Early interventions following traumatic bereavement

A ‘traumatic bereavement’ is such when the loss is sudden, violent or unexpected; for example, a road traffic collision, suicide or homicide. The experience is terrifying and shocking; individuals cannot prepare for, or protect themselves from, the event.

Many traumatically bereaved people find their profound shock, loss and grief is compounded by a lack of help at this terrible time. They need early support, information and advice to help them cope, understand the reactions they are experiencing, and make sense of what has happened. Accessing early support following a traumatic bereavement can make a significant difference to someone’s long-term recovery. This report explores: common reactions to traumatic bereavement and how they develop; the role of assessment; and some strategies to manage the challenges that arise as a consequence.

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Common reactions following a traumatic bereavement

People who are traumatically bereaved commonly experience a range of reactions, which can include:

- sadness, anger and rage, shock, or numbing;
- guilt;
- pervasive fear of anticipated violence toward self/others, sense of vulnerability;
- compulsive behaviours of self-protection;
- compulsive need for tangible reassurance of the presence and safety of other family members;
- behaviours and emotions directed towards retribution;
- reconstructed memories of an event not actually witnessed;
- difficulty sleeping, impaired concentration, and irritability; or
- mental and behavioural avoidance of memories associated with the circumstances of the death, as well as places, people or activities that evoke a memory of the event.

These feelings and reactions are distressing, but are normal reactions to the abnormal situation of traumatic bereavement. Although they are common, different people experience them in different ways based on their circumstances and experiences. For example, the extent of reactions can be affected by: the age of the deceased and relationship with surviving family; the nature of the death; degree and impact of media involvement; or the involvement of other agencies including healthcare professionals, police and the justice system.

Families affected by traumatic bereavement can feel isolated and stigmatised. Bereavement and loss can affect members of the same family in different ways. Different family members may well react differently and find various ways of coping, which can disrupt the family dynamic and cause greater problems in the long-term aftermath.

In some cases, more complex problems such as post-traumatic stress disorder (PTSD) can develop. PTSD is a chronic and disabling condition which can become intractable if help is not offered in within a few weeks of exposure to a traumatic event. While this is commonly associated with people who witnessed a traumatic death, it is also possible for people to develop PTSD after learning second-hand of the death of loved one through violent or unexpected circumstances. The more
significant the event, the greater the risk of mental health problems such as PTSD developing.

Why early interventions for traumatic bereavement?

Studies\(^3\) have found that in many cases early interventions are effective in reducing long-term psychological complications by facilitating help-seeking. Traumatically-bereaved people benefit from:

- early help
- outreach help offered proactively
- information about the event and potential reactions
- ongoing help over time
- opportunities to meet with others who have experienced similar situations

Studies\(^4\) have recommended crisis interventions should: treat the trauma reaction as normal, and within context, rather than as a medical problem to be fixed; and teach the bereaved person to understand and deal with their reaction through information, guidance and support. Such interventions help individuals and families recognise the course of reactions and expectations following exposure to trauma and traumatic bereavement.

‘Early intervention’, in this instance, does not refer to formal counselling or therapy. Traumatically bereaved people often experience a powerful need to talk, but many will not need therapy, and certainly not in the first few weeks. An intervention described as ‘structured social support’ (described below) can help people work through their experiences and come to terms with what has happened.

Assessment

Traumatically bereaved people should ideally be assessed within weeks of the incident by suitably qualified mental health professionals experienced in working with traumatic bereavement. This assessment can be conducted in a number of ways. A common method is a series of meetings, with family groups or individually, to assess their natural resilience and existing sources of support. It is often helpful for therapists working with a family to work with a co-therapist present. Specialist input should be sourced if assessing a child.

A ‘psychological triage’ – assessment to determine the severity of someone’s condition – enables the person to be offered appropriate care reflective of their needs. A ‘stepped care’ approach is often appropriate; this means someone can be ‘stepped up’ from a lower level of service to more intensive or specialist services as needed.

Assessment and re-evaluation should be a cyclical process [see Figure 1] to take account of changes in family circumstances and other developments brought about by continuous traumatic stressors following traumatic bereavement. For example press attention, legal proceedings, inquests, and new [potentially distressing] information coming to light as a result of any investigation, can all be sources of further trauma. Support professionals should also consider and prepare for anniversaries and other important occasions that may affect the family.

Figure 1: cycle of assessment and re-evaluation

Structured social support

The importance of social support cannot be over-emphasised as it is this, rather than formal therapy, which is usually of greatest help to the traumatically bereaved. There is plenty of research\(^5\) which indicates the provision of social support protects people who have experienced extreme stress and trauma from developing significant problems down the line. Conversely, the lack of social support is a strong predictor of long-term distress.

One of the key considerations in the early phases is the process of ‘normalisation’. Providing normalising information about usual reactions and coping suggestions soon after a critical event helps people to know the landscape they will subsequently inhabit, which can reduce feelings of uniqueness and help them feel ‘normal’. Research has shown that misinterpretation or negative appraisal of one’s own reactions can contribute to conditions such as PTSD\(^6\). Providing verbal explanations to help frame the event and one’s own and others’ reactions can help prevent unnecessary problems.

Following initial assessment, structured social support should be provided. This support should be based around education, information and guidance on:

- the impact of traumatic bereavement, common reactions and the course of those reactions;
- emotional and physical reactions;
- fear cues, intrusive thoughts or reminders, e.g. ‘media triggers’ from TV or other media sources;
- dealing with mental and behavioural avoidances [see below for an important note on this];
• predicted time frame of emotional reactions and any influencing factors based on contextual circumstances;

• self-care such as following a routine, structuring the day, and maintaining family rituals;

• the possibility of changes in outlook and attitude and the impact this can have on coping strategies;

• other support services such as self-help groups or relevant charities;

• appropriate reading or self-help literature;

• meeting others with similar experiences (this should also be arranged after careful consideration through organisations who have experience in the area of the specific nature of the bereavement and be carefully and closely monitored); and

• other information, advice and guidance specific to the nature of the bereavement.

All the above should be discussed within the context of the individual or family’s experience, using examples that are specific to them.

Note on mental or behavioural avoidance: this is a common reaction, as outlined above, but if this behaviour becomes entrenched it can lead to more serious psychological problems. Bereaved people should be advised to monitor their own behaviour and thoughts for consistent avoidance of triggers and reminders. However, this should be treated with caution: advising bereaved people to confront reminders and fear cues, especially in the early stages, can cause further trauma. This will depend on the individual’s resilience and access to regular support, and should be judged on a case-by-case basis.

Meetings should be informally structured to provide a sense of safety and containment. It can help to give the individual or family a brief written summary of each meeting, as it can be difficult to retain information under conditions of continuous stress.

Some may benefit from therapy or counselling at a later stage if they are suffering from marked depressive symptoms or post-traumatic symptoms. Usually post-traumatic symptoms are more likely to occur if: the individual witnessed the death of a loved one; they are exposed to graphic images and details as a result of attending a trial; or they begin to develop memories based on information they have been told about the manner of the death. The latter is known as a ‘reconstructed memory’. For example, a mother whose two young children were hanged by her husband who subsequently hanged himself, had regular nightmares for many years of three shadowy figures hanging on an upstairs landing. She did not actually witness the scene, but had constructed a memory of the event which manifested in regular nightmares for several years until she had psychological treatment.

Assessment is crucial in deciding whether formal therapy is required, or whether the individual or family is simply showing normal reactions within the context and circumstances of the bereavement. If individuals begin to display specific trauma symptoms or show signs of a clinical depression, they should be referred through their GP for assessment by suitably qualified therapists. Recommended treatments may include trauma-focussed cognitive behavioural therapy (TF-CBT), as recommended by the UK National Institute for Health and Care Excellence [NICE]. This treatment may include Eye Movement Desensitisation and Reprocessing (EMDR), also recommended by NICE. EMDR has been shown to be useful in treating specific trauma symptoms including nightmares and persistent intrusive thoughts that come to mind out of the blue . TF-CBT may not suit everyone, so individual needs and preferences should be discussed.

Many individuals who have experienced a traumatic bereavement describe instances where their counsellor or therapist actively avoided in-depth discussion of the circumstances surrounding the trauma or bereavement, because they themselves found it difficult or distressing. This leads the affected individual to ‘censor’ or minimise the impact of the trauma, which inhibits their ability to tell a full story and begin making sense of their traumatic loss. Therefore the therapist should have extensive experience in working with traumatic bereavement, and be able to provide a ‘safe’ environment and contain the often painful and at times graphic disclosures made in such encounters.

Conclusions

• Normalising the reactions that many individuals experience after a traumatic bereavement can reduce feelings of alienation and assist with processing the traumatic event and losses.

• Crisis interventions should treat the trauma reaction as normal and within context, and provide information, guidance and support on how to understand and deal with the reaction.

• Assessment of an individual or family’s resilience, presence of social support, and past ways of coping with previous difficult experiences can help predict what psychological problems may develop.

• Cyclical assessment and re-evaluation will identify developing problems brought on by continuous traumatic stressors following traumatic bereavement.

• Formal therapy or counselling should not be considered in the first instance, but ongoing assessment and evaluation will highlight any need for such interventions.

• An initial ‘psychological triage’ can help to assess the most appropriate support for referral in the first instance, using a ‘stepped care’ approach to refer on to more specialised support as needed.
• Structured social support should be provided in an empathic, practical and pragmatic manner, taking account of people’s natural resilience.

• Information and advice on understanding and dealing with reactions to traumatic bereavement should be tailored to the individual or family’s experience.

• If formal therapy becomes necessary, evidence-based treatments such as TF-CBT should be considered alongside other supportive approaches.

• Early interventions using structured social support, and therapy if needed, should both be provided by clinicians experienced in dealing with traumatic bereavement.

Further reading:


End notes


4 Ibid

