After a terrorist attack

Supporting the bereaved families

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The aim of this paper is to draw attention to the likely needs for care of the families of people lost in terrorist attacks, such as those in the USA on 11 September 2001. It is modified from a briefing paper written for bereavement workers after the return from New York of the author with the first batch of Cruse Bereavement Care's counsellors who were providing support there to families of British nationals affected by the disasters.

Bereavements which are sudden, unexpected, untimely and the result of human intent are particularly traumatic. If, as in the aeroplane bombings in the USA, there are long delays (for understandable reasons) in identifying and recovering the bodies of the victims, it makes it all the more difficult for family members to come to terms with the loss and some may even be at risk of lasting psychological difficulties.

In essence, what many people who have suffered traumatic bereavements need is a 'secure base' and a warm accepting relationship with someone with whom they can share their thoughts and feelings in whatever way feels natural to them. Some need a shoulder to cry on, others a good listener. Most will take time to make real the fact of loss. While they are explaining themselves to a friend or counsellor, they are also explaining themselves to themselves, getting their bearings and beginning the slow process of finding out what is lost and what remains.

This last discovery is not quite as straightforward as it sounds. Bereaved people often feel that they have lost every good thing that came from the lost person. In fact they have not. There is a literal truth in the statement 'He (or she) lives on in my memory' and much of the work of grieving is finding out to what extent the people we have lost 'out there' can continue to enrich our lives 'in here'.

DELAYED GRIEF

The fact that it will take a long time to identify bodies and that most remain unidentified may well lead people to continue to cling, for an inordinate period of time, to the hope that their 'missing person' will be found alive. The truth for relatives of those killed in the World Trade Center is that there are no unconscious people lying unidentified in any New York Hospital and the chances of people wandering the streets with amnesia are remote in the extreme.

Faced with people who react in this way we must respect their psychological defence without colluding with it. People do need time to make real the fact of loss, and we may be able to develop a relationship with them which makes them feel safe enough to think the unthinkable and to face a dreaded reality. When they do that, their feelings will erupt and we must hang in with them through the long valley of grief

ANGER

Perhaps the greatest problem faced, not only by people bereaved by violence but, to a lesser degree, by all of us, is anger. Anger is both the most understandable and justifiable reaction to hostile acts and one of the most dangerous. Directed where it belongs, against the perpetrators of the deed and against its underlying causes, it is possible to channel anger towards positive action and a creative outcome. But the rage engendered by events of this kind is so great that it can easily overflow to include people who are in no way responsible.

We must be aware of the destructive power of anger, which can alienate people from their own friends and families and lead to lasting bitterness. Our role is not to stop people being angry, but to help them to contain their anger until they can find assertive ways by which it can lead to good rather than bad consequences.

POST-TRAUMATIC REACTIONS.

The impact of traumatic loss is so great that, for a time, the sheer horror of the events which accompany the loss can preoccupy the mind and interfere with grieving. People who witnessed the horrific images of the American disaster which were shown on television may find it hard to think of anything else, or they may deliberately distract themselves and avoid anything which might remind them of the situation. If this reaction persists it may develop into post-traumatic stress disorder (PTSD). The diagnostic criteria for this condition are given in the appendix to this article. Psychologists have developed effective techniques for the treatment of this condition and those who suffer it should be referred for specialist treatment.

ANXIETY AND FEAR

More common than PTSD are the symptoms produced by the anxiety and fear which is triggered by danger and traumatic losses. These may produce panic attacks, agoraphobia (as when people are afraid to leave the house) and the physical symptoms which accompany these mood states – dry mouth, palpitations, breathlessness, muscular tension leading to headaches and pains in the limbs, indigestion, sleeplessness and loss of appetite. These symptoms may be so unpleasant that they give rise to a vicious circle of escalating fear and further symptoms.

Much of this anxiety can be mitigated by emotional support, reassurance and explanation, in a language which people understand, of the symptoms which they are suffering. Instruction in relaxation techniques or other methods of inducing relaxation which are acceptable to the client (such as meditation, aromatherapy

Ground Zero, site of the bombed World Trade Center. New York, 21 September 2001.

or yoga) can be very helpful. All of these techniques help to break the vicious circle and restore peace of mind.

DEPRESSION AND SUICIDAL IDEATION

A minority of people may plummet into severe depression or become inclined to suicide. The simple way to find out if someone is at risk of suicide is to ask, 'Has it been so bad that you have wanted to kill yourself?' A positive response to this question should always be taken seriously even if you think that it is 'only a cry for help' (A cry for help is, after all, a cry for help and should be answered).

You should always discuss such threats with a supervisor or refer on, even if the client has asked you not to. This is one of the two circumstances (the other is threat of injury to other people) in which confidentiality can, and must, be broken and this is recognised by the governing bodies of responsible counselling and therapeutic organisations.

Depression is characterised by intense feelings of helplessness and hopelessness which may be so great that people are unable or unwilling to talk. They turn in on themselves or become severely agitated. Often the mood swings are at their worst early in the morning when people wake from sleep in utter despair. Even if not associated with suicidal risk, severe depression often requires special treatment by anti-depressant drugs (which, contrary to popular belief, seldom interfere with grieving and may facilitate it) or cognitive behaviour therapy. When referring people for treatment try to liaise with the therapist, who may well be glad of your further involvement.

IN CONCLUSION

It is very likely that the aftermath of the New York disaster will be felt for a long time and may not be the last of its kind. People affected by disasters do not require preferential treatment – we care for the ordinary as well as the extra-ordinary – but they may be at special risk. In addition, the care which we give to them may, in a small way, contribute to reduce the risk that violence will escalate. BC

APPENDIX

Diagnosing PTSD

The following criteria are modified from The Diagnostic and Statistical Manual of Mental Disorders IV (1994).

There must have been exposure to a traumatic event which entailed:

Threat of injury or death
Experiencing, witnessing or being confronted by an event which results in actual or threatened death, or serious injury or threat to the physical integrity of the self or of others.

Fear, helplessness or horror
In children, intense fear, helplessness or horror may be expressed through behaviour and play rather than verbally.

There must also be the following symptoms:

- Re-experiencing of reactions, feelings and emotions associated with the incident
- Persistent avoidance behaviour and numbing of responses
- Persistent symptoms of arousal

In addition:

- The symptoms should have persisted for more than a month
- The symptoms should cause significant distress and impairment of functions in the individual, with family or with friends, and at work

Symptoms are:

Acute if they persist for less than three months after the incident

Chronic if they persist for more than three months after the incident

Delayed or intermittent when they occur later

NEWS AND VIEWS

LETTER TO THE EDITOR

Dear Editor

I write in response to your article in the Spring issue, 'Responding to the needs of schools in supporting bereaved children' (*Bereavement Care* 2000; **20**(1): 6-7).

As there is a growing interest and recognition of the need for dealing with grief in children, it is becoming more important that those who have done some work on the subject share resources.

The Gone Forever project has now produced three sets of guideline pamphlets, and two more will be published very shortly. These were influenced by similar publications from Bradford local education authority, so we were not starting from scratch. Already published are *Guidelines for Children*, *Guidelines for Young People* and *Guidelines for Teachers*. Those in press are both for parents. We have also produced a booklet *Gone Forever – Helping Children and Young People Cope with Bereavement*. Copies can be obtained from the Gone Forever Trust, Cornerways, Padley Road, Grindleford, Hope Valley S32 2HR, UK.

In the editorial comment to the article you suggest that Yule and Gold's book, *Wise Before the Event* (London: Calouste Gulbenkian Foundation, 1993) is 'gathering dust' in some areas. This may well be true, but some have certainly taken heed of it. Sheffield local education authority has had staff from every school attend a seminar on contingency planning, based on this publication. Yule and Gold suggest strategies for dealing with a major incident, however, not child bereavement as implied in your comment.

You also mentioned the need for bereavement services to let local schools know of their services. Rotherham Cruse has already done this and receives regular referrals.

BRIAN CRANWELL
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FORTHCOMING EVENTS

The social context of death, dying and disposal. 6th International Conference. 5-8 September 2002. York, UK. Papers and bookings to Julie Rigg, Cemetery Research Group, University of York, Heslington, York YO10 5DD, UK. ☎ 01904 433689; jr10@york.ac.uk

Working with bereaved couples. Workshop run by Tavistock Marital Studies Institute. 11, 25 January, 8 February 2002. London. Contact Sheila McAuliffe, Tavistock Centre, 120 Belsize Lane, London NW3 5BA. ☎ 020 7447 3725

Lost for words. Workshops. 27 February, for teachers; 6 March 2002 for trainers in education. Kingston-upon-Hull, UK. Contact John Holland, City Psychological Service, Essex House, Manor Street, Kingston-upon-Hull HU1 1YD ☎ 01482 613747; john@puma.karoo.co.uk

Aspects of bereavement. Workshops with Marilyn Relf, Daphne Briggs and Colin Murray Parkes. 26 January, 16 February, 9 March 2002. Oxford, UK. Apply to Oxford Cruse, Wesley Memorial Hall, New Inn Hall Street, Oxford OX1 2DH. ☎ 01865 202242.