Association for
Child Psychology and Psychiatry

Occasional Papers
Series Editor: Gillian Forrest

Occasional Papers No. 8

TRAUMA AND CRISIS MANAGEMENT

Papers presented at the ACPP Day Meeting, 24 February 1993

The Interplay of Trauma and Grief

ATLE DYREGROV
Center for Crisis Psychology, Norway

Introduction

How do we differentiate between trauma and grief? How does it impact the family system and what are the consequences for our help and intervention for children and families?

Within the field of thanatology, the study of death and bereavement, surprisingly little has been written about the traumatic aspects of many deaths. At the same time, within the trauma literature, traumatic loss of a close and dear person is often not included. Moreover, grief (simple bereavement) was excluded as a traumatic event when "post-traumatic stress disorder" was introduced as a new concept in DSM III in 1980.

While preparing this presentation I reviewed the bereavement literature on children losing a parent or a sibling. With the exception of studies of the murder of a parent (Pynoos, 1992; Pynoos & Eth, 1984; Pynoos & Nader, 1990), little is mentioned about the circumstances of a parent's death. Serious long term consequences, such as PTSD and complicated grief, have been documented following such murders.

In studies of children's reactions when siblings die of Sudden Infant Death Syndrome (SIDS), the circumstances around the death are sometimes mentioned (Mandell, McAnulty & Carlson, 1983; Rogers, 1966), as siblings are often present when the baby is found, or have had the responsibility for the baby at the time of death either as baby sitters or being responsible for the baby in its pram.

Grief and trauma

Most children experience grief for the first time in connection with a grandparent's death. However, each year many children experience the loss of parents (caretakers), siblings, other relatives and friends. The circumstances of a death are important determinants of psychological sequelae for the child. Figure 1 illustrates various deaths a child can experience.

The more uncomplicated losses are found to the left in the Figure, while the more complicated and traumatic losses are depicted to the right. When a death occurs in a stage of life where it is expected,

GRIEF

Expected loss
—child prepared

Expected loss
—child unprepared

Unexpected loss
—sudden death, illness
—child not present

Unexpected loss
—accidents, disasters, war
—child not present

Unexpected loss
—murder, suicide
—child not present

Unexpected loss
—sudden death, illness
—child witness

Unexpected loss
—murder, suicide
—child witness

Unexpected loss
—accidents, disasters, war
—child witness, survivor

TRAUMA

Figure 1

children can be prepared, and the circumstances can be organized to prevent the grief process from becoming complicated. But even the death of a grandparent occurring at an expected age can be upsetting when the child is unprepared, i.e. if the parents have not informed him/her about what will happen.

The Figure lists various types of expected and unexpected losses with an emphasis on the presence of the child as an important factor in determining if it will be a trauma or not. If the death happens suddenly

without preparation and in a phase of life where death normally does not happen, this can be categorized as a traumatic death. When the unexpected loss is caused by an accident, a disaster or murder or suicide, these deaths are traumatic, even without the child being present. If we move a step further to the right towards the traumatic side of the figure, the child witnesses or is present when his or her loved one dies. If death occurs in this way, the traumatic moment can "burn" itself into the child's memory:

> A 16 year old boy was present when his father had a heart attack. When he was helping the father to get dressed as they were waiting for the ambulance, his father died. The vivid memory of feeling his father's body falling back on the pillow and the touch sensations experienced during this moment led to strong impressions, which troubled the boy a lot afterwards. This, together with the fear that his father would return as a ghost, was the reason help was sought. These traumatic aspects had to be given priority in the follow-up, before the boy's grieving could proceed.

In certain cases the child is not present when the person dies, but discovers the body:

> A 12 year old girl found her father lying next to the hoover, which was not turned off. Her first thought was that he was just resting, but instantly it changed to:"He must have fainted". The staring eyes made her quickly think that maybe he was dead. Thoughts occurred very rapidly. She immediately called for help, but her father was already dead when the ambulance arrived. The vivid visual images were imprinted on her mind and led to her teacher contacting the psychologist for further help for the girl.

Among children witnessing murder, suicide or finding the deceased, there is a great chance of traumatization because the sensory impressions are so strong. Based on my experience from working with children in disaster and war situations, I cannot over-emphasize the importance of the child's sensory exposure. I think there is reason to believe that through evolution we have been equipped with a mechanism that "opens" all our senses in crisis situations, in order to secure a rapid intake of outer stimuli that can be used when deciding what to do. An altered sense of time, often experienced as slow motion, can accompany this, and reflects the rapid processing of information that takes place at several levels at the same time. These mechanisms help us survive. But the price we pay for this is the intensity with which the sensory impressions are imprinted on our memory. This form of "super memory" is the basis for later intrusive thoughts and images. The impressions can be registered in most senses; what the child sees, what it hears, what he/she smells, tastes and physically touches.

> Even when I try not to think about it, it keeps coming up. If I see anything burning, immediately I remember the shelter. If I see a match burning or if I see any dust or any ashes I remember. I went to see the shelter, and I turned my face and I wanted to walk away, and I wasn't looking, and a car bumped me, and I fell on my face. I wasn't hurt, it just hit me on the side, it was just a scratch. I went to see if they had removed the corpses from inside the shelter. (Rayed)
>
> It is the sight of the corpses I remember. All the corpses. (Sarah)
>
> I can't remove the event from my mind, because the shelter is right next to the school. I try hard not to think about it but I always end up thinking about it. (Nur)
>
> I feel trapped inside these memories. (Nasra)
>
> It's the pictures of corpses of children that always come to my mind. This is something I can't escape from. (Nawar)

These are quotations from children in Baghdad who experienced the bombing of a shelter where more than 750 people were killed, most of them children and women. The children gathered with their parents outside the shelter. In children's drawings, those who were not allowed to go to the shelter evidenced little traumatic elements in their drawings, compared to exposed children who drew bodies, body-parts, ambulances, bystanders and depicted the horror of the situation.

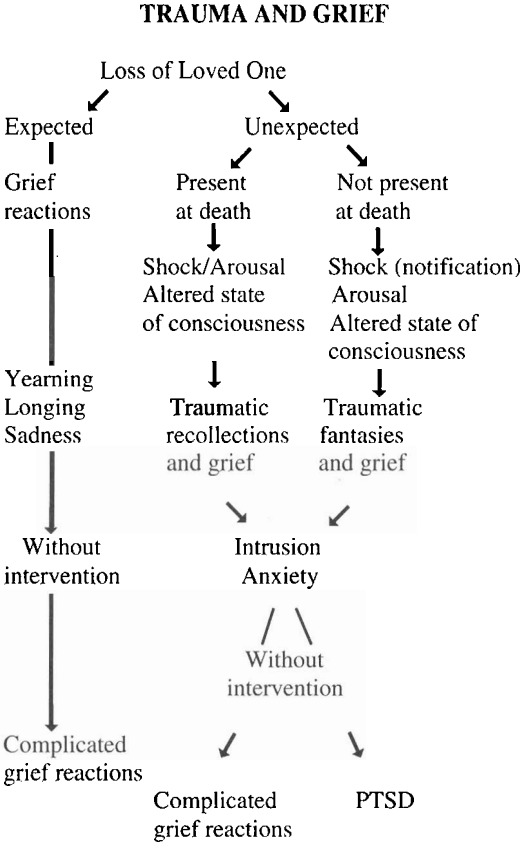
We met these children 6 and 12 months after the war, and it was incredible to see how they were trapped inside the trauma. The intrusive images and thoughts were so strong, and they used so much energy to avoid them, that most of them had serious problems at school. Their minds were like a landscape of mental ruins destroyed by the war, and the trauma was added to by

adults who were unwilling or incapable of talking with them about their experiences (Dyregrov & Raundalen, 1992).

The chances of experiencing a trauma is greatest among children who survive an event where someone from their close family dies, for instance in accidents or disasters. In addition to the loss of the close family member, they usually are exposed to strong sense impressions, as well as the threat to their own life.

Through showing the variations in the situation, as illustrated in Figure 1, we gain a better understanding of what children have been exposed to. This helps us decide on necessary and suitable follow-up. In Figure 2 this is shown in a different way.

Figure 2



The consequences of a loved person's death are divided into those following expected death versus sudden death. If a loss is expected, it will lead to grief reactions, characterized by symptoms such as longing, sadness and searching for the lost one. With the help of understanding parents, other adults and friends and, in some cases, professional support, more complicated grief reactions can be prevented.

If the death occurs suddenly, the child can be present or not present. In both situations the chance is high that the child will experience some form of shock reaction of varying length. If the child is not present, the shock will come when he/she is informed about the death. Present or not, on both occasions there will be an activation of the nervous system, particularly when the child is a witness or survivor of the event. Sometimes children also show an altered state of consciousness, where the child's senses are focused on the intake of outside information, and he/she experiences a more detailed and intense registration of information. The 12 year old girl who found her dead father described her sensory experience in the following way: "It did not fit into my everyday life".

When a death occurs suddenly, children who are present can retain strong impressions, while children not present often develop traumatic fantasies about what happened. In both cases, this lead to intrusive memories or fantasies, together with increased anxiety and fear as a result of the vulnerability and insecurity that has entered the child's life. Bereavement symptoms such as longing, sadness and searching can also be present, but will usually be overshadowed by the intrusive memories and the traumatic anxiety. Without intervention and help for the child and his/her parent, together with mobilization of support from the environment (teachers, nursery teachers), the child can develop post-traumatic stress disorders, complicated grief reactions, or a combination of these reactions.

Even when a child is not present at a disaster, there can be a transmission of behaviour or reactions within the family, described in the literature under terms such as: identification, indirect victimization, vicarious victimization, sympathy, secondary victimization (Figley, 1985). The child's fantasies about a traumatic death will often circle around "How was it?", "Did she feel pain?", "Was he afraid?".

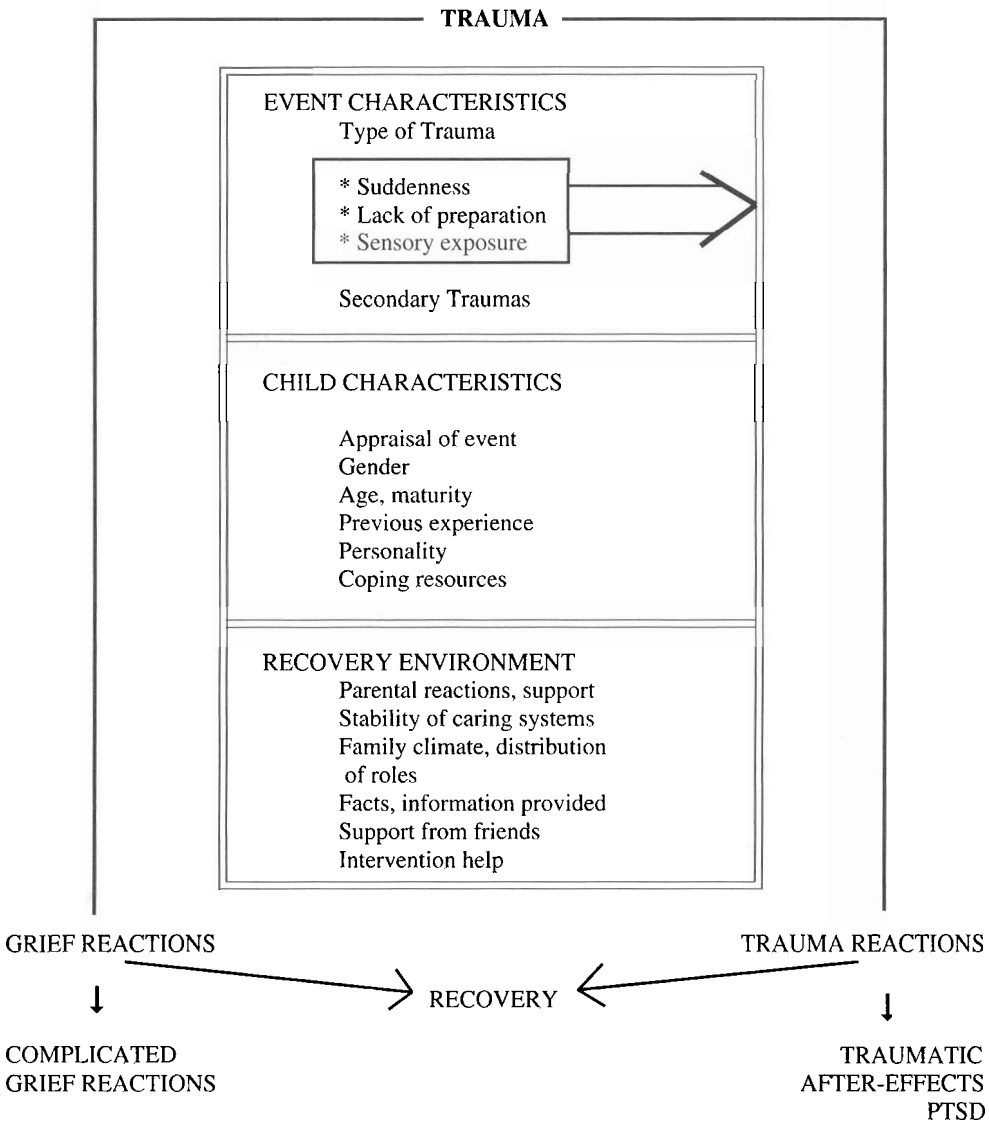
Circumstances determining a child's reaction

Although I will refrain from commenting on each factor, the various circumstances illustrated in Figure 3 will dictate how children will react after the loss of a

family member or close friend. Some of these conditions are very significant determinants of traumatic after-reactions. Factors are grouped into event characteristics, child characteristics or characteristics of the environment.

Our clinical work in crisis, disaster and war situations have made us believe that in many sudden deaths the *circumstances of the event* to a great extent determine whether or not the child will develop traumatic after reactions. If the death occurs suddenly,

Figure 3



without any preparation and the child is exposed to strong sensory impressions, i.e. being present when the person dies, this increases the chances of a traumatic aftermath. The possible secondary traumas that the child can experience can also influence the aftermath. Since secondary traumas in connection with a death are relatively usual, one example will be given:

> A young girl experienced her brother's death following an accident. He died on the operating table some hours after the accident. After the death the family was led in to see him. Even though they had been told that he was still connected to some medical equipment, the sight of the tube going into his mouth, together with the other probes he was connected to, made a very strong impression on the young girl. The perceptions were very intense and detailed - and they came back as visual intrusions that broke into the girl's chain of thoughts several times every day in the weeks following the death. The hospital personnel explained that they did not remove the medical equipment as they wanted the family members to see that the hospital had done everything they could to try and save him. The personnel lacked knowledge about the intensity with which our memory continues to register information in the post-event period. In this case, this created a secondary trauma for the girl and several other family members.

Conditions within the child will also affect their reactions. Children's understanding of the event vary depending on age and maturity. Smaller children have not developed an understanding of the long term implications of a parent's death. The perception and the appraisal of the event will vary with experience and personality. Gender differences in reactions to death and trauma are evident, but not well understood. Results show that girls can talk more easily about their thoughts, impressions and reactions in connection with critical situations, both to their friends and family (Dyregrov, 1988; Dyregrov, Mattiesen, Kristoffersen & Mitchell, in press). Factors such as age, maturity, earlier experience, personality and coping resources will all be important to determine grief or trauma reactions.

The last group of conditions to be mentioned concerns the *recovery environment,* in particular the reactions and the way the event is being handled by the parents or surviving parent. While adults are able to get hold of information, interpret the environmental reactions and contact relevant assistance, a child is dependent on the parent or caretaker's attitude and ability to be open and direct in communicating facts around the death. Furthermore, an accepting and open climate regarding emotional expression and discussion about various aspects of the death will have a major influence on how the child will be able to cope after the event (Balk, 1983; Bowlby, 1980; Gray, 1987; Rosen, 1984-1985; Siegel, Mesagno & Christ, 1990). Lack of care and understanding towards a child by his/her environment will influence both trauma and grief reactions in a negative manner.

The conditions mentioned in Figure 3 will be decisive when it comes to how the event will be processed, and to what degree it will constitute a trauma for the child. Too many negative factors will either lead to the development of PTSD or complicated grief reactions.

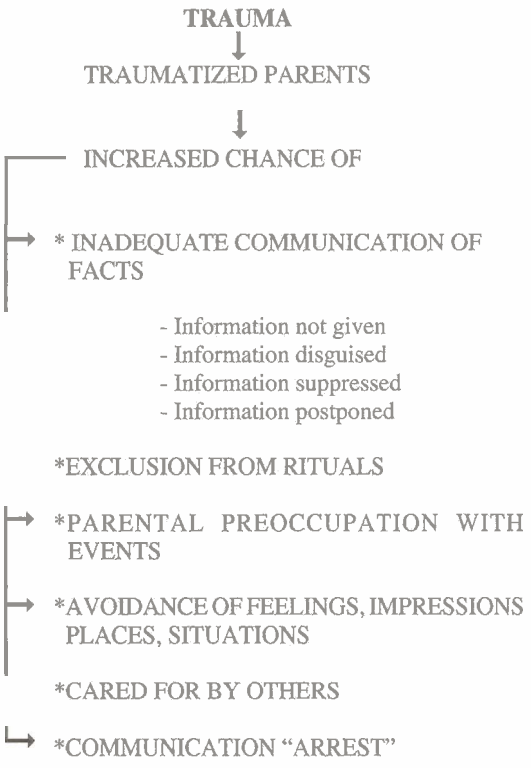
Traumatic deaths cause trauma in parents

From research on children's situations during crisis and disasters, we have learned that adults have a tendency to underestimate what the children can comprehend, how much they will react and the duration of their reactions (Earls, Smith, Reich & Jung, 1988; Handford, Mattison, Humphrey & McLaughlin, 1986; Yule & Williams, 1990). This has also been documented for grief (Weller, Weller, Fristad, Cain & Bowes, 1988).

When a child experiences grief, the event in most cases will influence the parental system dramatically, except when the deceased is a close friend of the child. If a grandparent dies, a parent will lose a parent, if a child's sibling dies, the parents have lost a child, and if a parent dies the remaining parent has lost a spouse. Even though the death might be "expected", we know that these deaths will have a major impact on the parent's mental condition and therefore on the child's situation (Dyregrov, 1990). A sudden loss will often traumatize the parental system: this is extremely important for helpers to understand. While children are trying to grasp, understand and make sense of what happened, they often face parents who want to shield, shut out, prevent and hide facts and feelings. In Figure 4 the various consequences this can have on the child are presented.

Often information is kept hidden from a child or it is manipulated before it reaches him/her. Many family secrets can have their origin here. In addition, children can experience being left out of rituals, in particular saying goodbye to a loved one whose body has been

Figure 4



badly disfigured[1]. Parents try, with the best of intentions, to protect their children against the pain and the loss (Becker & Margolin, 1967). Parents may become over-occupied about the loss, their traumatic impressions, fantasies and fears. McFarlane (1987) showed that PTSD in either parent had the potential to disturb family relationships to the detriment of other family members.

A traumatic death often leads to intense emotions, and parents try to override these by avoiding situations where they are reminded about the event. A mother in Iraq told us that she was shivering inside and she could not embrace her shivering child. She told her to go away, she had more than enough problems coping herself. The pain in a family can be so intolerable that it leads to mutual silence and lack of communication about the most important event in the family's life. This can lead to a climate at home where the expression of emotions is neglected or refused, with negative consequences for children. Sometimes the tempo in the processing of an event differs in children and adults:

> A 16 year old girl was angered and protested highly when her mother wanted to go out with a new male friend about a year following her husband's sudden death. When the girl was asked when she thought it would be alright for her mother to start dating she answered: "Never."

In the worst cases traumatic deaths can lead to a complete breakdown in communication within the family. Many times children protect their parents by not communicating their anxiety, grief and sorrow. They sense that their parents do not like it, that they do not understand or do not listen. Sometimes parents tell them to forget and be brave.

> A 14 year old girl was raped and did not dare to report it, as she was feeling so ashamed. When she finally did tell her parents two years later, the parents got angry, blamed her, and were not willing to let her talk. A sensitive teacher contacted our centre, and during sessions she explained how she feels totally alone, betrayed in a sense by her parents' lack of interest in her. No one took any action until she tried to commit suicide.

Some parents let others care for their children in this period as they do not think themselves capable of doing so themselves. This can lead to the development of high levels of anxiety in children, as they commonly worry intensively that something might happen to their parents. It should also be noted that disasters can lead to increased communication and care within the family, with a realization of what could have been lost. Value changes are sometimes profound following a disaster, with life being reorganized in "before-after" the disaster.

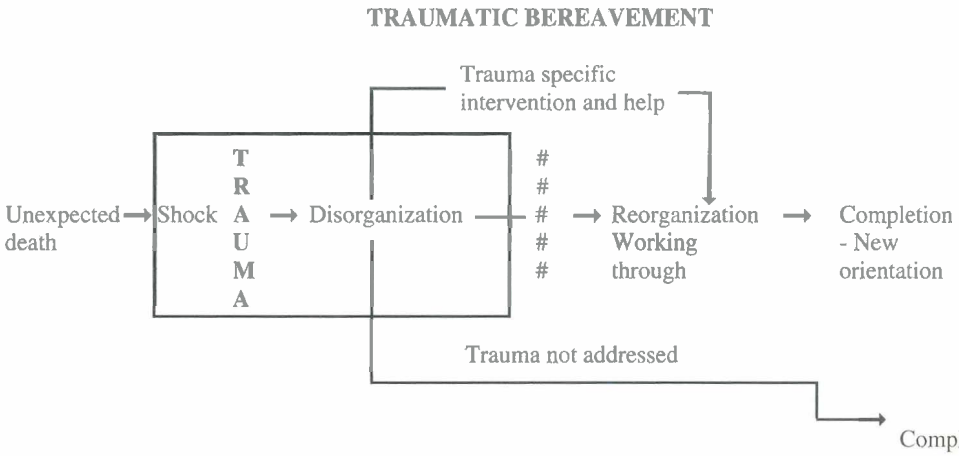
Intervention following traumatic death

With the above discussion as a basis we can state that when a death occurs suddenly and unexpectedly, and in particular if a child is witness to or survives the situation, this will lead not only to grief, but to trauma and traumatic after- reactions. It is not unusual for children to only get help in relation to the loss experienced, and no help in processing memories, anxiety or traumatic after-effects of the death. Without this, the trauma is being insufficiently focused. Figure 5 illustrates how an unexpected death leads to shock and trauma which can delay, disturb or stop parts of the grief process.

It is necessary to understand that the trauma can "over-shadow" the grief. There seems to be an increasing degree of understanding within the clinical

[1] Dyregrov (1990, 1992) has explained why it is so important to include children in such rituals, and how this can be done.

Figure 5



field that it is necessary to work through the trauma first before the grief process can continue (Pynoos, Nader, Frederick, Gonda & Stuber, 1987). A lack of working through of the trauma can lead to the development of PTSD or variations of complicated grief reactions. To facilitate reorganization and working through of the event, the child must be given specific trauma intervention and help.

A 16 year old girl lost her best friend in a traffic accident. Her friend was badly disfigured in the accident. Contact with a psychologist was not established until 6 months after the event. At that time the girl had isolated herself from her friends and leisure activities and had problems at school. During the first consultation with the psychologist, fantasies concerning how her friend had looked after the accident were uncovered, and found to prevent her from moving on in her grief process. Contact with one of the policemen who was present at the site of the accident was established. He gave the girl detailed information on her friend's condition. He was frank and direct, not protecting her. This enabled the girl to let a concrete picture replace the various fantasies that had caused her problems earlier. Even though the descriptions given by the policeman were brutal, they blocked her fantasies and she could go on in her grief process.

A detailed description on the support that should be given to children is too extensive to include here. This is provided elsewhere (Dyregrov, 1990; Dyregrov, 1992). Some important points are summarized in Figure 6.

Two points will be emphasized here: "Ease understanding" and "Confront with". It is the author's experience that cognitive work with children has been under-emphasized. When children experience trauma, it is important that they are provided with information and facts that help them understand what has happened. To be able to cognitively grasp what has happened, they often have to go through the event in fantasy or by visiting the place where the event took place, meeting with rescuers or helpers or in other ways confronting what happened. Through such work, children's understanding is improved, and mistakes, fantasies and anxieties are avoided. Obviously, these contacts must be arranged according to age and maturity level, but it is intriguing to see how young children can be helped by concrete information and detailed explanations of the event.

When intervention takes place shortly after the event, it is relatively easy to discuss what happened directly and concretely. In addition, as the sensory impressions are so important in forming later intrusive thoughts and images, a traumatized child or traumatized group of children should be given an early opportunity for detailed expression of these impressions, either through drawings, redramatizing, song, dance and art, or through detailed retelling of the event to someone capable of receiving such strong material. This allows for visual, auditive, olfactory, taste or kinesthetic memories to be given verbal representation or a more active

Figure 6

HELPING CHILDREN WITH TRAUMA

*Emotional First Aid

*Prevent secondary traumas
- exposure to media
- prepare for media coverage
- insensitivity from organizations (hospital, school, church, police)

*Mobilize recovery environment
- educate parents\caretakers on trauma and grief reactions
- secure continuity in caretaking, kindergarten, school, leisure activities and routines
- promote sharing of information, feelings and concerns
- tolerance of child's reactions
- help parents process event

*Facilitate understanding
- provide info. and facts
- go through event step by step
- sensory impressions
- talk about cause and effect
- discuss meaning aspects
- normalize reactions

COGNITIVE PROCESSING

*Secure prepared confrontation with
- facts and info.
- rescuers & helpers
- place of trauma
- rituals
- concrete reminders

*Facilitate expression
- drawings
- concrete tasks, behaviour
- compositions
- redramatizing
- song, dance and art

EMOTIONAL PROCESSING

*Help tolerate
- rescue revenge fantasies
- yearning, longing, pain
- strong emotions
- ambivalent feelings
- new relationships
- anniversaries

* Train
- new skills/behaviour
- retrain old skills/behaviour

expression (drawing, play, role play). This also allows images or fantasies to be "transported" out of the mental system, and it can lead to a transformation of the memory. Clinical experience indicates that this weakens the memory and the intrusive material becomes less unpleasant.

Summary

This paper has focused on the difference between grief following expected death and grief following sudden, traumatic death. When a child experiences a death, it is important to know how the death has occurred, and which possible traumatic circumstances were present. This helps to tailor-make help and intervention. It also makes it more easy to decide when professional help is called for. Such intervention is particularly important after a traumatic death. Although we do not know how common PTSD or complicated grief reactions are following traumatic deaths, professionals should be contacted at an early stage so that the family/child can be helped to process and express the trauma. How the professional will work, either directly with the child or through parents or the preschool or school personnel, will depend on the concrete situation they are facing.

References

Balk, D. (1983). Adolescents' grief reactions and self-concept perceptions following sibling death: A study of 33 teenagers. *Journal of Youth and Adolescence* **12**, 137-161.

Becker, D. & Margolin F. (1967). How surviving parents handled their young children's adaption to the crisis of loss. *American Journal of Orthopsychiatry* **37**, 753-757.

Bowlby, J. (1980). *Attachment and Loss, Volume lll. Loss, Sadness and Depression.* New York: Basic Books.

Dyregrov, A. (1988). Responding to traumatic stress situations in Europe. *Bereavement Care* **7**, 6-9.

Dyregrov, A. (1990). *Grief in Children: A Handbook for Adults.* London: Jessica Kingsley.

Dyregrov, A. (1992). *Katastrofpsykologi.* Lund: Studentlitteratur.

Dyregrov, A., Matthiesen, S. B., Kristoffersen, J. I. & Mitchell, J. T. (in press). Gender differences in adolescents' reactions to the murder of their teacher. *Journal of Adolescent Research.*

Dyregrov, A. & Raundalen, M. (1992). The impact of the Gulf war on the children of Iraq. Paper presented at the International Society for Traumatic Stress Studies World Conference "Trauma and Tragedy". Amsterdam, June 21 - 26.

Earls, F., Smith, E., Reich, W. & Jung, K. G. (1988). Investigating psychopathological consequences of a disaster in children: a pilot study incorporating a structured diagnostic interview. *Journal of the American Academy of Child and Adolescent Psychiatry* **27**, 90-95.

Figley, C. F. (1985). *Trauma and its Wake: The Study and Treatment of Post-traumatic Stress Disorder.* New York: Brunner/Mazel.

Gray, R. E. (1987). The role of the surviving parent in the adaption of bereaved adolescents. *Journal of Palliative Care* **3**, 30-34.

Handford, H. A., Mattison, R., Humphrey II, F. J. & McLaughlin, R. E. (1986). Depressive syndrome in children entering a residental school subsequent to parent death, divorce, or separation. *Journal of the American Academy of Child Psychiatry* **25**, 409-414.

McFarlane, A. C. (1987). Family functioning and overprotection following a natural disaster: the longitudinal effects of post-traumatic morbidity. *Australian and New Zealand Journal of Psychiatry* **21**, 210-218.

Mandell, F., McAnulty, E. H. & Carlson, A. (1983). Unexpected death of an infant sibling. *Pediatrics* **72**, 652-657.

Pynoos, R. S. (1992). Grief and trauma in children and adolescents. *Bereavement Care* **11**, 2-10

Pynoos, R. S. & Eth, E. (1984). The child as witness to homicide. *Journal of Social Issues* **40**, 87-108.

Pynoos, R. S. & Nader, K. (1990). Children's exposure to violence and traumatic death. *Psychiatric Annals* **20**, 334-344.

Pynoos, R. S., Nader, K., Frederick, C., Gonda, L. & Stuber, M. (1987). Grief reactions in school age children following a sniper attack at school. *Israeli Journal of Psychiatry and Related Sciences* **24**, 53-63.

Rogers, R. (1966). Children's reactions to sibling death. In Dunlop & M. N. Weisman (Eds), *Psychosomatic Medicine. Proceedings of the First International Congress of the Academy of Psychosomatic Medicine.* Palma de Mallorca, Spain, 12-14 September, 166. International Congress Series No. 134, 209-212.

Rosen, H. (1984-1985). Prohibitions against mourning in childhood sibling loss. *Omega* **15**, 307-316.

Siegel, K., Mesagno, F. P. & Christ, G. (1990). A prevention program for bereaved children. *American Journal of Orthopsychiatry* **60**, 168-175.

Yule, W. & Williams, R. M. (1990). Post-traumatic stress reactions in children. *Journal of Traumatic Stress* **3**, 279-295.

Weller, E. B., Weller, R. A., Fristad, M. A., Cain, S. E. & Bowes, J. M. (1988). Should children attend parent's funeral? *Journal of the American Academy of Child & Adolescent Psychiatry* **27**, 559-562.