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Bev Chappell

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BEV CHAPPELL



CHAPTER ONE

Inspiration

For far too long people did not die. Instead, they were “lost to us,” “went on a long trip,” “went to sleep,” “passed on,” “passed over” or “passed away.” Unfortunately, that is often still the case today. These euphemisms were, and continue to be, the walls that cut us off from death and dying, and the subsequent grief for those facing the death of a loved one.

In the early 1950s when I was a student nurse, there was no Dr. Elisabeth Kübler-Ross to advocate for dying patients or their families. It was unheard of for nurses and doctors to provide a family with support through the grief that followed a death. In fact, when I was a student nurse it was an offense to give extra, or even adequate care to a dying patient when there was a post-surgical or new admission patient on the care list. More than once I was reprimanded for spending too much time with a dying patient. It was not unusual for a dying patient to be placed in the room farthest from the nurses’ desk and frequently the last call light on the floor to be answered.

After a patient died, it was the norm to close all the doors to the other patients’ rooms on the hospital floor before attendants wheeled the sheet-covered body on a gurney down the hallway to the morgue in the basement. The hospital administration determined that the sight of a dead body would be too upsetting.

During my years as a nursing student and later as a young registered nurse, two of the worst polio epidemics in the United States took place. My husband-to-be, Allan Chappell, who was a physician in pediatric residency at the time, worked eighteen-to-twenty hour days caring for

polio patients. It was common for us as hospital staff to work long hours. Many patients died; most of them were children and teens.

There was never any emotional aftercare for these families. They were all on their own: Parents whose children had died; children whose fathers or mothers had died; siblings whose brothers or sisters had died. No one took these grieving parents or children under their wings. And certainly, no one ever acknowledged that doctors and nurses might be grieving as they faced the deaths of so many patients during these epidemics. The hospital chaplains, counselors, and personnel from the funeral homes all went about their business, ignoring the grief that shadowed their daily work. We all seemed to be the walking wounded, isolated and grief-stricken.

Since my first days as an eighteen-year-old nursing student I felt drawn to the dying patients and I was always comfortable being with them. From the beginning, it was not unusual for me to spend extra time with these particular patients. One day, early in my floor duty experience, I arrived at work to learn one of my favorite patients was close to death. She had a heart condition, hypertension, and kidney failure. Before long she was in a coma. In recent weeks, we had become especially close for a student and a patient, perhaps in part because she had no family and no visitors. In addition, she had been an industrial nurse at Meredith Publishing Company in Des Moines, Iowa, and we had several chats about what her nurse's training was like when she was young.

The day she was dying I stayed at her bedside longer than usual. At one point the doctor came into the room when she was very near death. He told me, "Go to lunch and on to class. There is nothing more you can do for her." He left, but I didn't. I stayed, wiping the uremic frost from her face with a warm wet washcloth. Until she died, I sat by the bed and held her hand.

As was required, I reported the death to the head nurse. When she saw me, she asked with a critical tone, "Miss Rosene, why are you still on the floor? Why aren't you in class where you belong?" That was the first of several similar situations in which I could have been expelled from training and sent home.

On another occasion I was lucky and did not get caught assisting a dying patient. I was working the night shift, alone, on the hospital's small

west wing predominantly occupied by elderly and dying patients—except for one. A young man in his late twenties was dying of leukemia. In the 1950s, hospital rules forbade small children to visit patients and strictly limited the number of adult visitors to specific visiting hours. One night the young man's wife slipped into his room after the strictly controlled visiting hours were over. I decided not to ask her to leave. She sat with her husband, held his hand, and they talked about their children. For a time she laid on the bed beside him. Before the hospital supervisor appeared on her morning rounds I hurried the wife out the emergency exit. Before she left I promised I would let her back in through the hospital's emergency door that night at a specific time. I encouraged her to bring their two children so they could spend time with their father.

That night his wife returned with their two small children who were four and six years old. They were delighted to see their daddy. They crawled on the bed, curled up in his arms, and fell asleep. It did not frighten them that he was dying. I realized somehow they were very wise for their young ages. Their mom must have talked to them about Daddy's dying, and they seemed to know how to be present for every sacred moment with him. Many nights when I was on duty, I let them in to be with their dad. In less than two weeks he died.

At the time I wondered why I had provided the opportunity for this family to be together while the father was dying. It would have meant certain death to my nursing career if I had been caught. I always knew I had been a rebel where death was concerned. Intuitively, I must have known then what I now know without a doubt—children and families need the support and the time to experience their grief in their own time, both during a loved one's dying and after.

Confusing Children About Death

Over the years I met many children who had experienced the death of a parent or sibling and they had never grieved. I also met many adults who, when they were young, had experienced the death of a parent or sibling and had never grieved openly with their surviving family, or with anyone else. Tragically, some grief-stricken and confused children were never told what had happened to the family member who had disappeared from their lives. Parents often put away photos of the deceased and/or never spoke the dead person's name again, making the situation

even eerier for those children. The bewildered expressions and feelings of loss I witnessed on so many children's faces haunted me.

Sometimes when a parent was dying of an incurable illness, well-meaning adults sent the children away from home to stay with family or friends. The children would not return home until after the death of the parent, and oftentimes not until after the memorial service. When children asked where a parent had gone, too many were given strange, unbelievable, and even untrue responses. "Dad went away on a long trip" or "Mom went to visit a cousin." Sometimes the adults would never even discuss why a parent was no longer present in the home. Many times the common answer to a child's question of where a parent or a sibling had gone was to tell them, "They have gone to heaven." For children whose family followed no particular religion, they often had no idea where heaven was. It could have been New Jersey as far as the children were concerned, and they didn't know where that was either.

One time while I was sitting in a room filled with family members grieving the death of a grandfather, a grandchild walked in and asked why everyone was so sad. The reply was, "We have lost Grandpa." Worried, the child quickly responded, "We need to go find him."

In the Beginning

Grieving children and families continued to cross my path through my husband's work as a pediatrician. Even with families in my own neighborhood, tragedy would strike, and all too often the children's grief and needs were completely unrecognized. Wherever I looked, there seemed to be an endless stream of grieving kids and their families whose needs were not being met. They were really on their own.

After our first child, Kathy, was born in 1953 my husband strongly encouraged me to quit my work as a nurse and stay home. I agreed to stay home and be a full-time Mom. This decision had been influenced by unfinished grief—my husband's. Allan was only thirteen years old when his mother died after a long struggle with breast cancer. Those teen years were agonizing for Allan and his sister, who was two years younger. Both children felt lost without their caring and loving mother. Their dad, as is often the case, remarried soon after his wife's death. This new stepmother truly rivaled Cinderella's. So, much later as I began to identify others' unspoken

and unresolved grief and loss, I could also see how it had played out in my own family.

On Allan's \$125.00 a month pediatric residency salary and our \$75 a month rent, my not going back to work was a financial catastrophe, but somehow we made it. Ultimately, I was grateful to stay home with my children, even though I was not practicing nursing. My profession became that of a pediatrician's wife and phone answerer. There were no pagers, no cell phones, and no answering service for private practice physicians in the 1950s. In those days, Allan encouraged patients to call our house after hours if they needed help, and I often felt like his at-home nurse. When Allan wasn't home or at the hospital after hours, he was often making house calls. In 1956, our second child, Steven, was born and my full time job as a mother and a physician's wife kept my days full for years.

One of My Most Significant Grief Teachers

In the early 1970s, I realized it would not be long until the primary focus of my life, two active and very busy teenagers, would be flying from the nest. I wondered what I would do when I no longer had to take care of my children on a daily basis and be involved with their many activities. I had not done any nursing in years so it would be necessary to take a refresher course even though my Iowa license was current. However, after taking the required refresher course, I was clear that I did not want to return to traditional nursing.

In September 1971, our son's best friend, Brian, faced a traumatic family situation. Brian was like a part of our family, often joining us on our family vacations. Brian's mother had been struggling with pain and nausea for at least six months. No one took her seriously and she received the medical run around—"it's all in your head" type of thing. Finally, she had major surgery and the doctors found uterine cancer that had already spread to her intestine. For the next thirteen months, she was in treatment with frequent stays in the hospital. At sixteen years old, Brian was just learning to drive so my husband, our daughter Kathy, or I became his transportation so he could visit his mother.

Brian's parents were divorced, and Brian's dad offered no emotional support whatsoever. A sister, twelve years older, and a brother, six years older, lived out of the area. The brother seldom came to visit during

the thirteen-month cancer fight and Brian's sister came occasionally, but reluctantly. During his mother's illness and hospitalizations, Brian spent long hours at lunchtime and well into the night at her bedside. He hated watching his mom suffer through her illness. He would stay with her holding the emesis basin when she vomited, and then get her settled. Once she was comfortable, Brian would run to the bathroom and vomit.

Even in exhaustion and in the beginnings of illness himself, Brian would not let me call his school to allow him a morning off or to come in late without penalty. He did not want the school to know what was happening in his life. Brian did not want to be different from his peers. Little did I know then that Brian's response is absolutely normal for most teens and children, even as young as six. Whether it is a loved one who is dying or someone who has died, children do not generally make this a subject for conversation. I now understand that this is a means of protection for them as well as for those around them. Young people also know that their peers can say and do cruel things to those who have suffered the death of a loved one. What children may not know is that cruelty can be rooted in the other person's own grief and ignorance, or fear.

In the end, Brian, his sister, and I were at their mom's bedside when she died. Following her death, Brian lived alone in the home he and his mother had shared. His father lived in another part of the city and supported Brian financially so he could remain in the same school district, but offered little more. Our family became Brian's main source of support and comfort. As soon as Brian's mother died we invited him to live with us. Four months later Brian decided to live with us until he graduated from high school.

During Brian's mother's final illness and death, I was fully reintroduced to the world of doctors, nurses, hospitals, pain, and dying. This rekindled a passion of mine first sparked in my early nursing career—concern for the dying patient. I did not realize at the time that Brian was to become one of the most incredible teachers in my life. Brian would teach me about children and teens in the process of anticipatory grief and the grief following death. It would be years later before I would more fully understand the pain, agony, and aloneness Brian had endured.

During this time with Brian, I would come to know for certain what I wanted and needed to do with my life. Before long I would meet

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I N S P I R A T I O N

a wonderful friend and mentor, Elisabeth Kübler-Ross, M.D. She, too, would offer much needed inspiration and guidance. My time with Brian was a perfect example of what Elisabeth Kübler-Ross repeated so often: *When the student is ready, the teacher will appear.*