THE DYING CHILD AND OVERT PARENTAL BEHAVIOR

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ABSTRACT

In order to study the immediate grief reaction in parents of children dying in the hospital each parental reaction was scored on a 'grief reaction and intervention' (GRI) scale (minimum 0; maximum 4). The death events of 73 children comprised the study. The GRI score was 0 in 10 (13.7%), 1 in 19 (26.1%), 2 in 21 (28.7%), 3 in 15 (20.5%) and 4 in 8 (11%) cases; the mean (±SD) score was 1.89 (±1.20). Crying, weeping spells, hostility, restlessness, denial of death, mutism, impulsivity and destructive behavior were observed. A significantly higher grief reaction was observed among parents of grown up children and those from an urban background. An intense reaction was also seen in cases when the course of illness was acute and death was not anticipated. Parents of male children of the first and second birth order also had higher GRI scores. Our findings suggest that socio-cultural factors may influence the intensity of the parental grief reaction.

Key words: *Dying children, Grief reaction, Death, Socio-cultural factor.*

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Pediatricians often face the difficult and painful task of caring for the dying children in the hospital. The dying child and its immediate environment, particularly the grieved parents are the most sensitive area of medical care that pose challenge to the attending pediatrician. This important aspect of thanatology receives scant attention in the busy and overcrowed hospitals in our country. The art of managing such situations is neither included in the medical curriculum nor has found sufficient attention in our medical literature(1), as compared to extensive information from Western countries(2-5).

In order to study the grief reaction in parents of children dying in the hospital, we studied the intensity of parental behavior and the intervention required by the attending doctor, and attempted to correlate the intensity of behavior with various socio-cultural factors.

Material and Methods

Cases who were believed by the attending physician to be suffering from a terminal illness were selected for the study. Their parents were observed from the time they were aware of their child's condition, till they settled down after the immediate reaction following the death of their children. The information was collected in the pretested proformas and was kept confidential. It included: (*a*) Age, sex, nature of the illness (acute or chronic), birth order of the patient and duration of hospital stay prior to death, and anticipated or unanticipated deaths; (*b*) Parental age, literacy, religion, cultural background (rural or urban) and past history of death in the family. Following the death of the patient, the parents were observed for the nature of the grief reaction and the intervention

required by the attending doctor. An attempt was made to know if the parents blamed anybody for the death.

The Grief Reaction and Intervention (GRI) Scale

The intensity of parental reaction and the intervention required by the attending doctor was subjectively scored for each case using the GRI scale consisting of 0 through 4 scores (*Table I*). To ensure uniformity of observations, the reactions were scored by the same observer. Of the two parents, the one with the higher score was considered because more attention was required to intervene in settling him/her down.

TABLE I–*Grief Reaction and Intervention Scale*

Score	Observation
0	No overt parental reaction, sometimes rather relieved; no intervention required by the attending doctor.
1	Parents accepted the death but with much disbelief and shock; attending doctor had to explain the whole event and help them settle down.
2	Parents reacted intensly, denied the death; attending doctor had to intervene actively (sometimes physically) to console the parents.
3	Parents reacted in shock like state, and/or aggressive behavior, hostile attitude, blaming staff/others, not ready to listen to the surroundings or the doctor. Considerable efforts and time required to intervene.
4	Extremely intense reaction, attempting to physically harm the doctor and paramedical staff, destroy and damage the equipment, inflicting injury over themselves; doctor alone was not able to control the reaction.

The information collected was correlated with various socio-cultural parameters and data were analysed into low scorers (0-2) and high scorers (3-4). Statistical analysis was done by the Chi square test(6).

Results

Of the 73 patients, who died 40 (54.8%) were male and 33 (45.2%) females; 25 (34.2%) were neonates, 23 (31.5%) were 1 to 5 years old and rest (34.2%) were more than 5 years. Majority of the families 62 (84.9%) were Hindus, 6 (8.2%) were Muslims and 5 (6.8%) Christians. Forty five cases (61.6%) were from the rural background. The type of parental reaction at the time of death was recorded (*Table II*). The common reactions included crying, weeping spells, hostility towards self/others, restlessness, denial of death, nervousness, mutism, impulsivity, destructive behavior, crying for sympathy, and breath holding. One parent attempted to harm the doctor with overt intention of homicidal behavior, while 6 parents reacted in a suicidal manner trying to inflict injury on themselves. The GRI score was 0 in 10 (13.7%), 1 in 19 (26%), 2 in 21 (28.8%), 3 in 15 (20.5%), and 4 in 8 (11%) cases with mean (±SD) of 1.89 (±1.20). Twenty two cases had a score greater than 3.

The GRI score among parents was significantly higher in cases of death in children beyond neonatal period (range 2.23 to 2.37, mean 2.31) as compared to neonates (mean 1.96; $p<0.05$). While a higher GRI score was seen among parents of male children (mean 2.20) than females (mean 1.45), the difference was not significant. The grief reaction was also higher for the 1st and 2nd born children (mean 2.40 and 2.42, respectively) than for the subsequent

TABLE II—*Parental Behavior at the Time of Death*

Reaction	No. (n=73)	Percentage (%)
Crying	60	82.2
Weeping spells	56	76.7
Hostility	53	72.6
Restlessness	36	49.3
Denial of death	36	49.3
Nervousness	26	35.6
Mutism	24	32.8
Impulsivity	23	31.5
Destructive behavior involving inanimate objects	19	26.1
Crying for sympathy/ affection	15	20.5
Breath holding	13	17.8
Pulling/plucking hair	12	16.4
Suicidal behavior	6	8.2
Homicidal behavior	1	1.3

ones (range 1.42 to 1.80, mean 1.61). Religion of the family did not show any relationship with the intensity of reaction. Families from the urban background had a higher GRI score (mean 2.17); as compared to those from rural areas (mean 1.80). Father below 25 years (13 cases) scored higher (range 2.36 to 2.50, mean 2.88) than those above 25 years (60 cases) (range 1.46 to 1.88, mean 1.52). This age difference was not seen among the mothers. The maternal GRI score ranged between 1.40 to 2.26 (mean 1.86) while paternal score varied between 1.46 to 2.50 (mean 1.89).

Mothers who were literate (45 cases, matriculate and above) had a higher GRI (range 1.66 to 2.3, mean 2.1) than those mothers who were less literate (28, middle class and below) (range 1.66 to 1.95, mean 1.79); however, the difference was not significant.

The grief reaction was higher amongst parents whose children had a shorter hospital stay (1 to 3 days) (range 2.11 to 2.31, mean 2.21), than those with a longer duration of hospitalization (range 1.40 to 1.90, mean 1.65). In 50 (68.4%) cases where the death was not anticipated by the parents, the score was higher (mean 2.12), as against 23 cases where it was anticipated (mean 1.30). The grief reaction was lower in families with a previous sib death (mean 1.72), as compared to first death (mean 2.09).

The parents blamed themselves for their child's death in 19 (26.1%) cases, the doctor and paramedical workers in 24 (32.9%), and misfortune, bad luck or God's will in 18 (24.6%). In 12 (16.4%) cases nobody was held responsible by the parents. A higher GRI score was observed (range 2.10 to 2.16, mean 2.13) when parents blamed themselves or others while the scores were lower (range 1.44 to 1.05, mean 1.45) when the situation was thought to be beyond human control.

Discussion

The issue of dying child, and care of the grieved parents has not received adequate emphasis. Most physicians lack the necessary experience in dealing with or in understanding the psychology of the parents of a dying child(7). An examination of the literature indicates that physicians have been avoiding the issue and often are not available to such families.

Schwalter(8) found that most medical officers treating a dying child tend to withdraw from their parents. Many house officers felt lonely and unsupported in the face

of dealing with dying children(2). According to Bergman(9), while some physicians are good at dealing with such situations, most often the issue is left to the individual to face it. Although reports from this(1) and other countries(2-5,7-10) are available, the comprehensive aspects of a dying child have not been previously studied in this country.

The parental behavior following death of their children varied form crying and shouting loudly to weeping spells, sobbing and occasionally most aggressive behavior which gradually weaned off with the passage of time. Bergman(9) and Friedman(4) have given similar account of parental grief reaction. Our observations reveal the influence of socio-cultural factors on the intensity of the grief reaction. Death of male child evoked intense reaction which is consistent with the socio-cultural norm of preference for male child in our society(12). The death of grown up children, because of their longer bonding period, and the first and second born children caused a higher grief reaction among the parents. A similar influence of cultural background on the grief reaction has been previously reported(13). Our study indicated a more intense reaction among urban families. Younger fathers and literate mothers scored more, as compared to older fathers and mothers who were less literate.

In unanticipated deaths and deaths after shorter hospital stay, the parents reacted more intensely because of the lack of time factor required to adopt with the crisis. Bergman(9) reports similar observation from parental reaction. Forty four families who had undergone past experience of death had a lower score as compared to the more intense behavior where death occurred for the first time. Influence of such experience in the past has been observed similarly by Eric *et al.*(13). The grief reaction was aggressive when the parents blamed the doctor or other workers for the death. Such reactions of blaming others and removing oneself from the situation has been described by Bergman(9).

Our observations suggest that the parental grief reaction is influenced by the age, sex and the birth order of the child. An intense reaction is expected in urban families and amongst younger and literate parents whose children have a sudden acute illness and unexpected death. These factors can forewarn the attending physician to anticipate intense grief reaction and provide effective intervention.

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