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Editors - Professor Frank Oberklaid, FRACP and Michele Meehan, RN, MCHN. Sponsored by Wyeth - Partners in Infant Nutrition.

Bereavement - the sudden death of a child.

The sudden death of a child is probably the most devastating event for any family. The way a family copes with the death depends on many variables, including the care given by health professionals.

Early Contact ◆

As a community health nurse you may have had close contact with the family prior to the child's death and are in a good position to provide support. In most cases the family will be numbed by what has happened and will not ask for help in the time immediately after the death. You may need to anticipate the family's needs. Making contact with the family in the first days after the death, either on the phone or in person, will help to ascertain their needs.

Providing Information ◆

The health professional can provide the family with information about funerals and procedures relating to a sudden death.

Extended family and close friends supporting the family may not be aware of the practicalities that need addressing or the services available.

There are a number of organisations that provide financial support and assistance with funeral and other associated costs. Regional hospitals or bereavement support organisations can provide information on local resources and services.

Funeral Arrangements ◆

Many young families have had little involvement with arranging funerals and may need information regarding the many options available. Contact should be made with more than one funeral agency. This allows a comparison of services and ensures the specific needs of the family are met.

The parents of the dead child should be encouraged to make the arrangements themselves, rather than well meaning relatives or friends taking on the task. The funeral is an important part of grieving and its planning should not be rushed. It should be a special and memorable occasion to farewell the child.

Culture and Grief ◆

People grieve differently and at different times. Cultural beliefs may influence the way a person grieves. However it is important not to assume the family from a specific cultural group will want to follow the traditional customs of that group.

Involving Children ◆

Children of all ages are affected by the death of family members or close friends, and need to be included in the family group at this very important time. Infants are also capable of reacting to a death in the family even though they do not understand what has happened (Schonfeld, 1993). A young child may react to the death by altered feeding patterns or other behavioural changes. The language used when explaining the death to children needs to be honest and age appropriate. The use of euphemisms such as "went to sleep and didn't wake up", "passed away" or "God needed another angel" should be avoided. Instead, use clearer phrases such as "the child is dead and will not be coming back." As long as children are told what to expect of the rituals surrounding death, such as viewing the body and attending the funeral, they will probably cope well. They should be involved with the rest of the family and told that it is all right to cry and feel sad, that these are normal feelings.

In order to protect surviving children from the family's grief parents may wish to send children away to stay with friends or relatives. Sometimes the parents feel they do not have the energy to cope with the demands of their surviving children. This in turn can lead to children feeling excluded and neglected. The parents need support at this time to enable them to keep the children at home. It is important to maintain normal routines as much as possible.

The Long Term Effects ◆

Weeks, months or even years after the death of a child, family members may require acknowledgment of the child's death by the health professionals they meet. Relatives and friends may have forgotten, or chosen to avoid discussing the event or mentioning the child's name to save "upsetting" the family. This denies the family the opportunity to talk about their feelings. Physical and/ or emotional symptoms may appear any time after a death. In addition to providing immediate care, it may be necessary to refer the family to counselling, psychotherapy or a bereavement support group in the area.

Grief is a normal process, but each individual deals with it in their own unique way. Health professionals are in an unrivalled position to facilitate family adaptation in their crucial time of need (Gibbons, 1992).

Author:
Gerry Silk, RN,RSCN,B.ED,
Clinical Nurse Educator -
Royal Children's Hospital,
Centre for Community Child Health and Ambulatory Paediatrics.

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Culturally appropriate care in the community...

The provision of culturally appropriate health care requires the professional to be aware not only of the culture of those in our care but also of the cultural assumptions we bring to our interaction with patients.

Effective Communication ◆

Effective communication with families from other cultures involves time and understanding to ensure information is transmitted and received correctly. It is not always enough to ask if someone understands what you are saying. In some cultures it is considered disrespectful to say "No", or disagree with someone in authority. In such situations, ask open questions to ascertain the level of understanding. A gentle tone of voice can go a long way towards relaxing the patient.

Trained Interpreters ◆

A trained interpreter should be used when possible as they are able to translate language along with its cultural implications. For example, a Vietnamese patient when asked if they are "feeling hot", may understand this to be an inquiry as to general malaise rather than temperature. Using untrained interpreters or family members may lead to incorrect translation as they may not understand medical terminology or may wish to protect the person from unpleasant or embarrassing information. Children should never be used to interpret for anything other than very basic information.

The introduction of an interpreter needs to be accomplished in a sensitive manner. Confidentiality of information needs to be guaranteed particularly if the community the patient comes from is small.

When working with an interpreter it is important to look at the patient rather than the interpreter to ensure behavioural cues are not missed.

Body Language ◆

An awareness of the meaning of body language within cultural groups will help communication. Avoidance of eye contact signifies respect within many cultures, including Aborigines and some Asians. Muslims, Aborigines and Hindu's may not approve of touching of the opposite sex. Muslim women may be reluctant to discuss "female matters" with male health practitioners.

Traditional Health Care ◆

There is extensive literature about the traditional health practices of different cultural groups. Practices such as the coin rubbing or cupping of Asian children for fevers produces bruising which the health professional may misinterpret as child abuse. Talismans are often used to protect children against "evil spirits" and should not be removed without parental consent. Knowledge of these traditions can contribute to improved communication between health professional and patient.

Many recent immigrants to Australia have experienced the trauma of war, famine or political unrest. Such events may affect the way they adapt to life in this country and their reaction to sickness or disability.

The provision of culturally appropriate care to families is within the reach of all health professionals. The critical starting point is the acceptance of each family's unique qualities and the health professional's willingness to listen and provide support.

Author:
Gerry Silk, RN,RSCN,B.ED,
Clinical Nurse Educator -
Royal Children's Hospital,
Centre for Community Child Health and Ambulatory Paediatrics.

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from the literature... ◆

Jan Shield,
Child Safety Centre,
Royal Children'sHospital,
Melbourne, Australia

DOES PRENATAL AND INFANCY NURSE HOME VISITATION HAVE ENDURING EFFECTS ON QUALITIES OF PARENTAL CAREGIVING AND CHILD HEALTH AT 25 TO 50 MONTHS OF LIFE?

DL Olds, CR Henderson & H Kitzman. *Pediatrics* 93 (1) Jan 1994 pp 89-98.

Previous studies of home visiting of high risk families by nurses during the prenatal period and for up to two years afterwards have shown positive results in improving pregnancy outcomes, and reducing the rate of child abuse, neglect, and smoking-related developmental delay. Home visiting also reduced government expenditure on low income families. High risk families were characterised by young maternal age, single parent status and low income.

The present study sought to determine whether there were any lasting effects from that program and followed up the 400 New York state women who were enrolled in the earlier study.

Children of families which had been visited by a nurse before the age of two years had 40% fewer notations of injuries or ingestions, and 45% fewer notations of child behaviour or parent coping problems at 34 and 46 months.

The authors conclude: "During the 2 years after the program ended, there were no enduring effects on the rates of child abuse and neglect or on children's intellectual functioning. There were, however, lasting program effects on the safety of the households; children's use of the emergency department; use of physicians' offices for injuries and ingestions and child behavioural and parental coping problems; and the qualities of care that poor, unmarried teenagers provided to their children. Moreover, nurse-visited mothers overall were observed to be more involved with and to punish their children to a greater degree than were mothers in the comparison group. The higher rates of involvement and punishment and improved safety of their households, we believe, are reflections of their greater belief that their children must be disciplined and protected for them to succeed in school, work, and mainstream society."

The researchers emphasise that their findings are preliminary and should be replicated elsewhere before being incorporated into policies or programs. The findings do indicate, however, that home visiting is an effective way to promote the health and well-being of low-income, at-risk mothers and children.