Pathological grief in doctors' wives

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The mental health of doctors has received increasing attention in recent years, but articles on the doctor's wife and family remain scarce.¹ Those reports that do exist emphasise the wife's reluctance to express her dependence on her husband because he is already burdened with trying to meet the needs of his patients² and her search for a personal identity that is not based solely on being a doctor's wife.³ Other studies have examined the treatment that doctors' families receive from other medical practitioners,⁴ and the anxieties that such treatment may impose on the treating doctor.⁵

These three interrelated issues—the emotional and physical health of the doctor's wife, their marital relationship, and the difficulties doctors encounter in treating a sick colleague—are important in understanding the problem of pathological grief in the doctor's widow.

The following account is impressionistic and is based on my experience of treating six doctors' widows who were referred to me. These cases were probably not representative of the grief process in medical families but nevertheless indicate the possibility that a debilitating yet potentially reversible psychosocial problem exists within the medical profession itself.

Personal characteristics

All six women were trained in areas closely related to clinical medicine—one was herself a doctor, four were nurses, and one was a physiologist. They had been competent in their work, saw themselves as generally self-reliant, and in both their vocational and domestic lives thought of themselves as practical-minded problem solvers who generally avoided displays of emotion and valued self-control and rational discussion. They were relatively young widows, ranging in age from 34 to 58 years, who had been married for 4 to 35 years when their husbands died.

At the time of seeking psychiatric opinion the features of pathological grief had been evident for periods ranging from 18 months to almost six years. In each case the comparative youthfulness of the woman combined with her self-reliant attitude and her professional status seem to have delayed her referral for psychiatric help. Such factors were also partly responsible for the intensive part each woman took in managing her husband's illness.

The husband's illness

In each case the husband's illness had been chronic, lasting not less than 14 months and in one case for almost seven years. The illnesses—five cases of malignancy and one of neuromuscular disorder—were characterised by relapses and remissions and cycles of hope and despair for the sufferer and his family. These women's husbands had needed constant medical and nursing care and had suffered pronounced changes in their appearance, strength, and mobility, although mental ability and conscious state had been affected only quite late in the course of the disease.

In each case the wife was deeply concerned in providing day-to-day care for her ailing husband at home, not only in "domesticated" ways but also in more professional ways, such as recording his temperature, pulse rate, and blood pressure and administering parenteral medications. As one woman recalled: "The place looked like an intensive care unit. It was just like being back in ICU except that after working night shift you didn't have the next day off—I just got myself so tired I couldn't stop."

Each wife had nursed her husband in a dedicated way, and most admitted that they had felt obliged to do this as well as sensing that others, particularly her husband's family, expected her not to falter: "They seemed to think that my training could make me take it all in my stride. They almost said to me how lucky it was that I wasn't affected by his sickness because I had been trained as a nurse." An important part of the psychotherapy with the widow was to examine the extent to which she shared in others' expectations that she should tirelessly attend to her husband.

Doctors are generally regarded by their colleagues as being difficult patients. As one wife mused rather bitterly: "He'd tell some dreadful lies, I couldn't trust him with his tablets, I didn't know what his doctor had said to him and felt like an idiot ringing up to check on my husband. . . . Sometimes he'd take off in the car and be gone for hours, I don't know where. It was his pride that was doing it to him—it was hurting him more than the cancer, eating him up. He was more hurt by the way he was going downhill, so he sometimes drank heavily. I guess we had some terrible tempers and scenes, but he only did it with me, never when anyone else was around."

The written word cannot convey the conflict of feelings this woman experienced—anger at her husband's selectively hurtful behaviour, compassion and understanding for his emotional pain.

The marriage

The conflict of feelings the wife experienced did not arise solely from the stresses and strains of her husband's illness. In each case there was evidence of disharmony, conflict, or hurtful behaviour by one or both partners before the onset of the husband's illness. The wife recalled that in their marriage she had often felt isolated, misunderstood, yet obliged to suppress her wish to complain, partly because of her own self-image and partly for the sake of the sick people who required her husband's time more than she did. Such feelings were re-experienced when she acted as doctor-in-residence during her husband's illness.

While the sincerity of the wife's dedication is not in question, it is important to recognise the influence of unconscious guilt and anxiety that sometimes motivates excessive therapeutic zeal by doctors and nurses, even more so when they are treating their own spouses. In one case the wife had decided to leave her husband after enduring several years of his philandering and alcohol-induced jealousy. His illness developed a few weeks after she had made this decision, however, and prevented her from implementing it. In another case the marriage had been blighted by the death of a child a few years earlier, for which the issues of neglect, guilt, and blame were vividly replayed in the mother's mind as she maintained her exhausting vigil over her dying husband, seeking atonement and an affirmation of her personal worth.

The attending doctors

Doctors as patients are often overinvestigated and undertreated. Most of the widows I saw were never very clear about who was in overall charge of their husband's treatment and were uncertain who to question, challenge, or complain to about their husband's management.

Sometimes important and potentially life-determining decisions such as medication schedules (particularly analgesics) and the need for admission seemed to be left to the wife to make. At other times, although she received considerable clinical and laboratory data about his condition, the implications of such information were not clarified for her. She often had to resort to her own medical knowledge, supplemented by consulting textbooks and journal articles and canvassing the opinions of other nursing or medical friends, to make up for the lack of detailed discussion with the attending doctors. At times the widows had been concerned that their inquiries or complaints might be embarrassing or insulting to a particular doctor, an insult made worse by the fact that he was often a social acquaintance or a friend of the husband. Another important aspect of the widow's

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treatment was to explore the possibility that her excessive concern about being insulting or ungrateful was in fact based on her wish to be critical of the treatment her husband was receiving.

These problems emphasise the need for one clinician to take a central role in the management of the patient and his family. This clinician also needs to show that he is receptive to challenge or criticism from his colleague-patient and the colleague's family without thinking that his own competence is being undermined.

Widowhood

A feature of all these cases was the apparent delay in recognising the abnormal grief reactions and starting effective treatment for them. The widow herself, the attending doctors, and friends, whether medically trained or not, all seem to have tried to minimise her expression of grief.

The widow usually recalled that when her husband died her initial feeling was one of relief, followed by a powerful awareness of her own great weariness. Although most of the widows admitted to having cried, the tears had not only been of sorrow but also of relief and fatigue. The widows realised how restricting and dominant a force their husband's illness had been, whereon they resolved to "get on with living" or to "make up for lost time." Each of the widows tried to return to work, resume a favourite pastime or membership of an organisation, to go on a holiday to a popular tourist resort, all within a short time of the husband's death. These activities were abruptly curtailed by the development of a variety of symptoms, including irritability, moodiness, insomnia, headaches, and weakness, which persisted for many months.

The widow usually had access to psychotropic and analgesic drugs, often from her husband's stock of samples, and attempted self-medication, sometimes supplemented by alcohol. When she did consult a doctor it was usually on an informal basis; the doctor was usually a family friend, and the "consultation" typically occurred during his condolence call or in the company of several other people at home. The treatment prescribed in these cases was symptomatic and included hypnotics, anxiolytics, or analgesics in varying doses and combinations arrived at in a trial-and-error fashion.

The widow seemed to share with her medically trained friends the denial of her grief as the emotional source of her symptoms. Such symptoms are recognised as a common manifestation of grief and can be resolved through the process of grief "work."⁶ The ability and opportunity to grieve are important factors in preventing pathological grief,⁷ and during the months after their husband's deaths the widows seemed to have made several abortive attempts to express their feelings, only to be prevented by their own expectations of themselves and by the perceived attitudes of other people.

Several of the widows commented that the attitude of friends who were not from medical families was particularly unsympathetic. One widow, more hurt and surprised than angry, explained: "They seem to be saying that because I've been left fairly well off, financially, so far as the house and educating the kids goes, that because [husband's] investments might leave us a bit better off than most, then I'll be all right. I suppose I am, compared to what some people have to face, but I really don't see it that way. When you lie in bed at night thinking all the time, there's no comfort in telling yourself that the mortgage is taken care of."

The medical profession has been subjected to criticism by the press in recent years over the alleged incompetence, dishonesty, and mercenary attitudes of its members. At the same time the press extol the technological innovations and chemical wizardry that form part of modern medical practice, so that the profession is viewed with a mixture of resentment and awe. The effects that such mixed attitudes have on the social relationships that doctors and their families form with non-medical people await sociological study, but the problems of personal identity in being a doctor's wife have been recognised.³ The widows I saw thought that others' concern and sympathy for them and their bereavement were tempered by the knowledge that as doctor's wives they might be beneficiaries of their husband's less-than-altruistic exercise of his professional skills.

Discussion

Excellent accounts of the management of pathological grief are available,⁸⁻⁹ but the cases I have described indicate a need to emphasise certain points in the management of the dying doctor

that may help to prevent the development of an abnormal grief reaction in his wife and family.

Firstly, a clinician who is familiar with the management of the doctor-patient and who understands the emotional bonds that dying and bereavement may impose on the sufferers and himself needs to be available to the family.

Secondly, decisions affecting the management of the patient should not be left to the patient himself or to his medically trained wife; clearly, the patient and his family may need detailed discussion about his clinical state, but the emotional impact of his illness on the sick doctor and his family is not necessarily lessened by their knowledge of the pathophysiology; nor does such knowledge necessarily confer on the sick doctor or his medically trained wife the ability to make certain clinical decisions about his own medical care.

Thirdly, where the treating doctor defers to his patient or his wife his own opinion should be stated clearly and unambiguously; he may need to restate his opinion on many occasions, indicating all the while that he does not consider his patients' disagreement an assault on his own self-esteem.

Fourthly, despite all efforts, the patient may die, and the treating doctor should recognise that anger and criticism are natural responses to dying and bereavement for the patient and his family and that the self-blame and self-doubts that the treating doctor may experience are also part of a response to loss. Encouraging his patients to discuss such feelings and listening attentively to them are not merely part of the professionalism of the doctor but compassionate recognition of the anxieties inherent in being human and mortal.

Fifthly, the marital relationship often contains the seeds of a disturbed grief reaction, and doctors' marriages have particular difficulties. The treating doctor's preconceived ideas about his colleague's marriage (or indeed about his own marriage) should not prevent him from encouraging the widow to explore her ambivalence toward her husband.

Finally, somatisation is a common vehicle for emotional interaction in medical families, and self-prescribed medication and alcohol are commonly resorted to for emotional suppression. While symptomatic relief with anxiolytics or antidepressants may be required, the widow's use of them should be monitored by the treating doctor, who should also make it clear to her that such drugs are not effective substitutes for grief "work."

Conclusions

During her husband's illness and after his death a widow may inhibit a display of feelings and behaviour because they are considered "inappropriate" for a doctor's wife.

The death of a colleague, particularly one who is also a friend, is a forcible reminder of the limitations of our therapeutic powers and of our own mortality. The response that we, as clinicians, make to such a reminder will affect our sensitivity and our ability to help our colleague's widow to grieve.

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