A LOOK AT BEREAVED PARENTS

Five years later

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It is hard to be an immigrant, even to the Promised Land, and the results of Michael Roskin's study of the effects on surviving parents and grandparents of the death of a child needs to be interpreted in this light. The family which gives up the wealthiest country in the world for the doubtful security of life in Israel makes a choice on behalf of generations to come. To ensure the future of these generations must be a major concern for all Jewish parents, and the death of a child strikes at basic assumptions which underlie the whole exodus. It remains to be seen whether other parents in other lands react quite so severely.

In many third world countries, the death of children is still common; they are the first to die in times of famine, and it is usual for parents to have large families to allow for "natural wastage". How this affects their feelings and their mental health has never been adequately investigated.

In countries where the death of children is a rare event, family size has dropped in the confident expectation that all will survive until old age. The idea of a "natural span" which is a God-given right gains credence despite the fact that nature offers no such guarantees. Hence it seems likely that parents from countries with low birth and death rates will find the untimely death of children a greater outrage and a cause for more lasting and disruptive grief than do those in other lands.

Unfortunately, cross-cultural studies which would allow valid comparisons to be made have not been carried out. Until they are, we have to rely on general impressions and on observations from within societies such as those in Britain, Israel and the U.S.A., where systematic information has been collected. In these societies it does appear that the death of a child is at least as distressing as the death of a spouse, although Fulton's study in Minneapolis showed that widows suffered more illness requiring medical care and more insomnia than parents losing a child.

As for grandparents, nobody seems to have considered their needs, and we are brought up short by Roskin's finding that their lives may even be shortened by the death of a grandchild. Clearly, parents and grand-parents must become the concern of all who work with the bereaved.

Colin Murray Parkes

ABSTRACT

Bereaved parents (N = 62) interviewed five years after the death of a young child (0-12 years) appeared to be less emotionally healthy and incurred more significant life changes than the control group. Bereaved mothers indicated their distress differently from fathers. College-educated bereaved parents appeared emotionally healthier than others. Mortality was greater in bereaved than non-bereaved grandparents.

Bereaved parents are a unique group. Deaths of infants and children produce isolation and diffusion among family members, and higher than average rates of marital discord.[1,2,3,4] Furthermore, the death of a child is associated with high intensities of grief, as well as the widest range of reactions among parents as compared to those who experience the death of either a spouse or parent.[5]

In Israel the loss of a child is regarded as the life change requiring the second greatest amount of social readjustment and more than the loss of a spouse,[7] whereas the loss of a spouse was selected in the USA as the highest and loss of child as fifth.[8]

Surprisingly, little research internationally has been done on parents grieving the loss of young children. This study attempts to provide a profile of the emotional health and socio-economic status of bereaved Israeli parents. The questions it attempts to answer are: (1) Emotionally, how do bereaved parents differ from comparable controls; and (2) What conclusions can be drawn regarding the risk of emotional disturbance and does a case exist for preventive intervention.[6]

METHOD

Subjects

Names of bereaved parents were selected from the records of the two Hadassah Hospitals in Jerusalem. All parents whose child (ages from birth to 12 years) died at the hospital five years earlier (1977-78) were contacted.

Of the 94 families sent the initial letter, 18 letters were returned unforwardable. Of the remaining 77 families, 19 could not be or were not reached. Four families refused to participate. Sixty-two parents in total (57 families) were interviewed.

Controls were systematically selected from Hadassah Hospitals'

employee lists of 1977 (about 4,000+ employees).

Bereaved and control groups were matched with respect to sex, age, education, religion, number of children and duration of marriage.

The typical participant in this study was 39 years old, Jewish, a parent of four children with 14 years of education, and was born outside Israel, immigrating around 1950.

Measurement

Three measurement instruments were utilised: The Symptom Check List—90, the Psychiatric Epidemiology Research Interview and a demographic questionnaire developed by the investigators of this study.

1. The Symptom Check List—90 (SCL—90)[9] was chosen because of its brevity and relative ease to administer. Its questions do not appear to imply mental illness. It is comprised of 90 items, self-rated on a 5-point scale of distress ranging from "not at all" to "extremely".

Validity studies[9,11,12] have indicated its effectiveness as a measure of emotional distress and its sensitivity to differential improvement and differences even among non-neurotic or "normal" populations. Of the original nine SCL subscales the current study utilized five: somatization, obsessive compulsiveness, interpersonal sensitivity, depression, and anxiety. Derogatis, Rickels, Covi, and Lipman[9,10] established the reliability of the SCL as a whole and of clusters of its subscales.

2. The Psychiatric Epidemiology Research Interview (PERI) was utilised also because of its standardised and validated results with non-psychiatrically ill populations and its administrative ease.[14] The PERI can investigate demographically complex samples from the general population where only a small number of "cases" have received professional mental health services. It has three main components:

   1. A set of symptom scales to measure various dimensions of psychopathology.
   2. A set of measures of social functioning.
   3. A schedule of questions about recent life events as a basis for measuring potential stressors.[15]

The usefulness of a Hebrew version of both these scales has been established by Dohrenwend, Levov and Shrout.[13,16]

3. The demographic questionnaire designed by the principal investigators elicited information on various demographic characteristics including data on immigration and major life changes that occurred in the previous five years including additional deaths, birth, difficulties at work as well as drug and alcohol use.

Procedure

Records of Jewish children (0-12 years of age) who died five years previously (1977-78) at Hadassah Hospitals in Jerusalem, Israel, were searched. All surviving parents were sent a letter informing them of the project and the forthcoming contact. The contact letter stated that research is being done on parents who have to cope with the death of a child and that it is known that they faced this situation about five years ago. It is believed that they can help the researcher to find new ways to help parents who will face the same type of situation in the future.

Appointments for interviews were set and held. Parents were interviewed in their own homes. Often this required the interviewers to travel throughout Israel to reach these parents.

Groups scores from each of the measurement instruments were compiled and comparisons and contrasts were made.

RESULTS

Bereavement and Emotional Health

Sixty-two bereaved parents and 56 control parents participated in the study. Experimentals had poorer emotional health scores than the controls on almost every parameter of the SCL and also on the PERI (see Table 1).

Gender, Bereavement and Emotional Health

Bereaved mothers indicated poorer emotional health when compared to control mothers with more somatic complaints ($T = 2.19$, $p = .032$); and interpersonal (over) sensitivity ($T = 2.39$, $p = 0.20$). Bereaved fathers experienced more somatic complaints than control fathers ($T = 1.95$; $p = .057$). On other emotional health parameters, no significant differences were found. Also, no significant differences in emotional health were found between males and females within each group or in both groups combined.

Education, Bereavement and Emotional Health

Emotional health of bereaved parents with at least a college education was not significantly different from comparable controls with at least a college education.

When comparing bereaved parents to controls with a high-school education or less, and also with an elementary school education or less, the bereaved parents were significantly less healthy. This was indicated on the PERI and for every emotional health index except depression on the SCL.

No correlation between age and emotional health or between change of residence and emotional health was found in either group.

Life Changes, Bereavement and Emotional Health

A greater proportion of bereaved parents changed residence and changed work in the 5-year period, but no differences in emotional health were found between them and the controls who also changed residence (and/or work); also no difference was found in emotional health between those who moved (or changed work) versus those who did not within each group.

Mortality Among Grandparents

Significantly more deaths of bereaved grandparents had occurred as compared to control grandparents in the 5-year period ($N = -2.94$, $p = .004$). No significant differences in emotional health were noted between parent groups in which grand-parental death had or had not occurred.

DISCUSSION

Main Effects and Passage of Time

Five years after losing a child, the results of this study indicate significantly poorer emotional health among the parents as compared to the controls. Why considerable suffering and symptomatology should exist five years later is only partially understood. Bereaved parents stated that when their child died it was as if they lost part of themselves, their hope and future. Sherman[17] relates that after a few months the initial shock wore off and the reality of the pain set in for the parents he spoke with.

continued on p. 28

continued from p. 27

Death of a child is seen as more disruptive, emotionally debilitating and more significant to the survivors than the death of an elderly parent.[18] "Bereaved parents are multiply victimised by the loss of the child they love, by the loss of dreams and hopes they had invested in that child and by the loss of their own self-esteem resulting from the experience of helplessness" (page 310).[17]

The impact of such multiple loss diminishes slowly. Horowitz indicated that there is a relationship between the severity of life changes and the rate of reduction in their perceived intensity. Changes that bring considerable loss and require considerable readjustment, diminish in intensity even more slowly.[19]

Rando suggests that parental bereavement may actually worsen with time.[20] In her study of 54 parents who were interviewed from two months to three years following the death of their child from cancer, there was a trend toward a decrease in the intensity of the experience in the second year of bereavement, which was followed by an increase in intensity in the third year.[20]

Gender Differences

It is interesting to note that in the Israeli "macho" culture in which pain and loss is usually not publicly expressed and particularly by men, the bereaved fathers indicated emotional disturbance only in somatic parameters: body, head, back and stomach aches. The bereaved mothers reported poorer emotional health than control mothers. This is in line with other studies of psychiatric symptomatology and gender. Hesbacher[21] et al., found that women report significantly higher symptom severity scores than men. In addition, many studies that have focussed specifically on depression have indicated correlations between women and depressive symptomatology.[22-25] The conclusion drawn by Craig and Van Natta[25] is that women are much more likely to admit to transient symptoms of depressed affect than men.

Education Differences

Formal education and its accompanying socialisation may have acted as a buffer for the bereaving parents, as a correlation was evident between increasing years of education and increased emotional health. This occurred to the extent that no significant differences in emotional health scores was found between college and postgraduate-educated bereaved parents and comparable controls.

This is compatible with the existing literature. Craig and Van Natta[25] found correlations between numerous depression persistence symptoms and educational background, suggesting that less educated individuals are more likely to exhibit the depressive syndrome than those with more years of education.

Classical epidemiological studies have found inverse relationships between class (education, income and occupation) and psychiatric symptoms.[26, 27] However, less data exists regarding the relationship between education and emotional health.

Frequent Life Changes

More frequent change of residence and work were noted as a trend among the bereaved parents, compared with the controls. Although it is not clear how the loss of a child directly contributes to the onset of additional subsequent life changes, it is clear that this relationship exists. One possible interpretive approach considers the ego's defensive mechanisms and strategies. Avoidance, flight and replacement measures are often utilised by people in crisis. In this instance, its concrete manifestation may be that of more frequent changes of work and residence.

Although this study did not set out to examine the physical and emotional health of grandparents, the finding of a highly significant increase in mortality in this group is of considerable interest and importance. Other studies (Young et al,[28] Parkes, Benjamin & Fitzgerald[29]) have shown a sharp increase in mortality among widowers, but this is the first time that loss of grandchildren has been reported as a cause of death. This finding will be examined in more detail in another paper.

In conclusion, the findings from this study suggest that a case exists for mounting a preliminary intervention for bereaved Israeli parents—both mothers and fathers—particularly of high school or lower educational levels, aimed at preventing and/or reducing emotional disturbance. The type and timing of such an intervention must be experimentally tested, measured and developed. Furthermore, additional comprehensive research on bereaved parents must be recommended, so that multiple controls, time frames, and measurement instruments and outcome measures could be utilised and evaluated regarding marital interaction, surviving sibling interaction and parental as well as sibling morbidity and mortality, onset and duration. In these ways the important unanswered questions arising from this study can begin to be addressed.

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continued on p. 30

Emotional Health of Bereaved Parents and Controls

Health Dimension	Bereaved Parents N = 61** Mean (SD)	Controls N = 55** Mean (SD)	t	p (2 tail)
Somatic Complaints	56.05 (14.54)	48.85 (11.43)	2.94	.004*
Obsessive Compulsiveness	57.44 (13.84)	52.82 (11.38)	1.95	.053
Interpersonal Oversensitivity	59.15 (13.54)	53.38 (10.75)	2.52	.013*
Depression	55.75 (14.42)	51.29 (12.04)	1.80	.075
Anxiety	58.97 (13.38)	54.27 (10.17)	2.11	.037*
PERI (demoralisation)	.894 (.69)	.690 (.43)	1.90	.060

* p = .05 or less
** one missing



continued from p. 29

it seems nothing but evil. It is acceptance of necessity, ultimately of death. According to Hindu thought, suffering becomes a problem when one cannot see that it is not the final truth. Like all other forms of existence it is an aspect of manifestation of the greater reality. This means grief or suffering, however distressing it may be, is still only relative. Attachment to anyone or anything as if they have an eternal validity gives rise to suffering.

The law of **Karma** needs a bit of elaboration. The word **Karma** literally means work or action. Generally speaking in Sanskrit the word means volitional action, and it shows the causation of things. **Karma** effects transmigration. Those whose conduct has been pleasant will have a pleasant re-birth, and those with unpleasant conduct will have an un-pleasant re-birth. Actions follow the soul from one life to another. The teaching is not necessarily fatalistic for one can improve one's lot by accumulating good **Karma.** The law of **Karma** advocates doing duty for the sake of duty without a selfish motive. Mahatma Gandhi described **Karma** yoga where one needs to give full effort with detachment.[4] In other words Hindu philosophy and especially the **Bhagavad Gita** recommends **Karma** yoga as a practical way of attaining peace by disassociating work from egoistic reasons. It is the journey rather than the arrival that matters. The emphasis is on appropriate action with dispassionate involvement.

Karma yoga can be useful for social workers or counsellors. We will not need to become so preoccupied or hindered by anxiety as to whether we are going to resolve someone's grief, or become eager to be seen as helpful, which is heavily related to our egoistic thinking. David Brandon wrote that we should try to do the job like a Zen archer who could fire an arrow with perfection when he was inwardly at peace. He is no longer hindered by the anxiety of whether or not he is going to hit the centre of the target[5].

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continued from p. 28

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CONFERENCE IN 1985

There will be an **International Symposium on Grief and Bereavement** in Jerusalem between 11th and 14th November, 1985. It is organised by the Division of Rehabilitation, Israel Ministry of Defence, and the Israel Rehabilitation Society. Main topics will include: Bereavement (in Childhood, of Parents, after Violence), Cultural Factors in Grief, the Nature of the Mourning Process, Crisis Intervention, Counselling (the Bereaved, Friends of the Bereaved), Training of Counsellors, the Rehabilitation Approach, Religion & Bereavement, the Therapeutic Approach to Prolonged Mourning, Social Rehabilitation of the Widowed, Long-Term Effects, the Impact of Bereavement on Family Dynamics.

The conference is open to health care workers, funeral directors, social workers, socialogists, religious and community leaders. Participants wishing to present a paper should submit an abstract of not more than 200 words to the Secretariat before 1st May, 1985. Their address is: International Symposium on Grief and Bereavement, PO Box 50006, Tel Aviv 61500, Israel.