Bereavement and trauma

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A death may, all too often, be the result of an accident, violence or disaster and thus survivors may have to deal with both bereavement and a traumatic experience. It has long been recognised that traumatic events can lead to health problems, but it is only recently that research has focused on the interaction between bereavement and trauma. It is important to understand this area and gauge the effectiveness of interventions as we may be increasingly called upon to help the survivors.

In more populated parts of the world, bereavement and trauma occur together frequently in road deaths and less commonly in train and aeroplane crashes, acts of violence involving killing such as terrorism, and community disasters as in Bhopar, India, where hundreds died after a massive leakage of deadly chemicals. In other areas, natural disasters, such as bush fires, volcanoes or earthquakes, can have the same effect, as well as acts of genocide and war[1]. Unfortunately, history is full of examples of man's inhumanity to man, perhaps reflected in the increasing numbers of refugees seeking asylum and safety.

Many studies of bereavement and also of responses to trauma have not considered whether trauma and bereavement have occurred together. Those studies which have considered both trauma and bereavement have often been unclear about the circumstances of death and/or the nature of the traumatic event, and have not taken sufficient account of other possible influences. Early studies were often of people already referred to hospitals or for other kinds of professional help, so it is unclear how typical the difficulties described are of the population at large. The control groups used for comparison have frequently been inadequate. Most of the research to date has been carried out in Western cultures, although there is now increasing awareness of the need to consider other cultures and also subcultures within populations. Relatively few studies have considered the possible interactions of such factors as political ideology on the experiences of trauma and bereavement. Work on bereaved children has tended to focus on the effects of the death of a parent on the child, rather than that of a sibling or friend, and studies of parental death have tended to neglect the effect on adults of the death of an elderly parent.

The introduction of post-traumatic stress disorder (PTSD) into the diagnostic classifications recognises the part life events may play in the onset of illness, as Parkes describes on p20 of this issue. Previously Turnbull and Gibson[2] outlined in *Bereavement Care* the diagnostic criteria for PTSD. Here, I review the history of attempts to describe responses to trauma and consider how this links in with our rapidly developing understanding of this area of bereavement.

EDITOR'S NOTE

Those who reach out to bereaved people will sometimes find that a reaction to bereavement is complicated by the effects of the traumatic circumstances in which it took place. In this paper Martin Newman reviews research in the field of psychological trauma and provides us with an introduction to a complex subject about which scientific knowledge is far from complete. Despite this, the reported results of therapy for post-traumatic stress and related orders are good. Perhaps the most important issues for would-be helpers are:

- **to identify the particular problems for which help is needed**
- **to be aware of the limits of our own knowledge**
- **to be prepared to refer on to specialists those whom we are not competent to help. *CMP***

EARLIER VIEWS OF TRAUMA

The meaning attached to, and the terms used to describe, reactions to traumatic events have varied over the centuries, influenced by prevailing beliefs and interests of the time and the existing culture. The famous diarist, Samuel Pepys, described his 'dreams of the fire and falling down of houses' after the Great Fire of London in 1666. Six months later, he was still unable to sleep 'without great terrors of fire'[3].

During the 19th century, the development of the railways stimulated interest in psychological responses to traumatic events. Doctors noted that there were many victims of railway accidents who appeared to suffer no physical injury and yet who complained of a variety of symptoms. One famous example is that of the novelist, Charles Dickens, who was involved in a railway accident in 1865. He subsequently became anxious about travelling and wrote, 'I am not quite right within, but believe it to be an effect of the railway shaking'[4]. Three years after the accident, he was still experiencing 'sudden vague rushes of terror'[5].

There were conflicting explanations for the symptoms that were observed in railway accident victims. Some argued that they were the result of physical damage to the nervous system (hence the term 'railway spine'). Others thought that the explanation was 'nervous shock', a functional (psychological) disturbance rather than physical injury. Charcot, the famous Parisian neurologist, supported the psychological model, arguing that the syndrome of railway spine was a form of hysteria and that, in the immediate aftermath of an accident, the victims were in a suggestible state and that their own idea of physical injuries influenced the development of symptoms. Charcot's opinion is important because he, in turn, influenced Sigmund Freud who later suggested that the physical symptoms of hysteria were due to the repressed memories of traumatic events.

The development in many countries of workmen's compensation acts, which provided for financial compensation to those injured during the course of their work, also led to increased interest in the psychological effects of traumatic experiences. Some suggested that symptoms were caused by a wish to recover compensation. Indeed, the term 'compensation neurosis'

was introduced in 1879 following the increase in invalidism reported after railway accidents. Even today, an important consequence of the diagnostic category of post-traumatic stress disorder is that it has facilitated, and arguably encouraged, claims for compensation after traumatic events.

During the 20th century, the major influence on the development of the concept of PTSD was war. The belief that the psychological responses to traumatic experiences were the result of physical injury or dysfunction of the central nervous system was strongly held and represented in the concept of shell-shock which prevailed during the World War I in Europe. Soldiers were frequently treated as cowards and deserters and punished, sometimes by death. However, many more were considered ill and in need of treatment[6]. Others saw the problem as a psychological one, proposing that an individual suppressed painful and terrifying experiences, which later became converted into physical and mental symptoms. Those who held this opinion tried various psychological techniques, such as helping patients to revive and recognise their repressed terror, or to express their strong emotions in a dramatic way, or by allowing them to talk about their traumas.

Despite more stringent selection of recruits, the World War II also produced large numbers of psychiatric casualties. Indeed, mental disorder accounted for 31% of medical discharges from the British Army. The involvement of the USA in the Vietnam War in 1960-70, during which 20% of combatants witnessed atrocities or abusive violence, provided further stimulus for the study of responses to trauma, and out of this developed the concept of PTSD. It has been estimated that, of all USA Vietnam veterans, approximately 15% (450,000) currently suffer from PTSD[6]. Many of these soldiers had also experienced bereavement, as a result of the death of colleagues.

Although the diagnostic category of PTSD was first developed as a result of studies of adults, the concept was subsequently extended to include children. It is still uncertain to what extent the developmental status of the child or other factors, such as the child's perception of its family's reaction to the disaster, influences the symptoms[7]. By the end of the 20th century, post-traumatic stress disorder and other psychological after-effects had been reported in both adults and children after a wide variety of traumatic events, including both man-made and natural disasters, kidnapping, sexual assault, torture, road deaths, and even domestic violence and childbirth.

POST-TRAUMATIC STRESS DISORDER

Of course, exposure to trauma does not cause psychiatric disorder in all those who experience it, possibly due, at least in part, to differences in vulnerability and resilience. Epidemiological studies suggest that PTSD, or sub-threshold PTSD, may be present in a significant proportion of a population, although it may not be recognised as such. It frequently co-exists with other psychiatric conditions – most notably, depression. Unfortunately, the recent burgeoning of interest in PTSD has perhaps given some the idea that it is the only response after trauma. This is not the case.

What causes PTSD?

No single model offers a comprehensive view of post-traumatic stress disorder. Psychodynamic models are concerned with the meaning a person gives to a traumatic event and its aftermath. Behavioural models have used the principles of conditioning theory to explain the development and maintenance of PTSD. Cognitive models have included several concepts: learned helplessness, the attributional style of individuals (eg, a tendency to blame themselves when difficulties are encountered), and cognitive appraisal (the process by which they attach meaning to an event). More recently, cognitive processing theory argues that traumatising events challenge our existing assumptions about the world, and that symptoms of PTSD may reflect a failure of attempts to alter the new information and assimilate it, or to change our underlying assumptions to allow accommodation of the new information. Some researchers have found changes in the way parts of the brain (such as the hypothalamus) and brain chemicals (such as encephalins) work in traumatised individuals, while others have suggested that understanding the process of memory may help in interpreting their responses. Research continues, and we hope that a clearer understanding of the origins of PTSD will lead to more effective therapeutic techniques.

Assessing PTSD

There are a number of questionnaires or scales that may be used to help assess psychological responses to traumatic events. One of the most widely used in research and clinical work is the Horowitz Impact of Event scale[8, 9]. This is a 15-item self-rating scale with two sub-scales: intrusion and avoidance. It is normally used to assess the response after a single traumatic event, rather than after exposure to a chronic stressful situation. The scale is not diagnostic. It gives a subjective estimate of the frequency of intrusive recall of the traumatic event and of attempts to avoid such recall, and thus a measure of psychological disturbance when compared to normative data. However, if it is used after a traumatic event in which there has been bereavement, the results obtained may be misleading since attempts to recall the deceased are a normal part of grieving.

BEREAVEMENT AND TRAUMA

In *Meaning, Reconstruction and the Experience of Loss*, Neimeyer[10] points out that during the 20th century bereavement was seen as a universal process. However, there is now more focus on differences between categories of bereaved people, and a recognition that patterns of adaptation after bereavement are complex and unlikely to be universal so that cultural and sub-cultural groups, in particular, may have variations. Bereavement in children may adversely affect the development of secure attachments to their caregivers, and later loss and trauma may exacerbate or re-awaken feelings of loss and abandonment. As well as looking at the emotional aspects, increasing attention is being paid to the cognitive processes involved, to the implications of major loss on the individual's sense of identity, and of the potentially healthy role of continuing symbolic bonds with the deceased person. Klass[11] has described the purpose of grief as constructing a 'durable biography' or narrative, where a continuing bond to the deceased person is validated and shared with others.

In trauma and bereavement, as well as in many other situations, we are increasingly interested in identifying the processes involved when psychological and psychiatric problems develop, and in factors that may be important in promoting resilience and opportunities for personal and professional growth and development. As mentioned earlier, both trauma and bereavement, especially when unexpected, may challenge our assumptions about the world and its predictability and safety[12]. Janoff-Bulman[13] has argued that one effect of trauma is to 'shatter assumptions' that the world is benevolent and meaningful and that the self is worthy. She suggests that the responses of a victim, which may appear to be maladaptive, can be explained as attempts to restore the illusions of comprehensibility and control. Neimeyer[10] proposes that both death and trauma change personal and family narratives, so that identity, meaning, and relationships may all have to be renegotiated and later

emotional, relational, and occupational choices are likely to be affected. Attig[14] has described this as having to 're-learn a complex world', and as 'finding and making meaning on many levels.'

INTERVENTIONS AND TREATMENT

While trauma and bereavement may increase the risk of psychiatric problems, the mechanisms by which this occurs are uncertain. The trauma or loss may act as a trigger, setting off a chain of events that may then lead to further adversities. Research has indicated that the presence of multiple adversities increases the risk of developing psychiatric illness. While most people may cope with a single stress, as the number of risk factors or stresses increases, so the risk of psychological or psychiatric problems multiplies rapidly. Professor Rutter[15, 16] at the Maudsley Hospital, and others, have researched the risks of multiple adversity and the pathways involved, as discussed in a recent editorial in *Bereavement Care*[17].

For some people, the personal experience of loss or trauma may be the trigger for developing an interest in a particular career or voluntary activity. They consider that their experience of loss or trauma has transformed their sense of identity, their relationships and sense of purpose for the better. This may, of course, not extend to all areas of their life and does not mean that pain and distress are not experienced[18]. We should, therefore, be cautious before jumping in to help the bereaved and traumatised. There is no clear evidence that routine counselling for all those bereaved or to all survivors of traumatic events is helpful or, indeed, not harmful[19, 20].

When treatment for PTSD is indicated, a variety of approaches are presently used, both with adults and in children. In adults, behavioural and cognitive approaches have been increasingly used over the past 15 years or so, usually involving re-exposing the victim to the trigger situation (either real-life or imagined), cognitive therapy, or anxiety management training. Psychotherapy or counselling can be offered to an individual, a group, or a family. A further technique, eye movement desensitisation and reprocessing (EMDR), has been reported as useful by many therapists, although the mechanism by which it works is disputed. There is little evidence that drug treatments have a central role in the treatment of PTSD but they can be helpful when there is associated psychiatric disorder, such as depression.

The emphasis when treating children with PTSD has been on cognitive-behavioural approaches that aim to help the survivor of the traumatic event make sense of what has happened and to master their feelings of anxiety and helplessness. Sometimes support may be best offered in groups. Since children live with adults, whose reactions to events are part of the context of that event for the child, most treatment plans for children should involve both families and schools. This may be especially relevant when the adults have themselves also experienced the traumatic event. Distress in the adults may mean that they are less able to recognise distress in the children for whom they have responsibility, or that they are unavailable to respond to the children's needs[21, 22].

THE FUTURE

Our understanding of responses to bereavement and trauma are increasing but remain incomplete. For example, PTSD is a developing concept, whose diagnostic criteria will surely continue to evolve in the light of clinical experience and information from research. The current emphasis on the 'medicalisation of distress' in Western cultures may, arguably, reflect the prevailing expectations of those societies and cultures. It is unclear whether it is appropriate to use the same concept to describe the responses seen after a wide range of traumatic events. Present systems of classification of responses to traumatic events tend to assume that disorder is either present or absent, with no opportunity to consider severity.

Further research is needed to evaluate the appropriateness and effectiveness of differing interventions and treatments. We also need to study the screening of populations at high risk (for example, the survivors of a major disaster) to determine how useful this is and what, if any, interventions may help prevent the development of emotional and social difficulties at a later date. BC

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