When Cancer Struck a Grief-Stricken Father

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Received Date: March 14, 2016, Accepted Date: June 02, 2017, Published Date: June 09, 2017.

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Abstract

The aim of this discourse is to present the story of our patient, an 85-year-old divorced Israeli male with no surviving children or significant others, who suffered from pancreatic cancer for more than a year and a half until committing suicide at the gravesite of his son who died in battle from friendly fire. Pancreatic cancer is one of the cancers most associated with suicide, especially within the first year after diagnosis. Parents who lose children, particularly if their deaths are violent, experience higher levels of anxiety, somatic symptoms, and difficulty coping with life’s vicissitudes. Our patient lived the last 25 years of his life completely in the shadow of his son’s death. His grief and emotional posthumous attachment to his son remained the only significant focal point in his life. The complex interaction between our patient's tragic life circumstances, his terminal illness, and patterns of healthcare utilization are analyzed through the prism of the relevant literature and in the context of Israeli society.

Keywords: Pancreatic Cancer; Friendly Fire; Complicated Grief; Healthcare Utilization; Suicide

Introduction

The aim of this study is to present and analyze the case report of a patient with advanced pancreatic cancer; simultaneously challenged by a confluence of additional stressors, each one sufficient to threaten well-being and quality of life. In order to form a framework for understanding his particular lived experience, which will be detailed in the case report, the nature of these stressors and the disease state will first be addressed from a general perspective.

Old Age

Old age is a stressor which by nature faces all those who live long enough, to greater or lesser degrees. It is accompanied by physiological changes, such as decreased mobility, which impinge upon function on a day-by-day basis. Old age, moreover, brings in its wake multiple losses: of loved ones, job security, social status, function, and health. Illness among the elderly is associated with more physical and psychological symptomatology and reduction in quality of life [1].

On an existential level, aging crystallizes the intimidating realization that life is nearing its end. This brings the elderly individual to take stock of the degree to which life was fulfilling and the degree to which he/she facilitated this fulfillment. Accepting as given the inherently imperfect state of life eases this endeavor of assessment, which Erik Erikson delineated as the crisis of “ego integrity versus despair” [2]. Individuals who are not in harmony with their past are, according to Erikson, et al. more vulnerable to the ravages of old age, especially those of an emotional nature [3,4].

The Loss of a Child

Unlike the “natural” losses of old age, the loss of a child at any age is against nature; children are meant to bury parents and not vice versa. The death of a child, as opposed to other loved ones, appears to be the most difficult to accept [5,6]. Parents lose their “assumptive” world [7], and the stability, predictability, and coherence of life break down [8]. Research findings point to the long-term effects of bereavement on parents’ physical, mental, and social well-being even many years after the death occurred [9,10].

Some studies have found higher rates of divorce [11,12] and an increased rate and severity of depression, especially among male parents, who report little purpose in life after the death of their child [6]. Many parents continue to maintain a relationship with their deceased child, and grieve throughout their lives; this phenomenon in and of itself is not considered pathological [13,14].

For most bereaved parents, it makes less sense to speak about closure or resolution with respect to their loss, but rather of reconstitution, that is, reassembling their identities to incorporate a fractured reality and to continue to find meaning in life in the context of their significant others [8,13,15,16]. Research, however, points to lower levels of meaning and purpose in life among bereaved as compared to non-bereaved parents [6].

Although this may not be obvious to the outside world, the process of grief is not linear in nature; additional life stressors, if and when they occur, tend to make coping with the bereavement more difficult [17].

Loss of a Child in Traumatic Circumstances

The sudden and traumatic death of a child adds additional dimensions to the stress of the loss. When death is unexpected and traumatic, such as death on the battlefield, there is no time for preparation. The torment of knowing the child met a violent death is in itself unbearably painful. In addition, there is potential for guilt feelings with respect to the possible prevention of the tragedy. Parents losing children under these circumstances may face a double burden: the loss and the trauma surrounding the loss [18]. Although there may be some overlapping risks between the two phenomena, they each have their own set of risk factors. The traumatic aspect of the event places the parent at risk for anxiety, thought disruption, intruding thoughts, illusions, detachment, and amnesia. The loss itself makes parents vulnerable to depression, social withdrawal, illness, guilt, loneliness, longing, and preoccupation with the deceased [19]. Finding a personally satisfying way in which to honor the memory of the child can contribute to purpose in life, thus making it easier to cope.

Parents memorialize their children in their inner world of thought. They may also choose to commemorate their child through a private philanthropic endeavor meaningful to them. If a child dies in defense of his/her country, memorialization is often shared with the public. In situations, where the bereaved parent approves of the
Advanced Pancreatic Cancer

Pancreatic cancer is a life-threatening and often painful disease. Although not one of the most common cancers in Israel, with an incidence of 600 new patients per year and a ranking of 12th to 15th in incidence of malignancies, it is the third in cause of death with a survival rate of about 5% [22,23]. These statistics are similar to those of other developed countries [24].

The high mortality rate of the disease is a function of the late stage of illness at which diagnosis is usually made. Although depression twice as prevalent in cancer patients as in the population at large [25], patients with pancreatic cancer were found to have the highest incidence of depression among those suffering all malignancies of the digestive tract [26]. The significance of depression is manifested in its negative impact on seeking out timely and appropriate health care and adhering to a regimen for optimal quality of life [25]. It also appears to impinge on the ability to use and enjoy social support which is associated with better physical and mental functioning and higher survival rates [27].

It is remarkable that research, although not conclusive, points to the possibility of depression as a precursor to pancreatic disease, perhaps through physiological mechanisms. As pancreatic cancer is a slow-growing malignancy, there may however be confounding factors. Possible early physiological changes due to the cancer may be the cause rather than the effect of the depression [28,29].

Suicide

Elderly individuals, especially males over 65, have higher rates of suicide than the rest of the population [30,31]. It is more complex to detect intention to commit suicide in elderly individuals as a preoccupation with death is considered natural at this stage in life. With respect to behaviorally inhibited individuals who tend not to share their emotional stress, detection is yet more difficult. It is also important to pay attention to indirect self-destructive behavior (ISDB), such as poor adherence or utilization of health care, as they can be precursors of suicide. Paradoxically, these behaviors may give a sense of control to an individual who otherwise perceives no other avenues for control in his or her life.

In Israel, the suicide rate generally is lower than in most countries. Israel ranks 109 out of 172 nations [32], probably as a result of cultural, historical, and religious influences on reverence for life. Nevertheless, as in other countries, the rate of suicide among the elderly in Israel is on the rise [31]. Depression is a most critical factor in suicide attempts as are feelings of hopelessness and hopelessness, which is not, as popularly perceived, a normal concomitant of aging [33].

Suicide is more prevalent in seriously ill individuals, especially within the first year of diagnosis [34]. Research undertaken in the United States revealed suicide rates among patients aged 65–74 with pancreatic cancer to be 134.4 per 10,000 person-years as compared to the general population with 12.5 per 100,000. Males had higher rates than females; men with pancreatic cancer were 11 times more likely to commit suicide than the population of their age bracket [33] [34].

Bereaved persons who experience extreme emotional loneliness and severe depressive symptoms are at risk for suicidal ideations. Those who have experienced traumatic grief are also at risk [35,36].

Case Presentation

Background

We presented the case of our patient, an 85-year-old divorced Israeli male with no surviving children or significant others, who suffered from pancreatic cancer for more than a year and a half until committing suicide at his son's gravesite. Tragically, his only son was killed during the Israeli-Lebanese War (1992) at the age of 24 by "friendly fire" in the midst of combat. Our oncology staff treated him as an out-patient in the daycare hospital where he received chemotherapy. Aside from these daycare visits and four very brief hospitalizations in non-oncology units, the patient's pattern of healthcare utilization was characterized by numerous admissions to the emergency room (ER), which is not set up for long-term holistic care. If the psycho-social components of his health status had been addressed earlier in the course of his illness trajectory, it is possible that the patient might have experienced better quality of life and perhaps the suicide would have been prevented.

Before presenting the details of our patient's medical history over the year and a half of his illness, we will relate what was revealed to us “after the fact,” which, in hindsight, sheds light on his health behavior. Perhaps if more had been known about his personal life it would have facilitated more sensitive care for our patient.

Acquaintances told us that our patient lived the last 25 years of his life completely in the shadow of his son's death. In his hometown for many years, he planted a garden in memory of his son, spending many hours tending it and telling passersby about the development of a larger and richer garden were denied. Another great disappointment for our patient was his failure to acquire funding from the Israeli Defense Ministry for the national military cemetery on Mount Herzl in Jerusalem. Often, when his mood was especially gloomy, he was known to spend the night at the gravesite, waking up energized.

History of the Illness

The first few visits our patient made to ER were prior to diagnosis of cancer; he complained of diffuse abdominal pain and fatigue. There were no remarkable findings on physical examination and in lab work, and the patient was released. Not long after, however, he visited the local chapter of his Home Health Maintenance Organization (HMO) in his hometown for many years, he planted a garden in memory of his son, spending many hours tending it and telling passersby about the development of a larger and richer garden were denied. Another great disappointment for our patient was his failure to acquire funding from the Israeli Defense Ministry for the national military cemetery on Mount Herzl in Jerusalem. Often, when his mood was especially gloomy, he was known to spend the night at the gravesite, waking up energized.

Prior to the CT scan, the patient presented to the ER with anxiety and abdominal pain. Physical examination revealed tenderness in the abdomen, which was otherwise unremarkable. Lab work, which included glucose and liver function tests, were within normal limits.

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Our patient made frequent visits to his son's grave located in the national military cemetery on Mount Herzl in Jerusalem. Often, when his mood was especially gloomy, he was known to spend the night at the gravesite, waking up energized.

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Our patient was released pending results of the CT scan which showed a 46 millimeter space occupying lesion under head of the pancreas. Within a number of days the patient again returned to the ER, despite having a scheduled oncological consult for that very day. This time, a more painstaking history in the ER revealed not only the significant weight loss but profound lack of appetite. The oncologist with whom our patient consulted later that day made a definitive diagnosis of pancreatic cancer.

Three weeks later the patient was admitted to the surgical unit for evaluation of his candidacy for a Whipple procedure. Another CT was performed; lesions were found in a lung, the largest of which was 4 mm and a subsequent CT-PET scan could not characterize their nature. An endoscopic ultrasound, however, revealed a growth of 3.5 cm with several satellite growths at the head of the pancreas, as well as tumorous material in the duodenum and the portal venous confluence. It was decided that the patient was not a candidate for surgery and he was released; a course of out-patient chemotherapy was scheduled.

Only three days after the decision not to operate, the patient returned to the ER complaining of diarrhea and generalized weakness. Again, no remarkable findings were revealed on physical exam or lab work. He was treated intravenously for possible dehydration and upon release, was encouraged to push fluids.

In the midst of the administration of chemotherapy in the oncology day hospital a week and a half later, the patient complained of weakness and headaches and was sent to the ER for evaluation where he quickly recovered. For several months, on an average of once a week, he visited the ER with complaints of pain, weakness, constipation, and/or diarrhea with no new significant objective findings. Establishing a pattern, shortly after arrival at the ER, the patient consistently reported relief of his symptoms.

Over the period of a year, however, there was a gradual but consistent and significant decline in functional ability. The medical staff in the ER recommended that he enter a skilled nursing facility since he lived alone and had been unsuccessful in finding an adequate fulltime caregiver to his satisfaction.

The patient nevertheless decided to remain at home, repeatedly returning to the ER with complaints of digestive discomfort and fatigue, and on most occasions recovered quickly. He continued with chemotherapy intermittently but did not adhere to the prescribed protocol. After an additional few months, on an average weekly one visit to the ER, the first social work consult was ordered. The social worker related that the patient reported spending nights in his car, which was strange as he had a home and lived in a supportive community. At this point, he requested additional assistance at home. He shared with the social worker his ongoing 25-year battle with the Ministry of Defense for additional compensation due to the place where he took his life.

This time he was hospitalized for three days in the internal medicine department. Again, our patient felt relatively comfortable during the hospitalization. He finally opened up with respect to the emotional turmoil he was enduring regarding his son, speaking freely, even obsessively, about him as well as about the earlier death of his brother in combat. He felt that his emotional state had been aggravated by the cancer and that the oxazepam10 mg which had been prescribed to him in the HMO clinic did not relieve the depression, but just made him drowsy. A psychiatric consult was finally ordered and a diagnosis of Adjustment Disorder with Depressed Mood was made. He was prescribed mirtazapine 7.5 mg, with an option of raising the dose.

Clearly, at this point, the patient was physically compromised but was still ambivalent regarding institutionalization. It was suspected that he was non-adherent to his prescribed medications, including those for pain and digestive discomfort. He discharged himself from the hospital and decided he would remain at home. There were several additional short hospitalizations in internal medicine and geriatrics, several interspersed visits to the ER, and a visit to the pain clinic in the oncological unit.

At this point, due to further deterioration in his condition, patient expressed willingness to consider hospice care. Unfortunately, the next thing our staff in oncology heard was that he had committed suicide at the gravesite of his son. Ironically, the same site where he used to visit many times past 25 years to draw strength, was the place where he took his life.

**Grieving for a Son Who Fell on the Battlefield through the Israeli Prism**

Appreciation of the Israeli experience of parental grief for fallen soldiers and its incorporation into the analysis of this case report necessitates understanding its historical and cultural dimensions. In Israel’s short 69 years of existence as a nation, a disproportionate number of approximately 19,000 soldiers were killed in the 1948 War of Independence and the numerous wars [37]. There is a strong national tradition in Israel of saluting not only the fallen soldiers but also their parents. The latter is related both to inculcating in their children the need to make sacrifices for their country and to the ultimate sacrifice they themselves have made. They are honorably referred to as “family of the bereaved”. There was, and still is to a certain extent, an expectation that bereaved parents appear stoic, minimize mourning at least publicly, and ostensibly return to their normal routine except on designated memorial days [38].

In 1947, during battles that led up to the War of Independence, famous Israeli poet Natan Alterman wrote that the men and woman who fell in battle for Israel “...are the silver tray upon which the country is handed to you [its people]” [39]. Parents are thus meant to mix their grief with pride and purpose. Organizations such as Yad/Cbenim (Memorial for the Children) were established to assist parents in commemorating their fallen and to lend them emotional support.

The climate in Israel regarding sacrificing children in war has been changed over years and there has been more and more criticism, and even protest, against the endless spillage of blood, with opinions being expressed regarding alternative, more peaceful, ways to preserve security. In the case of our patient, there is additional tragic element of a fallen soldier being killed by "friendly fire" and the nagging question: could the death have been avoided? As parents find strength in knowing that their child’s death was existentially meaningful, these are critical issues [20,40,41].

Several qualitative studies have been carried out in Israel in which parents of fallen soldiers have recurrently related that their grief never dissipates and maintained that only those who themselves have similar experiences could fathom the depths of the grief [37,42,43]. There were parents who revealed that they refrained from sharing their grief even with other bereaved parents.
of fallen soldiers, preferring to keep their pain to themselves. A study of elderly parents revealed that grief does not diminish over the years; on the contrary, frailty of old age arouses, in addition, the fear of their impending inability to commemorate the child due to disability or death. This fear is more intense than the fear of death itself. The latter is relevant to our patient in light of his age and advanced illness state. Elderly men tend to report more intense distress than women [20,44].

Analysis of the Case and Critical Points for Intervention

Inadequate Utilization of Healthcare Facilities: the Patient and the System

Our patient was both “alone” and a “loner.” Alone: beside from his son, to whom he related as part of his real life, he had no significant others. He and his wife divorced at some point after the tragedy, he had no other children, and an only sibling who had also been killed in battle. A “loner”: he had difficulty getting along with a caregiver in his home, and, although willing to entertain the idea of institutional care when the need was overriding, he never actually moved into a sheltered facility or hospice. He stayed at home near his memorial garden way beyond the point at which he could care for himself. There were also inexplicable, peculiar behaviors such as spending the night in his car, perhaps to avoid visitors. He lived in a supportive community where it is the cultural norm to reach out to those in needs, physically and emotionally, and he certainly could have availed himself of its assistance. It is remarkable that the fear of their impending inability to commemorate the child did not lead our patient to seek out care, especially by the nursing staff, to reach out to the patient via telephone and home visits. This can only be conjectured.

Nevertheless, with respect to his care, he neither accept support from others, nor care for himself. It appears, for example, that our patient did not visit his HMO for routine care, as a 12 kilogram weight loss was discovered by his primary health provider without a record of prior weight loss during the course of the year. Patient was sporadic in adherence to the prescribed course of chemotherapy, and given his frequent visits to the ER, he in all likelihood did not take medication for symptomatic relief. Serious analysis of the underlying causes for this behavior are precluded through lack of enough patient data, although the phenomenon may be partially explainable as a product of low self-esteem and perhaps even guilt with respect to his son’s death. If so, the patient might have benefited from cognitive behavioral therapy [45]. Nothing in the record was found regarding any behavioral intervention.

Aggravation of symptoms due to poor adherence brought our patient to the ER for episodic relief of symptoms when they became out of control. The ER is not equipped for the complex, long, or even interim needs of patients, especially the elderly, with advanced disease and at the end of life [46,47]. Its repeated usage precluded the possibility of tending to the totality of patient’s needs. In our patient’s case, who clearly was crying out for help, there were also inexplicable, peculiar behaviors such as spending the night in his car, perhaps to avoid visitors. He lived in a supportive community where it is the cultural norm to reach out to those in needs, physically and emotionally, and he certainly could have availed himself of its assistance. It is remarkable that the fear of their impending inability to commemorate the child did not lead our patient to seek out care, especially by the nursing staff, to reach out to the patient via telephone and home visits. This can only be conjectured.

Addressing the Grief as Part of the Care and Caring Process

It is of great import that when the patient finally reached out emotionally to his health care providers, he spoke about the cancer as making his grief more difficult to bear rather than vice versa. The grief was clearly more painful of the two. This is understandable in light of the patient’s posthumous attachment to his son who remained the only significant anchor in his life. When illness precluded our patient from engaging in activities related to memorializing his son, depression took over and life became devoid of purpose. It is remarkable that the dimension of the patient’s bereavement and grief was addressed only to a small extent by the health professionals and certainly disproportionate to its import for the patient’s well-being. The opportunity for life review might have given the patient the opportunity to take solace in the significance of the garden he tended in his son’s memory and the efforts he invested in extending funding. This might have bolstered self-esteem and perhaps empowered the patient to embrace remaining days of life sharing his memories with others, acknowledging what he had achieved, and perhaps even reconciling his anger against the establishment [48,49].

Addressing the Suicide

The risk factors for suicide were actually present at the duration of patient’s illness, yet there is nothing in his record to indicate concern regarding suicide or risk assessment. Both diagnosis and treatment of depression and anxiety, which are in and of themselves risk factors for suicide in addition to being detrimental for quality of life, were made late in the course of care. Granted, most of his treatment took place in the ER, which is often crowded, fast paced, and not “user friendly” to the elderly in general, especially those with complex psycho-social needs. Research in fact indicates that the ER is often not equipped for treating elderly; little attention is generally paid to behavior patterns such as adherence, emotional issues, and depression [50–52]. It is possible that the primary care providers at HMO would have dealt with these issues much earlier and better in the illness progression, but the patient did not make much use of their services. Perhaps not enough effort was invested, especially by the nursing staff, to reach out to the patient via telephone and home visits. This can only be conjectured.

Conclusion

The venue of our patient’s suicide was perhaps both a subjective expression of his failure to do more for his son’s memory, and a final act of unification himself, although in an “unearthly” existence. From our perspective, it may be difficult to accept the logic or morality of his act, but in his eyes, since his illness prevented him from being able to continue to commemorate his son—a burden too great for him to bear—the next best thing he could do for his son, as he perceived it, was simply to be with him once more.

There is no way of knowing whether the suicide was preventable. What is clear, is that the patient experienced poor quality of life. Perhaps treatment in an oncology unit rather than a geriatric or internal medicine unit would have facilitated better and self-care. Health providers in the oncology unit have a more holistic orientation and are generally psycho-socially sensitive. The complexity of the case—the patient’s advanced illness, non-constructive health behavior, traumatic bereavement and complicated grief, an inadequate support system (although partially by choice), as well as lacunae with respect to the patient’s past history—presented a difficult challenge for health providers. A number of interventions that might have improved the patient’s well-being and may even have convinced the patient to choose life have been presented.

Although health providers need to maintain humility with respect to their limitations in achieving care and cure, it is nevertheless an obligatory goal to maintain faith in themselves as caregivers and leave no stone unturned in their efforts on behalf of all patients regardless of circumstances.
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Received Date: March 14, 2016, Accepted Date: June 02, 2017, Published Date: June 09, 2017.

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