



NSW Health Disaster Mental Health

Handbook 4 – Bereavement, Loss, Dislocation: Disasters and the Aftermath

A collaboration between NSW Health and University of Western Sydney

Handbook 4 – Bereavement, Loss, Dislocation: Disasters and the Aftermath

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Loss and Grief: Disaster Deaths, their implications and management

Disasters can lead to multiple and mass deaths, through large-scale natural disasters, technological disasters, terrorist attacks, pandemics, and other hazards. Disasters are often defined, in terms of severity, by the numbers of deaths they cause. Such deaths are frequently in the context of extensive destruction of resources, e.g. home, community, workplaces, and many other stressors.

Disaster deaths are usually unexpected and untimely, and may occur in horrific and potentially traumatic circumstances. All these factors highlight the potential for more severe mental health impacts and very complex circumstances for those who are bereaved, particularly in terms of the multiple stressors associated with such disaster experiences.

This chapter will describe the normal reactive processes, the reactions that may occur with such unexpected and untimely deaths, and what is known about the health and mental health impacts. It will address the management of those bereaved by the death of a loved one in such circumstances, for adults, and the specific issues for bereaved children.

The impacts of such mass deaths, particularly deaths resulting from intended violence such as terrorism, shootings, or from human negligence as in some technological disasters, as they affect the population more broadly will also be considered. This will include the possible effects on mental health of exposure to multiple mutilated deceased bodies. It will also consider the nature of community grief.

The multiple other losses and experiences of grief that may result from a disaster; the loss of the sense of safety, of personal and national invulnerability, and for some, anticipated futures, will also be considered.

Aims

1. To describe **bereavement reactions** to the loss of a loved one generally and specifically in the disaster context, including potential for pathological processes
2. To describe the **scientific basis and rationale** for possible intervention
3. To provide **guidelines for the management** of those bereaved in disaster
4. To describe **specialised treatments** for those experiencing bereavement related pathologies
5. To describe and provide guidance for the management of **other aspects of disaster losses** including resource loss, dislocation and their impacts

1. Bereavement Reactions and associated mental health effects

Disasters involve many different stressors and experience is complex and multi-faceted, as suggested by Norris and Wind (2009). The exposure to these stressors is both direct and indirect. While much of the scientific literature has focused on “trauma” as the stressor, it is increasingly recognised that many other exposures may occur and may dominate peoples’ experience. Loss is a major stressor, and the losses in disaster may be at multiple levels, but the most profound is the loss of a loved one by death. Norris and Wind, in their examination of the experience of disaster, have provided a valuable overview of loss of life, and “traumatic bereavement” in disasters, which is encompassed in some of the studies discussed below.

“Normal” bereavement reactions need to be understood, so that such phenomena are not seen as “disease”. These reactions include shock, numbness and disbelief in the acute response, particularly if the death is sudden, unexpected and untimely; followed by intense distress reflecting recognition of the separation from and absence of the loved one. There is intense preoccupation with thoughts, images, and longing, yearning for them, plus angry protest, i.e. anxiety and anger. The bereaved person may “see” or “hear” the person; so intense is the longing. Over the early weeks this progressively moves to some level of acceptance, with sadness, sometimes feelings of guilt and regret, reviewing of memories and gradually adapting to the changes and absence of this person in their lives and families (Raphael, 1983). While acute distress settles progressively over the early months and the first year/s, anniversaries and other reminders may bring back distress and further aspects of grief. Research has shown that memories and ongoing attachments to the loved one,

become incorporated into our own sense of ourselves and our worlds. Most people do not have “problems” with grief – they may suffer greatly with the loss but it is an inevitable part of human experience. Deaths that are sudden, unexpected and untimely, for instance in disasters (Raphael, 1986), and particularly if deaths violent, they may be associated with “trauma”, or extra distress and may be more difficult in terms of grief and adaptation (see below). Complexities of the attachment to the person who has died may also make grieving more difficult, and can be associated with prolonged or complicated grief pathologies.

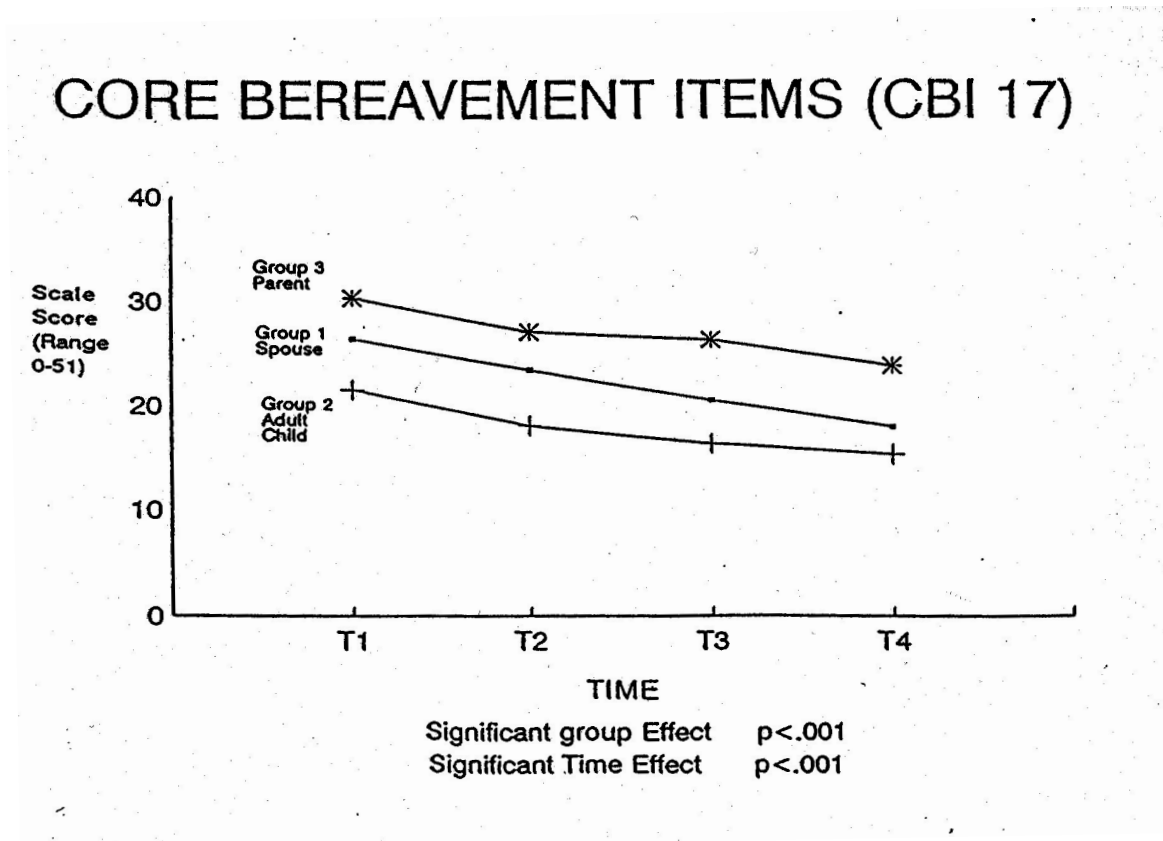
The “normal” or frequent patterns of grief reactions over time are reflected in the following symbolic graph. Consistently with a range of studies, about 9-10% of adults may have more chronic patterns of consistently high levels of grief phenomena beyond 6 months and over a year and more. Children’s patterns are less clearly defined and will be discussed subsequently.

Bereavement Phenomena Over Time

A number of earlier population studies have addressed the nature of bereavement phenomena, and their patterns over time (Middleton et al 1998, Byrne et al 1996; Kim & Jacobs, 1993), highlighting the natural decrease in these over the months and years that follow the death. Adults demonstrated the most intense reactions following the death of a child, compared to their partner, or parents. Approximately 9% demonstrated prolonged high levels of intense grief extending beyond 6 months (Raphael and Minkov, 1999).

Bereavement Phenomena Over Time

(population studies)



T1 = 1 month after loss; T2 = 10 weeks after loss; T3 = 7 month, T4 = 13 months post-bereavement.

Bereavement, for adults, following death of a parent, spouse, child (Middleton et al, 1996) are represented in the graph above with Group 1 being those bereaved by the death of a parent, Group 2, those bereaved by the death of a spouse, and Group 3, adults bereaved by the death of a child.

Bereavement in the context of Disaster

Disaster deaths, and the grief associated with them, have been studied by a number of workers in the field. Lindemann (1944) described the 'Symptomatology and Management of Acute Grief' on a classic study of those bereaved after the Cocoanut Grove nightclub fire on 28th November, 1942. This study showed the complexity of grieving in such circumstances and "abnormal" grief. Raphael (1977) and Singh and Raphael (1981) reported on the experience of those bereaved in a major rail disaster,

highlighting the importance of the opportunity for those bereaved to say their 'goodbyes' to the remains of the dead person. Gleser et al (1981), in one of the important studies from the 1972 Buffalo Creek dam collapse, found that 35% of the population had lost a close friend and 26%, family members. They also reported that two thirds of the adults and one third of the children evaluated had moderate or severe impacts with anxiety disorder and major depression being prominent. Those who had lost friends and family members showed higher levels of psychopathology than other affected persons who had just lost acquaintances or possessions. Studies of those bereaved in the Mount St Helens volcanic eruption found that they had higher levels of depression and somatisation symptoms than those who had not lost a loved one (Murphy, 1984).

In recent disasters, systematic research has revealed that mass catastrophes such as terrorism, where the deaths are the result of a malevolent attack, may be associated with heightened risk of psychiatric morbidity for those bereaved in such circumstances. Galea et al (2002) showed that those who had a friend or family member killed in 9/11 were at heightened risk of depression rather than Post Traumatic Stress Disorder. Neria et al (2007), in a web-based survey, found long-term grief reactions 2.5 – 3.5 years after this attack. They reported that complicated grief symptoms were present for most of the bereaved participants, and 43% of those bereaved met the study criteria for a Complicated Grief diagnosis. Neria et al (2008) also studied adult primary care patients, a quarter of whom reported they knew someone who died in the 9/11 attacks. Such patients were more likely to meet criteria for at least one psychiatric disorder, and reported pain and functional problems as well. The majority of studies indicate that the greatest difficulties for adults follow the death of a child, as is also found in non-disaster situations.

Cultural issues may also be relevant in the impact of grief, ranging from the capacity to fulfil cultural and religious rituals related to the deceased, to the impact of personal loss on collective experience (Yeh et al, 2006, Inman et al, 2007).

Children and young people have also been bereaved in many disasters and the impacts for them are likely to be even more profound, particularly with the death of a parent (Pfefferbaum et al, 2006). As noted in many of the above studies, depression is a frequent consequence of such losses, but may be comorbid with PTSD, although some studies have only looked at PTSD as a consequence.

Traumatic Bereavements: Concurrent Trauma and Grief

A range of bereavements occurs in very traumatic circumstances. This is particularly the case for sudden unexpected and violent deaths, and occurs frequently in individual circumstances such as homicide (Rynearson 2006), or mass circumstances such as terrorism and disasters (Raphael et al, 2004).

The phenomena of bereavement and bereavement reactions and posttraumatic stress reactions differ, and are sometimes confused. It is useful to consider these core phenomena, as they may co-occur in bereavements that occur in traumatic circumstances. The table below summarises these.

Phenomena of Posttraumatic Reactions and Bereavement Reactions (Source: adapted from Table 17.1 Raphael et al. 2004)

Posttraumatic phenomena	Bereavement phenomena
<ul style="list-style-type: none"> Intrusions of <i>scene of trauma</i> (eg. death) not associated with yearning or longing 	<ul style="list-style-type: none"> Image of <i>lost person</i> constantly comes to mind (unbidden or bidden)
<ul style="list-style-type: none"> Associated with distress, anxiety at image 	<ul style="list-style-type: none"> Associated with yearning or longing Distress that person is not there
<ul style="list-style-type: none"> Preoccupation with the <i>traumatic event</i> and circumstances of it 	<ul style="list-style-type: none"> Preoccupation with the <i>lost person</i> and intense images of him or her
<ul style="list-style-type: none"> <i>Memories</i> usually of the <i>traumatic scene</i> 	<ul style="list-style-type: none"> <i>Memories of person</i> associated with affect relevant to memory (often positive)
<ul style="list-style-type: none"> Re-experiencing of threatening aspects of the event 	<ul style="list-style-type: none"> Re-experiencing of <i>person's presence</i>, as though he or she were still there (eg. hallucinations of sound, touch, sight)
<p>Note: both may occur when the death has occurred in traumatic circumstances</p>	

Rynearson (2006) provided a valuable volume with contributions addressing the particular challenges of violent deaths in various contexts, including those of disaster. The appropriate immediate management issues may be a critical component of early intervention, in terms of preventing further traumatisation, by ensuring supportive processes are in place to assist those bereaved, especially in relation to the many uncertainties, and formal requirements. As indicated by the comments of a woman of bereaved in the Locherbie air crash of 1988, the way in which people are dealt with may have as devastating an impact as the deaths themselves. "How my family was treated during those 11 days remained with me and influenced my life ever since." (Pauline Dixon).

Recommendations following the London bombings on 7 July 2005, highlighted the needs of the bereaved in such circumstances, and suggested that, from the earliest times, these should be specifically addressed, for example with having a Family or Bereavement Liaison Officer who could support them through such complex processes.

Complicated / Prolonged Grief Disorder

The concept of a form of chronic grief has been accepted as the most agreed model of bereavement pathology for some time (Middleton et al 1993), but has been supported and developed through the studies of Prigerson (Prigerson et al 1995, Prigerson et al 1999). After going through a number of iterations including “traumatic grief” and “complicated” grief, this “syndrome” has been finally submitted for consideration for inclusion in DSM V as “Prolonged Grief Disorder”, by Prigerson and a range of colleagues (Prigerson et al 2009). Outlined proposed criteria are in Appendix A. It is at this stage uncertain as to how or whether it will be included. Prigerson et al have also developed an “Inventory of Complicated Grief: a scale to measure maladaptive symptoms to loss” (Prigerson et al 1995). She and other workers, particularly Boelen et al (2005), Boelen et al (2010) and Golden and Dalgleish (2010) have demonstrated that it is distinct from uncomplicated grief, and from anxiety and depression syndromes. The complicated interplay of these concepts and syndromes has been reviewed recently, highlighting their complexity (Raphael et al, in press). A shorter 12-item measure of ‘complicated’ or as it is now termed ‘Prolonged’ grief has been developed (Chiambretto et al 2008, in Italian). The concept is now in use for the study of bereavement pathologies, although still sometimes inferred to be “traumatic” grief despite the general agreement about its nature. Melhem et al (2008) have taken this concept to a similar understanding and model for children and adolescents. Here too there is still overlap with concepts of “traumatic grief”. The concepts of grief, and traumatic grief for children however were well established with Pynoos’ early work with children following a school sniper attack where grief reactive phenomena and traumatic stress phenomena were identified and measured on separate scales and demonstrated that the specific stressors also led to different outcomes (Pynoos et al 1987a & b, Pynoos et al 1988).

A very significant set of recent studies of adults bereaved in the South East Asian tsunami has contributed further to the understanding of grief reactions, relevant variables and outcomes over time of Norwegian (Kristensen et al 2009, 2010, 2011) and Swedish survivors (Johannesson et al, 2009). Kristensen et al’s work has also involved a detailed review of the limited systematic research in the disaster bereavement field, and the problems of dealing with diverse measures and conceptualisations. The researchers investigated a total of 130 adults representing bereaved family

members of the 84 Norwegians who died, including 26 children (< 18 years). These bereaved persons were first-degree family members, and were contacted 26 months after the tsunami, and included both those who had been themselves directly exposed, as well as others who were distant at the time. Both postal questionnaires and interviews were used and measures included the Inventory of Complicated Grief (19 items, see Appendix A), the General Health Questionnaire, Impact of Events Scale and measures of social support, work and social adjustment, suicidal ideation, self-blame and guilt, plus data on sick leave and mental health care utilisation.

These researchers found that 47.7% screened positive for Complicated Grief, that this was significantly higher for women, for the loss of a child, (O.R. 5.27), spouse (O.R. > 4.93) and time before death could be confirmed. Previous experience of loss, social support and being employed were protective. In more in-depth interview assessments, this research group extended their study and looked at the prevalence of the range of post-disaster psychiatric disorders using a structured face to face clinical interview in a cross-sectional study 2 years after the disaster. They found that these disorders were more than twice as prevalent in those directly exposed (46.9% compared to 22.8%). For different disorders the prevalence rates between the directly exposed and those not were: PTSD 34.4% vs 5.2%; MDD 25% vs 10.1%; PGD 23.2% vs 14.3%. Loss of a child predicted Prolonged Grief Disorder, and direct exposure PTSD, all these disorders were independently associated with impaired function. The associated burdens of these conditions with other health consequences, the burdens of trauma and loss, the frequent comorbidity, all demonstrate the complexity and potential for long-term health and mental health impacts. Also of significance however, are the findings that the experience of visiting the site of death (arranged by the Norwegian government in the year following the tsunami) was helpful in helping people to understand, feel closer to the deceased, and have a higher degree of acceptance to the loss than those who had not done so. This was probably particularly significant in that, even though all bodies had been found and identified, people were not able to view remains because of the physical deterioration and time taken, so were unable to “place” the death and dead psychologically.

These informative, disaster-specific bereavement studies also throw light on the links between direct exposure and traumatic stress phenomena / disorders, alongside and interacting with grief and separately Prolonged Grief Disorder, related more to the attachment to the loved one. These issues are important in management and are discussed further in the Intervention section below.

While Bonanno (2004) has highlighted the resilience of a great many of those bereaved in such post-disaster settings, it is important to recognise that many may still require support, and some at least, as indicated by the studies above, will require specific intervention. It is also important that the

multiple stressors that may follow the loss, or be associated with it, are recognised, for instance the challenges of the Disaster Victim Identification (DVI) process, the multiple consequent or concurrent stressors including those such as dislocation from home, place and support systems.

Children's Grief

Children grieve in ways that link to their age and level of development. They will be affected by the closeness and dependency of their attachment to the person who has died and thus are particularly affected by the death / loss of a parent, the primary carer. They may also experience separation distress, yearning, angry protest and may ask questions about the dead person, such as where they are. Younger children are likely to have difficulty understanding the finality of the death, and to show their distress in behavioural changes. Older children and adolescents progressively show patterns similar to those of adults, as they mature. Children may also experience vulnerabilities, and problems of grief. "Traumatic grief" has been described as a mixture of trauma and grief and is an accepted concept, with descriptions of this pathology post-disaster, as well as management protocols and research studies. Prolonged Grief had not been clarified conceptually for children, until the studies of Melhem et al below. "Complicated grief" is an accepted concept broadly, like "traumatic grief" for children, with these concepts overlapping when described for children. These issues will be discussed further in terms of interventions.

Bereavement Pathologies in Children after Sudden Parental Death

Of particular importance in considering children's patterns of grief are research findings of a study by Melhem et al (2011) of a cohort of children bereaved by sudden parental death, and followed up over 3 years following the death. These researchers found that despite the majority being resilient, 10.4% of this sample showed Prolonged Grief reactions with no change in their grief 33 months after the death. Such patterns were higher for those children and adolescents with a previous history of depression. This prolonged grief specifically contributed to increased levels of functional impairment and predisposed risk for the incidence of new depression pathology. Grief reactions were relevant for the surviving parent who was also at risk of prolonged grief, which added to the child's risk of depression. A further 30.8% of children in this study showed increased grief reactions at 9 months, which subsequently decreased gradually over time, but despite this was also associated with functional impairment and increased risk of incident depression.

These important findings for such sudden parental death have major implications for children and adolescents so bereaved in disaster. The associated impairments and risk are strong indicators of the need for effective treatments for such vulnerable children.

2. Rationale for Interventions for those bereaved in disaster

How those bereaved in a disaster are supported and managed through the earliest stages is likely to be very important for their wellbeing and mental health. It is discussed in detail in the guidelines below. It fits also into the evidence-informed framework of Psychological First Aid.

The research base to inform intervention for those bereaved in disaster is limited, as much of the research focus has been on Posttraumatic Stress Disorder rather than on bereavement, i.e. the focus has been on trauma and has not encompassed loss and grief, or indeed other stressors such as dislocation. While the needs of the bereaved are acknowledged, for instance after catastrophes such as 9/11 (Neria et al 2006), or in volumes dealing with disasters more broadly (Ursano et al 2007), there has not yet been adequate data to support the development of evidence-based guidelines, except for Shear's contributions. Katherine Shear's model of Complicated Grief treatment is the most researched and well-developed model for managing such morbidity post disaster. While there are earlier descriptions of interventions that have been provided, frameworks are currently informed chiefly by models such as those of "traumatic" or Complicated Grief and the evidence base for this, for instance Shear et al's (2001) pilot study and subsequent randomised controlled trial (Shear et al 2005 and later), a manualised but sensitive treatment for complicated grief and later also comorbid Complicated Grief and substance use disorders (Zuckoff et al, 2006). Shear's group (Shear et al 2005, Shear et al 2007) provides evidence about the nature of the attachment relationship and its significance for the management of Complicated or Prolonged Grief Disorder, which is the more criterion-focused category of bereavement pathology. Shear et al's 2005 paper is the critical work that has informed this field, plus her recent detailed overview (Shear, 2010). These interventions have been applied to disaster bereavements, but as yet require further randomised controlled trials in these contexts.

Some interventions that have been utilised have concepts relevant for practical management for those at heightened risk in such circumstances, often built on earlier studies such as those of

Raphael (1977), a randomised controlled trial of an intervention facilitating grieving and social support; Worden's (1991) "grief work"; and Stroebe and Schut's (1999) dual processing model.

The cognitive behavioural model had been applied previously with a group of bereaved adults and children following an air disaster in Pittsburgh, USA, in 1994 (Stubenbort et al, 2001). These authors describe the management of children in one group and adults separately. The children's group had seven sessions progressively addressing the following (p.267-270): introduction and purpose; "psychoeducation to normalise the experience and to increase coping skills"; "coping with traumatic death"; "strengthening group cohesion through the exploration of loss and unfinished business"; "continuing to explore and unfinished business"; "increasing coping skills"; "group closure and moving on". The adult group used similar themes but with session 2 focusing more specifically "adjusting to the environment in the absence of the lost loved one" (p.271); session 5 "identifying and building ongoing support structures" (p.272) and later, "relocating the deceased to memory and moving on" (p.272). This program was not formally evaluated, but the authors report that it was received positively by both groups. It led to ongoing support processes. This is a useful real-world discussion of a model that was not dissimilar to current developments.

Interventions provided after the Oklahoma bombing (Allen et al 2006) show the complexity, the need for outreach services and the variable degree and timing of when people may present. This report is important in highlighting some of the inappropriate models and expectations. As they suggest "closure" is an inappropriate goal and unlikely - such mass deaths are rather "endured". They also note the risks of "victim" identity or "survivor" identity, particularly as emphasised by media presentation, where the media "narrative" may interfere with people's attempts to find their personal narrative and meaning. They note also that "the capacity to acknowledge and accept one's suffering as real, even if unjustified" (p321) is very important, as is dealing with feelings of rage, helplessness and hopelessness that may occur following such loss. They also note the spontaneous memorialisations as well as the personal memorial processes, the acceptance of many different pathways of dealing with such losses, and that many different adaptations occur, for both the trauma and the grief. The mutual support offered by others who have been through the same incident is also of value.

A short-term group psychotherapy model, using Rynearson's (2006) method of restorative story telling, was used for families bereaved through the September 11 attacks (Shahani & Trish, 2006). These researchers reported that this therapy, (extended to 14 group sessions) was a valuable model, and one that was seen as helpful.

The concept of “Traumatic Grief” has been addressed in similar models, for example with Shear’s work using CBT and exposure-focused counselling dealing with both trauma and grief. Wagner and Maercker (2008) have developed an internet-based Cognitive Behavioural Intervention for Complicated Grief as one of the many developments in this field. What is clear from these many endeavours is that there is a need for better delineation of both the phenomenological and pathological aspects of the complications of bereavement, and then trials testing intervention strategies. The current interventions usually build on what is known from non-disaster settings. With the proviso ‘first not to harm’, it is also important, as suggested by Shear, that any such models are adapted to the experience of people in the disaster context and their priority needs, vulnerabilities and strengths.

The Australian Centre of Posttraumatic Mental Health has also developed a manual for core interventions for common mental health problems following trauma and disaster, which encompassed a Complicated Grief module (Forbes et al, 2009, ACPMH, www.acpmh.unimelb.edu.au/). This was developed to address the needs of adults bereaved in the Victorian bushfires of February 7th, 2009 in Australia and built on the available evidence, but has not been subjected to a randomised controlled trial.

This manual, “A Therapist Resource for the Psychological Treatment of Common Mental Health Problems after Trauma and Disaster” (Forbes et al, 2009) informs Level 3 training (see Chapter 12). It contains modules for: Psychoeducation, Arousal (Anxiety and Anger) management and distress tolerance; Behavioural Activation module; Exposure module; Cognitive Therapy module; Complicated Grief module; Relapse Prevention module. This overarching framework is useful, particularly in terms of the range of stressor exposures, and the frequency of depression, PTSD and anxiety disorder morbidities, and comorbidity with Complicated Grief. This is discussed in further detail in the Intervention Guidelines section of this chapter.

Those interested in further information about this resource, its adaptation and possible training programs are referred to the Australian Centre for Posttraumatic Mental Health (www.acpmh.unimelb.edu.au).

These and other initiatives need to be implemented in the contexts of:

- i) Detailed clinical assessment which recognises particular vulnerabilities; the disaster experience and context; ongoing and concurrent stressors; practical capacities to engage in therapy in the face of other demands; and likely comorbidities and their treatments

- ii) The readiness of, and relevance for, those bereaved for this type of intervention, or indeed any intervention, its meaning for them, over time, and the timing of intervention offered.
- iii) Recognition of cultural, religious, spiritual and social contexts, and specifically family issues.
- iv) The fact that complicated or prolonged grief is widely recognised and utilised as a concept by workers in this field, but it is not as yet a widely recognised psychiatric disorder, for professionals or the public.
- v) Traumatic aspects of the death, and complexities of the relationship with and attachment to the deceased, including high levels of dependence and/or ambivalence, may also need to be encompassed.
- vi) Some people take time to resolve their losses in their own way and this should be respected.

Interventions for Children

Pynoos's group identified the needs of children following a sniper shooting, highlighting both traumatic stressor and grief effects in children so exposed (Pynoos et al, 1987a and 1987b). Through multiple valuable studies subsequent to this, they developed school-based and other interventions for traumatic grief (Pynoos et al 2007). This model represents a management for traumatic grief and other aspects of mental health in disaster context, with four stages of post-disaster intervention: namely, Psychological First Aid; Skills for Psychological Recovery; Enhanced Services, and Treatment. The primary therapeutic foci in their school-based program, for the management of traumatic experiences and grief, are as follows: traumatic experiences; trauma and loss reminders; trauma-related bereavement; post-disaster adversities, and developmental progression. This program framework has been tested and evaluated in a range of disaster settings in a school-based framework, and has demonstrated significant and positive outcomes in lessening the risk pathology with high levels of symptomatology and problems.

Cohen and Mannarino (2006a and b) have developed and researched a model of Child Traumatic Grief (CTG) and continue, with colleagues to test and extend this, for instance after 9/11 and other disasters, and in building a comprehensive, translational framework. The components of this model of CBT-CTG include trauma-focused and grief-focused components (12 sessions). These are described in further detail in the interventions section.

A number of studies and programs post-9/11 highlight the complexity of approaches; the difficulties of engaging children and families at such times; and the need to be prepared. Adapting these to the disaster context and aftermath can increase access and utility. Some models include Salloum and Rynearson's (2006) family-focused strategy and enhancing family resilience and the sense of safety for children. Hoagwood et al's (2007) "Child and Adolescent Trauma Treatment Services" (CATS) was a system-focused service aimed at engaging children, adolescents and families in therapeutic processes to deal with traumatic bereavement.

Identifying children who are orphaned or bereaved, and who may be in need of care may also be difficult, as evidenced by Chemtob et al's contribution in developing a register of children so affected post 9/11 (Chemtob et al, 2007).

Schechter and Coates (2006) re: 9/11 described the programs developed to meet the needs of young children affected by such incidents; the critical importance of family functioning. They provided a clinical service "Kids Corner" at Pier 94, the Family Assistance Center. Their guidelines for children were: listen; clarify; facilitate; support the capacity to imagine repair; support attachment bonds. For parents it was: contextualise parents' reactions; support child's surviving attachment relationships, clarify. They emphasise that this work was "relationally and developmentally informed" (p.418) which they saw as essential, and also reiterated the specific needs for young children so affected. These real-world intervention programs post-terrorism, as with disaster experience post the 2009 bushfires, demonstrate how critical it is that mental health providers and service systems, be prepared, educated and trained, to provide such assessment and management of these vulnerable groups in the post-disaster context.

Significant resources to address the needs of children were developed post the 2009 Victorian bushfires and some dealt specifically with bereavement. They can be accessed on the Australian Children and Adolescent Trauma, Loss and Grief website (http://www.earlytraumagrief.anu.edu.au/Resources/resource_hubs/grief_loss/).

A presentation from a meeting dealing with bereavement in such contexts and the practice and evidence that could inform care are available (see Appendix B).

As with the development of a Level 3 resource for adults, a similar resource has been developed for children, (Cobham et al 2009, www.acpmh.unimelb.edu.au), titled "Therapist Resource for the Treatment of Common Mental Health Problems in Children and Adolescents after Trauma and Disaster". It is a training resource for management and includes broadly based components / modules dealing with: introduction and guiding principles; parents and parenting; psychoeducation;

cognitive therapy module; anger, anxiety and arousal; distress management; exposure module; behavioural activation; exposure and complicated grief module; relapse prevention. The Complicated Grief Module deals with grief in children and adolescents; developmental considerations; exposure and cognitive aspects of therapy for complicated grief; and relapse prevention strategies. As these authors suggest this needs to be carefully attuned to child's experience, current family and other contexts and developmental levels. Children, like adults, need compassionate and sensitive support, through times of such tragic and terrifying experience. They may need to reach some "place" of security, affectionate and loving understanding, before they are "safe" to grieve.

3. Guidelines for Supportive Management for those Bereaved by Disaster

As with all aspects of disaster there are timelines of experience and reaction. There is the time before, the adversities, the hopes the families, the communities, and the ups and downs of existence. Then, with or without warning, disaster "strikes". The nature of the particular hazard will determine the rapidity, recognition, impact, and immediate reactions of those most directly affected. These reaction processes are "normal reactions" to an "abnormal experience" and evolve over time – into trajectories of adaptation, resilience, difficulty, and so forth. Life threat and death are intrinsic to disasters.

The shocking nature of the impact, the consequences, such as the death of a loved one, the deaths of many, are such that people may well need support from the beginning, from others who are there, and from those who respond to assist. This support in the emergency is First Aid, and in terms of the reaction to death of a loved one, Psychological First Aid. But there is also the need in these circumstances for other ongoing "personal Support"; supportive processes through and beyond the emergency, and potentially, if needed, over time. These are described broadly in terms of the different levels of support that can be provided, such as level 2 – Skills for Psychological Recovery, or Level 3, Specialised Services. These themes are available for all those affected, but there are particular issues for those bereaved by disaster, and they are described as follows.

The principles described need to be integrated into the formal systems of response to such deaths, building on the strategies for dealing with smaller incidents, through to the requirements for mass disasters and terrorism.

a) Immediate Response

Recognition of the disaster, ensuring safety and protection as far as possible, shelter, rescue, other emergency measures, including resources such as water, food, and Physical and Psychological First Aid, are the priorities; followed by support strategies as below. These can assist all, including those actually or potentially bereaved. Those separated from loved ones may be desperate in their efforts to find them, ensure their safety or to provide help they may need. They may also need to be protected from placing themselves or others at further risk, through such behaviours.

Support strategies should then link them to information and follow up.

PFA / Safety, Security, resources and family reunion if possible – linking to ongoing systems as below, both practical and psychosocial.

b) Information and Communication

These issues are critical for those affected by separation from, and potential deaths, of loved ones, the more so in uncertain / violent circumstances. Communication should be compassionate, attuned to the distress and needs of those affected, and be clear and realistic. Those affected will need to know what has happened, whether their loved one has been found, is alive, has been injured, or is possibly deceased. Information sought will also need to involve advice as to what is known, what is being done, to address their concerns and questions, what will be done next, and what they can do. In addition it needs to be clear about what is not known and actions that are underway to address this. It may also be important to take into account the possibility that there will be crime scene and legal requirements, as could occur with terrorism or other incidents. These processes, i.e. what is being done, will depend on the nature of the incident, whether there will be prolonged uncertainty about the person or persons as “missing”, and the processes that are required to clarify whether they have died.

The information process or pathway will need to be identified so that those affected will know as far as is possible, where they can go for further information, when it is likely to be available, what the stages/strategies are. In mass catastrophe, as with the Bali bombings, 9/11, the Southeast Asian tsunami, there is likely to be a period of uncertainty, which may be prolonged. Furthermore, the period after such catastrophes confronts bereaved people with the challenges of information they themselves must provide. There are multiple agencies with which they may need to engage, including those that are involved in the outreach process, while at the same time they are dealing with their distress about the potential fate of their loved one. In some instances they will have also experienced threat to their own lives, injury, dislocation and multiple losses. They will need someone to support them through these processes, someone who is both knowledgeable and skilled. See Communication Principles Guidelines in Appendix C.

Public Source Information should also be available to assist the broader public with knowledge and understanding about the needs of those affected and those bereaved at such times. Such information can be provided through multiple channels, including web and print media, and include common reactions and support needs.

Information should also be available to inform the multiple agencies and personnel involved at this time about appropriate responses and support they can provide.

People's acute distress in such circumstances can be assisted with Psychological First Aid. Information and general support should be available from the earliest times, for instance about protecting people when they may place themselves at risk when searching for loved ones, and supporting them to find appropriate sources of information about what might have happened.

These processes do not represent, and are not, formal counselling. They represent personal support, Psychological First Aid and mental health protection strategies for those bereaved through the acute emergency phase. People may be highly aroused, intensely anxious, and fearful for themselves and for the fate of their loved ones. They may wish to talk or not. They frequently alternate between hope and desperation. Support aims to offer non-judgmental comforting, allowing people to talk if they wish, gently providing responses to their queries and helping them take practical steps as needed.

Some action, some gathering with others affected, some information, some guidance, may all help to mitigate distress associated with uncertainty and fear.

c) Outreach and Call-Lines / Centres

While there are extensive support processes outlined below which are essential to the care and management of people bereaved in disaster, the early establishment of a readily accessible outreach through a call line for those distressed, seeking information or support, is an important component of response. This should also be backed by web-based information. Call centres and outreach programs dealing with disaster or terrorism should be widely advertised and should be a component of the information strategy above, as well as complementing the support process outlined below. Project Liberty following September 11 is one such model <http://www.projectliberty.state.ny.us/> (Felton et al, 2006) but there have been numerous positive examples in Australia and elsewhere. Because there may be many help-lines at such times offering different services, it is important that each operate in sensitive and supportive ways with recognition of the distress many of those who make contact may experience. It is also important that there is consistent advice. Psychosocial outreach support should have technological capacity for “warm” and “hot” transfer to services that can respond to high risk clinical need, and to personnel who can make contact, visit or the like, as is appropriate. Call lines/centres can provide information, some supportive counselling and link people to necessary support persons and processes. Those manning such centres need to be sensitive, compassionate, well trained for such tasks, and cognisant of the many diverse needs people may present for at such times. Documentation, supervision and review are necessary processes. Follow-up outreach is also a vital component for those likely to demonstrate high risk or high need. It should be linked to the persons and processes identified below, who are suitably skilled mental health clinicians.

d) Immediate support persons and processes

i) General Roles

Such persons are variously named, for instance Family Liaison Officer, Bereavement Support Worker, and so forth. This support role can help with practical advice, access to resources, and as a guide through the complex systems that are involved in the emergency and afterward. These support persons need to be skilled professionals and knowledgeable about loss and grief, and the complex systems those bereaved may have to deal with. They may be both the emotional support person, and the practical guide to the system. Aspects of the role may also be fulfilled by Police, Mental Health Professionals, Disaster Victim Identification Team members, Counsellors attached to coronial or emergency services, or the like. It is also very important to recognise that people are likely to be focused on practical matters and information concerning actions that are being taken or what they

themselves can do to find out about their loved ones. Engagement with those who are experiencing such distressing circumstances is challenging, and more likely to be achieved if their practical needs can be understood and responded to supportively. Addressing priority needs actively is also emotionally supportive. It is important, where possible and appropriate, that other family members be involved, so that there is both shared understanding of what is happening and mutual support.

Family Liaison or Bereavement Support workers should have the knowledge, skills and experience to provide the following:

- Knowledge about the principles of Psychological First Aid, and general support to deal with immediate needs in the emergency subsequently. Details of this will be discussed below.
- General and personal support but not debriefing strategies, as these are inappropriate for acutely bereaved persons, and should not be used.
- Informal support that allows the person to talk of their experience if they wish, or be silent if this is helpful.
- Support for acute bereavement reactions, with understanding of what is helpful and unhelpful to people at such times, and skills to respond appropriately for the person's or family's needs, in sensitive and compassionate ways. This support should include the capacity to recognise the diverse ways people behave in such circumstances, from their first recognition of the possibility of the death including distress, disbelief, despair, denial, and anger. This support process should also recognise that the bereaved's need to survive psychologically as well as physically, may influence their behaviours. Behaviours may include, for instance, apparently unfeeling states, inappropriate responses (acting as though nothing had happened) or intense emotional outcry and anger. Support should respect the range of diverse needs at such a time.
- Recognition that Traumatic Stress reactions may co-occur, particularly when the circumstances of the loss are violent, shocking, horrific, untimely, unexpected, or a result of malevolent intent as with homicide or terrorism. The specific reactions to these differing stressors need to be understood. Traumatic stress and grief reactions may co-occur, at such times.

There has been much focus on these Traumatic Stress reactive processes, often not recognising the associated profound and hidden grief.

- Knowledge about the formal processes that may be required, including establishing who is the "next of kin", forms that may need to be filled in, legal / crime scene requirements, investigatory processes, the search for and processing of the body of the deceased, and

what will be required of the bereaved, including possible documentation, DNA tests and other potential evidence of the dead person's identity.

Bereavement support persons should themselves have been familiarised with the possible state of deceased bodies and body parts, particularly as these may be affected by burns or other violent injuries, or decomposition. These workers should have personally viewed such human remains with the support of an experienced worker, in their preparation and training for work in these roles and circumstances.

Specific Bereavement Support roles may require more detailed knowledge and skills that include capacity to deal with a range of more complex issues. These may include but are not limited to the following:

- What the role requires, including how it fits with the roles of other workers and who is in charge and responsible. They should coordinate their own activities in interactions with others such as police, DVI, coronial, welfare and related services.
- Knowledge about requirements for establishing the "next of kin", or who has the legal right to make decisions about what is to be done re: the death and for the remains.
- Knowledge about processes related to deaths in other countries, repatriation of remains, investigatory and evidentiary requirements, and formal Disaster Victim Identification (DVI) requirements will be essential for those supporting affected persons in settings outside Australia, but also in Australia if crime, terrorism or other circumstances exist.
- Knowledge about and skills to deal with formal processes about the deceased, the movement and release of remains, access to these (e.g. if contaminated, infected), legal, cultural, religious and disposal requirements. Faith based support may also be required.
- Support roles prior to the formal declaration of the deceased as dead are frequently required, for instance: as part of an Australian team, and subsequently through the later period, aftermath, and potential transitions and hand-over of care to "country of origin" designated organisation/s or team/s.
- Formal farewells to the deceased, viewing rituals and funeral needs may require support across different circumstance of death. How to discuss viewing of the deceased, with the bereaved, to ensure that the bereaved has the opportunity for informed choice about this, especially as the circumstance of the death and legal and other processes may have deprived those bereaved of any other choices. Explanation of the state of the

body in supportive ways may help the bereaved make such a decision. Support through these processes should also be available, although bereaved persons may seek to do this in privacy. The chance to sit with, touch (if possible and appropriate) and stay with the deceased to say goodbye, is usually valued, but may not be sought or seen as appropriate by some bereaved persons, and should not be in any way enforced. Other roles may require supporting bereaved families in decisions and processes for repatriating the deceased's remains back to "home" territory or country.

There are times when damage to the remains may be so extensive and mutilating that there is little sense of the human being who has died; or there may only be body parts. The situation should be carefully described to the bereaved. If it is decided that they do not want to view those remains, or are too distressed to do so, careful counselling may be help to allay their fears and distress, supporting their decision and with links made for ongoing support should this be required. It may be useful, in some circumstances, for those providing support to retain photos of these remains, should the bereaved wish to view them at some later time.

In some circumstances, there may be no remains, as occurred for some after September 11 or the recent Sichuan earthquake in China (2008). Such circumstances are likely to require support for those bereaved to work through the uncertainty at this at the time, to address their fears and fantasies about what this may mean and to deal with what has happened, as far as they can. Linking into follow-up counselling may be required for some bereaved family members experiencing these circumstances.

Further, more specific information about the roles and responsibilities of Bereavement Support persons and Family support persons is available in Appendix D.

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There are other roles and responsibilities that may evolve. However, central is the capacity to support bereaved persons and families through these processes in ways which will not harm, are responsive to their specific wishes and needs as far as this is possible, that do not in any way contribute to further traumatic or distressing experiences for them, and which may ultimately help to facilitate their grief and recovery. It is also important to provide them with pathways and guidance to link them into further services, should these be required. They should be informed by the principles and processes described above.

ii) Psychological First Aid

This describes universal principles for all those affected, and utilising the principles, within which concerns for the psychological trauma and loss may be addressed. These principles are supported by the US Consensus Conference on Early Intervention after Mass Violence 2002 (<http://www.nimh.nih.gov/publicat/massviolence.pdf>) and more recently the guidelines developed by the National Centre for PTSD, which has provided a detailed handbook <http://www.ncptsd.va.gov/ncmain/index.jsp>

The Australian adaptations / accepted models for PFA are described in Chapter 10.

Psychological First Aid is a commonsense approach, which like physical first aid, focuses on survival, safety, and supporting people acutely affected and distressed through their experience of the disaster. It aims to protect them from further harm, triage them if they are injured or very severely affected, to necessary assessment and care; to link them to family members and others if possible, and to comfort them or connect to other support. The person offering Psychological First Aid should identify themselves to and engage with those affected, clarifying their organisation and role, and assess what the priority needs are, and what assistance they can provide. It is very important to ensure as far as is possible that the person is not under current threat. Priorities for those affected and those assisting are maximising safety in the current situation or if possible moving to a safer place. During this process it is possible to observe the level of distress or difficulties, to clarify priority concerns (e.g. safety of loved ones, children etc) and to gather and provide information. Compassion, comforting gestures and words, as well as practical assistance to those who are bereaved and potentially traumatised can assist. Calming, helping them to manage intense arousal, working on shared actions to deal with their needs, including clarifying what has happened to their family members, are helpful both as tasks that the bereaved can engage in, and as assisting them to address the realities of loss, whatever these may be. Principles of promoting safety, calming, hope; connectedness with others for mutual support; and engagement in actions they can take to address their concerns, with support as needed, can enhance the sense of efficacy and lessen helplessness.

If severe distress continues, if Arousal is so intense that it continues to lessen the capacity to function; if Behaviours are so driven they place the self or others at risk, and if Cognition is impaired, then the person should be triaged for mental health assessment and management. This is the 'ABC' of psychological triage.

Psychological First Aid strategies should be used in flexible ways, taking into account the physical and emotional state of those affected and any injuries that require emergency care. In particular the developmental impacts and specific needs of children should be encompassed. In the event of separation from families, or the potential deaths of one or more parents it is a priority to ensure their protection in a physically and emotionally safe place, preferably with a supportive known adult and other family members. The principles above need to be integrated with other aspects of immediate response from rescue, through to dealing with the injured and any ongoing threat.

iii) Support through other systems

Many different systems have interactions with those who may be bereaved through catastrophic events. Emergency, health and other responders need to be informed about the potential reactions and needs of those bereaved in this way; and how they may optimally provide support while fulfilling their own roles, be they rescuer, police, health, and other emergency worker.

Response systems and organisations may need to recognise the centrality of loss in large scale and other adversities. These may be losses related to the deaths of members or leaders, to the mass deaths that have occurred, or the destruction of homes, places, infrastructure of so forth. More specifically there is also the loss of the sense of national, organisational, community or individual invulnerability, as occurs after mass events in previously “secure” environments as with the US after 9/11. Organisations need mechanisms for recognising the losses, internally or externally that are likely to affect them and be prepared to respond in supportive ways to their members and stakeholders. It is helpful to validate the significance of such losses and their impacts, for those affected and the organisation itself. Recognition and support for those bereaved, memorialisations, and support for traumatic stressor impacts are also important.

General principles to inform the response of first and other responders and support workers in other systems dealing with the emergency and aftermath:

- Psychological First Aid as a generic response
- Compassionate response to the distress of bereaved persons and survivors, acknowledging their experience, loss.
- Information provision that fits with the essentials identified above, including the two-way processes

- Working in collaboration with Coronial / Forensic Specialists Counsellors, Bereavement Support Workers, Family Liaison Workers, trained Chaplains and others in these specialised roles.
- Capacity to interact supportively with bereaved persons, without assuming either their resilience or pathology, but with capacity to identify matters of concern and respond appropriately.
- Knowledge of where and when to get extra help for such bereaved persons.
- Communal, mass, and organisational grief needs also to be recognised.
- Responders need the ability to understand and recognise their own potential for distress and grief in such circumstances, to address self care needs and support for themselves, their co-workers, and their families.

iv) Support for Children

When deaths occur through terrorist incidents, or other mass catastrophes, children are likely to experience the sense of threat that reverberates with their parents' experience. They also experience the disruptions of their family and school life, at least during the emergency phase. Where children lose a parent, sibling or family member, they will experience grief in ways related to their development, their understanding of the loss, their experience of separation from family members at the time and subsequently, the experience of psychologically traumatic stressors, and changes in family life in the aftermath. Children will require support through the emergency, ideally with surviving family members, particularly parents and older siblings or other mature close family members, such as grandparents.

Where possible, young children should be kept with surviving family members, comforted by them and given a clear, simple explanation of what has happened, what is known, and what is being done. They are likely to need reassurance that they will be loved and looked after. They should be included in family processes and rituals wherever possible. Those providing support to bereaved families may need to help grieving adults to understand and respond to the children's needs, including recognising that they may regress, act out, ask repeated questions as to the whereabouts of the dead person, and possibly play games related to what has happened. The key principles for children's care are outlined in the box below.

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This should take into account the child's immediate needs and reflect the following principles:

- i. Inclusion in family response and comforting
- ii. Reassurance of love and ongoing family life of some kind
- iii. Allowing and supporting the child to talk about the lost person, to ask questions, and providing simple, clear answers, with comforting
- iv. Engaging older children and adolescents more actively in processes to deal with what has happened, while at the same time recognising that their grief and trauma may, as with younger children, present a moodiness, withdrawal, other behavioural change, and even the appearance of being unaffected.
- v. Children, adolescents and adults will be influenced by family response, peers and broader impacts.
- vi. Children may only be ready to deal with their experience when they have some sense of ongoing security in their lives and relationships, possibly not for weeks or even months later.
- vii. School based initiatives and programs can be helpful, particularly if they involve other children who have shared the experience of the incident.

It is envisaged that people who fulfil such roles assisting children, adolescents and families, as well as people more broadly, should be educated, trained, and prepared beforehand. This knowledge and these skills are helpful in both circumstances of personal disaster, and in mass catastrophes.

It should also be noted that some groups may have special needs; the injured, displaced; people with past experience of severe loss and trauma; people of culturally and linguistically diverse

background; indigenous people. Access to necessary information, support, recognition of specific needs and cultural practices is important to support such groups of bereaved peoples.

It is particularly important for people working in such support roles to be aware of their own sensitivities, particularly related to any personal experiences of trauma and grief in their own lives, particularly the deaths of children. They should be sure that they are linked in to professional as well as personal support systems, and also monitor their emotional load, so that they do not become overwhelmed by the cumulative needs of those they are assisting.

It is important to recognise and respect a number of key elements:

- Every grief is personal, as well as public and shared by others
- Every person has a range of ways of dealing with loss, which may be both resilient and problematic. These are not easy to judge, and easy to misjudge. For instance some people may deal with their arousal and distress by involvement in action, doing; some may withdraw to “private” grief; others may present with intense emotional responses. People may use their own strategies and support networks; or they may seek help from diverse sources or professionals.

e) Memorials and Anniversaries

Many memories of those lost through terrorism or disaster will be painful. Anger is prominent in such circumstances. It is especially important that early support is provided so that those bereaved may gather their strengths for the tasks of living and the challenges of grieving over the weeks, months and years ahead. It is also important that such support makes it possible for them to deal with the realities of their bereavement, but also be able to save and cherish memories of their loved one as they move forward to the future. Spontaneous memorialisations by affected persons and communities, for instance photos, lit candles near the site, symbolise a core and important human need. Memorials, both personal and public, represent acknowledgement of the loss, and of those who died. Anniversaries also support the grieving process, although they may also bring reminders and renew the distress and sense of loss. Nevertheless, these and other social and cultural

processes are part of the wider spectrum of informal and formal processes that acknowledge the reality and inevitability of grief and loss in human life.

- Culture, language, religion, social and personal contexts will be influential throughout, from social practice to personal pain.
- The distress of grief is a constellation of normal, complex, human emotional reactions over time. The pain and the relationship are inseparable and the grief is a tribute, as well as suffering, in relation to the personal loss.
- Remembering and memorialisation are normal human and social processes that may require both recognition and support.
- Grief may become traumatic, complicated, prolonged, and disruptive of functioning. Follow-up, assessment, and interventions can help to prevent and manage such consequences (see below).
- Time is one of the domains central to loss and to grieving. All processes need to be attuned to the time that will be taken for those bereaved and the need for time out, and to do things in ones own time.
- Families in all their complexities are central: loss of family, damage to family, grief of family members which will be diverse, as well as the grief family units, may all need to be dealt with.
- Children's grief and needs are central and require special attention in families, schools and other settings.
- Mass or collective grieving and trauma are poorly understood, but also need recognition and support.
- Information and communication are important throughout, and particularly as these can recognise the needs of those bereaved.
- Working with people who are acutely bereaved, requires knowledge, skills and compassion and an empathic human response. It is intensely involving. Those working in this context need to have their own formal support and supervision systems to assist them.
- General health effects associated with loss and grief need also to be understood (Stroebe et al 2007, Stroebe et al2009). For instance increased death rates in those bereaved, death from a "broken heart" and effects on sleep, exercise, immune function, nutrition and health behaviours generally mean that health checks are important, ideally through the person's General Practitioner.
- Further research and knowledge building are critical to the field.

f) Transition to Aftermath

Recent work on principles guiding psychosocial response in the emergency and the early aftermath has highlighted 5 core themes on the basis of available evidence (Hobfoll et al, 2007). These themes reflect a further consensus process involving experts in this field. These general principles involve promoting safety, calming, self and community efficacy, and hope.

However for those who are bereaved, that period may reflect more the transition from hope to the reality of the death and loss. It may result in more overt expressions of grief, anger and distress at the loss. Or those bereaved may still retain desperate hope; or they may be focused on survival needs, psychological or physical; or the practical demands of children, the need for shelter, place; or their own trauma or injury.

It is important that their key support or contact person, the Bereavement Support or Family Liaison worker stays with them through this period, and ideally through the aftermath, or at the least until transition to an ongoing recovery support process which recognises their psychological needs in relation to the bereavement and other mental health effects related to the disaster experience.

This should also encompass the recognition of potential vulnerabilities and the needs that may emerge over time with respect to traumatic grief, violent circumstances of the death, or the deaths of children. The presence of any current psychiatric disorders, for instance depression, anxiety disorders or even psychoses, need to be taken into account at this early stage so specific assessment and continuity of care can be assured.

These principles are important across all areas of psychosocial response through the transition from the acute phase to the longer-term recovery processes.

g) Transition to Longer Term Management

The majority of those bereaved will deal with their loss over time, even though such losses bring significant suffering. Research has shown that the trajectories of recovery vary for individuals, with a great many people showing resilience, even in the tragic circumstances of losses that result from terrorist attacks (Bonnano 2004). It is also clear from Bonanno et al (2010a, 2010b), that there are several trajectories over time, from resilience to delayed and other patterns, as well as chronic and prolonged disorders. It is suggested that bereaved people in such circumstances are offered regular follow-up.

As noted earlier, the time trajectories of grief vary enormously, and the more so if there is uncertainty about the death over a period of time – i.e. it is not able to be confirmed that this person’s loved one is deceased. Furthermore, even though resilience is frequent, people are vulnerable when deaths occur in such circumstances because these entail many of the variables that have been found to be associated with higher risk of adverse outcomes.

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In assessing and managing the needs of those bereaved by disaster over time and longer term, several developments are important:

1. Establishing a system of contact, outreach, potential assessment to identify risk and need, and a range of accessible and evidence informed counselling programs.
2. Screening and monitoring for those who may be more vulnerable, i.e. at higher risk, or who experiencing significant problems in relation to their experience of bereavement in the disaster context, and potential morbidities of grief (Prolonged, Traumatic, Complicated), depression and trauma and anxiety syndromes (PTSD).
3. Recognising and supporting further resilience, and specifically linking people to supportive networks, and practical activities for recovery, can also help.

The ways in which follow-up is provided are also important, and need to be acceptable to those affected. It should be non-intrusive, again aimed at “touching base” to “see how you are going” in a supportive way. Time periods that are useful are in 1-2 months, 4-6 months, and/or towards the first anniversary. Critical to such processes is the recognition that people’s timelines, trajectories of grief will vary enormously, as will the readiness to take up any offers for counselling or more professional assistance. Trust is built through outreach and recognition of such differing needs and may mean that those affected can take up further options for counselling or other assistance, as they become psychologically prepared to take such a step. This may not be for weeks or months, particularly as such deaths, in such circumstances, may mean that the early weeks and months are focused on practical psychological survival, the needs of others such as children and their circumstances more broadly.

Risk and Vulnerability

Risk factors for adverse mental health and health outcome have been derived from multiple studies over the years, although the epidemiology of those associated with bereavements following disaster or terrorism are less well established.

They include the following:

- The nature of the way the person died
 - Violent, traumatic circumstances of the death
 - Sudden, unexpected and untimely deaths, particularly the deaths of children
 - Stigmatised deaths
- Multiple losses and / or concurrent or cumulative exposures to stressors and adversities including trauma, other losses, ongoing threat.
- The nature of the relationship with the deceased, particularly with very complex, dependent attachments; high levels of ambivalence in the relationship; closeness of the relationship; the parents' loss of a child; the child's loss of a parent, are all indicators of potential vulnerability
- Persisting mental health vulnerabilities including past psychiatric disorders or problems, past losses and trauma and adversities
- Personality styles / traits may be relevant, e.g. pessimistic, ruminative coping styles
- Relationships with and responses of significant others which may influence the support available to the bereaved.
- Lack of helpful support, further adversities, physical injury and illness.

While these variables have been shown in a number of studies, those most significant in the case of mass emergency are likely to be strongly associated with the nature of the death and the extent of concurrent stressors, as well as the nature of relationship with the person who died. Social support networks may be disrupted by these events, although strong bonds may be built with others who have "gone through the same experience". These may merge into support groups subsequently.

Protective factors supporting resilience

Positive support through the stressful experiences of finding loved ones, and the processes described above, are likely to facilitate a more resilient trajectory, as are networks of personal and mutual support. Personal strengths, family cohesion, and previous adaptive coping with loss and adversity may assist, although a profound loss in these circumstances may overwhelm traditional

coping strategies. Personal, family, and community support and validation are all likely to enhance resilience.

With these issues in mind, follow-up processes should be set in place. These should be such as to make contact with those bereaved within the first month, to check “how they are going”, and any practical or other needs for which they may require assistance. Such a follow-up may be earlier if initial contacts have indicated there are causes for concern. The follow-up can be a “therapeutic assessment” process if need be, i.e. gently exploring any grief or death/trauma issues, and identifying concerns, or needs and significant areas of difficulty.

Discussion may focus on issues that the bereaved may bring up, and can indicate options for ongoing contact if required. There should be supportive but hopeful expectations, as most are resilient and will deal with the loss over time. At the same time, it is useful to provide some general information on the normal processes - self-care strategies, web sites etc that can be accessed. General guidance about wellbeing, and potential contacts for further assessment or counselling can be discussed. Arrangements can be made to provide information/support for the needs of children and young people, and for family stresses in such circumstances. As noted earlier, outreach to schools and their linked communities can also be helpful when children and families are affected.

At this stage and later, information sessions, for instance with groups of those bereaved, can also be helpful in “breaking the ice” and are opportunities for those bereaved to link with others in the “same situation” (Raphael et al 2005). The focus on practical issues, information provision, access to resources such as financial support, are all likely to be less threatening than expectations that people will be required to discuss their feelings, particularly as many may not be ready to do so. Information provision may also be an important initial strategy that assists those affected to “connect” with one another. This information component is encompassed in many models, including Rynearson’s (Rynearson et al 2006), with subsequent segue into specific counselling of the bereaved when they are “ready” for this.

4. Specialised Treatments for People Experiencing Bereavement Related Pathologies

The death of a loved one may lead to great personal, social and health impacts, particularly with the sudden, unanticipated and shocking deaths that can occur with disasters. The major mental health problems that may arise, and require skilled specialised management include the following:

- i. Major depression or other psychiatric disorder precipitated by the stressor impact of the loss and as a direct consequence of this, or in terms of heightened pre-existing vulnerabilities (e.g. previous losses).
- ii. “Traumatic Grief”: a complex mix of bereavement reactions phenomena and traumatic stress phenomena where various symptoms may predominate, such as those of PTSD with arousal, re-experiencing, numbing, which may complicate the person’s grief, interfering with their capacity to remember aspects of the life of the loved one, because images and memories of the way they died predominate.
- iii. Prolonged, Complicated or Chronic Grief: a disorder reflecting ongoing intense yearning for the lost person, and a difficulty accepting the loss, associated with clinically significant distress and functional impairments, as described below. This type of problem had been called traumatic grief, but is chiefly to do with the attachment relationship with the person who has died. Comorbidity of complicated grief and PTSD is also possible (Raphael et al 2011, in press).
- iv. Exacerbation or precipitation of other psychiatric disorders, including psychoses, has also been described.

The importance of clinical management for these disorders is evidenced by the high levels of functional impairment, potential comorbidities, and associated adverse physical health consequences, including premature mortality with death from a “broken heart”. The extent of pathologies, in the case of Complicated Grief, is demonstrated by studies post 9/11 showing the high prevalence of this disorder 18 months later, for those who lost a family member (Shear et al, 2006) Population studies after Hurricane Katrina also reported 18.5% with severe Complicated Grief after the death of a loved one, and in all instances there was associated functional impairment, and often other comorbidities (Shear et al, 2011). High prevalence and comorbidity was similarly reported in studies of Norwegians bereaved by the 2004 tsunami (Kristensen et al 2009). The frequent

comorbidities of PTSD and Major Depression further demonstrate both the health burden and the complexity for management.

Of additional concern is the finding of Annberg et al (2011) in the 14-year follow up of a Swedish ferry sinking. They reported that while symptoms of traumatic bereavement decreased initially in the first year, little change occurred after this, with 27% of these bereaved people reporting significant long-term problems. Johannesson et al (2009) also reported studies where Traumatic Stress Reactions and Complicated Grief post trauma as a result of bereavement together contributed significant mental health sequelae.

The effectiveness of possible interventions is supported by studies such as those of Shear et al (2005, 2011 and others). A meta-analyses study has examined the “Prevention and Treatment of Complicated Grief” (Wittouck et al 2010). They found with this analyses of 14 randomised controlled trials that met the study criteria, that treatment interventions for complicated grief “could effectively diminish Complicated Grief symptoms” (page 69), and also that effects even improved further in the follow-up period after treatment had ceased. Prevention interventions did not demonstrate such effects. A very useful description of Shear’s model is provided in her paper, “Complicated grief treatment: the theory, practice and outcomes” (Shear, 2010).

Programs for intervention post-disaster have been specifically developed, such as the resources drawing together training programs to address level 3 program needs following the Victorian bushfires in Australia in 2009. These include specifically:

- “Therapist Resource for the Psychological Treatment of Common Mental Health Problems after Trauma and Disaster” (Forbes et al, 2009), a training resource for knowledge and skill development for those who would manage adults with significant psychiatric morbidity and including a Complicated Grief module.
- “Therapist Resource for the Psychological Treatment of Common Mental Health Problems in Children and Adolescents after trauma and Disaster” (Cobham et al, 2009).

The content covered by these will be discussed below but it must be emphasised that interventions provided should be those determined to be appropriate on the basis of thorough clinical assessment, and the evidence supporting their effectiveness.

Assessment

Assessment of potential bereavement related or other pathologies will require standard clinical assessments for possible psychiatric disorders such as depression, PTSD, and Traumatic, Complicated or Prolonged Grief disorders. The potential for such problems may be determined by a screen / filter / treat approach such as that of Brewin et al (2008) described in Chapter 11. It could encompass a brief bereavement screen as described by Shear et al (2011), as was used in studies post Hurricane Katrina. Screening of people presenting could include the use of brief or other measures as part of the clinical assessment process. Diagnostic criteria for other common mental health problems that may present post disaster are available in DSM-IV-TR (2000).

Mental Health Implications

Clinical assessment requirements are described in detail in Chapter 12. Clinical assessment guidelines require at least the following:

- History of current problems, their onset, course and evolution
- Current health and other relevant issues, plus sociodemographic variables
- Past history
- Disaster experience / stressors, at the time and current
- Assessment of capabilities and strengths
- Assessment of symptom patterns, severity, associated impairments and clinical significance
- Risk assessment
- Mental state assessment

This should be linked to clarification of the presence or otherwise of symptoms to the level of diagnostic criteria for specific disorders, including Prolonged or Complicated Grief so that appropriate diagnoses can be made to inform management.

Clinical formulation would include likely aetiological factors, the role of the disaster experience / stressor and consequences contributing to these processes, and the potential treatment required, both in terms of psychological interventions, but also medications should these be required.

Discussions of problems should occur in terms of the affected persons needs, presenting the issues clearly and empathetically, and their significance, including both problematic and positive aspects. Treatment / management should be determined in terms of the person's understanding and willingness, and arrangements made to implement what is agreed, taking into account the person's preference and choice.

Clinical assessment of children should be ideally carried out by those with expertise in this field (e.g. Child Psychiatrist, Psychologist) and take into account family and parent issues, developmental stages and schooling and other factors, with management negotiated with child and family (unless adolescent).

Clinical assessment is essential prior to intervention and can incorporate measures, but must encompass negotiated understanding of affected persons needs, wishes and likely benefits and risk.

The specific criteria from Complicated or Prolonged Grief are currently identified as follows in draft DSM-V in the section on Adjustment Disorders.

Bereavement Related Disorder

A. The person experienced the death of a close relative or friend at least 12 months earlier.

B. Since the death at least 1 of the following symptoms is experienced on more days than not and to a clinically significant degree:

1. Persistent yearning/longing for the deceased
2. Intense sorrow and emotional pain because of the death
3. Preoccupation with the deceased person
4. Preoccupation with the circumstances of the death

C. Since the death at least 6 of the following symptoms are experienced on more days than not and to a clinically significant degree:

Reactive Distress to the Death

1. Marked difficulty accepting the death
2. Feeling shocked, stunned or emotionally numb over the loss
3. Difficulty in positive reminiscing about the deceased
4. Bitterness or anger related to the loss
5. Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame)
6. Excessive avoidance of reminders of the loss (e.g., avoiding places or people associated with the deceased)

Social/Identity Disruption

7. A desire not to live in order to be with the deceased
8. Difficulty trusting other people since the death
9. Feeling alone or detached from other people since the death
10. Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased
11. Confusion about one's role in life or a diminished sense of one's identity (e.g., feeling that a part of oneself died with the deceased)
12. Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities)

C. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning

D. Mourning shows substantial cultural variation; the bereavement reaction must be out of proportion or inconsistent with cultural or religious norms

Specify if

With Traumatic Bereavement: Following a death that occurred under traumatic circumstances (e.g. homicide, suicide, disaster or accident), there are persistent, frequent distressing thoughts, images or feelings related to traumatic features of the death (e.g., the deceased's degree of suffering, gruesome injury, blame of self or others for the death), including in response to reminders of the loss.

As noted previously bereavement related distress and problems may also present with a complex mixture of bereavement phenomena, post traumatic stress phenomena and other clinically significant symptomatology and functional impairments. Early patterns appearing before the diagnosis of Prolonged or Complicated Grief “Disorder” can be made, i.e. less than 12 months, will need to be managed with appropriate supportive, psychotherapeutic and other interventions (e.g. some trauma-focused CBT, relationship components of interpersonal psychotherapy models, or utilising frameworks from dual processing or other early intervention initiatives). This management should take into account positive expectations that difficulties may settle over time; providing general support; risk assessment and management (suicide risk, harm to self or others, physical health effects, escalating problems and severity).

Measures available to assist assessment and monitoring of bereavement problems are listed in Appendix A. They include:

- Inventory of Complicated Grief (Revised), 36 and 19 item versions
- Texas Revised Inventory of Grief
- Core Bereavement Items Measure

The brief screening questions described by Shear et al (2011) are also important and useful tools. They are as follows: for losses “rated 3+”, i.e. death of a loved one or other major losses (see Shear et al 2011 p.649). They were asked about the following phenomena in the last 30 days across a 0-4 scale of “almost all, most, some, a little or none of the time” (p.650) for the first questions, and “not at all, a little, some, a lot, or extremely” for the other 3.

1. “How often have you found yourself longing or yearning for the people or things you have lost?” (p.650)
2. “How bitter do you feel over your loss?” (p.650)
3. “How empty or meaningless do things seem after your loss?” (p.650)
4. How difficult is it for you to accept your loss or to believe that it’s real?” (p.650)

Interventions for Bereavement Related Pathologies

Several models of intervention for bereavement related pathologies have been described above, and include diverse clinical programs, including multiple forms of “grief counselling”.

Early interventions, i.e. early supportive interventions post bereavement have been described above, but may segue into early clinical interventions if the severity of the symptomatology and functional impairments indicate need, and if clinical assessment supports this. Some of the options of clinically focused models are noted above, ranging from CBT strategies to others established as potentially beneficial in terms of research evidence supporting their effectiveness, for instance Stroebe and Schut's dual processing community program. Principles that should inform interventions which could be indicated prior to the capacity for a formal diagnosis of Complicated / Prolonged Grief Disorder are as follows:

- Severity of current bereavement symptoms and impact
- Comorbid, or related psychiatric disorder, e.g Major Depression, PTSD or physical health problems
- Worsening functional impairments / symptom trajectories
- Risk of harm to self or others
- Potential interventions strongly supported / informed by research evidence / practice
- "Readiness" of the affected person and seeking care
- Vulnerabilities such as lack of support networks, multiple other stressor exposures, concurrent mental health loss/ trauma or past similar vulnerabilities
- Capacity for monitoring, watchful waiting and "first not to harm", plus supporting person's own active adaptive strategies, and avoiding premature negative prognosis or pathologies

Ideally early interventions should have a prevention focus with the aim of lessening the risks of further, more severe pathology including Complicated or Prolonged Grief Disorder.

Strengthening the person's 'resilience' by assisting them to identify and utilise their personal resources and support networks, is important at all stages.

Complicated Grief Therapy

A number of interventions have similar core principles to those that have been seen as most relevant for the post-disaster context chiefly based on Shear et al's (2005) classic study. Others include Stroebe and Schut's "dual processing" model (1999) and potentially the related resource developed by the Australian Centre for Posttraumatic Mental Health, "Therapist Resource for the Psychological Treatment of Common Mental Health Problems after Trauma and Disaster" (Forbes et al, 2009) described below. Shear's model (2005) involved 16 sessions, which were tested in a randomised controlled trial. This 'targeted Complicated Grief treatment' involved components of

interpersonal psychotherapy (IPT), which focus on symptoms of sadness, social withdrawal, relationships and cognitive behavioural components for the distress and any trauma aspects. This therapy has three phases: introductory, middle, termination. It has been found to be more likely to be effective than IPT alone. If antidepressants are used concurrently, those being treated may be more likely to complete this therapy than IPT (Simon et al, 2008).

Mental Health Implications

A detailed description of this therapy has been published recently (Shear 2010). It deals with the following as listed by Shear in this report (p.4):

- i. Information about grief, CG and CGT.
- ii. A grief “monitoring diary”.
- iii. Involvement with ‘significant others’ i.e. social support / network.
- iv. Facilitation of optimal interpersonal functioning
- v. Personal goals / self care
- vi. Reviewing the story of the death and its consequences
- vii. Dealing with avoidance
- viii. Revisiting memories etc
- ix. “Conversation” / letter with the deceased

These themes are dealt with in the context of dealing with “thoughts, feelings and behaviours that activate the attachment system” (p.5) and which may hinder the grieving process. They also sit within the phase domains of introduction, middle, and termination. The more detailed discussion is available in Shear et al’s paper (2010).

Therapist Resource for the Psychological Treatment of Common Mental Health Problems after Trauma and Disaster

(Forbes et al, 2009). Another well-described framework, this resource was developed by the Australian Centre for Posttraumatic Mental Health (www.acpmh.unimelb.edu.au/) to train clinicians to manage the disaster consequences of the 2009 bushfires in a Level 3 training program. Details and training information are available from the developers of this resource.

It contains modules for: Psychoeducation; Arousal (Anxiety and Anger Management and distress tolerance); Behavioural Activation; Exposure; Cognitive Therapy; Complicated Grief; Relapse Prevention. This overarching framework is useful, particularly in terms of the range of possible stressor exposures, and the frequency of depression, PTSD and anxiety disorder morbidities, and comorbidity with Complicated Grief.

Mental Health Implications

The Complicated Grief module of this manual (p.160) addresses the following components, which aim to assist the bereaved person to deal with the emotional and physical reactions, memories, and to deal with the past and move on to the future. The strategies include the following: Rationale, post-trauma / complicated grief problems; and 4-6 sessions of core interventions which cover:

- Psychoeducation resource – “Understanding Complicated Grief”
- Exposure to memories of the dead
- Cognitive restructuring (e.g. dealing with grief / related distress)
- Addressing avoidance and rumination
- Working through blocks, for instance writing a “letter” about what you would say to the loved person
- Grief monitoring diary / forms (thoughts, feelings)
- Telling your grief story
- Facilitating positive memories
- Getting back to life activities
- Relapse prevention for complicated grief

This type of model should be used in terms of the clinical skills and knowledge of the provider; and with sensitivity to and respect for the person’s needs and problems at the time of assessment. It has many concepts that are also central to other bereavement intervention models, i.e. core concepts seen as effective.

Implementation of programs needs to fit with the assessment findings and be prepared to deal with comorbidity, complexity, traumatic circumstances of the death, the nature of the way the person died and the variety of other distressing aspects of the experience. Enhancing social support is also important. It needs to be recognised also that there may be multiple other challenges the bereaved person faces, and they may only be able to deal with their grief bit by bit, when they are ready. The way people choose to deal with their loss should also be respected.

While this model is a useful framework, problems may be severe, and for some, medication, for instance antidepressants, may be required. Helping people return to functioning, work or regular activities may also assist, potentially with rehabilitation programs.

Promoting resilience by helping those bereaved to identify their adaptive coping strategies, utilising positive support networks, and helping them to recognise and deal with the past as well as moving on to the future, that can both be encompassed.

Internet therapy models have also been shown to be effective, for instance Wagner et al (2006) demonstrated benefits for Complicated Grief in a randomised controlled trial of their model. Depression programs (Christenson et al. 2004), and traumatic stress programs (Litz et al 2004, Lange et al 2001; Litz et al 2007) have also been developed.

Family programs may also be helpful to some, although RCTs for this are limited and none have been identified post-disaster. These may help with children's grief (see below).

Group programs can also assist some bereaved people, particularly self-help and advocacy programs for those who have shared the experience, and are acting together to address needs.

Models described in the review of interventions above, could also inform clinical management and flexibility (e.g. Shahani and Trish, 2006). It is also important to recognise the significance of cultural, religious and spiritual themes and that these resources may also support the person's adaptation and recovery.

Past traumas and losses may emerge as important issues and may need to be addressed alongside current experiences, but should not distract from these needs. Concepts of "resolution" of grief and trauma are not well operationalised; rather grief goes on over time, with distress lessening and with adaptations, as well as dealing with any ongoing "suffering". It is important to recognise that these adaptations usually occur over years; that memories of both traumatic experiences and intimate losses will continue; trigger reminders and anniversaries may lead to increases of distress; and that these traumas and losses may also lead to personal and community growth and strengths and are

remembered. Those loved are not forgotten, but hold a different place in the bereaved's life and inner worlds.

Management of Children's Grief

Children's experiences of loss and grief will be influenced by their age, development, who has died, how family is affected, and how much life is disrupted, including home, school and other familiar environments. Parental grief, family grief will be relevant for the child and parents may find their own grief overwhelming, and have difficulties meeting the child's needs, i.e. being both comforter and bereaved. Children need to be assessed to determine the nature and extent of any bereavement or other disaster related pathologies and intervention models used accordingly.

Models described previously constitute the best options. It should also be noted that the child's problems are usually described as Child Traumatic Grief (CTG).

Pynoos et al's model (2007) deals with Child Traumatic Grief. It identifies the factors that need to be taken into account for children's recovery and 4 stages of intervention:

- Psychological First Aid
- Skills for Psychological Recovery
- Enhanced Services
- Specialised treatment

The primary therapeutic foci are:

- Traumatic experience
- Trauma and reminders
- Trauma-related bereavement
- Post disaster adversities
- Developmental progression

They identify: broad based interventions (Tier 1); specialised interventions for moderately to severely affected children and adolescents (Tier 2); highly specialised interventions for those with very severe psychotic consequences (Tier 3). The broadly based interventions (e.g. Skills for Psychological Recovery) is a set of important strategies that link to more specialised interventions if required. It involves helping with coping skills, family trauma and grief more broadly.

This type of program has been tested and found effective in school-based intervention programs covering the therapeutic foci as above, i.e. traumatic experience, trauma and loss reminders; trauma-related bereavement, post disaster adversities, developmental progression.

Cohen and Mannarino's Child Traumatic Grief Model (2006) and its extension has been shown to be effective in RCTs but with complex issues in reaching disaster affected populations. It covers 12 sessions using cognitive behaviour therapy CBT-CTG approach which deal with:

- Trauma-focused components of CBT-CTG:
 - Psychoeducation, parenting skills
 - Relaxation skills
 - Affective modelling
 - Cognitive processing
 - Trauma Narrative
 - In vivo addressing trauma memories
 - Conjoint child-parent sessions
 - Enhancing safety
- Grief focused components of CBT-CTG:
 - Grief psychoeducation
 - Grieving the loss – 'what I miss'
 - Resolving ambivalent feelings – 'what I don't miss'
 - Preserving positive memories
 - Redefining the relationship and connecting to present relationships
 - Making meaning of traumatic grief
 - Joint parent-child sessions
- Treatment closure issues

As noted earlier, here too family functioning and developmental progression are key themes.

A number of other models build on this or work in collaboration with Cohen's group (e.g. Brown et al 2008). What is clear is that the post disaster context brings significant difficulties in identifying and providing care for bereaved children and families, flexibility of approach, services through schools of family centres, groups, local settings, badging positively may all assist, as well recognising and meeting the needs of parents, siblings, and the family unit.

A model for children post disaster morbidity requires specialised programs as in that developed by the Australian Centre for Posttraumatic Mental Health (Cobham et al, 2009), "Therapist Resource for

the Psychological Treatment of Common Mental Health Problems in Children and Adolescents after trauma and Disaster”. Like the adult’s program this is an evidence informed training program and has not been subjected to randomised controlled trials. It offers a set of modules that can be used for a clinical training program. The outline below describes the core management themes. See www.acpmh.unimelb.edu.au/ for more information. It is comprised of the following modules:

- Introduction and guiding principles
- Parents and parenting module
- Psychoeducation module
- Cognitive therapy module
- Arousal (anxiety and anger management) and distress tolerance
- Exposure module
- Reclaiming your life, behavioural activation module
- Application of exposure to complicated grief
- Relapse prevention module

The Complicated Grief component covers the following and includes various handouts: (p.201-222)

- Model overview
- Grief in children and adolescents
- Developmental issues including children’s understanding of death
- Applying exposure therapy to Complicated Grief
- Applying cognitive therapy to Complicated Grief

Mental Health Implications

All models for children need to be carefully tuned to the child’s experience, current context (e.g. security, continuity of “family life”, schooling, etc) and development stage. Children, like adults, tend to grieve bit by bit, in their own time, and sometimes only when there is a sense of security in their world. “Family” in diverse ways will be the child’s framework for the future.

Cohen’s Child Traumatic Grief and Pynoos et al’s school based programs offer guidance for interventions for children. McDermott has also contributed to this field with school interventions.

Prolonged Grief and Children's Bereavement

Vitally important in the support and management of children post-disaster are the important findings of Melhem et al (2011) that children are vulnerable to a pattern of ongoing pathologies including prolonged grief; that this links also to family / surviving parent prolonged grief; and that this and other ongoing (or delayed) grief related symptoms are associated with significant functional impairment and risk of "incident depression". It is thus critical that the child is assessed, the family context and parental needs are taken into account. The management strategies above may well be effective, but specific studies and controlled trials are needed to ensure such ongoing effects can be mitigated.

Very Young Children

It is clear that infants and very young children can be adversely affected by the death of a parent, the loss of a primary attachment figure and the impacts on surviving parent and other family members. Interventions in such circumstances are focused on the surviving carer, in monitoring the infant for the range of possible impacts, and facilitating ongoing secure attachments to support developmental progression.

Children's Environments

Looking after bereaved children in the post disaster context involves providing information and support to help families and schools understand and respond appropriately to children's needs in such circumstances. Children's active engagement in activities such as memorialisation can be helpful, as can information about grief. Helping staff, and others in the child's world recognise the possible role of grief in behaviour change, learning difficulties and the like. It is also important that people affected in this way themselves, have access to support, and intervention should this be needed.

The critical role of carer's wellbeing after parental bereavement is highlighted repeatedly, particularly the surviving parent suggesting the provision of treatment for that person is critical to assisting the child.

Trauma focused interventions are likely to be important and further research is needed to optimise intervention programs building on models such as those of Shear et al (2005) for adults.

Narrative, Story, Meaning

People frequently have a need to tell the “story” of their loss, to give testimony to their grief, to make meaning of what has happened. People should be supported in this should they wish to do so, but “the story” should not take over the person’s life, or become their identity. As noted above, this is often incorporated into therapy models and can also inform an understanding of the relationship with the person who has died. Writing it down may assist some in dealing with the trauma of what has happened (Pennebaker, 1999). It may be part of the way the bereaved person deals with memories and their associated emotions, as they “sort through” the life shared, the relationship lost. Repeated storytelling, like the repetitive play of children, may be indicative of ongoing problems. Sadness, memory, photos, the sorting through of possessions, and the keeping of “linking objects” as symbolic attachments, all reflect the wide repertoire of human adaptations to the loss of a loved one.

Importantly, those bereaved should be supported in recognising that some attachments stay in memory, feelings, and how we see ourselves. The ultimate tribute to the person who has died is to remember them as the “real” person they were: good/bad; loving/difficult, and so forth. Idealisation of the deceased can lead to ongoing distortion for those bereaved in their perceptions of themselves and in their own relationships.

5. Other Losses, Dislocations, Disruptions, and their Impacts

Multiple other losses occur as a consequence of disaster. These too may be associated with grief, mental health impacts, and the need for understanding and care.

a) Loss of resources

This is reflected in Hobfoll’s (1989) resource conservation and loss model which continues to make important contributions to this field, by highlighting these more diffuse losses which can have substantial impacts on the community’s capacity to recover and on individuals. Some of the bereavement studies described earlier also indicate the distress and mental health impacts that may be associated with these broader losses. Some of the more obvious of these include the loss of home, destruction of workplace, loss of community resources, businesses, or damage to these.

These resource losses may be concrete and obvious, or more subtle. There may be opportunities for overt grief with the loss of a home or community, although even with such magnitude, there may be an unwillingness to express grief because those affected feel they should be “grateful”, that they are “lucky”, because they have survived, or others have lost more, have greater need.

Such diffuse losses, often with ongoing implications of additional life stress in dealing with them, and when concrete resources such as money, capacity to rebuild are not readily available, may have ongoing mental health consequences. There may be risk of depression or associated syndromes related to multiple fears and uncertainties.

Specific interventions to address such diffuse impacts are not well defined. Information for affected people and advice about accessing assessment and treatment should these be needed, can be helpful, particularly if access to practical counselling assistance is “normalised”, alongside recognising and supporting the community’s resilience. Community engagement in actions for recovery, and people’s involvement in these strategies can assist the sense of efficacy, achievement and capacity to deal with difficulties, to go forward. Enhancing networking and support to achieve practical goals, to manage difficulties such as insurance uncertainties, can all reflect an ongoing commitment to those affected by disaster in the long aftermath.

These broad “resource losses” can be grieved, in terms of what was, what has gone, what cannot go back to “the way it was”. This balance, with a focus progressively to the realities of the present and the challenge of the future, requires recognition of the pull of both, the powerful nostalgia of the hallowed memories of what it was like, but ultimately the mobilisation of hope, action and endeavour for the inevitable time ahead.

Mental Health Implications

Resource loss can be assisted by:

- Community engagement, shared actions to address need, to achieve practical goals, are of value for community and individual efficacy. Strengthening social networks and mutual support can facilitate recovery from these impacts. Communication and information sharing can assist recognition and resilience for individuals and communities. Resource access in real terms is also critical over time, i.e. SUPPORTING COMMUNITY AND SOCIETAL RESILIENCE.
- Recognising the impacts for individuals and providing assessment, support and interventions if and as needed, is also important for mental health.

b) Demoralisation, despair

These are negative consequences for some individuals and communities. These are likely to require further understanding, potential for assessment, and clinical intervention for some.

The broader syndrome of “demoralisation” has been a recent focus of interest, linking back to earlier concepts at community level, such as “The Road”. Clark and Kissane (2002) describe demoralisation as reflecting “essential despairs, hopelessness, helplessness and loss of meaning and purpose in life”. It differs from depression, is associated with a sense of “subjective incompetence”, but it may co-occur with depression. Importantly it may be associated also with suicidal ideation.

Mental Health Implications: Demoralisation

Group and individual action, building the sense of efficacy and shared achievement, through progressive positive goals and cycles reinforcing positive emotions, can assist dealing with demoralisation in communities and individuals. Profound demoralisation, beyond capacity to “Act”, hopelessness may require clinical assessment including for suicide risk.

Mobilising the person’s ‘fighting spirit’, or the community’s, can also shift to a sense of shared efficacy or personal determination and action.

c) Depression

Major Depression (MDD) is a very frequent consequence of disaster, potentially associated with losses, past vulnerability, lack of social support, and ongoing stressors in the aftermath. It is common in the community. Advice and resources should be made available, and local initiatives set in place to ensure those who seek care from their general practitioner or other sources can be assessed and referred for treatment as appropriate. Effective treatments, including web-based interventions (Christensen et al, 2004) can assist with the spectrum of depressive symptoms, which may also be present and respond to cognitive behavioural or other programs. When depression is more persistent or severe, medication may be required, or if suicide risk is high, inpatient care.

Mental Health Implications: Depression

Depression is prevalent in the community and as a mental health consequence of disaster. Referral for assessment and treatment, advice re: options including web-based resources, psychotherapy and medication if needed, should be made available. The ongoing challenge of disaster recovery may also require support, plus opportunities to be involved in community recovery initiatives. Suicide risk needs to be assessed and managed.

d) Dislocation

Dislocation from home, community, workplace not only leads to loss and grief, but complex adaptation to new environments which may have inherent stresses / difficulties. Dislocation / relocation stressor impacts include those of loss of home, possibly community, workplace or job, and importantly networks of social support. This stressor was first identified by Parker (1977) after Cyclone Tracy in the later months of the first year and was in contrast to the earlier 'mortality' stressor associated with the life threat experience.

Crowded temporary accommodation can be associated with increased family conflict, domestic violence and other consequences. Changed access to institutions such as schools, workplace, and having to adapt to new places, new geography, new neighbours, plus loss of the familiar, and the assumptive world, all contribute to mental health vulnerabilities in the aftermath. Repeated relocation can add extra stressor experiences. All these may contribute "tipping points" to negative outcomes. Those who have been evacuated are vulnerable, and as demonstrated by other studies after Cyclone Tracy, the non-returned evacuees are most vulnerable.

Despite all such challenges, most people deal with these difficulties with humour and hope, i.e. they are resilient. Access to resources can help people to manage, including financial assistance. Those who have resources can negotiate the aftermath better.

Mental Health Implications: Dislocation

This can have many social and potentially mental health consequences. Advice and support should be available, with a focus on what resources can assist, and building social connectedness and potentially rebuilding social capital. Communication including internet, and involvement in "new community" activities is also important. Those who are particularly vulnerable should have access to assistance, assessment and other supports.

e) Resilience

Resilience is the norm and should be supported, particularly for those who have experienced such losses and disruption of life and living. Resilience can however, at both community and individual levels, co-exist with problems and pathologies. The processes and trajectories of both need to be taken into account. Neither resilience nor vulnerability should be assumed. The spontaneous resilience of people, families, and communities should be recognised, celebrated and supported alongside practical, social and psychological support, with access to health and other assistance or resources.

Conclusion

Loss is ubiquitous, and disaster losses are profound. People have great capacity to adapt to inevitable loss, the realities of death, grief and change, the human needs for connectedness and support. Help where help is needed is a vital additional resource.

These guidelines for the support and management of the acutely bereaved have been provided with a specific focus on disaster and terrorism. They provide a range of support principles, systems and strategies that can be implemented through the various structures of response in different jurisdictions. They are informed by current evidence and extensive experience, although it must be acknowledged that there is an urgent need to advance the evidence through future research in this field. Research needs to focus on the acute period and address the needs of different populations, particularly the needs of children. These acute needs for bereaved people are for the most poorly recognised, either in disaster response guidelines and protocols, or in research. The focus of interest has been on Traumatic Stress, Acute Stress Disorder and Post Traumatic Stress Disorder or more recently, Complicated Grief. While those bereaved may also experience traumatic stress syndromes, their needs in terms of their grief and loss, should be much more specifically and urgently addressed.

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Appendices

Appendix A

Measures to assist assessment and monitoring of bereavement problems:

- A 4 item measure used by Shear after Hurricane Katrina
- Inventory of Complicated Grief – 19 Items
- Texas Revised Inventory of Grief
- Core Bereavement Items

Appendix B

“Children Grieving and Disaster – The Bushfires” – Powerpoint presentation from the ‘Helping Children in the Aftermath of Bushfires’ Conference, 19th October 2009, Melbourne.

<http://ebulletin.med.monash.edu.au/uploads/351/helping%20children%20bushfires%20flyer.pdf>

Appendix C

Communication Principles - Guidelines

Appendix D

Detailed information for Bereavement Support Persons
Prepared by Beverley Raphael

Appendix A

Inventory of Complicated Grief - 4 items by Shear et al after Hurricane Katrina (Shear et al, 2011).

1. How often have you found yourself longing or yearning for the people or things you lost?
2. How bitter do you feel over your loss?
3. How empty or meaningless do things seem since your loss?
4. How difficult is it for you to accept your loss or to believe that it's real?

Response options were coded 0-4 (almost all, most, some, a little, and none of the time for the first question; and not at all, a little, some, a lot, and extremely for the other questions).

A preliminary categorical classification was made with the following categories:

- Severe CG (15-16)
- Moderate CG (13-14)
- Mild CG (8-12)
- Subthreshold grief (5-7)
- No-minimal grief (0-4)

Inventory of Complicated Grief - 19 Item Scale

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Appendix: Inventory of Complicated Grief

Inventory of Complicated Grief (ICG)
 Holly Prigerson, Ph.D., Mark Miller, M.D., Charles F. Reynolds, III, M.D., Ellen Frank, Ph.D.

Subject Name: _____

ID Number: _____ Today's Date: 19 / /
(To be completed by office personnel) Year Month Day

PLEASE fill in the circle next to the answer which best describes how you feel right now:

- | | |
|--|--|
| <p>1. I think about this person so much that it's hard for me to do the things I normally do...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>2. Memories of the person who died upset me...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>3. I feel I cannot accept the death of the person who died...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>4. I feel myself longing for the person who died...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>5. I feel drawn to places and things associated with the person who died...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>6. I can't help feeling angry about his/her death...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>7. I feel disbelief over what happened...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>8. I feel stunned or dazed over what happened...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>9. Ever since s/he died it is hard for me to trust people...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>10. Ever since s/he died I feel like I have lost the ability to care about other people or I feel distant from people I care about...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> | <p>11. I have pain in the same area of my body or have some of the same symptoms as the person who died...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>12. I go out of my way to avoid reminders of the person who died...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>13. I feel that life is empty without the person who died...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>14. I hear the voice of the person who died speak to me...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>15. I see the person who died stand before me...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>16. I feel that it is unfair that I should live when this person died...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>17. I feel bitter over this person's death...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>18. I feel envious of others who have not lost someone close...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> <p>19. I feel lonely a great deal of the time ever since s/he died...
 <input type="radio"/> never <input type="radio"/> rarely <input type="radio"/> sometimes <input type="radio"/> often <input type="radio"/> always</p> |
|--|--|

The Texas Revised Inventory of Grief

Name:

Age:

Gender:

Race: White Black Latin American Oriental Other (Please list):

Religion: Protestant Catholic Jewish Other (Please list):

How old was your child when he/she died?

My child died (check only one box):

within the past 3 months 3-6 months ago

6-9 months ago 9-12 months ago

My child's death was: Expected Unexpected Slow Sudden

PART 1: PAST BEHAVIOR

Think back to the time when your child died and answer all of these items about your feelings and actions at that time by indicating whether each item is Completely True, Mostly True, Both True and False, Mostly False, or Completely False as it applied to you after your child died. Please check the best answer.

1. After my child died I found it hard to get along with certain people.

Completely True Mostly True True & False Mostly False Completely False

2. I found it hard to work well after my child died.

Completely True Mostly True True & False Mostly False Completely False

3. After my child's death I lost interest in my family, friends, and outside activities.

Completely True Mostly True True & False Mostly False Completely False

4. I felt a need to do things that my child had wanted to do.

Completely True Mostly True True & False Mostly False Completely False

7. I hide my tears when I think about my child who died.

Completely True Mostly True True & False Mostly False Completely False

8. No one will ever take the place in my life of my child who died.

Completely True Mostly True True & False Mostly False Completely False

9. I can't avoid thinking about my child who died.

Completely True Mostly True True & False Mostly False Completely False

10. I feel it's unfair that my child died.

Completely True Mostly True True & False Mostly False Completely False

11. Things and people around me still remind me of my child who died.

Completely True Mostly True True & False Mostly False Completely False

12. I am unable to accept the death of my child.

Completely True Mostly True True & False Mostly False Completely False

13. At times I still feel the need to cry for my child who died.

Completely True Mostly True True & False Mostly False Completely False

PART III: RELATED FACTS

Now please answer the following items by circling, either True or False.

1. I attended the funeral of my child who died.

True False

2. I feel that I have really grieved for my child who died.

True False

3. I feel that I am now functioning as well as I was before the death.

True False

4. I seem to get upset each year at about the same time as when my child died.

True False

5. Sometime I feel that I have the same illness as my child who died.

True False

Core Bereavement Items Scale

SCALES: CORE BEREAVEMENT ITEMS

Burnett, P.C., Middleton, W., Raphael, B., & Martinek, N. (1997). Measuring core bereavement phenomena. *Psychological Medicine*, 27, 49-57.

Name:		Age:	
		Gender:	

These questions are about your experience in relation to the recent loss of your loved one, whose name in these questions will be signified by the symbol X.

1. Do you experience images of the events surrounding X's death?
 Continuously Quite a bit of the time A little bit of the time Never
2. Do thoughts of X come into your mind whether you wish it or not?
 Continuously Quite a bit of the time A little bit of the time Never
3. Do thoughts of X make you feel distressed?
 Always Quite a bit of the time A little bit of the time Never
4. Do you think about X?
 Continuously Quite a bit of the time A little bit of the time Never
5. Do images of X make you feel distressed?
 Always Quite a bit of the time A little bit of the time Never
6. Do you find yourself preoccupied with images or memories of X?
 Continuously Quite a bit of the time A little bit of the time Never
7. Do you find yourself thinking of reunion with X?
 Always Quite a bit of the time A little bit of the time Never
8. Do you find yourself missing X?
 A lot of the time Quite a bit of the time A little bit of the time Never
9. Are you reminded by familiar objects (photos, possessions, rooms etc) of X?
 A lot of the time Quite a bit of the time A little bit of the time Never
10. Do you find yourself pining for/yearning for X?
 A lot of the time Quite a bit of the time A little bit of the time Never
11. Do you find yourself looking for X in familiar places?
 A lot of the time Quite a bit of the time A little bit of the time Never
12. Do you feel distress/pain if for any reason you are confronted with the reality that X is not coming back?
 A lot of the time Quite a bit of the time A little bit of the time Never
13. Do reminders of X such as photos, situations, music, places etc cause you to feel longing for X?
 A lot of the time Quite a bit of the time A little bit of the time Never
14. Do reminders of X such as photos, situations, music, places etc cause you to feel loneliness?
 A lot of the time Quite a bit of the time A little bit of the time Never
15. Do reminders of X such as photos, situations, music, places etc cause you to cry about X?

A lot of the time Quite a bit of the time A little bit of the time Never

16. Do reminders of X such as photos, situations, music, places etc cause you to feel sadness?

A lot of the time Quite a bit of the time A little bit of the time Never

17. Do reminders of X such as photos, situations, music, places etc cause you to feel loss of enjoyment?

A lot of the time Quite a bit of the time A little bit of the time Never

SCORING CRITERIA:

The responses for all items will be scored using the format:

Continuously
[3] Always [2] Quite a bit of the time [1] A little bit of the time [0] Never
A lot of the time

- Items 1 to 17 are added together to form a total score for the CBI (Range 0-51, alpha = 0.91).
- Items 1 to 7 are added together to form the Images and Thoughts Subscale (Range 0-21, alpha = 0.74).
- Items 8 to 12 are added together to form the Acute Separation Subscale (Range 0-15, alpha = 0.77).
- Items 13 to 17 are added together to form the Grief Subscale (Range 0-15, alpha = 0.86).

Appendix B

Children Grieving and Disaster – The Bushfires’ – Powerpoint presentation

CHILDREN GRIEVING AND DISASTER
THE BUSHFIRES

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CHILDHOOD BEREAVEMENT

- ▶ DEVELOPMENTAL LEVELS OF CHILD
- ▶ CONCEPTS OF DEATH –
 - NATURE
 - PERMANENCE
- ▶ RELATIONSHIP TO PERSON/S WHO:
 - HAVE DIED
 - ARE DYING
 - PROXIMITY, ATTACHMENTS
- ▶ PHENOMENA OVER TIME

NORMAL BEREAVEMENT / GRIEVING in CHILDHOOD

- ▶ CONCEPTS related to ATTACHMENT
 - BOWLBY: ATTACHMENT, SEPARATION AND LOSS
 - NORMAL AND “PATHOLOGICAL” MOURNING – CHILD’S RISK OF PATHOLOGY
- ▶ MULTIPLE CLINICAL STUDIES
- ▶ SOME SYSTEMATIC STUDIES (eg. Cerel et al 2006) of TRAJECTORIES OF REACTION, PHENOMENA (over time)
- ▶ MULTIPLE MODELS Eg. BLACK, WORDEN & ADULT, eg. STROEBE, DUAL PROCESS etc etc

EARLY STUDIES of CHILDREN GRIEVING AFTER DEATH OF A PARENT

- ▶ 2–8 YR OLDS – (Raphael et al 1980)
- ▶ BEHAVIOURAL CHANGES:
 - WITHDRAWAL
 - ACTING OUT, AGGRESSION
- ▶ SADNESS, YEARNING, WORDS
- ▶ QUESTIONS / ANSWERS
- ▶ CONCRETE – DECEASED’S PLACE
- ▶ CONTINUITY OF –“FAMILY”
 - SECURITY / SAFETY
- ▶ COMFORTING & AFFECTION

EARLY STUDIES cont'd

- ▶ NATURE OF DEATH:
 - SUDDEN, UNEXPECTED vs
 - SLOW, e.g. DYING OF CANCER
 - “PREPAREDNESS” or OTHER
- ▶ SURVIVING PARENT/S, SIBLINGS, OTHERS
 - PERSONAL GRIEF & CAPACITY TO RESPOND / RECOGNISE CHILDREN’S WORDS, QUESTIONS, REALITIES
- ▶ BELIEFS, MEANING & EXPLANATIONS
- ▶ RITUAL and INCLUSION e.g. FUNERAL etc

BEREAVEMENT and the NATURE OF CHILDREN’S GRIEVING OVER TIME

- ▶ MAY BE:
 - GRADUAL, INTERMITTENT
 - EXPRESSED VARIABLY
 - “ABANDONMENT”
 - ANGER / LIFE CHANGE
- ▶ MAJORITY: ADAPTATIONS AND VULNERABILITY
- ▶ SECURITY / CONTINUITY / MOVING FORWARD
 - HOME, FAMILY, SCHOOL, LIFE
- ▶ MEMORIES AND ONGOING ATTACHMENTS
 - REAL INTERNALISATIONS / IDEAL / OTHER

MULTIPLICITY AND DIVERSITY OF LOSSES

with BEREAVEMENT FOR CHILDREN (AND ADULTS)

- ▶ LOSSES OF PERSON, FAMILY STRUCTURE, ROLES AND RELATIONSHIPS
- ▶ EXPECTED FUTURES –
 - SOCIAL, ECONOMIC, HOME etc.
 - FAMILY LIFE AND MILESTONES
 - CHANCES UNFORESEEN
- ▶ SOURCES OF CARE AND COMFORT & ATTACHMENTS
 - OLDER CHILDREN / ADOLESCENTS
 - CARING FOR YOUNGER, VICARIOUS
 - "REPLACEMENTS"
- ▶ IDENTITY CHANGES

EMERGING CONCEPTS OF BEREAVEMENT PATHOLOGIES

- ▶ COMPLICATED, PROLONGED – (Prigerson et al) related to:
 - NATURE OF ATTACHMENT
 - DISTINCT FROM PTSD, DEPRESSION
 - HIGH SEPARATION ANXIETY (earlier labelled "traumatic grief"), ONGOING FOCUS ON DECEASED
- ▶ MELHEM ET AL (2007)
 - FOCUS ON COMPLICATED GRIEF
 - POPULATION STUDY ON PARENTAL LOSS, ON CHILDREN 7–18 YEARS
 - ICG-R –CLINICALLY SIGNIFICANT SYNDROME

CHILDHOOD TRAUMATIC GRIEF – IMPORTANT CONCEPTUALISATIONS

- ▶ TRAUMATIC GRIEF Raphael et al, Lilz etc
 - Related to NATURE OF DEATH, DYING & TRAUMATIC CIRCUMSTANCES / TRAUMA REACTIONS INTERACTING with GRIEF REACTIONS
- ▶ TRAUMA AND GRIEF DISTINCT PHENOMENA (Pynoos et al 1987, a, b)
 - DISTINCT REACTIONS after SCHOOL SNIPER ATTACK PLUS SEPARATION ANXIETY, TRAUMA AND DEPRESSION OUTCOMES
 - NADER, CHRIST etc

CHILDHOOD TRAUMATIC GRIEF – IMPORTANT CONCEPTUALISATIONS cont'd

- ▶ COHEN et al (continuing)
 - CHILDHOOD TRAUMATIC GRIEF – TRAUMATIC STRESS REACTIONS AND GRIEF REACTIONS INTERACTING
- ▶ DISASTER STUDIES
 - OKLAHOMA BOMBINGS
 - NAIROBI BOMBINGS
 - ARMENIAN EARTHQUAKE

STUDIES, CONCEPTS & PROGRAMS POST 9/11

- ▶ BROWN & GOODMAN 2005
 - Children 8–18 years bereaved: fathers worked for uniformed services (study plus RCT & Clinical evaluation)
 - EXTENDED GRIEF INVENTORY – found to be useful
 - "TRAUMATIC GRIEF" – (but strong aspects or prolonged attachments) and related to perceived need for help
 - ONGOING PRESENCE (NORMAL) – not major issue
 - POSITIVE MEMORY (NORMAL) – not related to PTSD but NEED FOR FURTHER DELINEATION OF ISSUES
- ▶ BROWN et al 2008 CONSTRUCT AND CORRELATES
 - MERGING OF CONCEPTS OF COMPLICATED GRIEF AND CHILD TRAUMATIC GRIEF
 - BOTH DISTINCT FROM PTSD, DEPRESSION ETC

RISK FACTORS FOR CTG

- ▶ PRE-DEATH – PAST TRAUMA & DEATH
- ▶ DEATH CHARACTERISTICS
 - VIOLENT, TRAUMATIC CIRCUMSTANCE
 - SUDDEN, UNEXPECTED; WITNESS, DISTRESS
- ▶ IMMEDIATE POST-DEATH – uncertain but ↑ arousal and fear
- ▶ MEANING, GUILT, BLAME, SELF / OTHERS

CTG RISK FACTORS cont

(Goodman & Brown et al 2008)

- ▶ **DEVELOPMENTAL DOMAIN: YOUNG CHILDREN**
esp. PARENT:CHILD DEPENDENCE ⇒ TRAUMA
- ▶ **FAMILY DOMAIN**
 - UNCERTAINTY; PARENT SUPPORT
 - PARENT TRAUMA & GRIEF esp. If violent death
 - NEEDS FOR PARENTAL EMOTIONAL SUPPORT ACUTELY and OVER LONG TERM
- ▶ **RISKS GREATER with GREATER TRAUMA**
 - VIOLENCE, CLOSER RELATIONSHIP, PERSONAL

CTG cont'd

- ▶ **MULTI-SITE STUDIES** using developed measures and clinical focus CARED (youth & parent versions plus psychiatric symptoms, extended grief inventory; child PTSD; mood & feeling, anger):
 - FOUND TRAUMA & GRIEF ISSUES
 - PARENTAL REACTIONS SIGNIFICANT IMPACT especially MH, ONGOING DISTRESS & ++ SADNESS
 - CHILD'S DISRUPTION OF LIFE
 - ONGOING THREAT
 - DIFFERENT DEATHS, SITES, INCLUDED eg.9/11 etc.

WHAT WAS LEARNED FROM 9/11?

(i) (Murray et al 2006)

- ▶ **NEEDS ASSESSMENT** 6/12 (Hoven et al 2006, school survey 4-12 y.o.)
 - ELEVATED RATES OF MENTAL HEALTH PROBLEMS
 - IMPORTANCE OF SYSTEMATIC SCREENING
- ▶ **OUTREACH: PROJECT LIBERTY**
UTILISATION by 6-17 year olds related to:
 - **HEAVILY IMPACTED and EXTREMELY AT RISK**
 - **EXPOSURE** to 1 or more such as **LOSS OF FAMILY MEMBER, INJURED, LIVING IN A HOME DAMAGED**
 - **LONG-LASTING & CONTINUING DISTRESS/ SYMPTOMS**

WHAT WAS LEARNED FROM 9/11?

(ii) (Chemtob et al 2007)

- ▶ **WHO IS BEREAVED**, and WHO NEEDS CARE?
- ▶ **SYSTEMATIC REGISTER OF BEREAVED CHILDREN**
- ▶ **5 YEARS COMPLEX TASK TO DEVELOP SUCH A REGISTER**
- ▶ **PROBLEMS FOR PROGRAMS TO MEET THEIR NEEDS**
- ▶ **CRITICAL ISSUE FOR FUTURE PLANNING**

WHAT WAS LEARNED FROM 9/11?

(iii) (Schechter & Coates 2006)

- ▶ **CATS Consortium** of groups for **TREATMENT OF CHILDREN**
 - **EVIDENCE BASE FOR CARE**
 - Assessment protocols – poorly tested, agreed
 - Evidence-based protocols developed based on earlier work
 - CBT for CTG in CHILDREN (Cohen et al 2001)
 - TRAUMA / GRIEF-focused PSYCHOTHERAPY (Pfeffer / Layne et al 2002) (both demonstrated effectiveness)
 - MULTIPLICITY OF EXPOSURES
 - **IMPLEMENTATION OBSTACLES**
 - ENGAGEMENT, OUTREACH, RECRUITMENT
 - TRAINING
 - DATA COLLECTION
 - **DIFFICULTIES OF EFFECTIVE MANAGEMENT** and little bereavement specificity

WHAT WAS LEARNED FROM HURRICANE KATRINA?

(Osofsky et al 2009)

- ▶ **ONGOING ISSUES OF MEETING M.H.NEEDS OF CHILDREN**
FAMILY AND FRIENDS KILLED
 - WITNESS, SEPARATIONS
 - EVACUATION
 - DISLOCATION – ONGOING eg. 1yr later, >50% not home, & MULTIPLE MOVES
- ▶ Yr 1: 49% met cutoff for mental health referral
- ▶ Yr2: 41.6% met cutoff for mental health referral
- ▶ **ODDS RATIO FOR PROBLEMS**
 - 4-6th grade 2.74
 - Family members, friends killed 2.01
 - Previous loss / trauma 2.08
 - Personal belongings destroyed 2.05

TREATING CHILDHOOD TRAUMATIC GRIEF

Cohen & Mannarino 2006

- ▶ TRAUMA-FOCUSED COMPONENTS of CBT-CTG
 - Psycho-education, parenting skills
 - Relaxation, Affective Modulation
 - Cognitive Processing
 - Trauma narrative
 - In-vivo mastery of trauma memories
 - Conjoint child-parent sessions
 - Enhancing sense of safety

TREATING CHILDHOOD TRAUMATIC GRIEF

cont'd Cohen & Mannarino 2006

- ▶ GRIEF-FOCUSED COMPONENTS of CBT-CTG
 - Grief psycho-education
 - Grieving the loss: what I miss
 - Resolving ambivalent feelings: what I don't miss
 - Preserving positive memories
 - Redefining the relationships and committing to present relationships
 - Making meaning of traumatic grief
 - Joint child-parent sessions
 - Treatment closure: planning for reminders and future trauma, loss and change

IMPACTS OF DISASTERS ON CHILDREN

PHYSICAL & DEVELOPMENTAL VULNERABILITIES BIOPSYCHOSOCIAL/CULTURAL/ENVIRONMENTAL

- ▶ DEATHS OF CHILDREN
- ▶ SEPARATION FROM FAMILIES
- ▶ NEEDS FOR PROTECTION (UNICEF)
- ▶ POST-DISASTER NEEDS related to
 - EXPOSURES, LIFE THREAT, INJURY
 - LOSSES: PERSONAL, MULTIPLE
 - ONGOING IMPACTS
 - DISRUPTION OF DEVELOPMENT, LEARNING, FUTURE
 - DISLOCATION etc
- ▶ TRAUMA is OVERWHELMING MODEL BUT LOSS AND GRIEF ARE DEEP, PERSISTENT, PERPETUATING and POORLY STUDIED & MANAGED FOR CHILDREN & ADOLESCENTS

PUBLIC HEALTH/POPULATION HEALTH and EARLY INTERVENTION

- ▶ PROTOCOLS NEEDED INCLUDING:
 - SYSTEMATIC PREVENTION, PREPAREDNESS & RESILIENCE BUILDING PROGRAMS IN PLACE eg.
 - Ronan & Johnston, Brom et al, etc
 - Often schools-based
 - Plus family plan
- ▶ PROTOCOLS FOR NEEDS ASSESSMENT (incl. grief) AND SURVEILLANCE (PRE AND POST)

PUBLIC HEALTH/POPULATION HEALTH and EARLY INTERVENTION

cont'd

- ▶ PROTECTING CHILDREN IN DISASTER - READINESS & KNOWN GUIDELINES (including bereavement) see below
- ▶ EARLY & OTHER EVIDENCE-INFORMED GUIDELINES FOR INTERVENTIONS as needed, appropriate to families, children, different ages / development, including grief eg. Pynoos et al 2007
- ▶ OUTREACH PROGRAM: READY TO GO
- ▶ DATA, DOCUMENTATION, REGISTRATION & FOLLOW-UP SYSTEMS
- ▶ PSYCHO-EDUCATION - PUBLIC INFORMATION

SOME SPECIFIC ISSUES that need to be CONSIDERED FOR THE FIRES

- ▶ THE THREAT AND TERROR and implications for children, DEVELOPMENTALLY and MENTAL HEALTH-WISE
- ▶ I COULD DIE - CHILDREN CAN DIE / DID
- ▶ NOW I "KNOW" DEATH - high arousal, high fear
 - Predict later problems
 - Return with reminders
 - Anniversaries
 - Fire seasons, heat etc

SOME SPECIFIC ISSUES that need to be CONSIDERED FOR THE FIRES cont'd

- ▶ A TERRIBLE WAY TO DIE: BURN TO DEATH
 - SAW OTHERS POSSIBLY
 - IMAGINED PROBABLY
 - MEDIA IMAGES & REPLAYS
- ▶ LOST THROUGH SUCH DEATHS?
 - PARENT/S?
 - SIBLING/S?
 - FRIENDS, OTHER FAMILY MEMBERS, OTHER CHILDREN?
 - NEIGHBOURS, TEACHERS, ETC?
- ▶ A TERRIBLE GRIEF

WHY DID THEY DIE?

- ▶ HOW DID IT HAPPEN? HOW TO CONTROL
- ▶ WHY SOME / NOT OTHERS
- ▶ BLAME
- ▶ SURVIVOR GUILT
- ▶ ANGER, RAGE OR FEAR
- ▶ INQUIRIES AND REVIEWS
- ▶ WHAT NEXT, FUTURE AND THREAT

LIFE COMPLEXITIES AND FIRE IMPACTS

- ▶ BLENDED FAMILIES - relationships, loss, ambivalence, support
- ▶ SEPARATION - UNCERTAINTIES FOR WEEKS - greater vulnerability
- ▶ ATTACHMENT TO PLACE, WAY OF LIFE
- ▶ PRE-DISASTER VARIABLES
- ▶ MULTIPLICITY OF ADVERSITIES (eg. Gill 2009)

LIFE COMPLEXITIES AND FIRE IMPACTS cont'd

- ▶ SOCIAL NETWORKS & IMPACTS MODERATING, SUPPORT
- ▶ CRITICAL ENVIRONMENTS
 - HOME, SCHOOL COMMUNITY and their DISRUPTIONS
- ▶ CULTURES AROUND DEATH & LOSS - family, community
- ▶ CAPACITY FOR FAREWELLS, RITUALS, MEMORIALS
 - SHARED GRIEF
- ▶ DISPARATE & DIFFERENT IMPACTS, PATHS
- ▶ FAMILY GRIEF & TRAUMA

MULTIPLICITY OF LOSSES

- ▶ LOVED ONES -
 - FAMILY, RELATIVES
 - FRIENDS - CHILDREN AND YOUNG PEOPLE
 - OTHERS - e.g. Schools, teachers, community
- ▶ HOME, PLACE, POSSESSIONS, PHOTOS etc
- ▶ RESOURCES: PRACTICAL AND EMOTIONAL
- ▶ MEMORIES, REMINDERS

MULTIPLICITY OF LOSSES cont'd

- ▶ LOSSES of SCHOOL, COMMUNITY, EDUCATION (Dyregrov 2004)
- ▶ FUTURES - CHANGED
- ▶ CONSEQUENT & SUBSEQUENT LOSSES e.g. Family breakdown, parental work, transient accommodation
- ▶ SENSE OF PERSONAL & COMMUNITY INVULNERABILITY

MULTIPLICITY OF REACTIVITIES

- ▶ SPECTRA OF DISTRESS & SYMPTOMATOLOGY
 - ? DISORDERS
- ▶ SPECTRA OF RESILIENCE, POSITIVE ADAPTATION
 - ? GROWTH
- ▶ DIVERSE ADAPTATIONS AND TRAJECTORIES OVER TIME

MULTIPLICITY OF REACTIVITIES cont'd

- ▶ MULTIPLICITIES OF FAMILY/SOCIAL GROUP NEEDS, REACTIONS & STRENGTHS
- ▶ MULTIPLICITY OF SUPPORT & SERVICES but UNCERTAINTY re: PATHWAYS and NEEDS BEING MET OVER TIME

UBIQUITY OF TRAUMA
SILENCE OF DEATH AND LOSS

STORIES, IMAGES AND PLAY of GRIEF

- ▶ MANY SPONTANEOUS NARRATIVES & STORIES OF TRAUMA AND LOSS
- ▶ VARIABLE IN ASSISTING FORWARD TRAJECTORY
- ▶ SPONTANEOUS -
 - USUALLY HELPFUL / INDIVIDUAL / GROUP
 - REPETITIVE eg TERROR & TRAUMA
 - MAY BE RELIVING, HOLDING TO DECEASED IN UNCHANGING RELATIONSHIP
- ▶ CHILDREN & ADOLESCENTS MAY TELL, WRITE OR DEVELOP MEMORY SOURCES or LINKED OBJECTS & FANTASIES
- ▶ THERAPIES eg GOODMAN ET AL 2004
 - CLIENT-CENTRED TREATMENT (CCT) FOR CGT. "Letting the story unfold", also some groups
 - GROUPS (Webb 2005)
- ▶ MEMORIALISED MEMORY AND PROCESSING

PUBLIC MENTAL HEALTH APPROACH

(Pynoos et al 2007)

- ▶ FACTORS THAT MEDIATE OR MODERATE CHILDREN'S RECOVERY:
 - Frequency of exposure to trauma
 - Frequency of exposure to loss reminders
 - Type and severity of secondary stresses and adversities
 - Impairment in caregiver functioning
 - Quality of family functioning
 - Overcrowded or adverse living conditions
 - School and community milieu
 - Quality of peer relationships
 - Physical injury, disability, and rehabilitation
 - Inter-current trauma and loss

▶ Source: Table 3.3 p.53, Children and Disasters: public mental health approaches in "Textbook of Disaster Psychiatry"

PUBLIC MENTAL HEALTH APPROACH cont'd

(Pynoos et al 2007)

- ▶ STAGES OF POSTDISASTER INTERVENTION
 - PSYCHOLOGICAL FIRST AID
 - SKILLS FOR PSYCHOLOGICAL RECOVERY
 - ENHANCED SERVICES
 - TREATMENT
- ▶ PRIMARY THERAPEUTIC FOCI
 - TRAUMATIC EXPERIENCES
 - TRAUMA AND LOSS REMINDERS
 - TRAUMA-RELATED BEREAVEMENT
 - POSTDISASTER ADVERSITIES
 - DEVELOPMENTAL PROGRESSIONS

▶ Source: Tables 3.4 & 3.5 pp 55 & 58, Children and Disasters: public mental health approaches in "Textbook of Disaster Psychiatry"

PUBLIC MENTAL HEALTH APPROACH cont'd

(Pynoos et al 2007)

- ▶ THREE TIERS OF POSTDISASTER INTERVENTION
 - TIER 1: BROAD SCALE INTERVENTION
 - TIER 2: SPECIALISED INTERVENTION
 - TIER 3: HIGHLY SPECIALISED INTERVENTION

HOW, WHEN and WHERE of INTERVENTIONS

- ▶ **SCHOOLS PROGRAMS – MULTIPLE**
 - TRAUMA & GRIEF eg. PYNOOS et al
 - SCREENING AND INTERVENTION
 - TEACHER MEDIATED – but own needs
 - FAMILY ENGAGEMENT & NEED, INFLUENCE OF PARENTS trauma / grief
- ▶ **“WHO’S LISTENING TO THE CHILDREN?”** Koplinwig et al 2004
 - THE DIFFICULTIES OF MEETING THEIR NEEDS
 - ENGAGING FAMILIES, COMMUNITIES AND SCHOOLS, TEACHERS & MEETING THEIR NEEDS AS WELL
- ▶ **PREPARING FOR THE FUTURE**

SYSTEMS ATTUNED TO CHILDREN'S NEEDS with DIFFERENT DISASTERS: TRAUMA AND LOSS; SUPPORT AND EXPERTISE ALONG THE PATHWAY

- ▶ **PREVENTION AND SAFETY**
- ▶ **PREPAREDNESS for FAMILIES, SCHOOLS, CHILDREN**
- ▶ **SYSTEMS FOR MENTAL HEALTH P.P.R.R – TRAINED, BRIEFED AND ABLE TO BE MOBILISED**
- ▶ **MASS DEATHS / DISASTER DEATH**
 - DVI ISSUES, SEPARATION / LOSS
 - INFORMATION (Psychoeducation web etc)
 - EARLY INTERVENTION / SURVEILLANCE for bereaved from beginning eg. Family liaison officers (London bombings)
 - RITUALS & RESPECT
 - VULNERABILITIES & LONG TERM NEEDS

SYSTEMS ATTUNED TO CHILDREN'S NEEDS with DIFFERENT DISASTERS: TRAUMA AND LOSS; SUPPORT AND EXPERTISE ALONG THE PATHWAY

- ▶ **MASS DEATHS / DISASTER DEATHS cont...**
 - SHARED GRIEF AND/OR PRIVATE
 - PROTECTING FROM CONVERGENCE OF COUNSELLORS
 - READINESS & THEIR WAY
 - STRENGTHS FOCUS
 - FAMILIES' NEEDS
 - SCHOOLS' NEEDS
 - COMMUNITY'S NEEDS
 - CONSULTATIVE SUPPORT FOR SYSTEMS
- ▶ **CARING FOR CARERS – SUPERVISION & SUPPORT** for those providing care & intervention, their own loss and grief, their own trauma

CHILDREN, ADOLESCENTS, THEIR FAMILIES and FRIENDS

- ▶ **TIME, COMFORTING, CONSOLATION**
 - GENUINENESS, EMPATHY, WARMTH
- ▶ **THEIR LOSS, THEIR LOVED ONES, THEIR MEMORIES, THEIR MEANING**
- ▶ **FAMILY and THEIR LOSS, CHANGE AND RENEWAL**
- ▶ **SCHOOLS and THEIR LOSS, CHANGE AND RENEWAL**
- ▶ **MULTIPLE COMMUNITIES and CULTURES OF LOSS, CHANGE AND RENEWAL**

CHILDREN, ADOLESCENTS, THEIR FAMILIES and FRIENDS cont'd

- ▶ **GRIEF as a KEY THEME in DISASTER – not only TRAUMA but also:**
- ▶ **MULTIPLICITY OF LOSSES – PAIN OF GRIEF & ONGOING LOSSES of LIFE with PERSONAL LAYERS AND LEVELS**
- ▶ **DEATH AND MEANING – “KNOWING” DEATH**
- ▶ **VALIDATION of EXPERIENCE – ACKNOWLEDGING COURAGE, STRENGTHS**
- ▶ **HOPE AND FUTURE**

Appendix C

Communication Principles – Guidelines

There are 5 key principles for effective communication in an emergency. They aim to provide information and knowledge progressively, to assist affected individuals and communities.

- i) Provide information about what is known using trusted sources, for instance about the deaths that may have occurred, and where and when information will be available. Information should be provided honestly, in clear and simple language, and with use of community languages. It is important to be honest about the real situation and the limitations of current information and where, when and how further information will be available.
- ii) Acknowledge concerns of those who are affected, with sensitivity and compassion. Be attuned to their emotional and mental states.
- iii) Listen and respond to queries and seek further information as required. Discuss what is known, what is being done to find out more, and what is not known, and where people can take their queries for more information.
- iv) Provide information about what people can do themselves, and what others are doing to address their concerns.
- v) Identify the information process i.e. how further information will be progressively made available; when, where, and through what media; what people can do to access these sources; and what sort of contributions they can make to the information.

Appendix D – Detailed Information for Bereavement Support / Family Support persons

Prepared by Professor Beverley Raphael

Practical actions for workers in these roles include:

Introduction by the support worker and a brief description of why they are contacting the bereaved should be done in a way which recognises the distress and uncertainty, and that those bereaved may not wish to consider or discuss the dreaded possibilities with anyone. Phrases such as - “I am here to assist you at this time, if you would find this helpful” - are open-ended enough to leave an opening for the next step of defining the nature the bereaved person’s priority needs, and the information, practical and other assistance through which the worker may be able to “assist” – i.e. spelling out - “who you are, and what you can do”. Such themes have been identified as central by forensic counsellors involved in such roles, for instance, through the Sydney Coroner’s Office team (Mowll, 2007). This outreach may be provided at the home, which is often preferable, or at assistance or reception centres post incident.

Key themes in assistance should commence with information, providing this in brief, clear ways, sensitively in response to the bereaved’s queries and needs.

A similar sensitive and complex area relates to the identity of the bereaved, and their relationship to missing or deceased persons. The complexity of family structures with blended, defacto, stepchildren and other primary family bonds, may sometimes mean that difficulties arise through privacy considerations, or determining who has a “right” to the deceased’s remains for decision and disposal, or to money to assist at such times. Supportive exploration of family response and structure, while interacting with bereaved family members can be helpful in clarifying such issues, although some may not be well defined until a later time. Workers may need to act in terms of what they believe to be relevant.

How the deceased is spoken about is also sensitive. Finding out his or her name and speaking of the person in that context is more supportive than formal phrases such as “the deceased”. However, it is also essential to recognise cultural requirements, such as those where the name of the deceased should not be mentioned.

Information is important so that DVI or evidentiary requirements do not come as a further shock at a subsequent stage of the process. For instance, following a terrorist attack or other violent death where homicide may be involved, the evidentiary requirements need to be stated in simple terms, and written information that is brief and clear should also be provided. The roles and requirements of other agencies, especially police, may need to be explained in supportive ways, as a key to the whole process. People often seek out their loved ones and may have viewed their bodies in other settings of the incident and see this as the “identification”, as with some family members involved following the Bali bombings of 2002. The formal requirements of Disaster Victim Identification (DVI) processes need to be spelt out, why they are required, and how they will happen and how the bereaved is involved. Again prepared information in clear formats is usually helpful. The detailed processes involved in DNA matching, for instance hair, relations’ DNA, family information and so forth may also need to be discussed and the bereaved supported in their roles in filling out forms and providing details of this kind, especially for “missing” persons.

It should also be recognised that exposure to large numbers of damaged bodies in the way many people experienced the multiple deceased as they searched for family at the site or in the morgues in Bali after the 2002 bombings, can traumatise them and they may need specific mental health assessment and support regarding this at some later stage. Such searching fulfils a basic human need. However, where possible, it is useful to lessen undue exposure to multiple deceased human remains, especially if mutilated or disintegrating, and it is particularly important for children to be so protected. Information about others: who will search, such as police and emergency responders, what they will do, and a process of updating the bereaved about what has been found, are important.

When a mass casualty transport incident occurs it has become common for people to go to the site to see if their loved ones are there, and to try to understand what has happened. They may view this as the last place their loved one was alive. Following experience in Norway and elsewhere, it is an increasingly common practice to offer bereaved people the opportunity to go to the site or provide a place for bereaved families to be together to wait while the search for survivors or deceased takes place. This provides opportunities for mutual support for people who may otherwise

not readily be in contact with one another through such disasters. It can also be a place where more formal psychological and bereavement support can be initiated.

The public story and depiction of incidents is also significant for the bereaved both acutely and subsequently. They may be sought by the media for the “human interest” story at a time when they are unable to deal with this, and distressed by the process. Commonly there are repeated images, building on their own imagery of the catastrophe, that replay and may further traumatise, as with the images from 9/11 of the towers, the falling man, people jumping and so forth (New York, 2001). Imagery is a common component of traumatic stress reactions and may contribute to difficulties in dealing with the loss. Other images of the person who has died, memories of them in life may be difficult to retrieve. Dealing with such issues may require specific counselling to manage both the traumatic stress component and the grief (Raphael et al, 2004). In a sense, those bereaved construct a “narrative” of the death, the way their loved one died, and another of the loved one, the real person they were and the meaning of their lives, and the relationship. It is to the latter that they will relate in weeks and years to come. These may be issues bereaved people will discuss when seeking support, explanation, and ways to remember him or her “as they were”. This usually evolves over time with grieving processes.

Early questions about the deceased’s possible suffering are frequent. Whether or not he or she suffered cannot be readily answered in some instances, but where it is realistic that the person was likely to have died instantly, or rapidly become unconscious, this may be more easily dealt with. Empathy, gentle discussion of realities and reassurances about these probabilities can be helpful.

As bereaved people talk of their loved ones spontaneously, such discussion, even if sad, painful, angry, yearning, can also assist the bereaved in their construction of their real and internalised ongoing linkages to the person who has died. Support for this discussion should be non-intrusive, interested, but not focussed on formal counselling strategies at this early time.

Dealing with uncertainties is a critical part of the process when the person is missing, or his or her death is not formally confirmed. Those bereaved may swing between hope and despair, disbelief and acceptance. Practical support, acknowledging uncertainties, staying with the bereaved through

the “roller- coaster” of their emotions are likely to be helpful. Knowing the structures of formal requirements, from coronial, to Disaster Victim Identification (DVI), from the requirements in natural catastrophes to those of terrorism or homicide, and assisting the bereaved to address these, is a platform for reality-based support at such times.

The formal processes of mourning and saying goodbyes to the deceased in person may commence at the site of the incident, at the viewing of the body / remains, at the coronial or at funeral premises. People seek many different options and may need the opportunity to work through these as they make their own choice. While there is significant research to suggest these opportunities for goodbyes are valued and helpful they may not always be possible. No body, only body parts, no identifiable remains, gross destruction of face and/or of other important aspects of the body of the person who was loved, may all contribute to further distress. People are likely to value to opportunity to discuss these possibilities beforehand and to work towards their own “goodbye” through these processes, or at later times. While studies support the potential value of such processes (Singh & Raphael, 1981; Chapple and Ziebland, 2010), these issues should be dealt with in ways that are flexible. There is no uniform approach, except the need to provide a framework of choice. Culture, religion, personal values, practical realities, personal ways of coping with this as well as other aspects of loss and grief, may determine what is done. Whatever the decision processes, information, compassionate support, appropriate timing and follow-through, can provide the opportunity to discuss these matters subsequently, to make further goodbyes, and to provide for future supportive contacts should these be needed. Photos, reports on autopsy or coronial findings, memorial ceremonies or occasions, are all opportunities for further remembering and grieving. Grief is not a “package” that can be “worked through” in set ways. Rather it is a process, intrinsic to human adaptation, but expressed in diverse ways. A sensitivity of memory and feeling may persist for many years when the relationship has been intense and close.