Coping with Traumatic Bereavement

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The Gulf War forced combatant nations to prepare for the possibility of large numbers of traumatic bereavements. As part of the response in the United Kingdom a conference on this topic was organised by Cruse —Bereavement Care, which took place on 20th February, 1991 in London. In the event deaths were largely confined to the Iraqi forces. Even so, traumatic bereavements occur in all countries at all times. The paper which follows is an edited version of one read at that conference.

Risk factors

All bereavements are traumatic but some are more traumatic than others. There are certain risk factors which we know can cause particular problems—things we can observe at the time of bereavement that enable us to identify people who are likely to have difficulties later. Not everyone will need counselling—some will do well, but others will do badly, and we should assess the risk factors when we have the opportunity to do so. These risk factors include bereavement due to:

1. Sudden, unexpected, untimely deaths in youth or middle life—people who were not expected to die, or where the death was horrific.
2. Multiple losses—more than one member of a family or group.
3. Death associated with severe pain or mutilation.
4. A death where no body has been recovered, or where there was a long delay between the time of death and the time when the body was returned for burial, or when the body had been buried overseas and the family has not had the opportunity to attend the burial.
5. A person missing where it is uncertain whether they are dead or not.
6. Uncertainty about the circumstances of the death. The bereaved have not been told, or they have been told but do not believe it. When people do not know the circumstances of the death they imagine all sorts of things. Imagination is usually much worse than the reality.

Reactions

1. Unanticipated grief

The numbness is very pronounced and very prolonged. Disbelief and unreality may help people to cope for the first few weeks but, like all forms of denial, if it goes on for weeks and months it leads to trouble. This attempt to shut out reality does *not* prevent high levels of anxiety; thus, alongside a great deal of avoidance and denial, are high levels of anxiety and tension, with all the physical accompaniments of anxiety: aches and pains, difficulty in sleeping, palpitations, dry mouth, indigestion and a whole range of bodily symptoms.

When people have suffered a massive loss these symptoms may be seen as a sign of further danger. This adds to their anxieties, setting up a vicious circle.

It will amplify fears if doctors carry out numerous tests. While waiting for the results to come through, patients may become convinced something is wrong; by the time they are told that the tests are normal, they may not believe it. The more tests the doctor does, the more likely it is that one will give an abnormal result and have to be done again. This further increases the patient's anxiety.

High levels of anxiety create hypersensitivity and hyperalertness; twitchiness, inability to concentrate and difficulty in carrying out everyday tasks occur. People forget things and worry that they are going mad, or developing dementia. Grief goes on much longer than people expect; even three or four years after bereavement, victims of traumatic bereavement will still be less likely to be able to cope with life than other bereaved people.

There is a tendency for people to withdraw socially and remain locked up with their problems. The more shut off from everyday life they become, the more difficult it is to get out of that rut. In this way, chronic grief can become self-perpetuating.

2. Post-traumatic stress disorder

When the circumstances have been unusually horrific, for example, witnessing helplessly the death of a loved one, or when the survivor's own life has been threatened, post-traumatic stress disorder may result. Thus anything afterwards which reminds them of the event (e.g. loud noises such as thunder) can bring on severe anxiety which is quite disabling. Nightmares and flashbacks, where the trauma is relived, are common. People will avoid going to places where this might happen. After the Zeebrugge Ferry Disaster hardly any of the sailors who were serving on board returned to work at sea. The disaster remains a haunting nightmare.

Post-traumatic stress disorder is difficult to treat, but may be preventable by encouraging detailed re-telling of the trauma soon afterwards. Post-traumatic stress disorder inhibits the grief process.

3. Survival guilt

This occurs when people have been involved in a horrifying situation and survived. They may be left with a feeling that it is they who should have died and they may attempt to assuage this guilt by idealising and memorialising the dead. Sometimes the dead seem to have become more important than the living.

4. Ambiguous loss

When someone dies at sea, or abroad, the family may not have seen the body. It was important for bereaved families after the Falklands conflict to have the opportunity to visit the graves and the Islands. There is a big gap between *knowing* something happened and *feeling* it to be true. A meaningful event which brings home the reality of this happening in the history of a person's life, is important. Without it, fantasies of the persisting presence of the dead person may continue, and a feeling that nothing needs to change. In the course of their voyage the families bereaved in the Falklands met each other, and became part of a community who had suffered a similar experience.

5. Children and the wider family

Bereaved and traumatised children are more likely than adults to be missed out. Few condolence letters are sent to them and they may be faced with a cloak of secrecy. Adults talk 'up there' not 'down here'. Children need a different language at a different level. It is often hard for counsellors to get near the children. If you ask parents how their child is doing they will probably say 'all right', but this may simply mean that the children are keeping their problems to themselves. Cruse produces and/or stocks a number of useful Schools Packs for teachers describing how they can help in this situation[1, 2, 3]. Parents, grandparents and siblings may also suffer a great deal. Despite this they often play down their own needs in favour of those of a widow or widower, and counsellors may need to take initiatives in reaching out to this group. Survival guilt can be a special problem for children.

How can we help?

1. Preparing people

There is a lot we can do to prepare people for the possible dangers:

- By making them aware, and not concealing from them the real dangers associated with certain life-styles and diseases.
- By encouraging the expression of grief and other painful emotions in the face of the common crises of life.

2. Breaking bad news

- How the news is broken is important—not only what you say, but how and where you say it.
- Recognise the dangers of delays, which may keep people in uncertainty for a great deal of time.
- We must emphasise the importance of giving correct information *with authority*. The person who breaks the news needs to be someone of importance.
- Reassure where reassurance is possible, e.g. about the degree of suffering.
- Give credit to the value of the death—enhancing the importance of that death.
- Be prepared to take time to break bad news.
- Encourage spontaneous emotional expression.
- Allow people to come back and ask questions.
- Be spontaneous and genuine.
- Don't worry if you cry too.

3. Practical help in the early stages

During the *early stages of bereavement* people need advice on practical issues. It helps if they have something to do, but be there to help if needed. Involvement in activities is not a bad thing.

- Encourage people to talk.
- Reassure.
- While doing this assess risk and determine the need and availability of further support.

4. Further support

- Those requiring counselling visits need to be assigned counsellors who will be acceptable to them—people similar in age and sex, someone who is not necessarily a great expert, but a shoulder to cry on.
- Discourage bereaved people from rushing into doing things, e.g. selling up, moving away, etc. What is needed is time to take stock.
- Establish a time scale, letting the bereaved choose their own priorities.
- Manage high levels of anxiety and tension. Reassure people that even though they have overwhelming feelings, they can still be in control of the things that really matter.
- Recurrent nightmares can often be stopped. We make our own dreams and, to an extent, can actually choose and control them. In particular, we may find it useful to think of another ending.
- People who did not accept the full reality of bereavement in the early stages may have delayed reactions. At first they may not feel secure enough to talk, and time needs to pass before they can feel more secure. A continuing supportive relationship which enables trust to be built up without putting pressure on the bereaved will often provide the secure base that is needed.
- In the face of massive or multiple losses, acknowledge that neither you nor the bereaved person can deal with more than one thing at a time—nor do we have to. Help people to decide what issues take priority, and to review each problem in detail before going on to the next. In this way we help to bring order out of chaos and convince people that, however daunting the problems that they face, they are not completely helpless.

5. Support for the supporters

Traumatic bereavements can traumatise the caregiver as well as the recipient of care. We need to monitor our own needs and to pace ourselves, offering only what we know we can give. We also need to share our own thoughts and feelings about the situation with a supervisor or other third party who can give to us the understanding and support which we are giving to others.

References

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2. Ward B and associates. Good Grief 2: Exploring Feelings, Loss and Death in Under 11s. Middlesex: Good Grief, 1989. Available from Cruse—Bereavement Care, 126 Sheen Road, Richmond, Surrey TW9 1UR.
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LETTER TO THE EDITORS

Dear Editor,

How I agree with Ursula Bowlby about her reaction to the bereavement experience (*Bereavement Care* Vol. 10, No. 1, Spring, 1991, p. 5). Neither the death of my husband, nor of my son, left me with the emotional reaction so commonly accepted in bereavement counselling as we now know it. To me both men are very much alive and, while I do not live with ghostly presences, I am always warmly aware of their caring and presence with me. This does not mean they make decisions for me, neither would I expect them to break into my life as I must live it. But I am happy about both of them with no sorrowing for them, although in difficult times I might be sorry for myself carrying the weight of living alone. Of course there are times when I miss them and their companionship and all that we shared together, but this is so much less important than the certainty that my menfolk are together using their skills 'in the Company of Heaven' and learning new ones.

Of course there will be those who question my certainties, but since I was a youngster of 17 I have never had any belief in the void or abyss of death which has to be the pattern of secular or atheistic thinking if people are honest with themselves. Indeed, we should not weep for the dead but for the living. In a very true sense we can be glad for the expansion of their experience which in due time we hope to share. I believe, too, that emphasis on grieving is helpful neither to those who have moved into the next dimension nor to those still here. Tender, loving care while innumerable practical readjustments and changes must be made is much more to the point. It is this that the bereaved will remember long after the rough places have been made plain.

Margaret Torrie,
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Margaret Torrie, MBE, is the Founder of Cruse—Bereavement Care—Ed.

CONFERENCES

Learning and Loss. The 1992 Working Conference and Third Annual General Meeting of the National Association of Bereavement Services. 18 May 1992. London. Details from NABS Conference, 68 Chalton Street, London NW1 1JR, 071-247 1080.

The Stillborn Thought: Disturbance of Thinking in Perinatal Bereavement and Mental Handicap. 20 March 1992. London. Details from Angela Norris, Conference Co-Ordinator, The Training Office, Tavistock Clinic, 120 Belsize Lane, London NW3 5BA, 071-435 7111 ext. 2469.