

Traumatic grief in the children of a Northern Irish police officer

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This article outlines the treatment of two adolescents who suffered trauma-related pathological grief after the suicide of one of their parents. Both parents served in the Royal Ulster Constabulary (RUC) in Northern Ireland and pressures resulting from this contributed to the mental health problems experienced by the whole family.

The political landscape in Northern Ireland peaks and troughs on what seems like an almost day-to-day basis. It is often only during periods when the situation is somewhat more settled that officers and their families have the chance to begin counting the cost of service-related pressures, and issues around past incidents that have been put 'on hold' come to the surface.

Whilst in many ways the situation for police officers and their families in Northern Ireland is unique, the traumatic incidents and bereavements that are experienced there, and in particular the emotional and psychological distress that accompanies them, are common to many groups and individuals the world over.

POLICING IN NORTHERN IRELAND

The international media from time to time portray the unusual nature of policing in Northern Ireland, whether it is being caught in the middle as a divided community vents its rage, or providing protection for children so they can get to their school safely. The security situation in the province has made policing an extremely high-risk profession. There have been 302 police officers killed and 9333 injured as a direct result of 'the troubles', the violence of the last 30 years¹.

Studies looking into the psychological injuries sustained by police officers in this context are rare. One, of serving RUC officers involved in critical incidents six months previously, showed that PTSD² was present in 5% of respondents³. A more recent study of retired RUC officers found that 16% of those medically retired and 6% of those normally retired had PTSD⁴.

The Child and Adolescent Service

The Child and Adolescent Service at the Police Rehabilitation and Retraining Trust outside Belfast was set up for two main reasons. Firstly, traumatised officers were unable to make a full recovery in treatment because of the guilt they felt about the psychological damage their service and resulting symptoms were inflicting on their families, particularly children. It is not unusual for RUC officers to suffer from the effects of trauma for 20 or more years. As is the case with any long-term mental health problem, the prognosis would be poor if only one family member received treatment and was then returned to a family unit that has technically become co-dependent.

Secondly, the children of police officers have generally been discouraged from using the statutory mental health services when their symptoms are related to their parent's occupation, because of the security risk involved if this comes to light. If a child's presenting symptoms are described without any information about how they were caused, obviously this will have a major impact on the success of treatment.

Impact on the children

Interestingly, it is commonplace for police children in Northern Ireland either to be completely unaware, even to quite a mature age, of their parent's occupation or

more often to be schooled from a very early age to hide it by, for example, saying 'daddy is a fireman/milkman/postman'. This dynamic, forced on the family by fear, creates all kinds of issues about trust and moral mixed messages. 'We send our kids to Sunday school, teach them always to tell the truth and then tell them they must lie about what we do for a living' (retired woman police constable).

Policing generally is a stressful occupation that impacts on the entire family, but in Northern Ireland the pressures can be even greater. Terrorists can attack at home as well as at work, so there is a feeling of never being off duty which has a cumulative negative impact and can also instil hypervigilance. Children often speak of the bizarre rituals that become the norm at home: the door only opened if the caller's identity is known; certain information not to be given out over the phone; signalling systems using lights or blinds to warn a returning parent that something is wrong; an escape plan in case the house has to be evacuated in a hurry. A young child recently described how he would wait at a safe distance as daddy checked beneath the car in the garage, just in case... and was then consumed with guilt for thinking 'if there is a bomb I hope it goes off now before I get in'.

In Northern Ireland, children of a police officer are at risk of witnessing a terrorist attack on their parent or themselves. After an attack or other act of intimidation, the emergency evacuation of their home can have a dramatic impact, particularly if, as mentioned earlier, their parent's occupation has been kept a secret or if they feel that their own life may be at risk. Sadly too, police officers' children can be the targets of peer bullying and intimidation.

The police officer's child is also at high risk of being exposed to any parental post-trauma symptoms. It can be traumatic to witness their parent experience terror during flashbacks and nightmares, and the associated poor anger management and mood swings of a parent can have a direct effect on attachment, leading to distancing and communication problems⁵. It can be extremely alarming for children to see the person who is supposed to be big and strong to protect them becoming vulnerable and helpless. Physical injuries may suggest to a child 'if bad men can do this to

EDITOR'S NOTE

In a recent issue of *Bereavement Care* (Summer 2002; 21[2]: 27-29), we discussed how trauma and bereavement may co-exist. Drawing on his work with the RUC in Northern Ireland, Alastair Black discusses the interaction between trauma and bereavement, using clinical vignettes to illustrate his themes. MN

my parent, then they can do it to me'. An adjunct to the post-trauma symptoms can be psychological abuse of the other parent or a sibling, something that can be extremely distressing for a child to witness. Symptoms are often further complicated by the use of alcohol to diminish the effects of the parent's intrusive memories.

A common report by many people referred to the service is the feeling of 'forever walking on eggshells'. Children who do not have information about why things are occurring around them often blame themselves for the current scenario. At times a reversal of parent/child roles can take place, with children assuming responsibility not only in day-to-day activities, but also for making their parent happy or 'well'. When, inevitably, their parent's mood does decline, the child can feel responsible for this. Feeling that their parents have enough problems to deal with, children internalise this anger, leading to symptoms such as *self-harm, eating disorders etc*, or they may act out towards authority figures in other settings, for example, school.

CASE STUDIES

Background

As is often the case, a medically-retired police officer being treated by the Police Rehabilitation and Retraining Trust referred his daughter and son, aged 12 and 15 respectively. Both had been exposed to the escalating impact of their parent's PTSD symptoms at home for approximately ten years. The children were both aware of their parent's past occupation and, to some degree, the current level of security risk that still surrounded the family. The elder son was more aware of the dangers his parent had faced whilst policing and had early memories of being evacuated from the family home because of a threat against his parent's life. Their other parent, also an ex-police officer, had committed suicide several years previously due to work-related pressures. The children had discovered their dead parent together first thing in the morning as they went to apologise for an argument the previous night.

Both clients were having significant problems at school, in and out of the classroom, with frequent violent physical altercations with pupils and verbal clashes with teachers. Their academic performance had declined, which was of special concern because important exams were coming up. The son had been threatened with suspension.

Assessment

On assessment, the son displayed many post-trauma symptoms, the most severe

being nightmares and flashbacks occurring at least once nightly and resulting in chronic sleep disturbance. The nightmares were so vivid and resulted in such high levels of fear and physical anxiety that, on waking, he would run to the bathroom and hold his head under the cold tap until the feelings subsided. The content of the nightmares was identical every time: masked terrorists would enter the family home and murder his parent and sister as he watched from a hiding place; then, as the attackers advanced on him, he would wake up. The only respite from these symptoms was on one or two nights each month when he would not sleep at all.

A common report by many referrals to the service is the feeling of 'forever walking on eggshells'

This client said he had come for treatment because his nightmare attackers were getting closer and closer before he awoke, and he was terrified. The daytime and night-time flashbacks revolved around intrusive images of the discovery of his dead parent. For approximately one year after his parent's suicide, the client would secretly check his other parent was still breathing during the night. In the past he had at times thought about and planned ways to end his life.

The daughter displayed quite different symptoms. Overall she was more introspective with aggressive outbursts at school being less frequent but extremely explosive. Her trauma symptoms were much less marked, with sleep disturbance being caused more by her racing mind and accompanied by periods of depression. Frequently she would see her dead parent standing before her and was constantly ruminating about the loss. The emotions associated with this traumatic bereavement were fresh and raw but, in contrast with her brother, she felt disbelief, as if 'it's all a dream'. Her parent's death was never mentioned in the family home.

On a psychometric measure of complicated grief symptoms, both clients scored well within the clinical range.

TREATMENT

Both clients chose to work initially on reducing their intrusive symptoms, as these caused the most distress and also physical fatigue and an increase in irritability levels. The treatment chosen was cognitive behavioural psychotherapy, using eye movement desensitisation and reprocessing (EMDR)⁶ as a tool within this model. EMDR consists of bringing together

an image, negative self-referencing thoughts, emotions and associated bodily sensations. This information is held by the client whilst some form of 'bilateral stimulation' is introduced, such as the client moving their eyes from side to side as guided by the therapist, or auditory tones or alternate left and right hand tapping. This combination leads to the changing and distancing of intrusive images along with irrational beliefs and emotions.

The son

The son chose to work on a 'movie' of his entire nightmare scenario⁷, and then its most distressing part. Finally we re-scripted a new ending together. After our first session there was only one further visitation of this nightmare – the re-scripted version that we had worked on together. Following session two, the nightmares ceased completely. We engaged in some similar work on his flashbacks in subsequent sessions and, once these were resolved, we were then able to move on to work on challenging the irrational beliefs and negative automatic thoughts which had developed since these events and which were feeding this client's aggression.

The daughter

The daughter wanted to deal with her intrusive feelings of guilt and the frequent visualisations of her dead parent standing before her. We worked through therapy and rather than, as in her brother's case, the image gradually fading away, this client experienced a shift in irrational feelings of guilt associated with her bereavement. She started treatment with an image of her parent's open eyes staring at her accusingly, and this gradually shifted to her parent's eyes 'smiling' and saying 'it's not your fault, I love you, and I'm at peace'. By session two this client reported no further occurrences of seeing her parent, and the shift of guilt feelings had led to a general increase in mood. As with her brother, we worked during the following sessions on challenging negative beliefs which had developed and which were affecting her self-esteem.

CONCLUSION

Treatment for both clients took an average of ten weekly sessions. At discharge both clients hardly registered at all on the pre-treatment complicated grief and trauma psychometric measures. It was interesting to see two people who had experienced the same traumatic event at the same time display distinctly different symptoms as a result. As treatment progressed there were

many signs of appropriate grieving beginning to take place with the experiencing of grief-related affect. For the first time the subject was discussed openly at home. Reports from school on both behaviour and academic performance were also positive and both clients passed their exams.

The clients' parent also worked hard in treatment, leading to a successful outcome that allowed the family to have a common understanding and recover together. As in any such case, the successes achieved in treatment would not have occurred

without the courage of both of these clients in facing acutely painful issues, and their investment in the therapeutic process. **BC**

References

1. Royal Ulster Constabulary. Security Statistics. Northern Ireland: Central Statistics Unit, 2000.
2. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 4th edn. Washington DC, USA: American Psychiatric Association, 1994.
3. Wilson FC, Poole AD, Trew K. Psychological distress in police officers following critical incidents. *Irish Journal of Psychology* 1997; 18: 321-340.

4. Paterson MC, Poole AD, Harkin N (in press). The psychological and physical health of police officers recently retired from the Royal Ulster Constabulary. *Irish Journal of Psychology*.

5. Matsakis A. Vietnam Wives: Facing the Challenges of Life with Veterans Suffering from Post-Traumatic Stress. Towson, MD, USA: Sidran Press, 1996.
6. Shapiro F. Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures. New York: Guilford Press, 1995.
7. Greenwald R. Eye Movement Desensitization and Reprocessing (EMDR) in Child and Adolescent Psychotherapy. Northvale, NJ, USA: Jason Aronson, 1999.

A B E R E A V E M E N T F E D E R A T I O N

Vivre Son Deuil (*Live Your Grief*)

Paris, France

Michael Hanus MD

Président de la Fédération Européenne Vivre Son Deuil

Vivre Son Deuil (VSD) is a European federation now represented in Belgium, Switzerland and in several areas in France. The association was founded in Paris in 1995 by various palliative care and other support organisations. Our charter is based on two fundamental concepts – the value of networking and of voluntary support – and on the importance of competence, respect and confidentiality. All volunteers, no matter what their professional origin, are very carefully chosen, regularly trained and supervised.

The main activities of the various groups within VSD are aimed at helping bereaved people, and providing training on different aspects of grief. Whilst quite a number of the groups have been founded by VSD itself, many other groups, and conferences, have been set up at the request of outside institutions and associations from French-speaking Europe.

Initial help for bereaved people is provided by a telephone listening service operated by specially trained teams of volunteers. The possibility of self-help and other support is then discussed with the caller.

This can lead to the caller joining a group. Some of these are self-help groups open to all bereaved people, while others are closed support groups where the members remain the same from beginning to end. The closed groups are particularly for children, teenagers, and those bereaved by suicide and miscarriage.

VSD publishes a newsletter addressed not only to every member but also to all the bereavement associations. This is how the association ensures the publicity of particularly successful initiatives. For example, three videos – of which two are about children – have been produced and widely distributed. We have also

published two booklets. One is for all bereaved people, *Vous êtes en Deuil (You Are Grieving)* and the other is for bereaved children, *Quelqu'un que Tu Aimes Vient de Mourir (Someone You Love Has Just Died)*.

VSD's main sponsors are: La Fondation de France (*The French Foundation*), La Ligue Nationale contre Le Cancer (*The National*

League Against Cancer), many pension funds and Les Pompes Funèbres Générales (*The Funeral Directors' Association*).

The association organises innovative projects and specialist training, for example, in running groups for children and those bereaved by suicide. Soon we intend to begin to make contact and, if possible, form networks with other non-French-speaking European associations with similar goals.

Contact VSD at 7 rue Taylor, 75010 Paris, France; ☎ and fax (0033) 142 081116; email fevsd@vivresondeuil.asso.fr; website www.vivresondeuil.assoc.fr **BC**

B O O K R E V I E W

WHAT FOREVER MEANS AFTER THE DEATH OF A CHILD Transcending the Trauma, Living with the Loss.

Kay Talbot

London: Brunner-Routledge, 2002, 261 pp. £17.50 pb. ISBN 1 58391 080 8

Talbot's American-based study examines experiences of parents, primarily mothers, after a child dies. She differs in her approach from writers like Klass¹ and Rubin² by making her own experience part of the research, and adds an important dimension to existing literature by exploring loss of the parenting function, or role loss, that inevitably follows the death of an only child.

She distinguishes between two groups of bereaved parents: 'chronic griever' and 'survivors'. Although both are equally devastated by their loss, the latter, she argues, are characterised by their motivation and will to find meaning in life again. This 'meaning-making', she believes, presents a particular challenge to bereaved parents because for them the natural order, of children surviving their parents, has been reversed and the world has become meaningless.

The book includes a review of familiar grief process models and a lesser-known one which refers to the importance of motivation in the healing process. A major part of the book is concerned with the unique and multifarious ways in which bereaved parents deal with their grief and Talbot makes an impassioned plea for greater understanding of their needs and for individualised responses from professionals and lay people alike. She emphasises that for bereaved parents grief resolution is not about grief ending, but about learning to live – or having to live – with it.

Although Talbot's pervasive belief in the transformational potential of suffering to change the bereaved into better beings will not be shared by everyone, hers is a life-affirming view. **BC**

Els Footman

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1. Klass D. The deceased child in the psychic and social worlds of bereaved parents during the resolution of grief. In: Klass D, Silverman PR, Nickman SL (eds). *Continuing Bonds: New Understandings of Grief*. London: Taylor & Francis, 1996.

2. Rubin SS. The death of a child is forever: the life course impact of child loss. In: Stroebe MS, Stroebe WW, Hansson RO (eds). *Handbook of Bereavement: Theory, Research, and Intervention*. Cambridge, UK: Cambridge University Press, 1999.