Working with the legacy of trauma





Mike O'Connor MA DEP CPsychol
Senior Psychologist

Ali Russell MA MAppSci CPsychol
Senior Psychologist

Clackmannanshire Psychological Service, Alloa, Scotland, UK

When bereavement occurs suddenly or in a way that is distressing or frightening, grieving may be impaired by traumatic memories. These may need to be dealt with before grieving can begin. It is important to distinguish between the effects caused by trauma and those caused by grief.

In this article we reflect on our experience of helping children cope in the aftermath of a major traumatic bereavement, illustrating this with two case studies. For both of the children in the studies, the immediate legacy was the complete disruption of their sense of security, resulting in them being unable to participate in the normal day to day activities of childhood without fear and anxiety. These emotional responses to everyday situations persisted for many months and were only resolved following a comprehensive therapeutic intervention combining eye movement desensitisation and reprocessing (EMDR), play therapy and family counselling.

THE LEGACY OF TRAUMA

During the past 15 years or so, scientific and clinical research has taught us a number of lessons about the impact of trauma on children[1-7], so that those of us who care for, or work with, children can now better understand the effects of trauma and grief on their lives.

For example, we now know that:

- Trauma disrupts children's sense of psychological safety. This may be temporary or long lasting
- The range of traumatic stress and grief reactions is wide and varied. This is true not only in major disasters but also in situations when children are exposed to more common events such as sudden death, accidents, witnessing domestic abuse or bullying
- The timing of children's reactions to trauma and loss shows wide variation. Reactions may appear immediately or be delayed and therefore more difficult to recognise
- A significant minority of children, even very small infants, exposed to trauma will develop PTSD (post-traumatic stress disorder) and other psychological conditions such as anxiety and depression. While very young children may be protected from the effects of trauma because they do not perceive the danger in situations, this is often not the case
- Reporting of trauma-related stress by children to adults shows a consistent pattern of under-reporting[8]
- The responsibility that children feel for what has happened is often quite irrational and potentially very damaging to them
- Vulnerability to lasting harm depends on a range of factors. The most significant of these are the nature of the trauma or loss, availability of parental and social support, and a prior history of trauma

EDITOR'S NOTE

When grief and trauma co-exist, grieving may be impaired by the emotional consequences of the trauma. The authors describe their work, which includes the use of EMDR, to help bereaved children process their traumatic memories, thereby allowing grieving to begin. *MN*

- The brain does not process traumatic memories experienced as a result of trauma in the same way as ordinary memories.

The immediate effects of trauma on children are that they feel scared and may worry about the safety of their family and friends. They may also worry that they did something wrong or feel responsibility for what happened.

Following trauma, it is not just bad dreams that are scary: real life is frightening too. Faced with this new view of the world, children look first and foremost to their parents and trusted adults for reassurance and support. Ideally, the most important people who can restore a sense of emotional safety for children are parents or carers. Schools and teachers can also play a crucial role, given the significance of school in the daily lives of most children. In the absence of family and social support, children are more vulnerable and are more likely to need special help to overcome the effects of their experiences.

Traumatic memory and grief

There is evidence to suggest that traumatic memory is encoded in a different way from non-traumatic memory[9]. Traumatic events have the potential to overwhelm the normal coping strategies of the individual. When this happens the individual is capable of processing only part of their experience at a conscious memory level. The more disturbing memories are likely to be inaccessible to verbal recall because they reside in a part of the brain that is not readily accessed by language. They are primarily sensory: sound, touch, taste, smell and vivid visual imagery. Later, they might be experienced as 'flashbacks' or intrusive thoughts.

With a greater understanding of the nature of traumatic memory and, in particular, the role of sensory memories of traumatic events we can begin to make better sense of children's behavioural responses. We can more effectively help children who have witnessed a disturbing and frightening death if we can differentiate between traumatic and bereavement reactions, and recognise that they may first need help to process the traumatic memories before grieving can begin.

Recovering from trauma

A helpful way to consider the process of recovery is to use the framework described by Judith Herman in her book *Trauma and Recovery*[10] in which she outlines the three key tasks on the path to

recovery following trauma. These are:

1. Establishing safety
2. Reconstructing the trauma story
3. Restoring the connection between survivors and their community

In the case studies that follow, the therapeutic work involved all three of these tasks. They also involved EMDR[1], a relatively new form of psychotherapy, in these cases adapted to incorporate play therapy and storytelling.

THE CASE STUDIES

Fiona

Fiona, aged six years, had been involved in a major disaster in which many of her friends had been killed or injured. She lived with her parents and younger siblings. One of the authors (AR) worked with her in two stages: the first around ten months after the disaster, the second about one year later. Before the disaster, Fiona was reported to be a strong-willed child but presented no significant behavioural problems. However, soon after the tragedy, Fiona began to be oppositional, to have problems sleeping and to display separation anxiety. She also had headaches and 'sore tummies'.

Treatment 1

Some months after Fiona began play therapy, her therapist approached me to ask if I would consider working with Fiona using EMDR. Play therapy had not been able to help Fiona with her traumatic memories which we triggered by a number of reminders (the sight of blood and items of clothing she associated with the trauma) and she had begun to avoid situations where she might be exposed to them. She did not talk at all about what happened.

Fiona continued in play therapy while we had a number of sessions, including EMDR, in which we targeted the triggers of her traumatic memories. During the sessions Fiona had great difficulty tolerating the fear and guilt associated with the horror of what had happened and sessions were short. She drew and talked about specific aspects of the events that were troubling her. At the end of our sessions she was reported to be coping with the triggers and had begun to talk a little about one of her friends who had died.

I decided that further EMDR sessions were not appropriate at this stage but that it seemed likely Fiona would benefit from more of this treatment in the future, once she became stronger emotionally.

Treatment 2

Around one year later her therapist again approached me, at the request of Fiona's mother. Fiona had become defiant as well as aggressive towards her younger siblings and she was also having problems in peer relationships. She had major problems getting to sleep at night and in separating from her mother. She was having flashbacks.

Fiona had been able to develop greater emotional strength in her play therapy sessions but had been unable to process her traumatic memories and was showing a number of signs of PTSD. She was still unable to talk about what happened or about her friends who had died, and had not begun to grieve. She was clear that she wanted to try to 'get rid of the pictures' she kept getting in her head.

Treatment consisted of eight sessions, lasting about one hour each, during which Fiona told her story in words and drawings. This time she was better able to tolerate her scared feelings and, with them, sensory detail of her memories of the trauma. Fiona began to add more and more detail to what she was remembering. She described the smells of blood and smoke, saying, 'I am just hearing things', 'I can hear the screams', 'I can hear the quiet.' She talked about movements and gradually added colour to her descriptions. She spoke of her belief that she was going to die and that her mother was already dead, of feeling scared, creepy, sad, and sick.

Each week she would go back over the same memories, adding in more and more sensory detail as she did so. She began to ask questions to fill in parts of the story she did not have, building up a more logical coherent narrative each time. Whereas she had begun by recalling only peripheral detail of what had taken place, now she gradually talked about her friends and then about what she herself had experienced.

By the eighth session Fiona was able to put together the whole sequence of events and voice her guilt that she had survived when others had died. She said she felt 'calm now and not scared', though she continued to feel sadness. She spontaneously voiced her belief 'I can be safe'.

Her mother reported that Fiona was now able to sleep alone and that her nightmares and flashbacks had stopped. She had begun to talk to her family about some memories of her friends who had died. Our sessions were finished.

Fiona's sense of safety had been shattered by the tragedy and she continued to present with separation anxiety, remaining in therapy for some time to develop strategies to deal with this. During this period she was able to begin to grieve for her friends who had died in the tragedy. At follow-up four years later she continued to make good progress.

Brian

In the second case, Brian, aged eight years, was referred to one of us (MC) by Brian's head teacher. This was 21 months after the death of Brian's younger brother

EMDR – Eye Movement Desensitisation and Reprocessing

Most people will 'get their heads around' or process difficult and traumatic experiences spontaneously, some may take a little while, but there are others who will not manage to do this without help. For people who are bereaved traumatically, their final and lasting image of the dead person may be a terrifying one, so 'sharp' negative images associated with the death may override 'softer' happier memories. In order to mourn effectively it is necessary to bring the dead person to mind. However, if the predominant image is distressing, the bereaved person may avoid doing so, which can then stall the mourning process.

EMDR is a therapeutic technique that can be used to help those traumatically bereaved to process their experiences, thus enabling the mourning process. The research evidence for the effectiveness of EMDR is good and generally shows it to be as effective as any other treatment available. However the method by which it works is uncertain. It is a structured technique consisting of eight clear phases of treatment, from taking a client history through to re-evaluation, and is easily integrated into other treatment approaches. Practitioners must already have a relevant professional training (eg psychiatry, psychology, psychotherapy or counselling) before completing the specialist EMDR training.

Essentially the technique requires the client to bring to mind one or more of the following: an image of the memory, an associated negative thought, and a sensory response. Simultaneously, they attend to a competing stimulus – traditionally following the therapist's fingers moving in front of the client's eyes (hence the 'Eye Movement' in EMDR). Common alternatives are knee tapping or clicking fingers. The client reports to the therapist any changes that occur and the procedure is repeated with the changes. This continues until the distress associated with the original image is minimal. Then, the process is repeated in order to link a preferred positive thought to the incident.

As with many well-researched therapies, the strict format developed for use in research sometimes requires some adaptation for use in the real, clinical world, especially when children are involved, and this calls for a certain amount of skill on the part of the clinician. Further information about EMDR practitioners and training is available from: EMDR Association UK and Ireland, PO BOX 32283, London W5 3YB; ☎ 020 8752 0429; email: emdrenq@btopenworld.com. *DT*

in a fire. At the time of his referral Brian was placed in a Challenging Behaviour Unit where he received individual tuition. His behaviour was such that he could not be with other children. He had been in the Unit for over a year and the head teacher was keen for him to be reintegrated into a class with other children and hopefully then back into his own school. The problem was that whenever Brian was placed with other children he became very fearful and reacted very aggressively.

He was one of four children from a caring but chaotic family. His younger brother, aged four, had been killed in a fire at the family home some 21 months earlier. The precise circumstances of the fire were not known but it was believed that all the children had been playing together with matches, on a bed, and that the mattress had caught fire. All the family, including the parents, survived with the exception of the youngest, who died from the effects of smoke inhalation.

Brian was a child with a history of developmental delay including delayed language. Before the fire, he had been assessed as having moderate learning difficulties (MLD) and had been placed in a school for pupils with MLD. At this stage, he was was described as a passive, placid child who did not interact readily with other children.

In the immediate aftermath of his brother's death he became fearful, anxious and overactive. When he returned to school these problems intensified and he regressed in his language, learning, social and emotional skills. He had an extreme reaction to being returned to class with other children, becoming hysterical and aggressive. Additional concerns were loss of appetite, disturbed sleeping pattern, screaming and tantrums. Nearly two years (21 months) after his brother's death he was still displaying the same behaviour and emotions.

His reactions were typical of the significant minority of those involved in major traumas who do not recover quickly, and who go on to develop PTSD. Although he was unable to say why he became so distressed in the presence of other children it seemed likely that these circumstances triggered memories of the trauma, causing him to feel frightened and unsafe.

Treatment

I saw Brian for ten sessions over a four-month period during which time he was provided with opportunities for therapeutic play and EMDR to address trauma issues and his grief.

At his first session Brian drew his house at the time of the fire, with a window to represent each family member he named. A black squiggle was a snake entering the house, moving from room to room, to kill his family. He drew a yellow line to protect each person from the snake and then to kill the snake, telling me that he did not like snakes. When I asked about the fire, or his brother who died, he shielded his face with his hands to make it clear he could not bear to talk about this. However, he did allow me to read a story to him about a young boy whose friend had been killed in a road traffic accident. This became a ritual, each session beginning with the story. In later sessions I was able to construct the 'story' of what had happened to him at the time of the fire and to tell the story to him.

Despite his history of developmental delay and associated problems, his concentration was excellent, his play purposeful and imaginative. The nature of the play was repetitive, involving family groups of animals or puppets, moving between fantasy and reality, and involved Brian moving around the room without much engagement with me.

By our sixth session he indicated that he wanted to talk about the fire and told me that he 'got pictures' in his head. These were trauma memories of the fire, which continued to intrude into his life without warning, triggering fear responses and severe anxiety. This disclosure allowed me to use EMDR to address the unresolved trauma memories in our next session. The following week, quite spontaneously, Brian told me, 'pictures gone'.

Within two months of our last session Brian was settled in a new school. By that time all his other symptoms had abated and there were signs of that he was beginning to grieve for the loss of his brother. A year later his head teacher phoned to say that he continued to be well integrated. Her call had been prompted by the fact that around that time in a class lesson on loss, Brian had been able to tell his story to his classmates without fear.

SUMMARY

Many believe that children as young as this remember little of their trauma, but Fiona and Brian had vivid and enduring memories long after the events had ended. For both, the overwhelming nature of their experiences had prevented them from grieving. In Fiona's case the catastrophic nature of her experience had a severe impact on all her natural sources of social support leaving her particularly vulnerable to the effects of trauma. At the time of initial contact Fiona had been unable to bear the pain of her memories. Her parents' own reactions had left them unable to restore the security she needed to do this. Once her parents were able to provide her with an emotionally safer environment and she herself had developed greater emotional resources, she was better able to bear the pain of her traumatic memories and, eventually, to tell her story.

In Brian's case, his parents and the agencies supporting him and his family did not have an understanding of the impact of trauma on children and therefore had not taken this into account when planning supportive measures. As with Fiona, it took two years for Brian to re-establish his sense of safety, to tell his story, to begin to grieve and for him to begin the process of reconnecting with his life.

EMDR was crucial to the success of these treatments because it enabled the children to process the sensory memories associated with their past trauma so that they were no longer incapacitated by them. Once they were freed from the burden of trauma, grieving could begin. BC

References

1. Black D. Children and Bereavement, Highlight 120. London: National Children's Bureau, 1933.
2. Black, D Traumatic Bereavement in Children, Highlight 121. London: National Children's Bureau, 1993.
3. Dyregrov A. Grief in Children: A Handbook for Adults. London: Jessica Kingsley, 1991.
4. Pynoos R. Grief and trauma in children and adolescents. *Bereavement Care* 1992; **11**: 2-10.
5. Pynoos R, Frederick C, Nader K. Life threat and post-traumatic stress in school age children. *Archives of General Psychiatry* 1987: **44**: 1057-1063.
6. Pynoos R, Nader K. Psychological first aid and treatment approaches to children exposed to community violence. *Journal of Traumatic Stress* 1998; **1**: 445-473.
7. Yule W, Gold A. Wise Before the Event: Coping with Crises in Schools. London: Calouste Gulbenkian Foundation, 1993.
8. Udwin O. Children's reactions to traumatic events. *Journal of Child Psychology and Psychiatry* 1993; **34**: 115-127
9. Siegel DJ. Memory and trauma. In: Psychological Trauma: A Developmental Approach. Black D, Newman M, Harris-Hendriks J, Mezey G. London: Gaskell, 1997.
10. Herman J. Trauma and Recovery. New York: Basic Books, 1992.
11. Shapiro F. Basic Principals, Protocols, and Procedures. New York/London: Guilford Press, 2001

The Best of Bereavement Care

12 packs of selected articles

Catch up on articles you have missed – packs covering topics in this issue

Disasters	**£6.25**
Cultural and religious aspects	**£6.25**
War, murder and violent death	**£6.60**

Order from Cruse Bereavement Care
126 Sheen Road, Richmond TW9 1UR
☎ 020 8930 9300; fax 020 8940 7638;
email crusebereavementcare.org.uk