

References

- Brewin T B (1977) *British Medical Journal* ii, 1623
Brown G W, Bhrochain M M N & Harris T O (1975) *Sociology* 9, 225
Coblner W G (1977) *Hospital Physician* 10, 38
Maguire G P, Lee E G, Bevington D J, Kitchemann C, Crabtree R J & Cornell C E (1978) *British Medical Journal* i, 963
McIntosh J (1974) *Social Science and Medicine* 8, 167
Morris T, Groer H S & White P (1977) *Cancer* 40, 2381
Plumb M M & Holland J (1977) *Psychosomatic Medicine* 39, 264
Trachtenberg J M (1972) Paper presented at National Conference on Human Values and Cancer, Atlanta, Georgia (22–24 June)
Weisman A D (1976) *American Journal of the Medical Sciences* 27, 187

Psychological consequences of childhood leukaemia

G P Maguire MRCPsych DPM

University of Manchester Department of Psychiatry

University Hospital of South Manchester, Manchester M20 8LR

It is now established that life-events characterized by the threat of serious loss, and uncertainty if and when this loss will occur, are likely to be associated with the development of psychiatric problems (Brown *et al.* 1975, Cooper & Sylph 1973). The diagnosis of acute leukaemia in a child represents this kind of event for the parents. In addition to the threat of death the situation is compounded by the distressing side-effects of treatment such as vomiting, weight gain, hair loss or mouth ulcers, which may affect up to half of treated children. The need for repeated visits to hospital, sometimes many miles away, may also increase the strain imposed on the parents. It is not surprising therefore that recent studies (Kaplan *et al.* 1976, Maguire *et al.* 1979) have found a high psychiatric morbidity among the parents.

Depressive illnesses or anxiety states, necessitating psychiatric treatment, have been found in 20–30% of parents of children with leukaemia, and this proportion is similar in families with a surviving well child and in those where the child has died. It was found that many fathers appeared to be using alcohol to tranquillize their distress, and psychosomatic disorders were common. About a quarter of the mothers experienced chronic sexual problems, and one in five of the couples had developed marital problems, with some husbands feeling neglected because of the time mothers spent with the sick child, and some mothers feeling resentful that their husbands did not share the burden of care.

The affected children themselves are liable to behavioural problems such as temper tantrums, soiling and school refusal. Howarth (1972) found that 42% of leukaemic children were so affected compared with 8% of children with benign disease. These problems may result from the disease, from the treatment, or from changes in the parents' behaviour, since at least one-third of parents relax discipline, in order to give the child a remaining life as free from unpleasantness as possible.

The understandable worry that parents have about the sick child may lead them to neglect the healthy siblings, up to half of whom may also develop behaviour problems (Binger *et al.* 1969; Kaplan *et al.* 1976). Yet, as with the parents, these problems are not usually detected or treated by those involved in the child's care.

Since the families of children with leukaemia do appear so much at risk for developing serious emotional problems, and since so few are treated appropriately, there is an urgent need to consider ways of improving this aspect of care. Provision of counselling, together with systematic monitoring of the emotional wellbeing of families, especially in the first few years of treatment, would be a major advance. Such counselling could be provided for groups of parents (Heffron *et al.* 1973) or for the whole family. Volunteer counsellors who have themselves had or have a child with leukaemia could be enlisted, although experience of their use in general programmes suggests that they would have to be carefully selected and trained (Kleiman *et al.* 1977). Possibly a better method would be to use a specially trained nurse or social worker (Foley & McCarthy 1976) to provide advice and counselling to the family. She

could then report back any problems to the medical team of oncologist and general practitioner and with them and the family, possible ways of alleviation emotional morbidity could be formulated.

References

- Binger C M, Ablin A R, Feurstein R C, Kushner J H, Zoger S & Micklesen C (1969) *New England Journal of Medicine* **280**, 414
Brown G W, Bhrolchain M & Harris T O (1975) *Sociology* **9**, 225
Cooper B & Sylph J (1973) *Psychological Medicine* **3**, 421
Foley G & McCarthy A M (1976) *American Journal of Nursing* **76**, 7, 115
Heffron W A, Bommelaere K & Masters R (1973) *Pediatrics* **52**, 6, 831
Howarth R V (1972) *Proceedings of the Royal Society of Medicine* **65**, 1039
Kaplan D M, Grobstein R & Smith A C (1976) *Health and Social Work* **1**, 71-82
Kleiman M A, Mantell J S & Alexander E S (1977) *Community Mental Health Journal* **13**, 115
Maguire P, Comaroff J, Ramsell P & Morris-Jones P (1979) Report to the Leukaemia Research Fund, London

Discussion

Rapporteur: **Jocelyn Chamberlain** MB FFCM
Institute of Cancer Research
Sutton, Surrey SM2 5PX

The theme of communication with the patient kept reappearing during the course of this thought-provoking meeting at which different aspects of care for cancer patients were discussed. All three papers emphasized that traditional clinical care of cancer patients, oriented as it is to physical attributes of the tumour, has often neglected the emotional effects of malignant disease upon the patient and his family. This was illustrated by the numerous quoted studies of unmet psychological need in a high proportion of patients. In discussion, some of the real problems encountered by clinicians in this area were expressed. These include the difficulty in communicating with patients of different social and cultural backgrounds, whose expectations and values are not always understood by the clinician; and uncertainty about uncovering emotional problems for which the clinician has no solution. Nevertheless it was felt that efforts must be made to alert all concerned with the care of the patient to possible psychological problems, and by counselling or appropriate psychiatric therapy to alleviate these as far as possible. Although it is obvious that much further research needs to be done in evaluating counselling, present evidence suggests that when health workers of different disciplines and training are working together with the patient, mutual advice and support enable both patient and staff to come to terms with his illness, its prognosis and its effect on his life and family.