

Traumatic Bereavement



Approaches to grief

are many. Recognise and value the individual's adaptation.

At a time of acute bereavement people may feel they are just surviving. While talking about the loved one may provide solace it may also be the last straw. A compassionate response is all that is needed and offering opportunities for future contact.

Three realms

may be touched on supportively following a bereavement:

- the detail of the death **can you tell me how he/she died?**
- the history of the relationship **can you tell me about him/her?**
- what has happened since the death **how have you been since the death?**

While all deaths may be perceived by the survivors as personally traumatic, there are some circumstances that influence reactions and the potential long term outcome. These may be seen as traumatic bereavements.

- Suddenness and lack of anticipation
- Violence, mutilation and destruction
- Degree of preventability/randomness
- Multiple deaths
- The mourner's personal encounter with death involving a threat to personal survival
- Massive and shocking confrontation with the deaths of others

Traumatic bereavement can result in a difficulty in moving on with the grief process due to preoccupation with the trauma and its imagery. The continual intrusion of the death event may alternate with denial and interfere with the emotional response necessary to accommodate to the loss.

Traumatic bereavement brings with it two different but powerful forms of distress. The **separation distress** that comes with death and the **trauma distress** that comes with how they died. Both types of distress may be experienced simultaneously.

Trauma distress after a sudden and unnatural death can be prolonged and intense.

- Numbing where everything feels unreal or blank
- Intense anger, frustration, irritability
- Arousal (increased startle, sleep etc)
- Search for justice

Separation distress has some unique features

- Intense longing for loved ones
- Searching behaviours
- Pining
- Cognitive distortions (touch, voice, face of loved one)

Support Services

For links to a range of self help and other groups and services for people with mental health problems contact:

The Association for Mental Health NSW Inc Information Service

Sydney Metropolitan Area 02 9816 5688
Outside Sydney Metropolitan Area 1800 674 200

Rape Crisis Line 1800 424 017 (Counselling) 9819 6565

STARTTS - For issues relating to torture and psychological trauma 9794 1900

NSW Refugee Health Service - Provides consultation and support to GPs. 8778 0770
A free telephone interpreter service is available to GPs. 1300 131 450

The Bereavement Care Centre provides counselling. 1300 654 556
www.bereavementcare.com.au

The National Centre for Childhood Grief: Counselling for children and young people (3-18years) 1300 654 556

The National Association for Loss and Grief. www.griefaustralia.org.au

NSW HEALTH
Working as a Team

Acute stress, trauma and bereavement

Information for general practitioners

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Who is affected?

Many people directly or indirectly experience events, which are traumatic. Kessler et al found 60% of men and 50% of women had experienced at least one traumatic event in their life time.

Some Australians have been directly affected by large scale events such as war, terrorism and torture. Most refugees and asylum seekers have been exposed to traumatic events.

Within Australia, traumatic events such as rape, assault, robbery, road and rail accidents, bushfires and other disasters of nature have effected individuals and in some cases whole communities.

Most people will recover from traumatic events without professional intervention.

Those who seek help from a health professional will most often go first to a GP.

Ordinary people, extraordinary events

What happens when ordinary people are exposed to traumatic events? In the immediate aftermath and for days and up to weeks:

distress
denial
disbelief

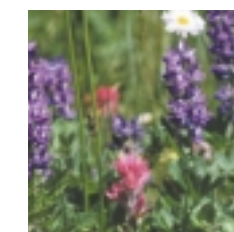
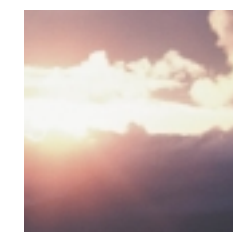
are normal reactions to shocking events. In the first hours and days after a trauma, people may be stunned and dazed, the more so if the impact has been sudden and devastating.

The search for comfort and soothing, and for safety and structure will be paramount.

With time, experiences may be integrated, or if this is not possible, put to one side.

Further reading

Interventions for acute trauma response. Z. Solomon. Current Opinion in Psychiatry, 12, 175-180 (1999).
Treating Psychological Trauma and PTSD. Edited by John P. Wilson; Mathew J. Friedman and Jacob D. Lindy 2001.
Posttraumatic Stress Disorder in the National Comorbidity Survey, R. Kessler et al. Archives of General Psychiatry 1995; 52:1048-1060.



What to do immediately



Psychological First Aid

A simple way to think of the immediate help after trauma is psychological first aid:

Arousal

Calming advice, the presence of a trusted other, slow breathing techniques may be effective. Sedation may be useful in more severe states of arousal.

Behaviours

Distressed people may behave irrationally, putting themselves at risk. The person should be calmly contained.

Cognitions

Cognitive dysfunction may show as dazed, disoriented or dissociated behaviours, inability to concentrate on the task at hand.

Consider delirium (for example: toxic agents, head injury)

1. Survival, safety and security

A stunned mental state leaves people relatively unaware of their own safety.

A medical assessment of ongoing threat or damage including an assessment and treatment of physical injuries. The provision of a safe place to stay is required.

2. Comforting

Providing comfort to a distressed person is a basic human response.

Being quietly responsive, and sometimes touching the person, if appropriate.

3. Ventilation

Ventilation can wait.

Talking about the experience may help some people and may worsen others. Be guided by the individual.

4. Goal Orientation

Trauma can leave a continuing sense of chaos and fear in some individuals. Regaining a sense of order and reality can counter this.

Structure can lessen the stress. Suggest:

- basic routines (meals etc)
- another appointment soon
- stay in the company of others until the acute distress/denial subsides (hours-days)

5. Systems of support

Family and friends will most often provide care and comfort. If a person has no local family and friends they can be linked into a local system of support such as local church; local community service.

Tours of Duty

Doctors can become overloaded by the traumatic experiences of others, both the emotional intensity and the horror of the stories. Early indicators of this may include:

- **Heightened response to the patient.**
- **Increased levels of arousal** (sleep disturbance).
- **Avoidance** (increased use of alcohol may be a form of avoidance).

Things the doctor might consider to avoid becoming overloaded:

- **Discuss** distressing or difficult experiences with colleagues.
- **Refer** the patient on if you need to.
- **Self care** is an important part of sustaining medical practice, limit your exposure to a tolerable level.
- **Seek** help if you need to.

The Doctor's Health Advisory Service offers a confidential crisis and referral service 24 hours a day, 365 days a year. Phone (02) 9437 6552. www.doctorshealth.org.au

The NSW Doctor's Mental Health Program has a website which includes general information on doctors health and how to access confidential treatment.

www.dmh.org.au

Further reading

Psychological Debriefing: Theory, practice and evidence. B. Raphael and JP Wilson (Eds) Cambridge University Press 2000.

Website: National Centre for Post Traumatic Stress Disorder (US) website has links to current trauma research, clinical interventions and self help.

<http://www.ncptsd.org/disaster.html>

What to do in the longer term



There may be specific cultural and linguistic issues that effect the experience of grieving and the way that help can be provided. These may include the isolation of expressing grief in words that are not primary language; the need for a female doctor for women of some cultures (muslim); previous traumatic experiences with migration and disrupted social networks. For assistance with cultural issues contact :

The Transcultural Mental Health Centre can provide assistance with bilingual counsellors and other information. 9840 3767 or 1800 648 911.

People at greater risk of developing longer term problems include: children; people with previous experience of trauma especially childhood trauma, people who already have psychological or psychiatric problems.

In general there is a greater risk of longer term problems with increasing intensity of exposure to life threatening events or witnessing of gruesome deaths and injuries.

General practitioners should feel confident to assess and refer on for specialist mental health treatment those who develop longer term problems after a trauma.

The major psychiatric syndromes following trauma are post traumatic stress disorder (PTSD), major depression, panic disorder, anxiety disorders, substance use, personality change as a result of the trauma. Some people may present following trauma with multiple physical symptoms where no underlying abnormality can be found or with drug and alcohol problems.

To find what local services are available contact the local Area Mental Health Service or locate your nearest service. Contact details for health services are available on: www.health.nsw.gov.au/services

A person may need extra help if after a month if he or she:

- Still feels upset or fearful most of the time
- Acts very differently compared to before the trauma
- Can't work or take care of kids or home
- Important relationships are continuing to get worse
- Uses drugs or drinks too much
- Feels jumpy or has nightmares
- Can't stop thinking about the event
- Can't enjoy life at all, feels numb or shut off

Effects of Trauma in Children

- More clingy
- Whiny, irritable, angry or withdrawn
- Headaches, stomach aches
- Regression to younger behaviours- thumb sucking, bedwetting, baby talk
- Over reactions to minor hurts, physical and emotional

Child and adolescent mental health services and local community health centres offer help for children and families.

Contact details are available on: www.health.nsw.gov.au/services

Further reading

When Disaster Strikes: How Individuals and Communities Cope with Catastrophe. B. Raphael (1986). New York; Basic Books.

The National Institute of Mental Health (US) website has useful information concerning children's reactions to trauma. Helping Children and Adolescents Cope with Violence and Disasters;

<http://www.nimh.nih.gov/publicat/violence.cfm#viol1>

Managing Survivors of Torture and Refugee Trauma, A Desk-top Guide: Caring for Refugee Patients in General Practice. Available from the NSW Refugee Health Service. 8778 0770