Post-traumatic stress disorder following traumatic bereavement in children and young people

Post-traumatic stress disorder (PTSD) can affect anyone who has experienced a traumatic, violent or distressing event, such as a road death. UK National Health Service (NHS) guidelines suggest that about 30% of people who experience a traumatic event may suffer from PTSD.[1] Rates of PTSD can also be much higher following particularly traumatic events.

Leaving PTSD untreated may increase the distress and disruption sufferers experience.[2] It is therefore helpful if those working with people who have suffered a traumatic bereavement are aware of the signs and symptoms to look out for, and of the treatments available.

This Sudden guidance summarises advice on how to support children and young people who have suffered a traumatic bereavement and may be at risk of developing PTSD, delivered at a 'meet the expert' seminar co-ordinated by Sudden in March 2013.

Meet the expert: David Trickey

Lead consultant clinical psychologist, Child Bereavement, Trauma and Wellbeing Service (CHUMS)

david.trickey@chums.uk.com

David has extensive clinical experience working with children and families, and since 2000 he has specialised in working with traumatised and traumatically bereaved children and young people. He worked for six years at the Traumatic Stress Clinic in North London (which during this period became part of Great Ormond Street Hospital), and was then lead consultant clinical psychologist at Leicester Royal Infirmary Children's Hospital. He is now the lead consultant clinical psychologist of CHUMS, a service providing specialist treatment for traumatically bereaved children and young people in Luton and Bedfordshire, UK. CHUMS is an approved NHS provider.

About this report

This guidance report is one of a series for support professionals produced by Sudden, a not for profit initiative providing information and guidance to assist people who have been suddenly bereaved, including help for professionals supporting those people.

These reports highlight research and best practice from papers presented at Sudden events and from other relevant sources, and aim to help raise the professional standards of people who care for those bereaved by sudden death.

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Following bereavement, children and young people suffer from a wide range of psychological problems rather than a single clearly defined mental health disorder. Research[3] indicates certain things can help children to adjust to the death of a loved one:

- being able to say goodbye;
- feeling safe and secure;
- understanding what happened to lead to the person's death;
- understanding grief and being able to express their emotions;
- having a healthy attachment to a carer;
- feeling socially supported;
- developing an ongoing positive connection with the person who died; and
- fitting the death into a useful view of the world.

However, in the event of a traumatic death, many of these things may be undermined or completely absent.

Children and young people may struggle after any traumatic event because of the way in which the memory for the event is formed, and/or because the event changes their assumptions about the world and their place in it.[4] Such difficulties are often maintained by avoidance: because the event is unpleasant to recall they try hard not to think about it, so do not "process" the memory to make it into a story and fit it into their world view.

Symptoms and impact of PTSD

Approximately one third of children and young people will develop PTSD after traumatic events.[5]
The symptoms[6] consist of three clusters of difficulties:

- re-experiencing the event: intrusive memories; nightmares; flashbacks; repetitive play
- over-arousal: difficulty falling or staying asleep; irritability or outbursts of anger; difficulty concentrating; jumpy and always on the lookout
- avoidance and numbness: avoiding anything associated with the event; memory loss; loss of interest in activities; feeling different from others; sense of foreshortened future

The above symptoms may be common in any bereavement, but are classed as PTSD if they persist for more than one month, or if clinician and patient agree they are "clinically significant", i.e. causing distress or impairment in day to day life.

It is difficult to predict who will suffer from PTSD, but it seems the child or young person's emotional response and interpretation of why or how it happened is more important than any objective measure of trauma severity. How they understand the event is more important than how much of it (if any) they actually witnessed.[7]

Symptoms of PTSD, particularly intrusive memories and avoidance, can hinder the grieving process: children in particular may have been too horrified by the event to begin to be saddened by their loss. Traumatic deaths are often accompanied by a number of other factors that further complicate the adjustment of those bereaved, such as a coroner's inquest or a criminal trial, which can affect the ability of adult carers to look after bereaved children.
In some circumstances where children were witnesses to the death they may be directly involved in a trial.

Supporting children with PTSD

There are things that can be done to minimise such impediments and help the child or young person to grieve and adjust as best they can to their bereavement. Adults may understandably want to protect children and young people from further distress by not giving them information about a death; however in the absence of a sufficient explanation the child or young person may construct their own account, which may be even worse than the reality. They may be confronted with details of the death in insensitive ways such as on the news or from other young people. By giving children and young people a frank but sensitive account of events, ensuring their questions do not go unanswered, and providing them with support, carers can help them to make sense of even traumatic deaths.

Before specialist support for a child with PTSD can be considered, basic needs must be met to repair the child's sense of safety and stability. Routines are likely to have been disrupted due to the impact of the death on parents or carers. Carers may need help from schools or other support professionals for example, to re-establish routines.

A child's attachment to a carer may be affected by the child's trauma-based belief that others will die, leading to clinginess or rejection. Carers may also be unavailable due to their own grief, avoidance, or dealing with pragmatics. Support professionals should ensure carers are able to access the help they need so that they are able to cope with supporting a traumatically bereaved child.

Treatment

Trauma-focussed cognitive behavioural therapy (TF-CBT) is the only intervention recommended by the UK National Institute for Health and Care Excellence (NICE) for children and young people with PTSD.[8] TF-CBT consists of some or all of three core components [9]:

- bringing the event to mind to create a coherent narrative and "process" the memory;
- developing a meaning of the event that is both truthful and useful; and
- reducing avoidant coping strategies.

TF-CBT should only be provided by clinicians who are trained as cognitive behavioural therapists. There are national bodies that accredit CBT therapists, including the British Association of Behavioural and Cognitive Psychotherapists and the National Association of Cognitive Behavioural Therapists in the USA, although accreditation is not compulsory.

Parents, carers and support workers seeking to arrange appropriate intervention for a child should first discuss the problem with the child's family doctor, who can arrange referral to an appropriately qualified clinician.

There is also some evidence that an approach called eye movement desensitisation and reprocessing (EMDR) can be effective for children with PTSD.[10] Treatment involves the patient making side-to-side eye movements following the therapist's hands (or other left-to-right stimulation, including hand-tapping or sounds), while recalling the traumatic incident. The way in which this treatment works is still subject to debate, but while EMDR is yet to be recommended by NICE in the UK for children and young people, it is recommended for adults. EMDR should only be provided by clinicians who have been trained in its use on a course approved by the EMDR Institute.

Non-clinical support and treatment

Support practitioners who are not trained in CBT or EMDR can also help people at risk of developing PTSD by supporting them to talk through their traumatic experience as and when they are ready and wish to do so, ensuring they feel safe. This will help create a 'narrative' (or 'normal') memory of their experience, to replace the 'sensory' memory (sights, sounds, smells, etc.) laid down at the time of trauma. This sensory memory creates the feeling that the event is still happening, leading to the intrusive thoughts and anxiety that symptomise PTSD.

Conclusions:

- Following bereavement, children and young people suffer from a wide range of psychological problems rather than a single clearly defined mental health disorder.
- Children are better able to adjust to the death of a loved one if they: are able to say goodbye; feel safe and secure; understand the death; understand grief; feel socially supported; and can fit the death into a useful view of the world.
- Approximately one third of children and young people will develop post-traumatic stress disorder (PTSD) after trauma such as a sudden bereavement.
- Symptoms of PTSD include: re-experiencing the event; over-arousal (such as difficulty falling asleep or concentrating); and avoidance and numbness. Symptoms like these can hinder the grieving process, preventing the bereaved from processing the loss and their memories.
- Although adults may want to protect children and young people by not telling them the whole truth, this can ultimately be harmful: children need to know the facts in order to come to terms with and make sense of what has happened.
- Re-establishing the child's routine and meeting basic care needs are essential before more specialist support can be considered.
- Trauma-focussed cognitive behavioural therapy (TF-CBT) is recommended for treatment of children with PTSD. TF-CBT includes processing the memory in a healthy way and addressing harmful thought patterns associated with PTSD.
- Eye movement desensitisation and reprocessing (EMDR) can also be effective for treating PTSD (although this is not yet formally recommended for children and young people).
- Non-clinical support can include helping children and young people with PTSD feel safe and calm; supporting them to talk through their traumatic experience in a safe way if they wish; and if appropriate arranging referral for specialist treatment.

End notes:

1 *NHS Choices guidelines on PTSD, available at: http://www.nhs.uk/conditions/post-traumatic-stress-disorder/pages/introduction.aspx*

2 *National Collaborating Centre for Mental Health (UK). Post-Traumatic Stress Disorder: The Management of PTSD in Adults and Children in Primary and Secondary Care. Leicester (UK): Gaskell; 2005. (NICE Clinical Guidelines, No. 26.) 7, Early interventions for PTSD in adults. Available from: http://www.ncbi.nlm.nih.gov/books/NBK56498/*

3 *Rosner, R., Kruse, J., and Hagl, M. (2010). A meta-analysis of interventions for bereaved children and adolescents. Death Studies, 34, pp.99-136*

4 *Meiser-Stedman, R. (2002) . Towards a cognitive-behavioural model of PTSD in children and adolescents. Clinical Child and Family Psychology Review, 5(4), pp.217-232*

5 *Fletcher, K. E. (1996). Childhood posttraumatic stress disorder. In E. J. Mash and R. Barkley (Eds.), Child Psychopathology (pp. 242–276). New York, NY: Guilford Press.*

6 *American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders: DSM-IV-TR (4th ed.). Washington DC: American Psychiatric Association.*

7 *Trickey, D., et al. (2012). A meta-analysis of risk factors for PTSD in children and adolescents. Clinical Psychology Review, 32, 122-138.*

8 *National Institute for Clinical Excellence (NICE) (2011). Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care. Available from: http://publications.nice.org.uk/post-traumatic-stress-disorder-ptsd-cg26*

9 *Smith, P., et al. (2010). PTSD: Cognitive Therapy with Children and Young People. Routledge.*

10 *Rodenburg, R., Benjamin, A., de Roos, C., Meijer, A.M., and Stams, G.J. (2009). Efficacy of EMDR in children: A meta-analysis. Clinical Psychology Review, 29, pp.599–606*

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