Makes Me Mad* may be

144. Kathryn Patricelli, "Stages of Greif Models: Kubler-Ross," accessed 3 March 2016, http://www.amhc.org/58-grief-bereavement-issues/article/8444-stage-of-grief-models-kubler-ross.
145. Steven Kroll, *That Makes Me Mad!* (New York, NY: Random House, Inc., 1976).

good for parents who are unsure as to how their child has been affected by the return of the deployed parent.

That Makes Me Mad is 32 pages long. It is written at a 1st grade-reading level but is still suitable for reading up through the 6th grade. This book deals mostly with anger but also with the importance of talking and having open and honest conversations within the family. *That Makes Me Mad!* could help children deal with feelings of frustration and anger directed at their parents due to symptoms of primary trauma that their parent/s may be exhibiting.

Why Are You So Scared?: A Child's Book About Parents With PTSD.[146] *Why Are You So Scared?* is an informational book for children about PTSD and how PTSD can affect the whole family via secondary traumatization. The language is simple to understand and the illustrations are engaging and soft. The book is broken into six sections: Overview of PTSD, Causes of PTSD, Effects of PTS and PTSD, Professional Support for PTSD, Secondary Traumatization, and Support for Secondary Traumatization. Each section is three to six pages in length. As such the book can be read in one sitting, or the reading can be done in portions, such as one section per day. Each of sections of *Why Are You So Scared?* includes a page for the child to draw or write in their thoughts, and emotions. *Why Are You So Scared?* can be a great tool to help parents and others to create space regarding how PTSD and secondary trauma affect children.

The author of *Why Are You So Scared?*, Beth Andres, is a Licensed Clinical Social Worker. Because of the author's credentials parents can feel confident that the information presented

146. Beth Andres, *Why Are You So Scared?: A Child's Book About Parents with PTSD* (Washington, DC: Magination Press, 2012).

in *Why Are You So Scared?* is accurate and age level appropriate. Furthermore, the publisher, Magination Press, is a subsidiary of the American Psychological Association.

In addition to PTSD, *Why Are You So Scared?* discusses the secondary effects of PTSD, support for secondary traumatization, and the importance of talking and self-care. *Why are you So Scared?* is useful when trying to explain PTSD and secondary traumatization to older children and younger adolescents. Also, this book is helpful in that it offers ideas to help facilitate parent-child conversation.

Why is Dad so Mad?[147] *Why Is Dad So Mad?* tells the story of a family whose father/husband suffers from PTSD. In the book the mother answers her child's question of why dad is so mad. The child notices some of the times and places where the father gets upset but is confused why his father no longer handles stress as well as he used to. The book helps explain in simple terms the ideas of avoidance, memory struggles, and anger that the father struggles with as a result to his primary trauma. The book concludes with a reminder of the importance of love and safety for the child.

Why Is Dad So Mad? is very different from most books that deal with PTSD or secondary traumatization in that the author, Seth Kastle, himself is a combat veteran who spent 24 months deployed between January 2002 and April 2004. Mr. Kastle, wrote *Why Is Dad So Mad?* in an effort to help his children understand what happened to him in combat and to help his children cope with the changes in their home life. *Why Is Dad So Mad?* is a well written and thought out book. However, this book

147. Seth Kastle, *Why Is Dad So Mad? A book About PTSD and Families* (Hays, KS: TallTale Press, 2015).

does not use analogies like the other books reviewed to explain PTSD and secondary trauma. This book may not be suitable for younger children.

In 32 pages Kastle offers an overview of PTSD, plus the cues, triggers, and symptoms of PTSD. The importance of family support is also discussed as a critical component for children and family member who suffer from PTSD and secondary trauma.

Wounded.[148] *Wounded* is a story told by 15 year old Marcus Campbell. Marcus lives with his ten-year-old sister Megan and mother who are anticipating the return of their father from his first tour in Afghanistan. As the "man of the house" while his father is away Marcus takes on many rolls of caring for, comforting, and supporting his sister and mother through the difficulty of deployment. Soon before his father's return, Marcus' discovers that his friend/girlfriend Courtney's father was killed on the same tour as Marcus' father. Marcus becomes a support to Courtney during this difficult time, but the roles shift as Marcus' father comes home and deals with the effects of war. Marcus' father has trouble sleeping, is started by loud noises, drinks more than normal, has night terrors and is overly preoccupied by the ongoing activities of his former company still in Afghanistan. Marcus confides these things to Courtney and she understands, as her father was deployed once before. She encourages Marcus to get his family to see a counselor. Marcus is extremely hesitant to do so as he feels talking won't fix anything. It isn't until Marcus' father, after having had too much to drink one night, hits Marcus' mother and injures Marcus that Marcus is able to convince his father that there are things that they need help working through.

148. Eric Walters, *Wounded* (New York, NY: Penguin Group, 2010).

Wounded is a great book for adolescents (grades 7-12) as it is written from the perspective of Marcus and his personal experiences. The main themes that the book discusses include, PTSD, counseling, military families, and reintegration stress. Marcus explains a lot of the emotion, concern, and worries that adolescents in a similar situation might feel and could easily relate to. This book may not resonate with all adolescents as *Wounded* is just one boy's personal experience. Some adolescents' experiences may be drastically different and not all teens are going to experience deployment and post deployment struggles in the same way.

Summary of Bibliotherapy

Doll and Doll define bibliotherapy as "sharing a book or books with the intent of helping the reader deal with a personal problem."[149] Therefore, bibliotherapy can be an effective way to help create a dialogue.[150] Nevertheless, the better prepared a parent is to use the methods of bibliotherapy, the likely that bibliotherapy can help parents can create healing conversations and facilitate the teaching of coping skills and insight.

However, after a review of the research literature available, it appears that though bibliotherapy has been qualitatively shown to be effective in helping teens and children better understand themselves, others, and the world around them, recent quantitative data and statistics supporting the effectiveness of bibliotherapy is clearly lacking. As such, "it is important to note that bibliotherapy should not be viewed as a magical fix or the sole

149. Beth Doll and Carol Doll, *Bibliotherapy with Young People: Librarians and Mental Health Professionals Working Together* (Englewood, CO: Libraries Unlimited, Inc., 1997), 1
150. Doll and Doll, *Bibliotherapy with Young People*, 10-13.

intervention for promoting change."[151] Parents must therefore

> be cautioned: (1) Bibliotherapy should be viewed as one of many… tools, not the sole intervention; (2) when implementing interventions that include bibliotherapy, monitor [a child's] progress…; and (3) Carefully select books with topics and storylines that appropriately address the child's emotional needs.[152]

Summary Supporting Research

The supporting literature provided an overview of the research examining primary trauma, in particular posttraumatic stress disorder, a summary of literature dealing with secondary traumatization, and lastly a look at bibliotherapy as a way for parents to mitigate the effects of primary and secondary traumatization in their children and adolescents.

The symptoms of Posttraumatic Stress Disorder (PTSD) affect not only the service member who directly experienced the trauma but the effects can transfer through a family unit. This effect is called secondary traumatization. As has been shown, some children and adolescents will only experience minor negative effects of secondary traumatization, while others will be greatly affected. As a child/adolescent is exposed to secondary trauma the child/adolescent may experience similar symptoms to their traumatized parent. Some of the symptoms include anxiety, avoidance, and depression. Symptoms of anxiety, avoidance, and depression may be a normal developmental response to the reintegration process. However, if children and adolescents continue to experience these symptoms the child/adoles-

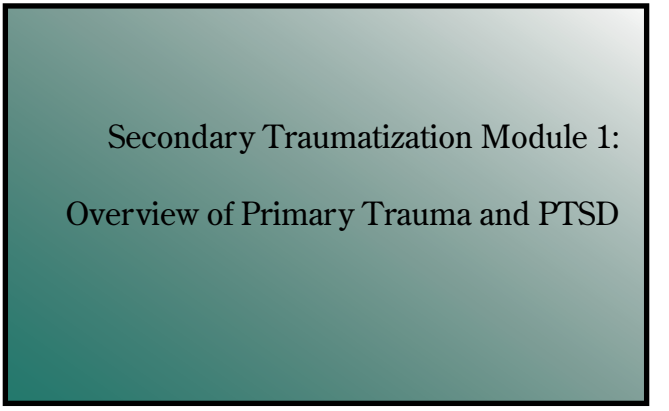
151. Melissa Heath, et al., "Bibliotherapy: A Resource," 565-566
152. Melissa Heath, et al., "Bibliotherapy: A Resource," 566.

cent may need to receive professional care.

One way a parent can help gauge how their child/adolescent is doing and to help the child/adolescent build coping skills is to utilize bibliotherapy. Bibliotherapy is the intentional use of books and other media to help provoke healing conversations and the teaching of coping skills. As families experience the effects of primary and secondary trauma, bibliotherapy may be a worthwhile tool to help families heal and make toxic stress more tolerable for the children and adolescents. However, it is not the only tool that can lessen the effects. Nonetheless, as not all families are not the same, bibliotherapy may not equally suited for each child, or adolescent. As such, parents should wisely choose the book(s) they will use, and if needed seek professional help for themselves and their children or adolescents.

Module 1, PTSD

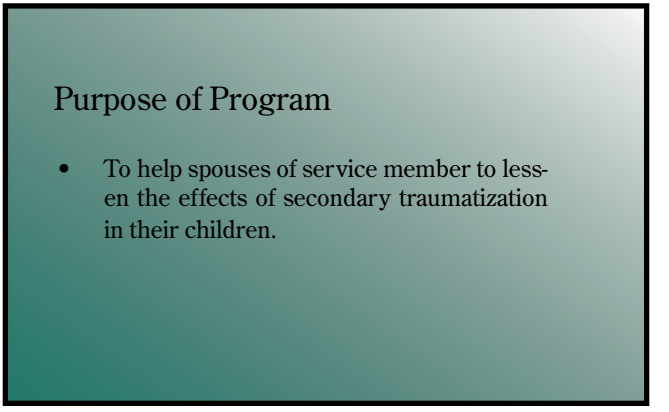
Slide 1



Note: Use this slide to introduce yourself and begin the class.

"Good afternoon ladies and gentlemen. My name is Chaplain..."

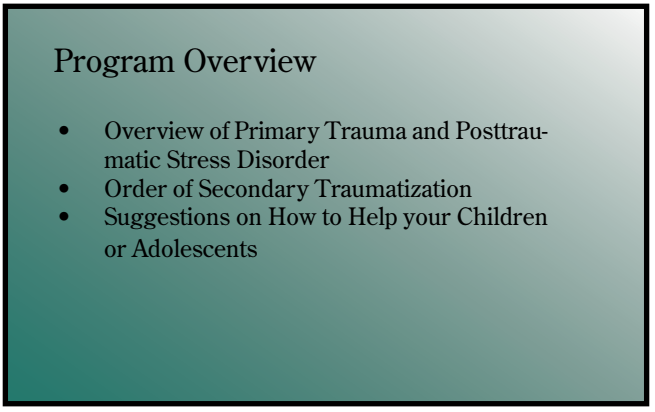
Slide 2



Note: Use this slide to give an overarching introduction to the purpose of the 3 modules.

"The purpose of this three-part training program is to help you, as a parent or caregiver, understand how the primary trauma of your spouse can become secondary trauma within your children and to offer some suggestions on how to lessen the effects of secondary trauma in your children or adolescents."

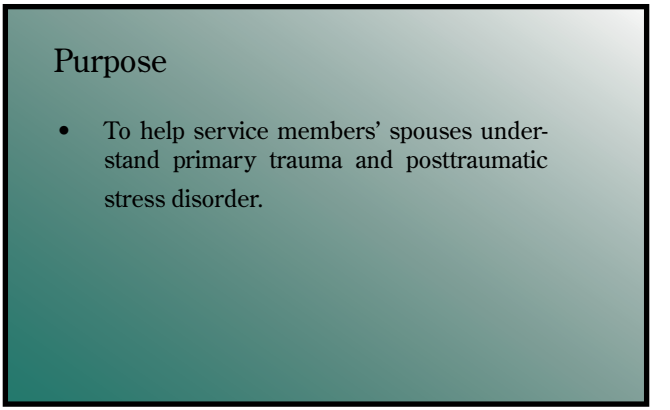
Slide 3



Note: Use this slide to give an explanation of how the three modules will work and when the next class will be.

"Today we will be coving primary trauma and Posttraumatic Stress Disorder, or PTSD, as a result/reaction to primary trauma. We also will be looking at the effects of secondary traumatization and finally we will cover the use of bibliotherapy as a technique for creating dialogue with your children/adolescents." *Note: These materials can be used as 1 hr. classes or as a training seminar (three to four hrs.)*

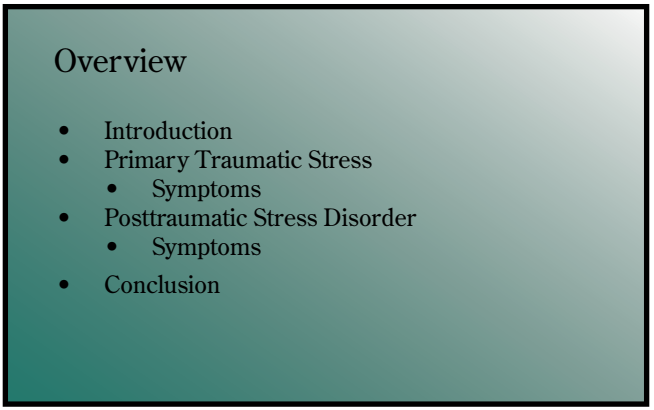
Slide 4



Note: Use this slide to explain your end goal for the class. ***Bottom Line Up Front.***

"I hope that after today's class you will be able to converse smartly about trauma and posttraumatic stress disorder and know what to look for in your spouse so you can help your children by helping your spouse get help if they need it."

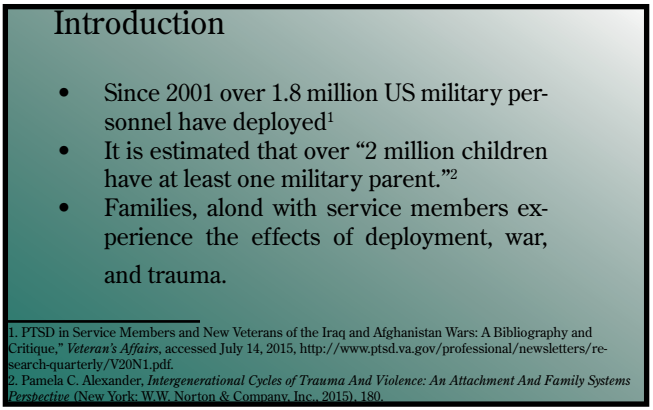
Slide 5



Note: Use this slide to explain where you will be going with the material and to help set expectations, i.e., this class will not make anyone an expert concerning how primary trauma effects secondary trauma in your children or adolescents.

"Today's goal is not to make any of us subject matter experts on primary trauma or the symptoms of primary traumatic stress or PTSD. Rather, today's goal is to help us all understand a little better what **MAY** happen with our loved ones as they are deployed and offer some understanding regarding PTS and PTSD. Today's class is important as it will help set the stage of our understanding of how our spouses' primary trauma can affect our children in the form of secondary traumatization." *It should be noted that when using children, it is understood that it is also referring to adolescents.*

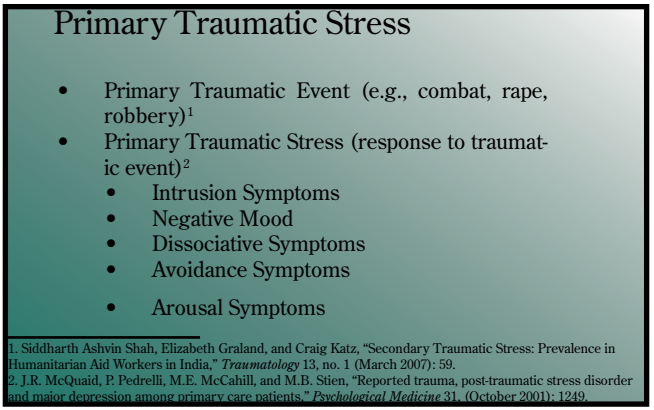
Slide 6



Note: Use this slide to show that the effects of war and combat are not limited to the service member themselves. Rather, these effects extend to the spouses and their children as well.

"From the social sciences, our experience, and our common sense, we understand that everyone in a family is affected by the deployment cycle. We also, understand that children and teens also are affected by a parent's exposure and reaction to combat and trauma." *Note: You might ask those present what they think the effects of deployment are on military families and individuals.*

Slide 7



Note: The purpose of this slide is to introduce the terms "Primary Traumatic Event" and "Primary Traumatic Stress." As you present these symptoms, make sure that you give examples.

Note: The following definitions are taken from both of the articles mentioned on the slide, as well as, from the DSM-5, Acute Stress Disorder

A "**Primary Traumatic Event**" refers to an event that is personally witnessed or experienced by an individual. Examples include combat, rape, robbery, and car accidents.

"**Primary Traumatic Stress**" (PTS) is not equated to Posttraumatic Stress Disorder (PTSD) though the two are closely related, and share many of the same symptoms PTS is **not** PTSD. The symptoms of PTS may only last up to one month after the traumatic event, or may not include all of the symptoms characteristics of PTSD.

"**Primary traumatic stress** is the term used for individuals who respond with intense fear or helplessness after experiencing a traumatic event firsthand." Siddharth Ashvin Shah, Elizabeth Graland, and Craig Katz, "Secondary Traumatic Stress: Prevalence in Humanitarian Aid Workers in India," *Traumatology* 13, no. 1 (March 2007): 59.

Intrusion Symptoms – Includes recurrent, involuntary, and intrusive distressing memories, dreams, and reactions related to the traumatic event(s).

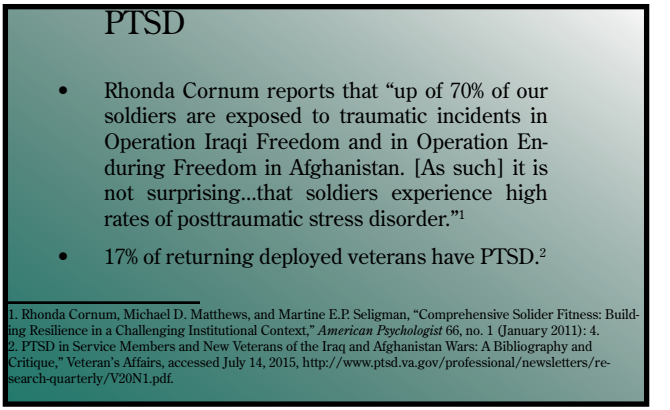
Negative Mood – For example the inability to experience happiness or satisfaction.

Dissociative Symptoms – An altered view/sense of one's reality. Such as feeling in a daze or being unable to remember important aspects of the traumatic event(s).

Avoidance Symptoms – Efforts to avoid internal and external reminders of the traumatic event(s). (e.g. people, memories, feelings, objects, thoughts, etc.)

Arousal Symptoms – Difficulty falling or staying asleep, irritable behavior, hypervigilance, exaggerated startle response.

Slide 8

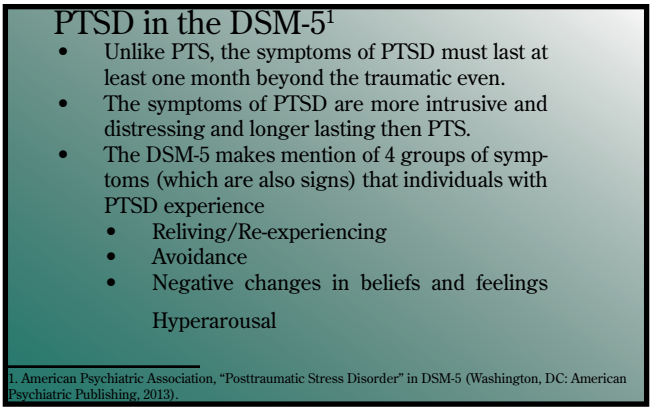


Note: This slide should be used to introduce and define the term Posttraumatic Stress Disorder (PTSD).

"Most military spouses understand that their loved one is likely to be exposed to traumatic events. However, though 70% of soldiers are exposed to traumatic incidents, only 17% have PTSD. That means about 1 out of 4 service members who experience traumatic events meet the criteria for PTSD. Conversely, it means 75% of service members who experience traumatic events do not develop PTSD.

Therefore, while PTSD is something to be aware of prepared for, the majority of service members do not experience/PTSD, but may still have PTS."

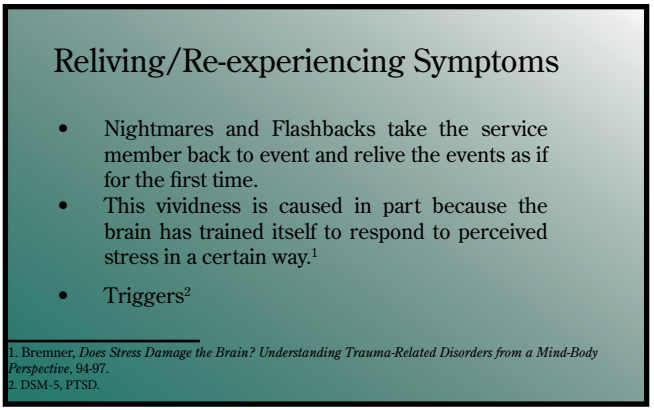
Slide 9



Note: This slide is to introduce the DSM (Diagnostic and Statistical Manual of Mental Disorders) edition 5's criteria of PTSD.

"Unlike PTS, PTSD requires that an individual experience all the types (or clusters) of symptoms beyond one month after the traumatic event(s). That to say, that an individual with PTS may only experience some PTSD symptoms for one month or less. However, an individual with PTSD will have at least one symptom in each of the following symptom clusters/groups for longer than one month, 'reliving/re-experiencing, avoidance, negative changes in beliefs and feelings and hyper- arousal."

Slide 10



Note: This slide is designed to offer an overview of the reliving/ re-experiencing cluster of PTSD symptoms. If time permits, give examples of reliving or re-experiencing symptoms.

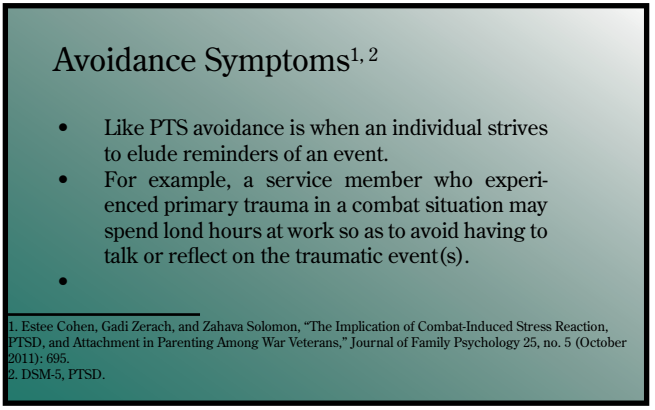
"Just as the title suggests individuals with PTS and PTSD can, in their minds, be taken back to the traumatic event and can remember and re-experience the event as if they were experiencing it anew for the first time. This vividness is caused because of the way memories are formed and how the brain has been trained to respond reminders of the traumatic event. These vivid memories are sometimes called flashbacks, while reminders to the event are called triggers."

Note: This Definitions are taken from the PTSD section of the DSM-5

Flashbacks – Occur on a continuum, where the memories cause great distress on one end, but on the other end there may be a complete loss of awareness of the present surroundings.

Triggers – An event that resembles or symbolizes an aspect of the traumatic event. (e.g., car backfiring, windy days after a hurricane, smells).

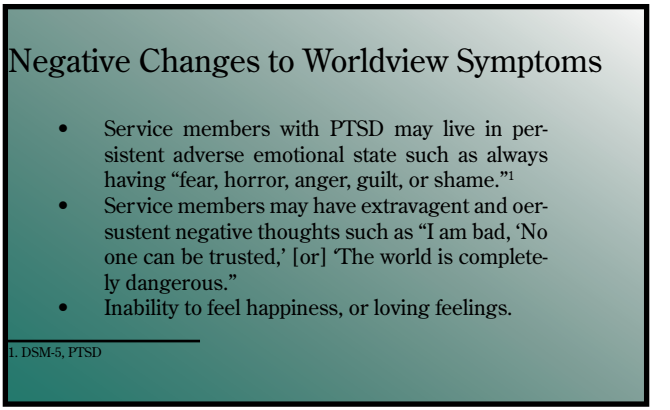
Slide 11



Note: This slide is designed to offer an overview of the avoidance symptom cluster of PTSD.

"Service members with PTSD may manifest avoidance by circumventing or eluding certain "people, places, conversations, activities, objects, situations [that are] closely associated with the traumatic event(s)." DSM-5."

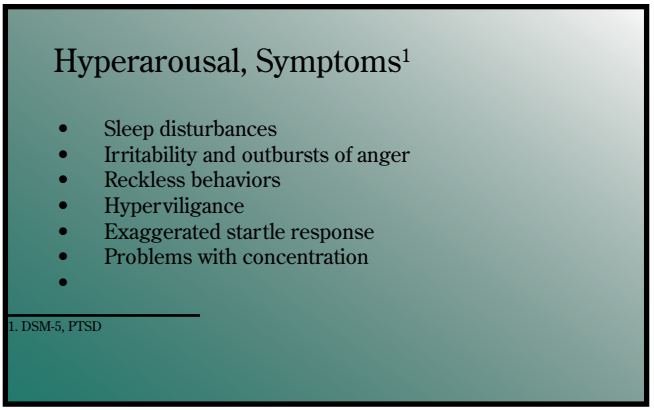
Slide 12



Note: This slide is designed to offer an overview of the Negative Changes concerning the symptoms of PTSD.

"If your spouse experiences PTSD, their worldview may have somehow changed. Where they were once trusting, they may now think that 'no one can be trusted.' And they may struggle with how to express feelings of love or happiness. This will be frustrating and may be a point of shame or anger for them."

Slide 13



Note: This slide is designed to offer an overview of the Negative Changes (worldview) concerning PTSD symptoms.

"Hyper-arousal symptoms refer to how the brain of a person with PTSD cannot calm down. They are always on alert and are always on the lookout for danger and respond to perceived and real dangers as if they were in back in the deployed environment. Examples of hyper-arousal symptoms are:

(Explanation of Symptoms—DSM-5 PTSD)

Sleep disturbances – Service Member may be overly concerned with safety or nightmares, so that they cannot sleep. Or do not enter REM sleep.

Irritability and outbursts of anger – Yelling, getting into fights, typically with little or no provocation.

Reckless behaviors – Excessive substance use, dangerous driv-

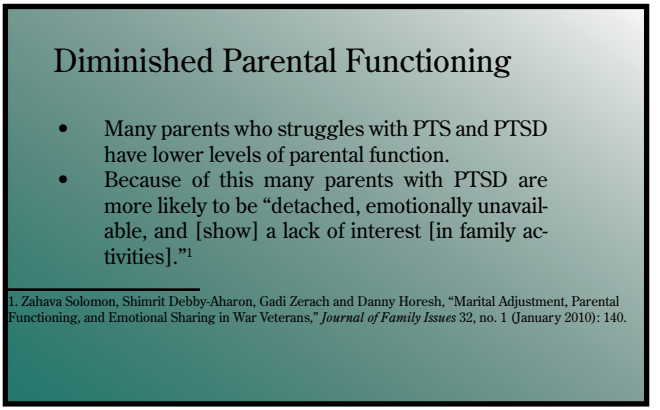
ing, self-injury

Hypervigilance – Being on heightened alert for potential threats related to the traumatic event (not driving cars, etc.) and threats not related to the event (fear of suffering from a heart attack).

Exaggerated startle response – Jumping at a phone ringing, hitting the ground as a firetruck passes the house.

Problems with concentration – difficulty remembering daily events or having difficulty attending to daily tasks."

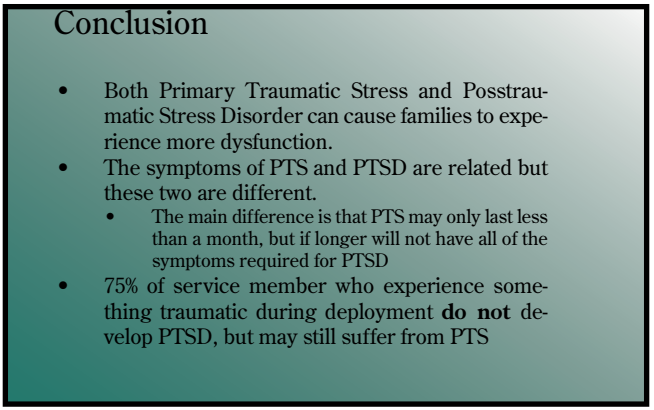
Slide 14



Note: The effect of PTSD is often the parent having less capacity to parent well.

"Because of the symptoms that a parent with PTSD experience they are more likely to become disengaged from the family and may become "detached, emotionally unavailable, and show a lack of interest in family activities."

Slide 15



Note: Use this slide to summarize the presentation and to offer hope and to answer any questions (time permitting).

"Posttraumatic Stress and Posttraumatic Stress Disorder causes families to experience more dysfunction. The root of the dysfunction is related to the symptoms that those with PTS and PTSD exhibit and the fact that 'no man is an island unto themselves'. As such we expect, and the research supports that PTS and PTSD can cause a rippling effect of symptoms throughout the family unit, causing dysfunction and stress.

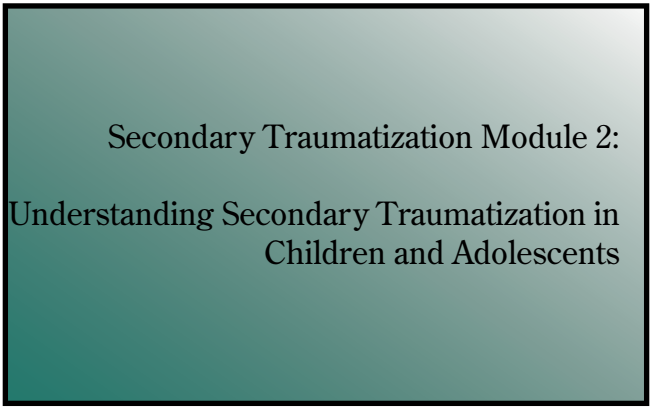
While both PTS and PTSD lead] to personal and family stress the effects of PTSD last longer and are typically more severe in nature.

However, let us make mention again, that not all service members who experience something traumatic develop PTSD. Furthermore, families with a parent/spouse with PTSD are not doomed to chaos and misery forever. Next time we will talk about how

PTS and PTSD (primary trauma) can affect you children and teens. The time after that we will discuss an intervention technique that can help you as you work to protect your family from the effects of secondary traumatization."

Module 2, Secondary Traumatization

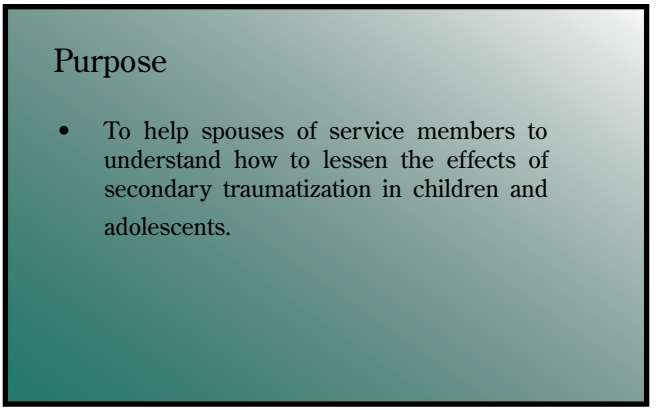
Slide 1



Note: Use this slide to introduce yourself and begin the class.

"Good afternoon ladies and gentlemen. My name is Chaplain…. "Thank you for attending this class on how primary trauma effects secondary trauma in children and adolescent of military families."

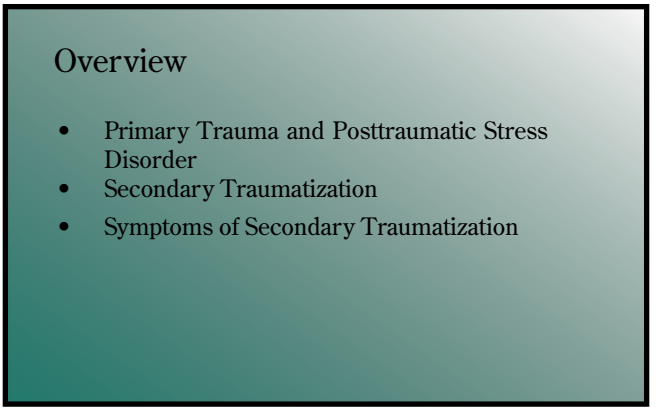
Slide 2



Note: Use this slide to give an overarching introduction to the purpose module three.

The purpose of this training is to help you, as a parent/caregiver, understand how the primary trauma of your spouse can become secondary trauma within your children and to offer suggestions on how to lessen the effects of secondary trauma in your children.

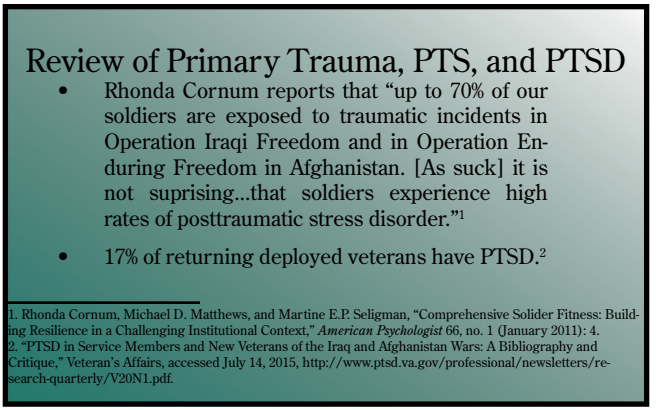
Slide 3



Note: Use this slide to give a brief overview of what you will be presenting.

"Today we will review the differences between Posttraumatic Stress and Posttraumatic Stress Disorder. We will then discuss how primary trauma **may** affect children and become secondary trauma as a result or reaction to a parent's primary trauma."

Slide 4



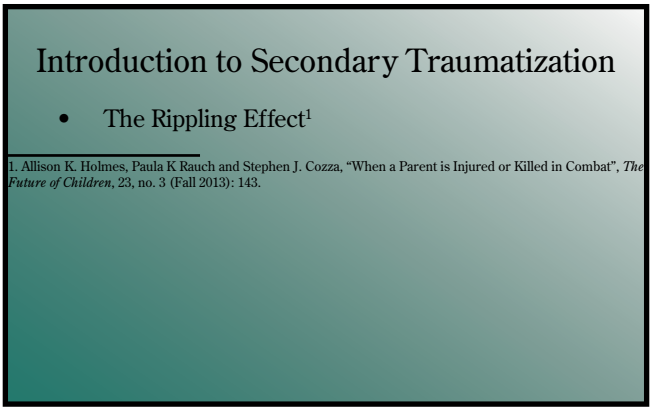
Note: Use this slide to briefly review what Primary Trauma is and the difference between PTS and PTSD.

"As a reminder, PTS and PTSD are related. However, PTS typically only lasts for about one month, when PTS lasts longer than one month its symptoms are not as strong or debilitating as the symptoms of PTSD."

PTS – May only last for up to one month following the traumatic event(s). When it does last longer than one month the symptoms are not as strong or as debilitating as the symptoms of PTSD

PTSD- The symptoms of PTSD last beyond one month following the traumatic event and include at least one symptom from each of the four symptom clusters (Reliving, Avoidance, Negative Changes in Beliefs and Feelings, and Hyperarousal)

Slide 5



Note: This slide should be used to offer an introduction to what secondary traumatization is. Make sure that you explain or demonstrate what rippling means. Tell the participants to think of a smooth pool of water. Then, have them imagine that a small rock drops into the smooth pool. What happens? Most will say that the effect of the rock dropping into the smooth pool of water causes small waves to ripple across its surface. The effects of secondary trauma are like what happens when a rock is thrown into a pool of smooth water. The rock when dropped into the pool represents the rippling effect. The rock symbolizes traumatic material. Therefore, the concept of the rippling effect. Continue with….

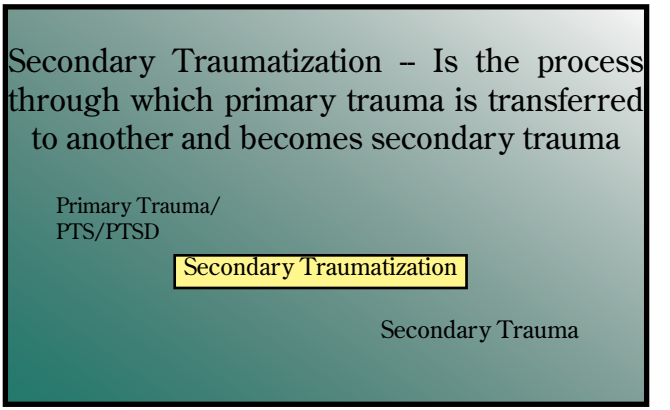
"The rippling effect of trauma is related to systems theory, which states that no single person in a family, a parent, a child, or a sibling, is an island unto themselves. As a parent or another family member experiences trauma that trauma has the capability to affect all of the family members.

Much like how a large rock thrown into a lake has the potential to disrupt the whole lake through ripples."

Secondary Traumatization – Is the process through which primary trauma is transferred to another and becomes secondary trauma.

Rippling Effect – Based on systems theory. When any part of the family system is affect (e.g., parent experiencing PTSD) the entire family unit is affected. So it is like a pebble being dropped in a pool of water and the water get rippled. The effects of PTSD are similar in that they spread through the family.

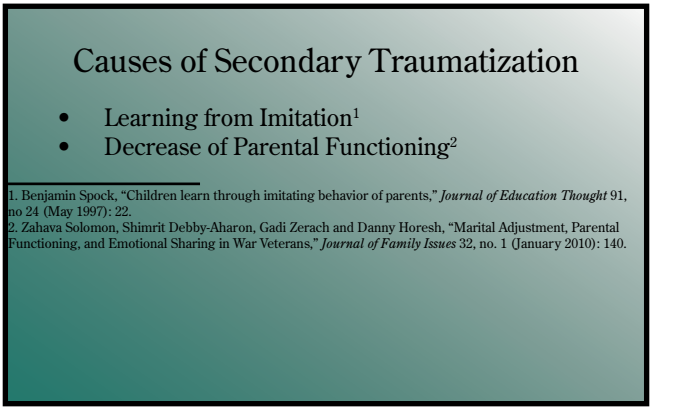
Slide 6



Note: This slide is a visual aid to help explain that a child/or adolescent is exposed to/learns about their parent's Primary Trauma, PTS or PTSD, the child develops secondary trauma through the process called secondary traumatization.

"As we have been discussing, the process of primary trauma in a parent becoming secondary trauma in a child/adolescent is called secondary traumatization. As the spouse of a service member who experiences PTSD you too could likely experience secondary traumatization; however, this training is focused on children and adolescent of military families. If you have questions, or concerns regarding your own reactions to your spouse's trauma please talk to me later concerning possible resources."

Slide 7



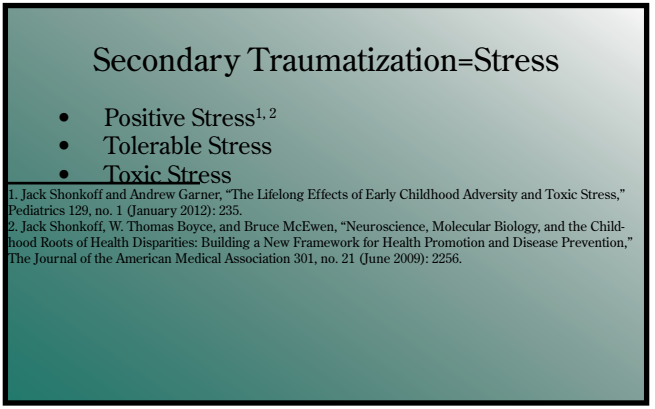
Note: This slide should be used to offer an introduction to what secondary traumatization is.

"Learning from Imitation – Children learn by "identifying with and imitating their parents." (see Spock). Such as toddlers learning new words or learning to walk. So as a child sees their parents overreact to the sound of a fire engine the child in turn may become scared of fire engines."

Decrease of Parental Functioning – As discussed last time par-

ents who suffer from PTS or PTSD often have lower parental functioning. Meaning that they may be less emotionally available for their families. Because of this the child may lose a portion of their secure base and may experience increased levels of stress."

Slide 8



Note: Use this slide to explain the differences between the levels/types of stress that children and adolescents may experience.

Three Types of Stress – "All children and adolescents experience stress. However not all children experience the same stress nor do they react the same to similar stressors. Dr. Shonkoff and Dr. Garner puts the stress of children into three types: positive, tolerable, and toxic."

Positive Stress – "According to Shonkoff and Garner, examples of positive stress include the first day of school, getting shots, and day-to-day frustrations. Positive stress is

> Brief and mild to moderate in magnitude. Central to the notion of positive stress is the availability of a caring and responsive adult who helps the child cope with the stressor, thereby providing a protective effect that facilitates the return of the stress response systems back to baseline status.

When children and adolescents experience positive stress and receive the needed support from a caring and loving adult the child is able to quickly return to their normal self: their baseline status. This type of stress and response is vital to normal life and development."

Shonkoff and Garner, "The Lifelong Effects of Early Childhood Adversity and Toxic Stress," 235.

Tolerable Stress – "Conversely, tolerable stress stems from stressors that are non-normative. Examples include "the death of a family member, a serious illness or injury, a contentious divorce, a natural disaster, or an act of terrorism." Shonkoff and Garner argue that

> When [tolerable stress is] experienced in the context of buffering protection provided by supportive adults, the risk that such circumstances will produce excessive activation of the stress response systems that leads to physiologic harm and long-term consequences for health and learning is greatly reduced.

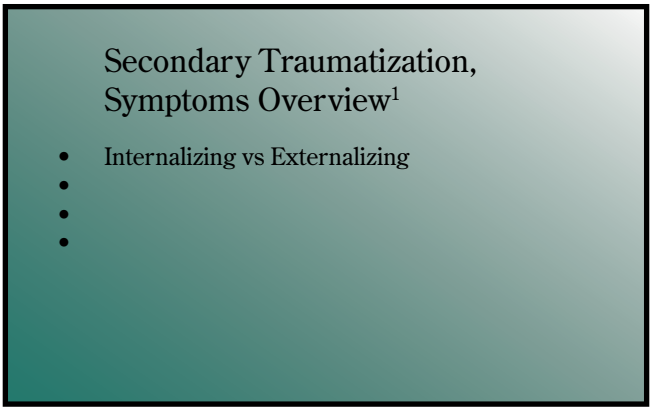
Shonkoff and Garner, "The Lifelong Effects of Early Childhood Adversity and Toxic Stress," 235-236.

When children do not receive support in these non-normal stressful situations the stressors are more likely to cause long-term physiological, health, and developmental harm. However, even with heightened levels of stress, when children are supported by loving, caring adults the children are less likely to experience long-term negative effects of stress."

Toxic Stress – "Examples of toxic stress include "recurrent physical and/or emotional abuse, chronic neglect, severe maternal depression, parental substance abuse, and family violence."4 Toxic stress can be severe in terms of duration, intensity, and/or frequency and is also characterized as lacking the support of an adult. Watching a parent deal with the symptoms PTSD (e.g. reliving the experience, avoidance, etc.) and the accompanying problems (e.g., parental neglect, and anger outbursts) can be a form of toxic stress for a child/adolescent when adult support is nonexistent. Chronic toxic stress in a child can lead to a number of long-term symptoms of secondary traumatization."

After presenting the material on this slide make a statement along the lines that, **"The goal of this program is to help parents make toxic stress more tolerable, and tolerable stress more positive for their children through understanding, dialogue and interventions."**

Slide 9



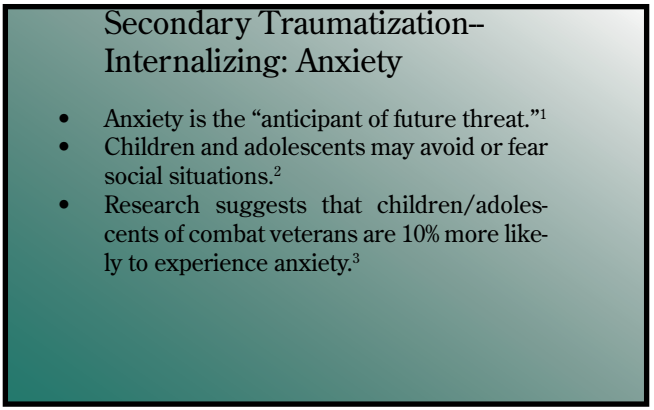
Note: Use this slide to explain the difference between internalizing and externalizing behaviors

Externalizing behaviors – Include actions that are taken against others by means of aggression, defiance, etc.

Internalizing behaviors – In many ways, the mirror opposite in that the harm is against one's self such as through depression, anxiety, and suicidal ideation.

Both the internalizing and externalizing of behaviors are methods of coping with stress. Both can be drastically dangerous to a child or adolescent's mental well-being and health. Give examples of internal vs. external behaviors.

Slide 10



Note: Use this slide to discuss the symptom of Anxiety

- "Research has shown that when compared with the children of non-traumatized parents, the children of traumatized parents 'show more anxiety symptoms.'"

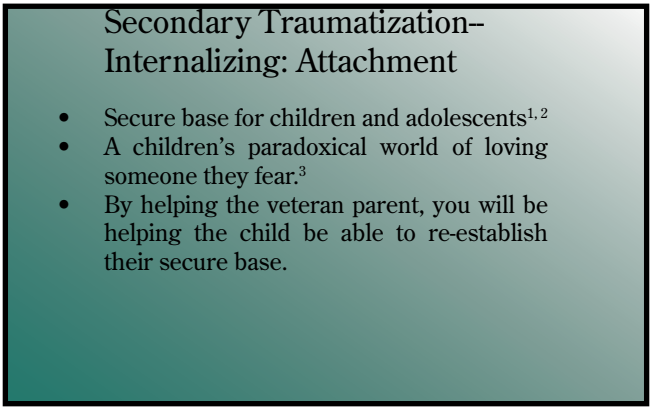
- A. Daud, E. Skoglund, P-A. Pydelius, "Children in families of torture victims: transgenerational transmission of parents' traumatic experiences to their children," International Journal of Social Work 14, no. 1 (January 2005): 29.

- "These anxiety symptoms include excessive worried moods, thoughts, and behaviors."

- "In summary, as a child/adolescent experiences secondary trauma, they are more likely to experience the symptoms of anxiety. Experiencing anxiety, whether said anxiety is diagnosable or not, can lead a child/

adolescent to express abnormally higher levels of restlessness, fatigue, irritability, muscle tension, and sleep disturbances."

Slide 11



Note: Attachment theory suggests that one's circumstances, environment, and personality affect both the way in which relationships are formed and the healthiness of those relationships.

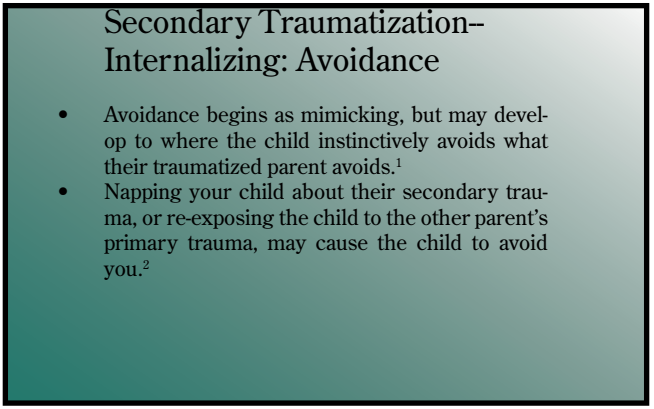
- Marsanic argues that "because of veterans' unresolved sadness and fear of another loss, he may have difficulties in establishing and maintaining attachment, especially with children." Because of the military parent's potential diminished parenting abilities, they and their children may have difficulty forming healthy, normal developmentally important bonds and relationships.

- van Ee, Kleber, and Jongmans, argue that "the attachment of children of parents with unresolved trauma often becomes disorganized because the children are placed in the paradox-

ical situation of being attached to parents who sometimes behave in a fear-provoking way."

- As the supporting parent you need to be aware that your children will need to have a secure base so that they can cope with the changes of their recently returned parent. Just as you were the source of security for your children while you spouse was deployed, you may remain the source of security with the return of your spouse.

Slide 12



Note: Use this slide to discuss the symptom of avoidance.

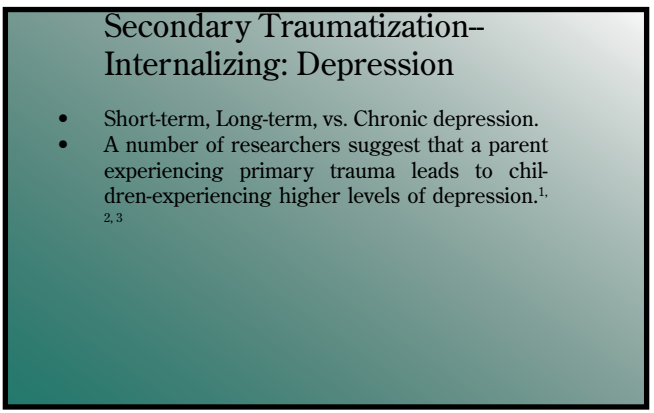
"As discussed last week, avoidance is a common symptom of PTSD. Avoidance occurs when an individual puts forth effort (consciously or not) to evade reminders of the traumatic event, e.g. conversations, news, sounds, crowds, etc.

Avoidance with secondary trauma occurs for two reasons:

Mimicking – Children mimic what they see their traumatized and non-traumatized parent avoid (conversation topics, places, people, etc.)

Preoccupation of Parents - Scheeringa and Zeanah suggests that "if a traumatized parent (i.e., a secondarily traumatized parent) repeatedly asks questions or discusses the traumatic event (that is to say, the secondary traumatization of the child), this unwelcome preoccupation in the parent may re-traumatize a young child."

Slide 13



Note: Use this slide to discuss the symptom of Depression.

"Though the word depression, is a clinical term used in defining a set of mental disorders, depression is also a lay term to describe someone who has "the presence of [a] sad, empty, or irritable mood." Additionally, the symptoms of depression are typically "accompanied by somatic and cognitive changes that significantly affect the individuals' capacity to function." DSM-

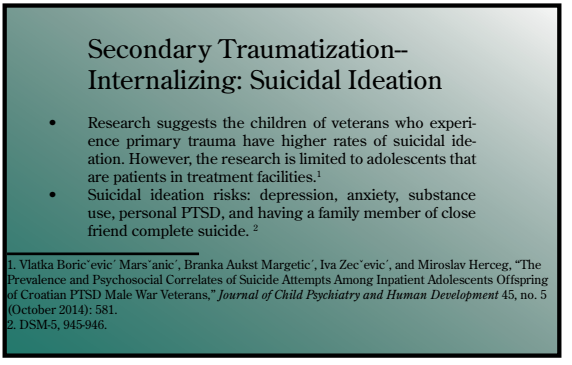
5, 155.

"We all have sad, bad days. The most important thing is that if you notice that your child/adolescent has sadder days than before and if sad days out number happy days the child or adolescent may need to see a counselor."

"Elevated parental [posttraumatic stress symptoms]/PTSD appears to be related to… negative offspring outcomes, including… depression."

"Mothers'… depression scores that predict child depression scores." This is to suggest that the non-traumatized parent's own mental health may have a greater impact on a child or adolescent's ability to cope with the traumatized parent's symptoms. Patrick Smith, Sean Perrin, William Yule, and Sophia Rabe-Hesketh, "War Exposure and Maternal Reactions in the Psychological Adjustment of Children from Bosnia-Hercegovina," Journal of Child Psychology and Psychiatry, 42, no. 3 (March 2001): 402.

Slide 14



Note: Use this slide to discuss the symptom of Suicidal Ideation, Attempts, and Completion.

- "Suicidal ideation" is defined commonly as suicidal thoughts. Suicidal ideation ranges from an individual having detailed plans to momentary contemplations regarding killing one's self, and do not include the act of attempting to kill one's self.

- "Suicidal attempts" are simply defined as an attempt to end one's own life, whereas "suicidal completion" is when an individual carries out their plans of suicide to fulfillment.

- Lisa Cook and Jo Borrill, "Identifying suicide risk in a metropolitan probation trust: Risk factors and staff decision making," *Legal and Criminological Psychology* 20, no. 2 (December 2015): 255-256.

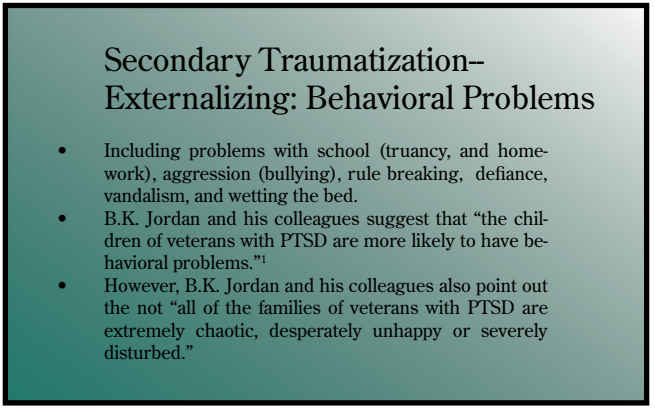
- Having a family member complete suicide is one of the leading risk factors for suicidal ideation and attempts.

- Alexandra Pitman, David Osborn, Khadija Rantell, and Michael King, "Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults," BMJ Open, (Dec 2015), accessed 18 February 2016, http://bmjopen.bmj.com/content/6/1/e009948.full.pdf+html.

"Because no research was completed with outpatient adolescents or adolescents who were not receiving professional help for their personal challenges it is beyond the scope of the re-

search available to show exact prevalence of suicidal ideation, suicidal attempts, and suicidal completion among children and adolescents who have experienced secondary traumatization. However, it is not beyond the research to suggest that the children and adolescents of traumatized parents are at a higher risk of suicidal ideation and attempts."

Slide 15



Note: Use this slide to discuss the symptom of behavioral problems.

- The literature suggests that children of a parent with PTSD may exhibit higher levels of behavioral problems as measured by the CBCL (e.g., aggressiveness, somatic complaints, truancy at school, sulkiness, vandalism, and wetting the bed). TM. Achenback, *Child Behavior Checklist for Ages 6-18*, accessed 5 February 2016, http://www.aseba.org/forms/schoolagecbcl.pdf.

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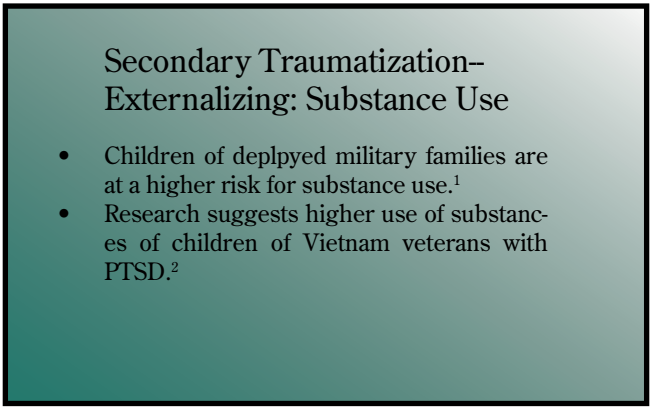
- However, just because there may be an increase in behavior problems and challenges does not mean you or your spouse is a bad parent. Rather these increases in behavioral problems are often a reflection of how a child or adolescent is feeling.

Slide 16



Note: Use this slide to discuss the symptom of substance use.

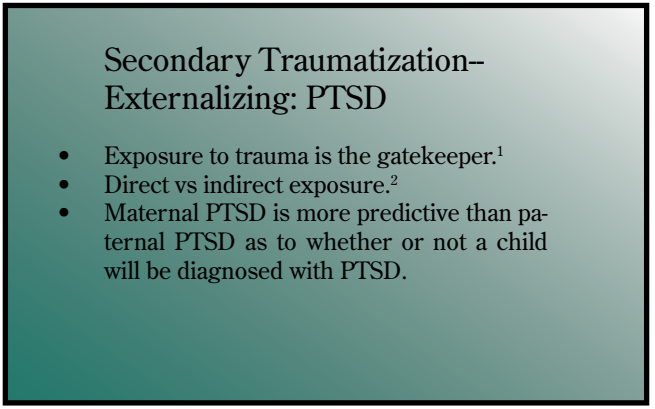
- Acion, Ramirez, Jorge and Arndt show through their research that children and adolescents of deployed military families are at a higher risk for substance use, misuse, and abuse. However, Acion, et al., do not make any distinction between children of non-traumatized parents and children of traumatized parents.

- Beckham, et al., nearly 20 years ago reported that 40% of children of Vietnam veterans with PTSD use illegal drugs. But again, Beckham's research, as good as it was, is not recent, and therefore may only suggest similar

substance use among returning OEF/OIF/OND veteran's families.

- However, we can only infer similar correlations between Vietnam Veteran offspring and the offspring of current service members.

Slide 17



Note: Use this slide to discuss PTSD as a symptoms of secondary traumatization Note: The following definitions are derived from the PTSD of the DSM-5

- **Direct exposure** is defined as when an individual has personally experienced or witnessed, a traumatic event.

- **Indirect exposure** is defined as when an individual learns "that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend the event(s) must have been violent or accidental."

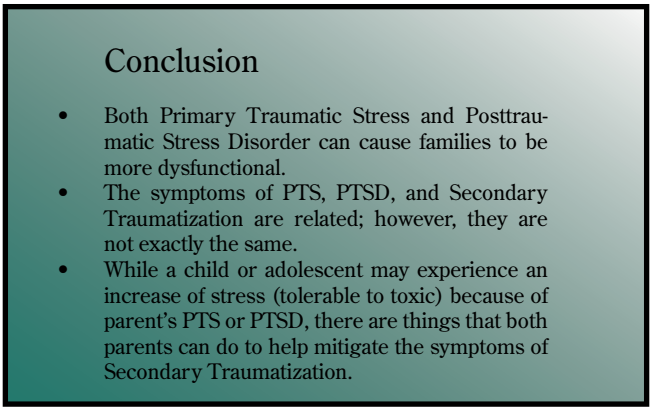
- Both direct and indirect exposure can pass a person (adult, child, or adolescent) past the gatekeeping criteria of PTSD.

- Of women married to a PTSD veteran 40.3% were diagnosed with PTSD themselves, an additional 58.4% of spouses expressed PTSD like-symptoms without being diagnosed with PTSD, leaving only 1.3% experiencing no symptoms of PTSD.

- Yehuda, Halligan, and Bierer report that when compared with non-traumatized parents' offspring, a child/adolescent of a father who suffers from PTSD are 10% more likely to be diagnosed with PTSD.

- Interestingly, Yehuda, Halligan, and Bierer report that when the mother is the traumatized parent, the children are nearly 40% more likely to be diagnosed with PTSD sometime in the child's life. To clarify, maternal PTSD is more predictive than paternal PTSD as to whether or not a child/adolescent will be diagnosed with PTSD. By extension female service members' families are in need of greater support, etc. especially when the female service member is a single parent.

Slide 18



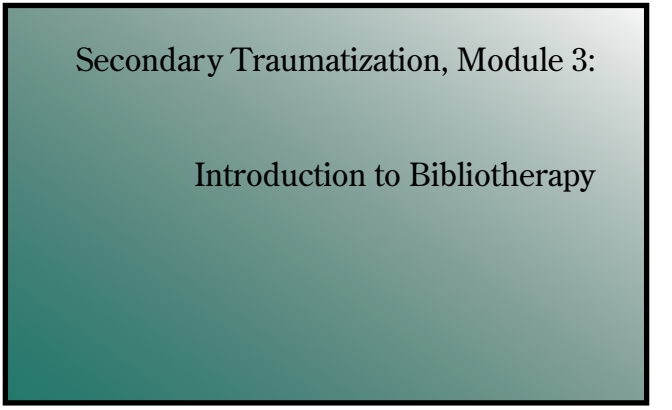
Note: Use this slide to summarize the presentation and to offer hope and to answer any questions (time permitting) from the audience.

"The greatest difference between PTS and PTSD are typically only experienced by the service member themselves. However, PTSD and the other symptoms discussed today can be experienced by the children and adolescents of service members. It is important that you as a parent remain aware of how your child or teen's behavior may change with the return of their deployed parent. If you notice the child remaining bitter, sad, or distant for a period of time, it may be very helpful to seek professional help."

"Also, next time we will be discussing what you, as a parent, can do to help your child/adolescent with secondary traumatization."

Module 3, Bibliotherapy

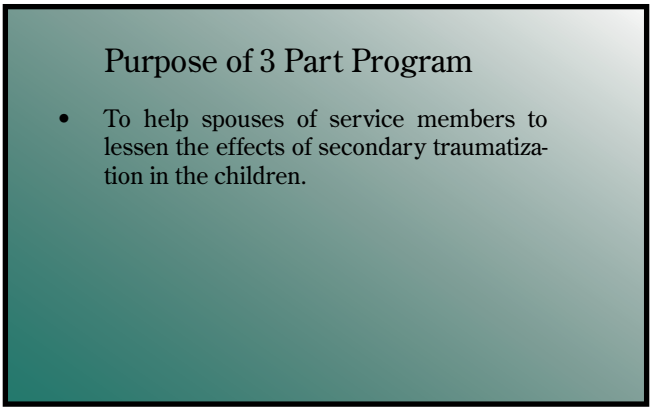
Slide 1



Note: Use this slide to introduce yourself and begin the class.

Good afternoon ladies and gentlemen. My name is Chaplain …. During today's class…

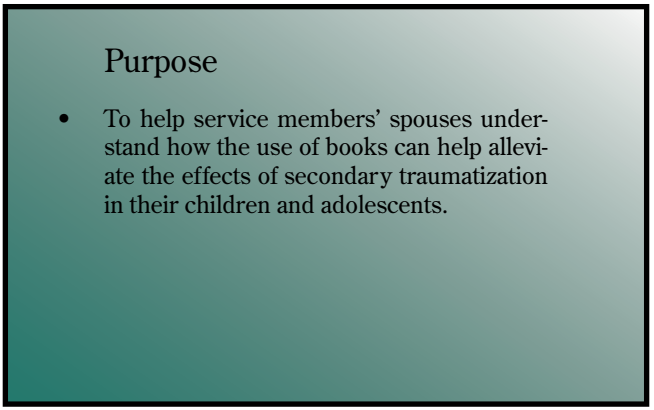
Slide 2



Note: Use this slide to give an overarching reminder of what the whole purpose of the 3 modules has been.

"The last two times we have met we have discussed primary trauma that your spouse may experience and how that primary trauma may affect your children in the form of secondary trauma. Today's we culminate these trainings with a discussion of a method you might consider to help lessen the effects of secondary traumatization

Slide 3

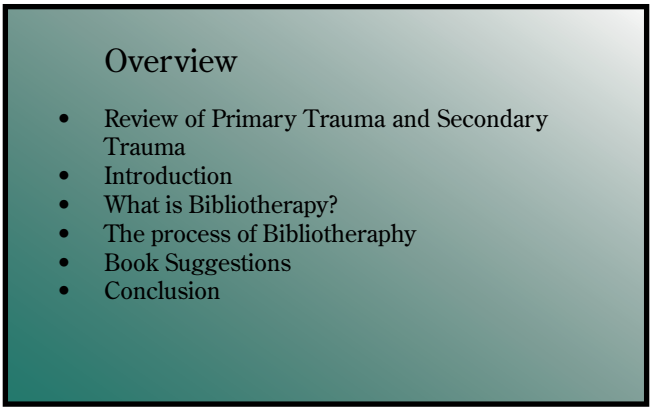


Note: Use this slide to explain your end goal for the class. ***Bottom Line Up Front.***

"The purpose of this Module (3) is to provide training to help you, as a parent/caregiver, understand how the primary trauma of your spouse can become secondary trauma within your children and to offer an intervention method (bibliotherapy) you may consider to lessen the effects of secondary trauma in your children."

"I hope that after today's class you will have a basic understanding how you can use age appropriate books to help your children and adolescents as they cope with secondary traumatization."

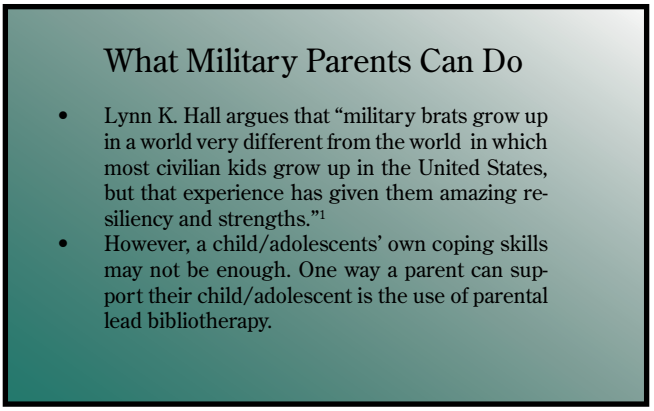
Slide 4



Note: Use this slide to explain where you will be going with material and to help set expectations that this class will not make anyone an expert, but is intended to offer suggestions, explanations and hope concerning the effects of secondary trauma and to provide one intervention technique to help ameliorate its effects.

"Today's goal is to introduce the intervention technique of bibliotherapy. I know it may sound very 'psycho-mumbo-jumbo' but the research and hopefully our experience as parents shows that the intentional use of books in healing and teaching is very effective."

Slide 5

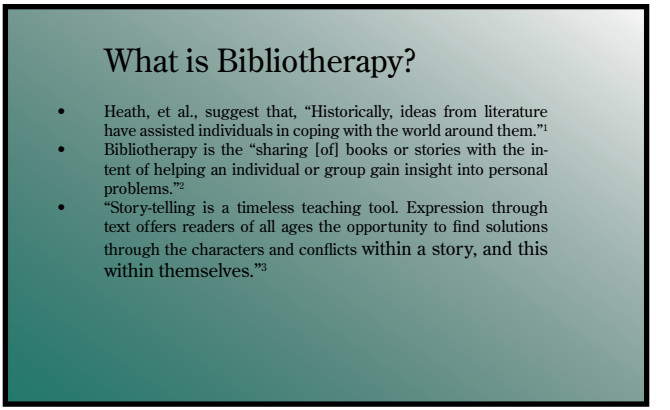


Note: This slide should be used to show that the parents may already be teaching their children and teens good coping skills. These slides are meant to offer hope.

"Through the use of latent coping skills, Lynn Hall suggests that 'military brats have are: taking responsibility seriously, getting along with everyone, being resilient and flexible, being loyal and self-sacrificing, having a 'bring on the challenges' attitude, being productive and efficient, living their diversity, and talking care of the world.' (see Hall, *Counseling Military Families*, 101-128.)

"We have all seen our kids be amazingly resilient in the face of deployments, PCSs, etc. These challenges teach them coping skills. However, sometime these coping skills are not enough. As such, you as a parent may need to step in and offer help to make toxic stress more tolerable, and tolerable stress more positive. One way you can do this through the use of bibliotherapy."

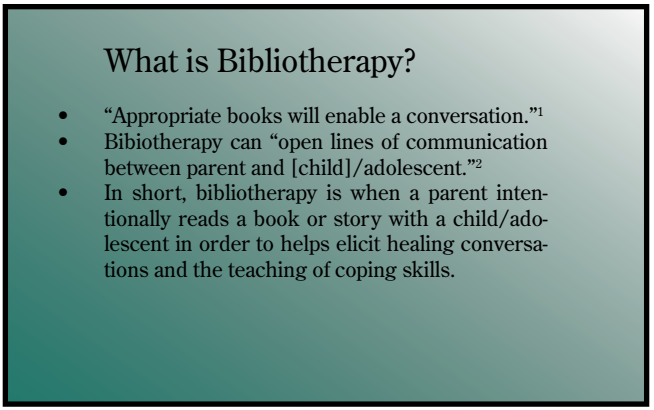
Slide 6



Note: Use this and the next slide to introduce the use of books to help a child or adolescent gain personal insight into personal and family challenges.

"We have all heard that reading books with our children is a good thing. However, bibliotherapy is more than a passive reading of a book. Rather it is an intentional use of a book to teach and/or support coping skills."

Slide 7

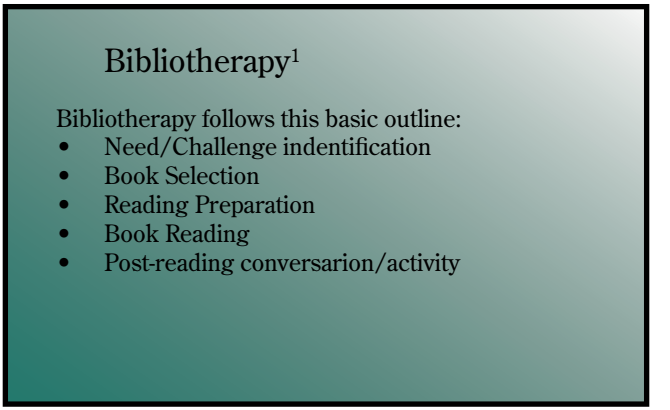


Note: Use this and the previous slide to introduce the use of books to help a child or adolescent gain personal insight into personal and family challenges.

"Books can help children and adolescents understand, 'what might happen in situations surrounding deployment, separation, divorce, moving, illness, or death [and this] demystifies children's fears associated with these difficult times.' Furthermore, quality children's books model ways to cope."

Because books have so much potential for helping, I hope that you will consider the use of bibliotherapy, or healing through books, with your children and teens as they struggle to communicate and work through their secondary trauma."

Slide 8

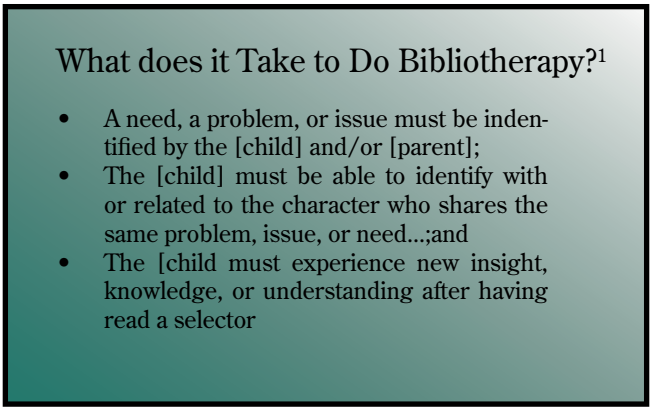


Note: Use this slide to offer a brief overview of how bibliotherapy works.

"Bibliotherapy occurs in 5 steps:

- Need/Challenge identification
- Book Selection
- Reading Preparation
- Book Reading
- Post-reading conversation/activity

Slide 9



Note: Use this slide to reiterate that bibliotherapy is much more than a passive reading of a book.

"For bibliotherapy to work there are three things that must take place:

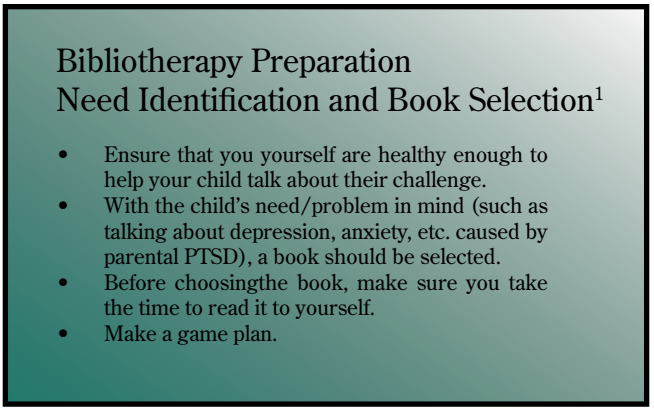
- *(bullet 1)* A need, issue, or problem needs to be identified.

- *(bullet 2)* The child need to be able to identify or relate to the book's character and their challenge, etc.

- *(bullet 3)* The child needs to find new insight, understanding, etc. because of their reading and identifying.

Because of this process, the choosing, reading, and discussion about the book with the child/adolescent requires intentionality and preparation on the part of the parent."

Slide 10

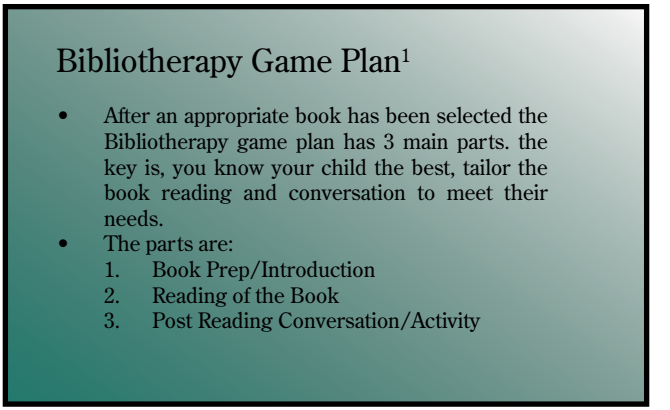


Note: Use this slide to explain that a parent must be healthy (not suffering from poor mental health) before engaging in bibliotherapy with their child.

"We all have challenges, that is part of life. However, sometimes our challenges make parenting very difficult. Sometimes we simply need some rest and relaxation. Other times we need some help. I want to re-iterate that as a parent your mental health is closely tied to the mental health of your child. As such, if you need help, one of the best things you can do for your child or teen is to get help. It is not a shameful thing to talk with a chaplain, or a mental health professional.

Note: Slides 19-32 offer examples of books that could be used in bibliotherapy. For further suggestions consult your librarian.

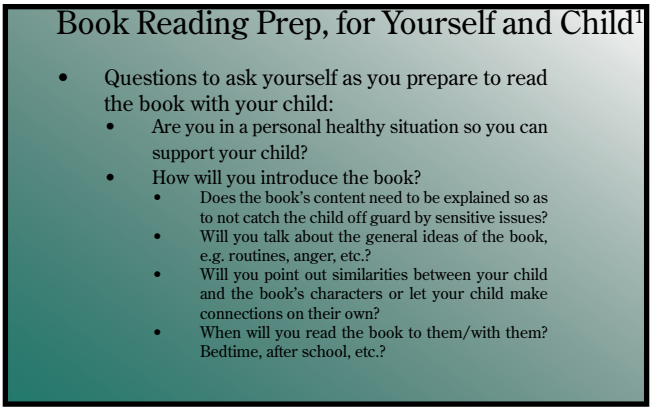
Slide 11



Note: Use this slide to discuss the three main points of bibliotherapy and to develop a game plane.

"Once you have selected a book it would be wise to make a game plan including: how you introduce the book to your child; how and when you will read the book with your child; and what questions, conversation topics, or activities you will engage in with your child after the reading of the book."

Slide 12

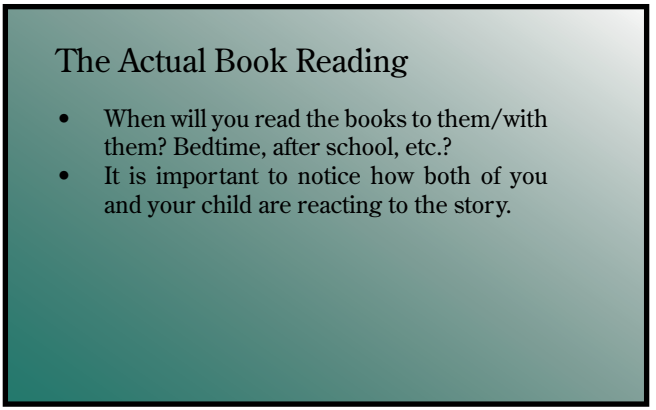


Note: Use this slide to help the parents begin to thinking about how they might introduce the book to their child.

"After selecting a book and before you can really make a game plan you will of course need to read the book. Some of the ways you might prepare include *(go through each bullet point on the type of things the parent might consider before reading the book with the child).*

"For example, you will need to decide how they will introduce the book to child. Bedtime story? Special reading time? What questions will you ask? Will you lead out or will you let the child lead? What if they don't lead out? What if they don't want to talk?"

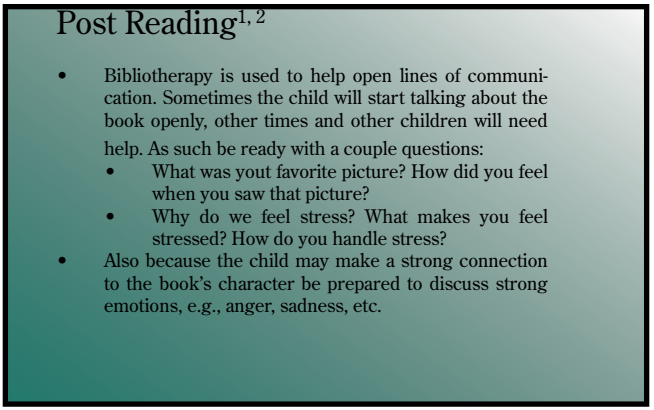
Slide 13



Note: Remind the parents that while reading the book to/with the child, they need to remain self- aware of their thoughts, emotions, and reactions to the book.

"As you read the book to/with your child they need to remain self-aware of their thoughts, emotions, and reactions to the book. This attention to self and child is important as it will better enable the parent to have an honest conversation with their child/adolescent regarding the contents of the book." Heath and Sheen, *School-Based Crisis Intervention*, 67-68.

Slide 14

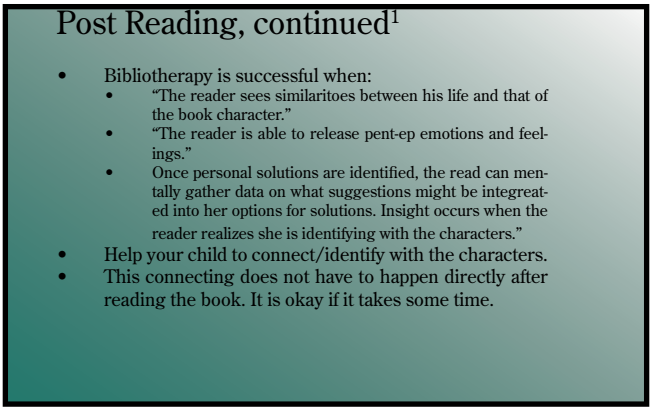


Note: Use this slide and the next slide to help parents see what must happen after the reading for bibliotherapy to be successful.

"If you are prepared you shall not fear. But it is still okay to be nervous. After reading the book, what questions will you ask? How much will you self-disclose about your reaction and thoughts about the book? How much about PTSD and secondary trauma can your child handle. How much do they need to handle?

As you discuss your child's thoughts and reactions, it is important to be non-judgmental. Let them vent. Let them think. Let them feel. They may feel sad, angry, or isolated. Let them feel and express themselves. One of the best parenting skills you can use as part of bibliotherapy is to listen."

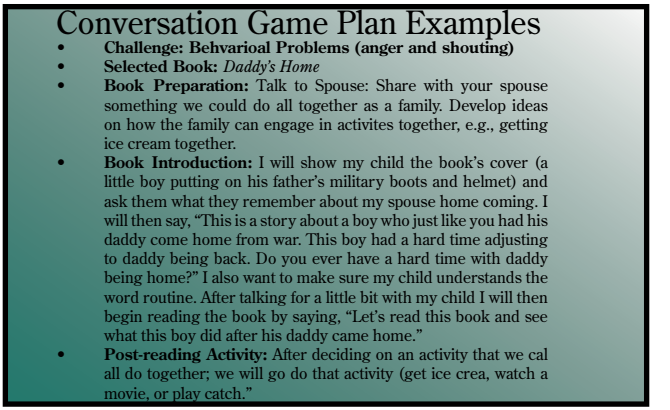
Slide 15



Note: Use this slide and the previous slide to help parents see what must happen after the reading for bibliotherapy to be successful.

"In regards to helping your child identify with the character you need to choose how much, if at all, you will help your child make the connection. Of course younger children might need more help than older teens. However, older teens may still need help navigating their thoughts and emotions. By being present and being non-judgmental you can be that loving, caring adult that your child/teen needs to help bring their stress down from toxic to tolerable, and tolerable to positive."

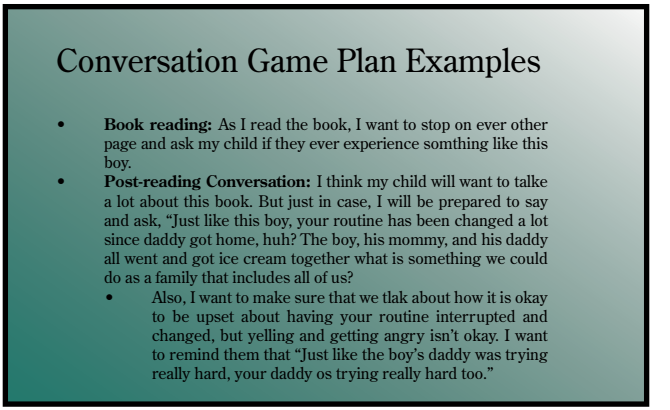
Slide 16



Note: Show an example of a conversation game plans to suggest that it may be helpful for some parents to write down their game plan on bibliotherapy.

Reiterate that parents adapt instructions and suggestions of how they will do bibliotherapy to the needs of their children and adolescents. As no two children, even in the same family, are the same. Parents should be aware of how their child and adolescent may respond to various questions and suggestions for activities. As such, they should feel free to adjust the suggestions given herein. **However, if the parents feel their child is not improving or is getting worse, it could be worth the effort to seek professional help.**

Slide 17



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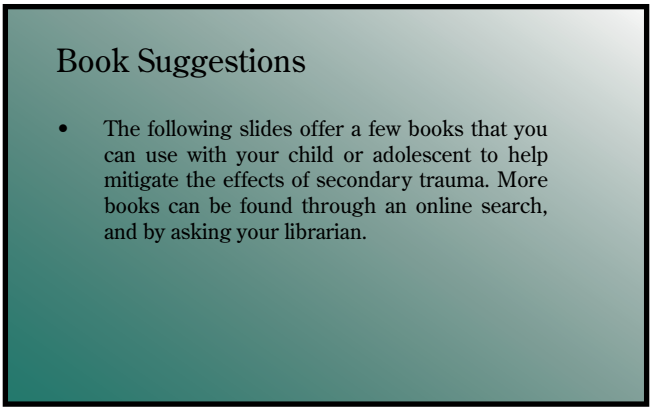
Slide 18



Note: It is recommended that you choose 2 or 3 of books to display. Each of the 13 books included in these slides are included in the booklet for parents as is a summary of this brief

Because of time restraints, this brief should be no longer than 21-22 slides (including title and conclusion).

Slide 19

A Terrible Thing Happened, by Margaret M. Holmes.
Publisher: Magination Press (Washington, DC, 2000): 31 pages.
Reading Level: 1st Grade-5th Grade.

A Terrible Thing Happened tells how Sherman Smith, a raccoon, is affected by a terrible thing. The reader never finds out what the terrible thing is. As such A Terrible Thing Happened is universal in that it allows the child to connect with Sherman and the child's own terrible thing. At first Sherman tries to avoid thinking about or remembering the terrible thing. Next Sherman tries other outlets to forget the terrible thing. However, as none of his coping mechanisms are working Sherman gets angry and bitter. Sherman eventually meets Ms. Maple who helps Sherman thing and talk about Sherman's feelings. Though meeting with Ms. Maple is hard for Sherman as he continues to work with Ms. Maple he starts feeling stronger and less angry.

Key Vocabulary and Concepts
- Counseling
- Talking about feelings
- Response to bad things, e.g. nightmares, avoidance, anger, etc.

Note: This slide is to simply introduce the book. The instructor may want to have a physical copy to show the group and have links on where the book can be found.

Slide 20

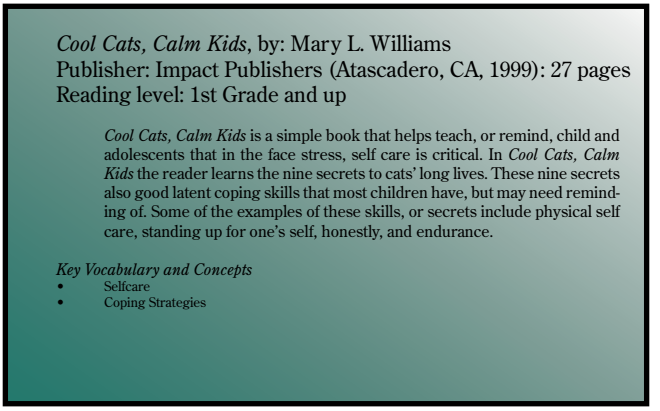
Alexander and the Terrible, Horrible, No Good, Very Bad Day, by:
Judith Viorst
Publisher: Atheneum Books for Young Children (New York, NY, 1972): 28 pages
Reading level: Grades 1-6

Many children may know the story of *Alexander and the Terrible, Horrible, No Good, Very Bad Day* because of the movie that was based off the book. In this lighthearted, Alexander has a day where nothing goes his way and that for him seems worse than all others. In response Alexander wants to leave his problems behind and move to Australia. However, his mom teaches him that even those who live in Australia have days that are terrible, horrible, no good, and very bad.

Key Vocabulary and Concepts
- Avoidance
- Bad Days
- Parental support
- Self determination

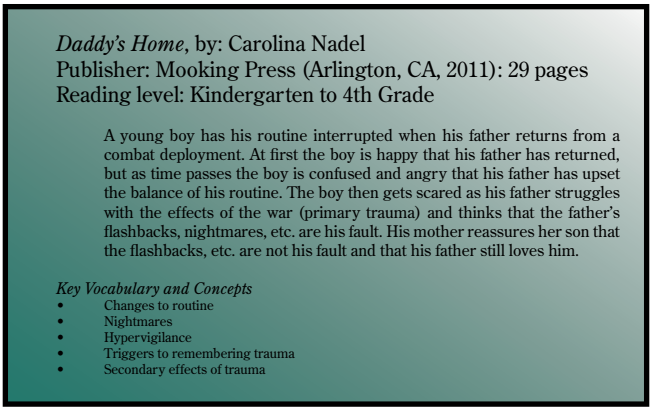
Note: This slide is to simply introduce the book. The instructor may want to have a physical copy to show the group and have links on where the book can be found.

Slide 21



Note: This slide is to simply introduce the book. The instructor may want to have a physical copy to show the group and have links on where the book can be found.

Slide 22



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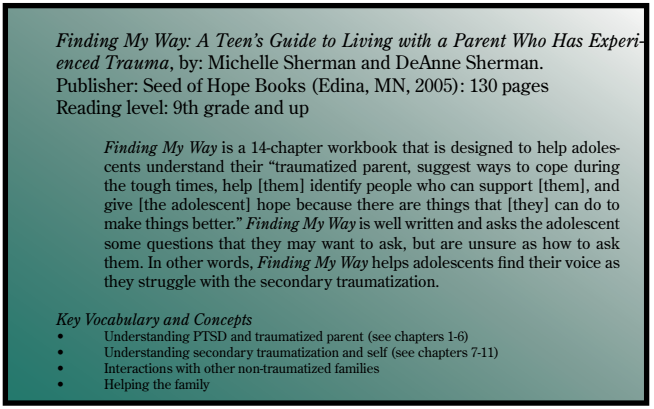
Slide 23



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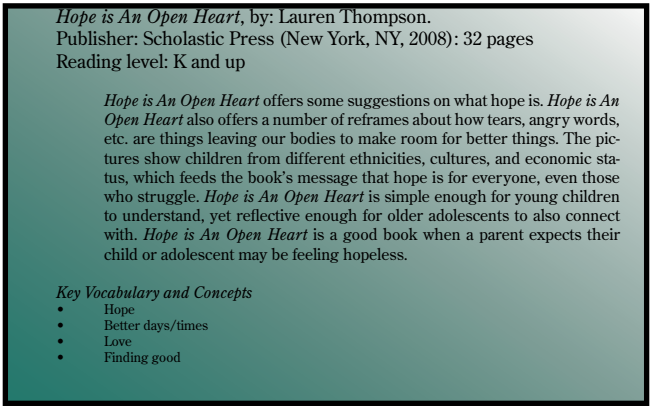
Slide 24



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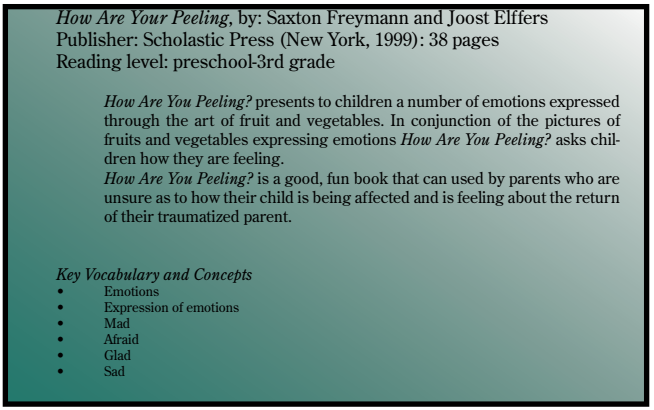
Slide 25



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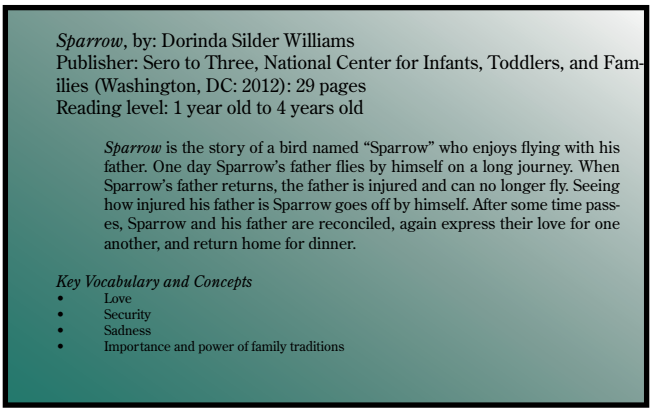
Slide 26



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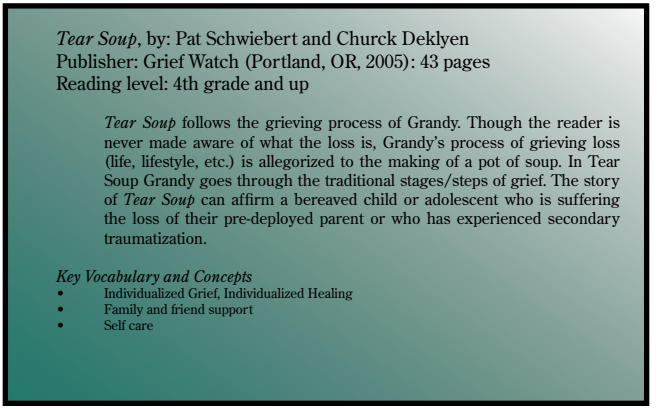
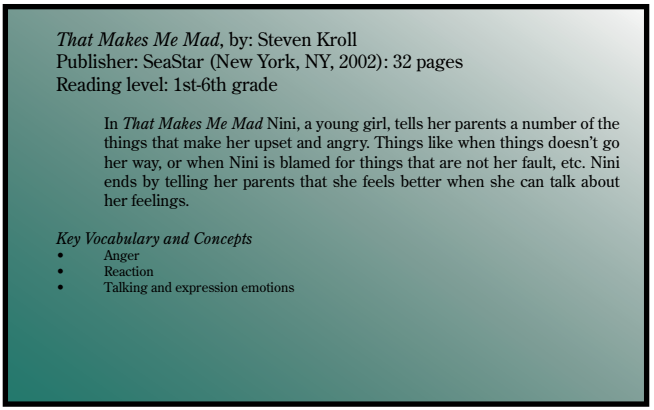
Slide 27



Note: This slide is to simply introduce the book. The instructor may want to have a physical copy to show the group and have links on where the book can be found.

Slide 28



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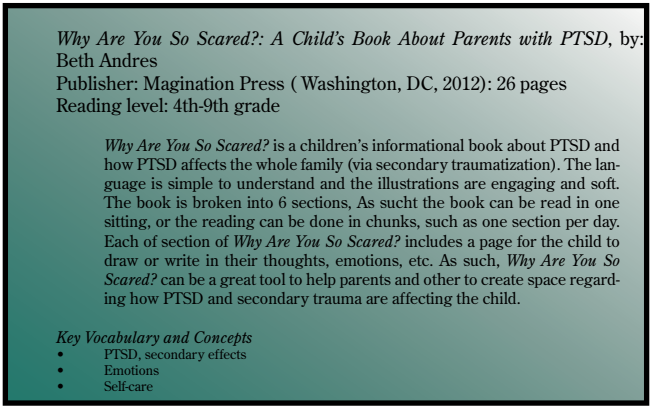
Slide 29



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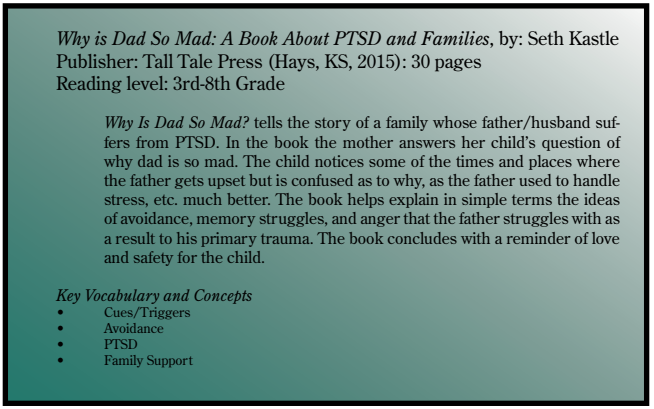
Slide 30



Note: This slide is to simply introduce the book. The instructor may want to have a physical copy to show the group and have links on where the book can be found.

Slide 31

Wounded, by: Eric Walters
Publisher: Penguin Group (Canada, 2010): 221 pages
Reading level: 7th-12th Grade

Wounded novel is a story told by 15 year old Marcus Campbell. Marcus (with his 10 year old sister Megan and his mother) is greatly anticipating the return of their father from his first tour in Afghanistan. As the "man of the house" while his father is away Marcus takes on many rolls of caring for, comforting, and supporting his sister and mother through the difficulty of deployment. Soon before his father's return, Marcus' father has trouble sleeping, is started by loud noises, drinks more than normal, has night terrors and is overly preoccupied by the ongoing activities of his former company still in Afghanistan. Marcus is extremely hesitant about talking as he feels talking won't fix anything. It isn't until Marcus' father, after having had too much to drink one night, hits Marcus' mother and injures Marcus that Marcus is able to convince his father that there are things that they need help working through.

Key Vocabulary and Concepts

- Cues/Triggers
- Avoidance
- PTSD
- Family Support

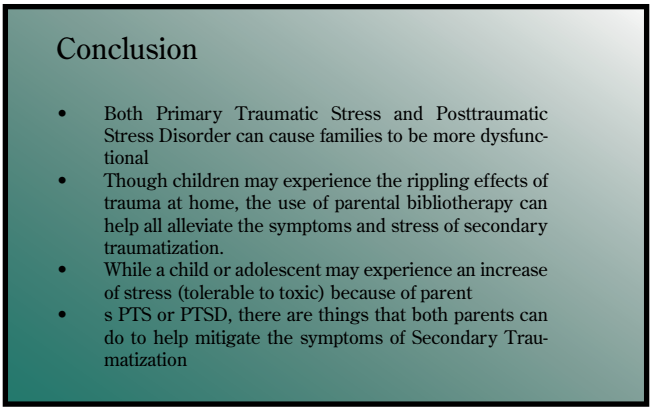
Note: This slide is to simply introduce the book. The instructor may want to have a physical copy to show the group and have links on where the book can be found.

Slide 32

Note: This Slide is to be used to show all the titles discussed in the research and booklet.

"Even though we were unable to discuss all these books. Here is a quick snapshot of the type of books available out there. I am positive that a conversation with a librarian or an on-line search will yield other options."

Slide 33



Note: Use this slide to summarize the presentation and to offer hope. Answer any questions (time permitting).

"PTS and PTSD can cause your children to experience the symptoms of secondary traumatization. However, the intentional use of books via bibliotherapy can help your child build coping skills and further help lower their stress level."

Note conclude with: There are many things that a parent could do to help their children such as exercise, personal counseling, meditation, recreational activities, to name a few. Bibliothearpy is only one of many techniques that parents can use to deal with the effects of secondary traumatization."

Training Files Access

Included with this trainer's manual are access to four digital files, the three training module PowerPoints and a booklet for parents summarizing bibliotherapy books listed in this training. Each slide has notes on it to help the instructor with training preparation and delivery. The booklet is intended to be given to parents during the third module.

As noted previously, chaplains and other trainers, especially those with greater knowledge and training with subjects should feel free to make adjustments to the slides once they have been downloaded. All of the training materials can be found and downloaded at goo.gl/DmwDUH.[153]

153. If the provided link no longer works please try the long URL, https://drive.google.com/folderview?id=0ByP356k1oxGjVGJhTUUtSmFLMG-M&usp=sharing. If you have any problems accessing the training materials, please feel free to contact the author at nt.smith26@gmail.com

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