Adult orphans: psychological problems following the loss of a parent in adult life

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It is commonly assumed that the death of a parent in adult life is less traumatic than other kinds of bereavement. Yet 'adult orphans' are the second largest category, almost a quarter, of all those who seek the help of the UK charity, Cruse Bereavement Care (widows are the largest), and make up 29% of those referred to me for treatment of psychiatric problems.

EDITORIAL

Systematic inquiry into the topic of bereavement began in 1913, when Freud postulated a relationship between grief and severe depression and speculated on the meaning and significance of this association for the survivor. In 1932, Eliot, an American sociologist, called for a general socialpsychology of bereavement. It was his belief that through the active collaboration of a network of concerned scholars a body of knowledge concerning the phenomenon of loss could be developed that would be of significant clinical value. Except for his own students his plea went unheeded.

Research into bereavement continued to be intermittent throughout the next two decades, although there were classic studies by Freud and Burlingham on separation, and by Lindermann on acute grief. It was not until the 1960s that bereavement research intensified. The focus, however, was primarily on the widow or widower. It is only recently that attention has been directed toward parental death in adult life, even though this is the most frequent form of bereavement today.

The three studies reported in this issue of *Bereavement Care* address a peculiarly modern form of bereavement. In doing so they not only help fill a serious void in the literature on grief, but they also move us that much closer to the goal set for us by Eliot more than 60 years ago.

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THE NEED FOR RESEARCH

Most of the research into the psychological effects of bereavement has focused on the effects of the death of spouses or children or the effects, during childhood, of the death of a parent. Little has been written about the death of a parent in adult life despite the fact that this is the commonest kind of bereavement. Exceptions are a recent book by Abrams[1], *When Parents Die*, which gives a clear account of the problems which arise in young adults who have lost a parent and a more general book by Marshall[2], *Losing a Parent*. Both of these are directed at people bereaved in these ways, as is the short pamphlet by Morcom, *After the Death of a Parent*[3].

In 1963, when I studied the frequency with which parent bereavements preceded the onset of the illnesses of psychiatric patients referred to the Bethlem Royal and Maudsley Hospitals in London, I found this to be no greater than would have been expected by chance alone. It may be that times have changed since 1963, but there is another possible explanation of this statistical finding. It may be that the death of a parent can be a maturing experience for some people, allowing them, at last, to grow up. In these circumstances the death of a parent may be associated with an improvement in overall mental health, rather than a deterioration. If the number whose health improves balances the number whose health deteriorates, no overall change in psychiatric morbidity would be expected.

EDITOR'S NOTE

Grief, we have come to learn, is neither a unitary concept nor an unvarying experience. On the contrary, the perspective on grief that is emerging from the literature is that of a highly complex, multi-dimensional phenomenon that varies widely according to social as well as psychological attributes.

In this study, Colin Murray Parkes underscores the important role that these factors play in the determination of a particular grief response. While it has been observed elsewhere in the literature that social processes, such as the changed nature of the nuclear family, the diminishment of the elderly's role in contemporary society and the institutionalisation of the dying, serve to influence both the meaning and the character of the bereavement experiences, Dr Parkes' research compels us to consider still other factors. He demonstrates that the individual's life course and the nature of his or her marital bonds, as well as interpersonal relationships (besides those that pertain to the deceased), play a crucial role in the outcome of bereavement.

While Dr Parkes's sample of bereaved, psychiatric patients is relatively small, possibly self-selected and weighted heavily toward the bereaved woman, his study is, nevertheless, a significant step forward in our understanding of the grief experience. It invites careful analysis and offers intriguing new pathways for further research into this profound human experience.

Be that as it may, there is no doubt in my mind that the death of a parent was a major influence in the psychiatric problems of the people referred to me, 27 of whom have been studied for the purpose of this paper. They may not be typical of those who seek help from bereavement counsellors but I suspect that they are not much different.

The majority, 22 (81%), were women and only five men. In this they resemble most other types of bereavement leading to referral to my psychiatric clinic, in all of which women outnumber men. I see many more widows than widowers and bereaved mothers than bereaved fathers.

FINDINGS OF THE STUDY

How do parent-bereaved differ from other bereaved psychiatric patients? It will be clear from the table that the parent-bereaved were younger than other bereaved psychiatric patients, with a mean age of 37 years. This implies that many parental deaths took place when the parents were under 65 and were, therefore, untimely.

The most striking distinguishing feature of the members of this group was their lack of a satisfactory relationship with a partner. Almost a third (30%) had never married (compared with those bereaved in other ways who had all been married) and of the other 70%, there was only one who did not report marital conflicts (compared with 23% with marital conflicts among the rest).

In addition to lacking the support of a partner, no less than 70% said that they lacked confidence in themselves (compared with 36% of the rest). It is this combination which makes it so important for this group to have a parent to rely on and explains their distress when that parent dies.

Another feature distinguishing parent-bereaved from the rest was the existence of a dependent relationship with the deceased parent in 45% (and 11% of the others).

In the light of these findings it is not surprising to find that 45% of the parent-bereaved were complaining of panic attacks (compared with only 20% of the rest).

For some time now I have been interested in the way in which the relationships with parents in childhood influence the reaction to bereavement in adult life and this is nowhere more obvious than when it is a parent who has died. Parent–bereaved patients were more likely than the rest to report that their mothers were nervous or over-anxious (40% *v* 14%), and 40% said that instead of being able to depend on their mother, it had been their mother who had been dependent on them, an inversion of the normal mother–child relationship which places an enormous burden on the child (this had been a problem in only 11% of the rest). A common reason for this dependency was conflict between the parents who were not, therefore, available to support each other (measured in various ways).

We might have thought that the effect of having mothers who were dependent on them would be to teach children to rely on themselves, but in fact this was not the case. Far from increasing self-confidence, this parenting undermined the children's trust in themselves (two-thirds said they had lacked self-confidence as a child, compared with one- third of the rest) and paradoxically it had increased their tendency to cling to their parents (45% *v* 7 %).

This tendency to cling to anxious parents is a reflection of what Ainsworth terms an 'insecure attachment'[4]. Contrary to popular belief, an extremely close relationship between parent and child is more likely to reflect insecure attachment rather than to be a sign of secure love.

Because they constitute a special minority group, I shall leave further discussion of the men who lost a parent to the end of this article

COMPARISON OF PARENT-BEREAVED WITH OTHER-BEREAVED

	Parent	Other
Mean age	37	48
Never married	30%	0%
Marital conflicts	96%	23%
Lacks confidence in self	70%	36%
Dependent on dead parent	45%	11%
Panic attacks	24%	20%
Mother nervous or over-anxious	40%	14%
Mother dependent on child	40%	11%
Clung to parent as a child	45%	7%

PARENT-BEREAVED WOMEN

Seven of these (32%) had lost a father, 11 of these (50%) a mother, while four women (18%) had lost both parents

Loss of Mother

These patients were distinguished by:

- All being locked into close and anxious attachments to their mothers who were themselves insecure. Several of the patients had been seriously ill as children and this had increased the intensity of their relationships with their mothers.
- Fathers who were reported to have been absent, inadequate, rejecting or rejected by the patient who had taken sides with mother in marital conflicts. Hence, the women all grew up distrusting men.
- Their own marriages, which were spoilt by distrust, by their intolerance of closeness (in two cases) or by the patients' tendency to cling to their partners (which got worse after bereavement).

Betty was 48 years of age when she was referred to me after her mother had died suddenly of a stroke. She had been told that the stroke had been caused by 'stress' and thought that this must have been her fault. She felt guilty, anxious, lonely and insecure, slept badly and lost weight. She was clinging to daughter, Anna (21), who remained at home.

She described her father as an alcoholic. Mother had been over-anxious and over-protective. Betty, an unhappy child, never did well at school. She was married at 22 to a soldier who subsequently left the army to become a gardener but never settled to civilian life. He was dominant, strict and violent to patient and daughter. Two years before her mother's death Betty had divorced her husband after he deserted her. She said that she had missed him but had been well supported by her mother.

While telling me the history of her problems, Betty was clearly taking stock of her life. She found this very therapeutic and did very well with only three interviews. By the last visit she was clearly coming to terms with her losses. She was

going out more and had found a new role in caring for her grandchildren. She was aware of the danger of her relying too much on her daughter and was determined to make this a reciprocal relationship.

Two cases which did not fit the above type were women who were highly ambivalent towards their mothers who, they said, had interfered with their lives. This led to conflicted grief in which mixed feelings of anger and guilt complicated the course of mourning. All did well in therapy.

Loss of Father

These patients were distinguished by:-

- Having a close tie to their fathers – several described themselves as 'Daddy's girl' or a special 'baby'. Although highly prized, they had also been seen as fragile or delicate, the 'Dresden vase'.
- All having had an impaired relationship with their mother. Thus one mother had been preoccupied with a handicapped sibling and another had been unable to show affection.
- Either being distrustful of their partners or having an absent partner.
- Describing their fathers as alcohol abusers, in three cases, despite the closeness of their ties to them.
- Having grown up with little self-confidence.

Sheila (32) was referred for the treatment of anxiety, depression, tension and panic attacks which had come on since her father had died suddenly of a coronary thrombosis at the age of 75, 14 months previously.

Father was a retired chemical worker, a jolly, supportive man but with a fear of thunder since being blown up in WWII. At that time he had received psychiatric treatment. Mother was described as a quick-tempered agoraphobic to whom the patient clung. The youngest of four children, Sheila was always underweight and seen as 'delicate' since suffering from scarlet fever at the age of seven, an insecure, anxious child with few friends. Things improved after she left school and became a barmaid. At 24 she married Derek, a telephone engineer who was inclined to be jealous and to drink too much but who had stopped drinking five years before. They had two children. Dick (nine) had congenital dislocation of hip from birth and was always in trouble and Barry (six) had a speech defect.

Recently Derek's drinking had got worse again and this had aggravated Sheila's anxiety. It was obviously important, in this case, to see the couple together and to give Derek a chance to share his own feelings about the situation. He admitted that he had always felt that Sheila put her father before him and he resented this. He listened carefully to Sheila's account of her childhood and showed himself much more understanding than she had expected. He again stopped drinking and at subsequent visits their relationship had improved a great deal and Sheila was symptom-free.

Loss of Both Parents

The circumstances of the women in this category resembled the patterns described above, one bereavement being the main cause of the problem and the lesser bereavement simply adding to the stress.

PARENT-BEREAVED MEN

Among the five men whose psychiatric problems had come on after the death of a parent, two had lost a mother, one a father, and three had lost both parents.

None was married and only one was in a lasting relationship. Four out of five were only sons and three out of five, only children.

The three men who had lost both parents all felt a failure. Two of them had been under pressure to succeed where their parents had failed.

The only two men who became depressed after the death of a mother had both been brain damaged, one from birth and the other as a result of encephalitis. This had caused them to become unusually dependent on their mothers. In other respects they resembled the mother-bereaved women.

The only man who sought help after his father's death was the only child of an alcoholic father. The son had himself taken to the bottle after his father died.

Edward (44) had suffered from palpitations, loss of confidence and difficulty in coping for many years but this had become much worse since both his parents had died. His father had died suddenly of heart disease six months before, and mother followed four months later. Edward was the only son and eldest of three children of Jewish parents. His father, a tailor, had been a nervous, insecure worrier, dependent on his spouse and over-protective of Edward. During his childhood his mother had suffered from clinical depression for which she received in-patient treatment. Both parents put pressure on the patient to succeed but he lacked confidence at school and grew up a shy boy who never went out with girls. After working as a printer from 16 to 31, he was made redundant since when he had worked as a salesman in a department store where he had never received the recognition and promotion he felt he deserved. At 33 he became engaged but was too indecisive to set a date for the wedding and eventually his girlfriend gave up and married someone else.

Edward always remained at home with his parents, caring for his mother when she became sick. He was not upset by the death of his elderly father and held himself together for the sake of his mother who died peacefully. Since then he had been very lonely and anxious. He moved to his sister's house where he slept on the sofa, but she was clearly not keen for this to continue.

Seen in the clinic Edward appeared pessimistic and mildly depressed. His main complaint of 'palpitations' is one which often responds well to drugs which block nervous impulses to the heart. This, plus relaxation exercises and reassurance, produced a rapid improvement and he soon returned to part-time work. This went better than expected, his confidence improved and, when last seen, he was much improved and 'trying to think positive'. He was planning a trip to China!

CONCLUSION

It seems from this study that having a supportive marriage is the best way of ensuring that someone will not develop psychiatric problems after the death of a parent. Being male also helps and the only men at risk in this study were unmarried only children with a persisting dependent relationship with a parent with whom they lived. Even they only sought psychiatric help if both parents died or if they were brain damaged.

Women are at risk if they lack self-confidence and are locked into an insecure, dependent or ambivalent relationship with a parent who then dies.

To help them it is necessary to give them the security that they need if they are to talk about and explore the world which they are now entering. They need reassurance of the normality of grieving, explanation of the physical symptoms associated with anxiety and panic, and reassurance of their own worth and strength. Given this they will soon improve but will easily develop a dependent attachment to their counsellor. The emphasis during the later stages of counselling must be on establishing autonomy by task setting and positive feed-back. Nothing succeeds like success.

References

1. Abrams R. When Parents Die. London, UK: Letts, 1994.
2. Marshall F. Losing a Parent. London, UK: Sheldon Press,1993.
3. Morcom C. A fter the Death of a Parent. Richmond, UK: Cruse Bereavement Care, 1994.
4. Ainsworth MDS, Blehar MC, Waters E, Wall S. Patterns of Attachment: A Psychological Study of the Strange Situation. Hillsdale, NJ: Erlbaum, 1978.