Parental Bereavement

Preliminary report of an important research project Hospital for Sick Children, Gt. Ormond St., London

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In the UK each year it has been estimated that over 5,000 families experience the sudden and unexpected death of a child between birth and the age of 16 years. Nowadays many of these deaths will occur in the stressful high technology environment of a paediatric intensive care unit (ICU) in which day-to-day decisions have to be made about continuation or withdrawal of life support systems. The families to whom this tragic event occurs are undoubtedly under great stress and the risk of serious psychiatric and psychosomatic morbidity must be considerable. In a recent study involving the parents of 25 children who died in the paediatric intensive care unit at Great Ormond Street, a standardised psychiatric interview was undertaken three months after the death of the child in the parent's home to assess the effect of sudden bereavement on this group. A further set of parents of 25 children who had survived admission to the same unit was used as a control group for comparison.

Both groups found the admission to the Intensive Care Unit extremely stressful. However, the bereaved parents' total level of psychological dysfunction was significantly higher than the controls', and in a substantial proportion there was evidence of serious psychological disturbance and difficulty in coping with day-to-day life following the death. In the control group a small number of parents also experienced serious symptoms themselves; a number of their children were still very unwell, critically ill or handicapped. There were no differences between social classes in these findings.

Mothers whose child was more than one year of age at the time of death had significantly more psychological dysfunction than fathers in the same group. Under the age of one year these differences did not exist. In the control group there were no significant differences between the parents no matter what the age of the child.

There was an indication that those parents who made frequent aoproaches to ICU staff during the child's admission had the most difficulty in accepting and coping with the death of the child when seen at follow-up.

The majority of bereaved fathers found that the most intense period of grief occurred in the first month; half of the mothers were still experiencing the same intensity of grief three months after the death. About one third of parents reported a worsening in the marital relationship since the child's death, although others reported either no change or a closer relationship.

It was concluded that bereaved parents who lose a child suddenly and unexpectedly are particularly vulnerable during the immediate bereavement period. Those expressing the most psychological disturbance, in particular mothers whose child is older than one year at the time of death, appear to be at greatest risk.

There is a great need for appropriate bereavement counselling and support for parents at this time.

OBITUARY

Dr. David Morris

The death of Dr. David Morris has robbed us of one of the most colourful and creative personalities in paediatrics. Children have lost a great friend, advocate and a doctor with an almost magnetic capacity to communicate with them.

David Morris qualified at the Middlesex Hospital, joined the Navy during the war and also worked with the Free French Navy. His love of children was apparent from the outset and he worked with displaced children in a refugee camp in Lubeck. After appointments at the Prince of Wales Hospital and the Queen Elizabeth Hospital, Hackney, he followed Dr. Waller as consultant paediatrician to the British Hospital for Mothers and Babies. He was later appointed to the Brook General Hospital, proudly claiming he was 'with the Woolwich' until his retirement from the Health Service in June, 1980.

David's interests were diverse and in a very real sense his personality and work ethic were finely interwoven. He was paediatric consultant to the National Childbirth Trust, honorary paediatric tutor to Guy's Hospital, vice-chairman of the Institute of Research into Mental and Multiple Handicap; a valued member of the Voluntary Council for Handicapped Children, on the Advisory Council of NAWCH and adviser to the Royal Society for Mentally Handicapped Adults and Children. All reaped the benefit of his expertise, innovative thinking and enthusiasm. David was also delighted to be made president of the Hunterian Society for 1980. He was the prime mover in the seminars for paediatricians held by the late Anna Freud in the '60s.



Dr. David Morris (left) talking to Lord Skelmersdale at the International Conference on Grief and Bereavement in Contemporary Society held in London in July 1988.

In day-to-day clinical work, Dr. Morris was in the forefront of paediatric practice in the broadest sense. 'Tell me what you think is wrong with your child' might initially panic the mother who expected the doctor to give the answers. But parents came to appreciate that consultation with Dr. Morris included the extra dimension

of parents' feelings, relationships and lifestyle.

He was among the first paediatricians to recognise the importance of unrestricted visiting of sick children. Parents and siblings were freely accommodated in his children's ward. The importance of play and its role in helping children act out their fantasies and anxieties led to the appointment of the first play leader, financed by Save The Children Fund. He retained his interest in this aspect of child care throughout his retirement. His sensitive concern for the disabled child was always apparent and later led to his forming the Uphill Ski Club. What sounded to some like a crazy venture enabled very handicapped children to go on skiing holidays and enjoy an exhilarating freedom of movement they did not normally experience.

From the 1950s Dr. Morris recognised the importance of spending time with parents whose child had died. He held a weekly counselling clinic in Woolwich, and parents were supported in an ongoing way. His weekly ward rounds in the maternity unit were a revelation—sharing the tears of mothers who had sick babies that might never be 'normal' and allaying anxieties of those who were experiencing motherhood for the first time. He was a founder member of the Stillbirth Association, and in his latter years deepened still further his work in the bereavement field, for example, running a group for health visitors on bereavement work.

Dr. Morris experienced much grief and tragedy in his own family. He marshalled all his skills and insights in meeting the pain and heartache of these events—and in helping the family to do so. He showed great courage in living with his own illness, supported always by his devoted wife, Netta.

Most colleagues saw Dr. Morris as a larger-than-life, gregarious, exuberant, outgoing personality. He was an excellent chairman and presenter, and had the rare ability to generate discussion at awkward moments in meetings. His chuckles, his fun, and puckish sense of humour were never far away. There were times, perhaps, when he had a tendency to 'play to the gallery'. Most friends saw behind and beyond this to a paediatrician of profound humanity, with great spontaneity and a creative capacity to care in the broadest sense for sick children and their parents.

MARGARET ATKIN

PERSONAL VIEW

To comfort, always

Peter Barnes

Dr. Barnes is a General Practitioner from Enfield, Middlesex.

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The Reithe Spitze is a mountain over 2,300m overlooking Seefeld in the Austrian Tyrol. From its summit there are spectacular views in all directions. Yet for me the most memorable sight is a simple cross on top of the mountain on which is set a verse by Paula Grogger.

> Was wir bergen, in den Särgen,
> ist das Erdenkleit.
> Was wir lieben, ist geblieben
> bleibt in Ewigkeit.

Translation tends to detract from its lyricism but it literally means:

> What we bury in coffins
> are only the earthly remains.
> What we love, is always loved,
> and remains with us for an
> eternity.

When my wife and I read that inscription as we stood on top of the Reithe Spitze last summer it seemed to sum up what had been a long and tragic story. It is not unique, but it may be that in the telling of it, someone, even if it is only us, may find comfort.

In February 1987 our nine year old son died from lymphoblastic leukaemia. He had fought the disease for two and a half years and for much of the first year had been in a steady remission. We were looking forward to the distinct possibility of a cure. But a testicular relapse while still on chemotherapy was a prelude of what was to come. Despite further horrendous doses of chemotherapy and a bone marrow transplant from his older brother, there was to be no further relief for him. He died peacefully at home surrounded by his family. Lear's words come to mind when I look back on the whole saga: 'Poor naked wretches whereso'er you are, that bide the pelting of this pitiless storm'.

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What might seem to be the end of the story was far from it. When a child dies in your practice it is, of course, a tragedy and you are saddened by it. When the child is your own it raises fundamental questions in your mind that bring into doubt all your previously held beliefs. Coming as I do from a long line of doctors there had never been much doubt in my mind about the infallibility of the great medical ethos. Nor were there discomforting thoughts about the existence of an 'afterlife' and 'heaven'. Surely 14 years of general practice in a working class area of north London had convinced me that there was no orchestration of this chaotic symphony of life by someone on high?

At first my son's death only tended to confirm those beliefs. Yet after a while I began to think that my son must have gone to a better place; there must be someone looking after him somewhere. Otherwise, what is the point of it all? To reconcile these feelings with my established, mainly existentialist personal creed, produced great mental anguish.

It made me wonder why I should carry on practising medicine when all it had promised over the years had been blown away like ashes on the wind. What had I done to bring this on him and us? There are as yet no answers to these questions. It may be that eventually there will be purely scientific answers. I doubt if that will be enough, whereas three years ago I am fairly certain it would have been.

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With all this uncertainty in my mind it was hardly surprising that my work began to suffer. 'Why on earth do I have to sit here and listen to this? Don't they know that their problems are non-existent beside those of mine and my family?' It reached the stage where every morning I was physically shaking at the thought of going to work. Not to go would be an admission of defeat. How could I become immune to all these mundane trivia? Should I throw my hand in and do something else? 'Why is it that I, in need of consolation, always seem to end up consoling others? Surely there are others in this practice who can deal with this. Leave me alone.'

It was when I was at my lowest point mentally that two things happened that at the time I did not understand. Two of my patients died, from cancer. The first was an older man, but the second was a little girl. She was three years old and had disseminated bone cancer, despite an initial amputation of her arm.

Although my partners wanted to shield me from the stresses of looking after these patients, I had insisted. I had known both families for many years and the little girl had been in the same oncology unit as my son. We had something in common; perhaps I could be of use. I was with her and her parents when she died. Afterwards they were kind enough to tell me how much they felt it had helped them