Post-traumatic stress disorder and bereavement – Jane' story

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On Saturday 15 August 1998 the largest single atrocity of the Northern Ireland conflict took place in Omagh, a market town with a population of 26,000. Mid-afternoon a car bomb exploded in the town centre and 29 people, including a set of unborn twins, were killed and many more were injured. Of those killed, 19 were aged 17 years or under.

The bomb had a devastating effect on the community with entire families affected. A large number of those injured were children and young people or adults with young families. Many young people sustained injuries resulting in loss of limbs, loss of soft tissue, scarring and disfigurement. Many more were exposed to scenes of intense sorrow and suffering.

The Community and Recovery Team was established by Sperrin Lakeland Health and Social Care Trust after the bomb to work with both children and adults. The team was operational for almost three years and during this period 130 children and young people (aged under 18 years) were referred. The majority were diagnosed with PTSD and 15% had co-existing diagnoses, including depression, anxiety, drug and alcohol abuse, and pathological or abnormal grief reactions.

PTSD

It is only in the last 20 years that traumatic stress reactions in children have been widely studied[1]. Prior to this, it was generally accepted that children only responded to frightening or life-threatening events with transient distress. It is now known that children, like adults, react to traumatic events and are at risk of developing not only post-traumatic stress reactions but also depression, anxiety, phobias and grief reactions and if recognised, such reactions can be successfully treated. Post-traumatic stress disorder (PTSD) is a particular form of anxiety that may occur after exposure to a traumatic event that causes intense fear, helplessness or horror. The traumatic event is persistently re-experienced in one of several ways including intrusive recollections, recurrent distressing dreams, flashbacks or intense distress at reminders. In addition, there is attempted avoidance of reminders of the trauma and/or numbing of responsiveness. Symptoms of increased arousal also occur and may include sleep disturbance, irritability, poor concentration and hyper-vigilance.

Children's responses to trauma depend not only on the nature of the trauma itself but also on the child's emotional, social and cognitive development. As children mature and approach adolescence, they are more likely to exhibit adult-like symptoms, with younger children displaying a different picture depending on their specific developmental stage.

TRAUMA AND BEREAVEMENT

PTSD can negatively influence complicated bereavement and pathological grief reactions. It can effectively block the person from grieving at all or can prolong the grief reaction beyond what one would consider normal. The symptoms of PTSD and grief are, in many ways, similar. Both involve a traumatic event and can include symptoms of acute distress, sleep disturbance, intrusive memories, intense distress at reminders of the traumatic event or the loved one, denial, avoidance, numbing or heightened physiological arousal and anger.

George Engel[2] believed that the loss of a loved one was as psychologically traumatic as a physiological trauma. He argued that, just as a period of healing is necessary to recover from a physical insult, a period of healing (mourning) is necessary to recover from bereavement. Various different models are used to describe the bereavement process. Worden[3] developed a model of grieving that identifies four tasks of mourning: accepting the reality of loss, experiencing the pain of loss, adjusting to the new environment, and investing in new relationships. If someone is involved in a traumatic incident in which a person they were close to was killed, it is important to determine whether they are presenting with an abnormal grief reaction, PTSD or a combination of both, especially when considering treatment.

JANE'S STORY

Jane was a 15-year-old girl who was referred to the trauma centre by her medical practitioner because of psycho-

EDITOR'S NOTE

In the Spring 2004 issue, Black discussed his work with the RUC in Northern Ireland*. Here, McDermott and Moore describe an example of their work following the 1998 bomb explosion in Omagh, also in Northern Ireland, illustrating the interaction between trauma and bereavement, and considering the implications for interventions. *MN*

*** Black A. Traumatic grief in the children of a Northern Irish police officer. *Bereavement Care* 2004; 3(1): 11-13.**

logical difficulties following the bomb. She lived with both parents and older siblings. Her mother worked in the local hospital and was in casualty on the day of the bomb.

Jane was standing close to the bomb when it exploded. She was laughing at tourists who were panicking at the bomb scare. Jane was not worried, having experienced previous bomb scares and firmly believing this one was a hoax. She made a light-hearted joke that the terrorist organisation involved would not blow up their 'own people'. She was standing with three of her own friends but had intended spending the day with two of her mother's friends to whom she was very close. At the time of the explosion, Jane was looking towards her mother's friends but had not as yet spoken to them. Both were killed in the explosion. Jane was unable to attend the funerals as she felt she would not be able to cope. She herself was not physically injured in the explosion.

Her mother felt Jane dealt with the bomb and the deaths of those close to her by pretending neither had happened. She refused to talk about either the bomb or the deaths and denied any associated problems. Four months after the bomb, Jane's mother brought her to the doctor because she was aware Jane was having difficulty sleeping, was irritable, withdrawn and seemed depressed.

When seen individually, Jane reported episodes of dissociation, recent recurrent intrusive thoughts, nightmares, flashbacks, hallucinations, sleep difficulties, irritability, mood swings, poor concentration, decreased self-esteem, generalised anxiety and feelings of hopelessness and worthlessness. In addition, she reported strong feelings of self-directed anger that had resulted in self-injurious behaviour (superficial cuts to the abdomen). She had begun to experience thoughts of life not being worth living, death wishes and intermittent suicidal ideation. She said she did not want to die but wanted to stop thinking about the bomb and those who had died. She reported strong feelings of shame and survivor guilt and experienced recurrent images of a man with his head on fire jumping up and down in front of her. Jane also had symptoms of clinical depression. She was identified as presenting with PTSD, an abnormal grief reaction and depression.

In relation to the four tasks of mourning[4], Jane was blocked at the first stage – that of denial. She unconsciously focused her energy trying to repress memories of the day of the bomb and the associated intrusive thoughts. In so doing, she denied not only the actual fact of the bomb but also the deaths of her friends and thus prevented herself from processing what had happened.

As we all do, Jane functions on the basis of assumptions that are implicit and not actively thought of in the conscious mind[4]. These assumptions include a belief in personal invulnerability, the perception of the world as meaningful and comprehensible, and the view of ourselves in a positive light. Jane was unable to accept what had happened at a conscious level because the potential threat to her psychological equilibrium was too great. Her sense of invulnerability was significantly damaged in the explosion, as was her view of the world as a meaningful place.

Jane not only lost friends in the explosion, but also experienced a profound sense of betrayal (as did many in Omagh) because of the optimism and sense of hope that had been in place following the Good Friday Agreement earlier that year. In addition, because of misinformation received, the police directed people towards rather than away from the site of the explosion.

Jane's view of herself in a positive light was particularly damaged. She had always viewed herself as a disappointment to her mother and intended to do well academically to prove herself. Her PTSD and abnormal grief reaction interfered with her ability to do so, as she could not study because of her symptoms. Jane was also aware that her mother had seen the bodies of her friends in the casualty department and did not appear to be suffering psychologically, and this re-affirmed her sense of failure and worthlessness.

Jane's difficulties were further compounded by her age and developmental stage. Adolescents are egocentric and believe they are unique and invulnerable, and this belief can actually heighten their vulnerability in the presence of a stressor. Jane not only had to process the bombing but also the deaths of those close to her.

Jane remained in treatment for approximately 18 months. In addition to individual psychotherapy and sessions with her mother, she required antidepressant medication. She was, with help, able to successfully integrate the trauma of the bomb and negotiate the tasks of mourning. She is now off medication and studying at university.

CONCLUSION

When dealing with trauma and death, it is important to be aware of the extent to which the psychological consequences of one can impact on the other and can distort the clinical presentation. Jane's difficulties were attributed (by those close to her) to the bomb. It was only in therapy that the full extent of her abnormal grief reaction was realised. Once this was acknowledged and addressed, it greatly aided treatment of her PTSD. BC

References

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BOOK REVIEW

AND THE PASSENGER WAS DEATH

The Drama and Trauma of Losing a Child

Douglas Daher

Amityville, New York, Baywood Publishing Company, 2003, 126pp, $26.95 pb, ISBN 0 89503 244 9

This is a story of a father trying to come to terms with his adult son's sudden, tragic death. Agonising and uncertainty ensues, and persists to some extent, even after a verdict of accidental death is declared, because the question of how it happened is never fully resolved.

As the title indicates, the book is structured like a drama and divided into six acts, in turn subdivided into scenes whose headings further contribute to theme of a play. Most people who have experienced the death of a person close to them will recognise the inevitable sense of unreality which engulfs the bereaved initially, and often for some considerable time afterwards. It seems unnecessary, therefore, to add to this disturbing feeling by describing the loss of a child as if it where a staged drama. Although Douglas Daher's story contains universal elements, at heart it describes his unique way of experiencing and dealing with this poignant event.

Certain aspects add to a sense of 'otherness' when reading this book. Based in West Coast, USA, the writer's use of language and rituals – he is also a psychologist and therapist – convey cultural attitudes that will feel alien to many Europeans. Above all, the various legal wrangles arising from this young man's death, and his father's way of dealing with these, strike an uneasy cord, at least with this reviewer. BC

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