

**CHILDREN AND STRESSFUL LIFE EVENTS:  
SEPARATION, LOSS, VIOLENCE, AND DEATH**

**Maria Trozzi, M.Ed**

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## Introduction

Losses are unavoidable. They are an inevitable part of the landscape that defines a child's development. Examples might be: the first time an infant is aware of her mother's momentary absence; the toddler's struggle with separation and autonomy at bedtime, the preschooler's brave leap from her safe, known environment to a bigger world of a classroom. But with each loss comes an opportunity for the health care provider to offer the child's parents reassurance that each loss is an opportunity for growth. In each successful resolution and adaptation to each developmental spurt accompanying loss comes a built-in energizer and predictor of future successes.

In contrast to the normal losses we expect as part of development, death, even though an inevitable part of the lifecycle, represents a true crisis to many adults as well as children. The Chinese, in a prescient written form, express the concept of crisis well when they write the word as a combination of two pictographs: one representing danger and the other, opportunity. With death, there is a real danger of being overwhelmed and of finding one's coping skills and strategies inadequate for the situation. Fortunately, even crisis situations, (including death) also present an opportunity for growth and for strengthening our capacity to deal with future stress. Even children facing a death, in danger of being overwhelmed, can be directed in the skills of mastering the crisis and emerging with new emotional strengths. For this to happen, help is required in the following areas:

- Realistic perception of the loss: having adequate and age-appropriate information about what happened
- Help in expressing immediate feelings

- Adequate situational supports: having a network of people currently or potentially in the child's life to assist with the variety of the practical needs that arise
- Adequate coping mechanisms: having in place well-functioning ways of dealing with the anxiety generated by the loss<sup>1</sup>

For adults, it is almost unthinkable that a young child may need to face these losses. Therefore the adults in children's lives are often inadequately prepared to assist them. This chapter focuses on the conceptual assumptions, interventions and insights that will help clinicians assist bereaved children and their families.

### **CHILDREN'S UNDERSTANDING OF DEATH**

A simple child  
That lightly draws its breath  
And feels its life in every limb  
What should it know of death?  
-Wordsworth

For adults, death is a disruption in their usual "steady state" - a sense of disequilibrium. For children, however, death can represent a "developmental interference that results in a suspension of their ongoing growth. The goal of clinical intervention with children is to get them "unstuck" - to help them get through, over, under, or around a temporary barrier to their normal and healthy forward movement.<sup>2</sup> The health provider should view the child's ability to cope with a significant loss or death in relation to three factors:

- The child's ability to make sense of the death developmentally
- The child's history of loss and death
- The child's normal ability to cope with change, temperament and situational stress

### **Developmental Framework**

To support the child in understanding and coping, we need a developmental framework ourselves to appreciate a child's cognitive abilities. Although Piaget did not specifically address children's ability to understand death, much of the current thinking about how children perceive death comes from his theories about children's cognitive development. This framework is very helpful in assessing a child's reaction to the death of a loved one and the clinician's role in providing anticipatory guidance to the adults in the child's life. Remember, however, that as useful as this framework is, children regress under stress and the boundaries are meant as developmental markers only. A child's history with loss or death as well as her individual temperament and prior ability to cope with change also inform us of her reaction to death.

### **Infants (0-2 years)**

Prior to the third year of life, infants and toddlers have no cognitive understanding of death. However, Bowlby, who made a significant contribution to current thinking about attachment and loss, argued that even infants and toddlers who experienced maternal separation grieve:

If a child is taken from his mother's care at this age (18-24 months), when he is so possessively and passionately attached to her, it is indeed as if his world has been shattered. His intense need of her is unsatisfied, and the frustration and longing may send him frantic with grief. It takes an exercise of imagination to sense the intensity of this distress. He is overwhelmed as any adult who has lost a beloved person by death. To the child of two with his lack of understanding and complete inability to tolerate frustration, it is really as if his mother had died. He does not know death, but only absence; and if the only person who can satisfy his imperative need is absent, she might as well be dead.<sup>3</sup>

It seems indisputable that infants and toddlers react strongly to the loss of a meaningful person, and show their grief reactions in conformity with Bowlby's three stages of protest, despair, and detachment. However, what is more controversial is whether the very youngest child is capable of mourning without the mature understanding and meaning of that loss. Clinicians are often asked how a death of a significant person in the life of an infant or toddler should be approached. The following suggestions can be useful:

- If the deceased was the primary caregiver, identify a surrogate caregiver.
- Learn the caregiver's routines.
- Provide a consistent, nurturing, dependable environment.
- Be prepared for regression.

### **Preschooler (3-5 years)**

Preschoolers view death as temporary or reversible<sup>4</sup>, as going someplace else.

Four year old Alexandra, whose grandfather died the previous Christmas, proudly showed her aunt a picture she had drawn on Christmas eve and said, "Last year Papa was very sick and he died. But this year he's coming back on Christmas."

With that said, she placed her little drawing under the Christmas tree, awaiting his return.

Children this age want to continue a relationship with their deceased loved one, via prayers, writing, or engaging in one-sided conversations. They think the person is coming back. Children this age often place the deceased loved one in "heaven". They want to visit, call or write to him. Their thinking tends to be egocentric, making their own unique sense of each situation. They often attribute magical thinking to the death.

When a three year old child died in daycare after choking on a grape, her little classmates concluded that, "Sally died because she ate her dessert before her sandwich."

This magical thinking is consistent with the toddler's understanding of death and their perceived causal link between two independent factors in the story.

They need simple, straightforward explanations of death. "Grandpa died. His body totally stopped working." At this time, many preschoolers will help you operationally define death. "Can he eat? Can he sleep? Does he still dream? Does he go to the bathroom? Will he breathe under the ground? Can he hear me in heaven? Does he need his wheelchair still?" Be particularly careful to respond with concrete, simple explanations. Avoid euphemisms like "lost, sleeping, gone to heaven, with the angels." At the best they confuse young children. At the worst, they terrify them. A bereaved parent told her five year old child that "The angels came down

and took your baby sister," after she had died suddenly of SIDS during the Christmas season. Six weeks later, Five year old Jeffrey presented to counselor an inability to sleep at night. When asked to tell her about his baby sister, he said, "I don't want to talk about *her*. I want to talk about angels. There's two things to know about angels. There are lots of them, and they're on the loose at Christmas. And, they don't have *headlights*. So you can't see them coming and you have to stay awake at night so they won't get you."

Adults, in explaining death to their very young children, often jump to their own spiritual beliefs. Although this can be comforting, it is also confusing. For instance, preschool children are confused by how the body and spirit can simultaneously be in the grave and in heaven.<sup>5</sup> One preschooler found for himself an adequate explanation: "The insides go up, and the outsides go down!" However, adults should resist elaborate stories about heaven that suggest a composite of Disneyworld and Nintendo, or stories about Uncle Henry dancing with angels or Grandpa watching over you (and all your behavior!).

### **Latency age (6-8 years)**

Children this age understand death to be final, irreversible but *not universal*. They know that people who die stay dead, but they don't think that they, themselves, will die. Further, they place those who *do* die in three categories; elderly, physically disabled, and to make their sense of all the others, klutzes.<sup>6</sup> Death is often perceived as a male, Darth Vader character, who can grab you. Those who are vulnerable can't run; e.g. elderly, physically disabled. All the others who get caught must be klutzes. This explanation works for the six to eight year old who is healthy and physically competent. He distances himself from death. But, unlike younger children, a death presents him with the challenge of questioning his and other's safety. "Is life still safe?" becomes an overriding question. There is an ongoing sense of impending disaster or unpredictable happenings unless their safety issue is addressed.

Six year old Beth was vacationing with her parents when, while crossing a Vermont country road at dusk, her mother was struck by a car and died. Beth reasoned thereafter that crossing the street led to disaster. Understandably, she refused to cross any streets following her mother's death. At the September start-up of school, her teachers were perplexed as to how to handle this issue, especially since the temporary playground was across a busy street. Their solution was to allow her to stay in at recess with the school nurse. After a consultation with a grief specialist, they understood that being motherless is isolating enough; any further isolation would not only exacerbate the isolation, but would ultimately lead to the challenge of weaning her from this temporary solution. They decided instead to "normalize" her fear of crossing the street and allow her and her classmates to strategize ways to stay safe while crossing. This plan was not only successful the first day of school, but within the first week, Beth had taken on the role of "crossing guard" for her class!

What an opportunity for healing!

Predictability; that is, what will be the same, what will be different due to this death, is another inescapable concern confronting the latency aged child. The child needs direct, simple answers. She may ask after a sibling's death, "Will I have my own room now? Can I have Jimmy's nintendo?" Although adults may initially view these questions as egocentric, the child is asking how his world will change due to this death. These superficially stated concerns mask the underlying issue of what will change for the child more fundamentally.

Typical of this age is the concern, "If Beth's mom died, are you (i.e. the parent) going to die also? Who will take care of me?" Parents, particularly those in single-parent households, should face these important questions directly and seriously. It would not be useful to respond, "Don't worry about that" or "I'm too healthy to die." Reminding the child that *everyone* dies someday, but that, unlike Beth's mom, most people live to be very, very, very old," is useful to the child. If I were to die, your Aunt Susie is prepared to care for you (and your brother) until you are grown up." Children are generally satisfied with that response and teaches them that you can talk about even "the unmentionable death of self, loss." Although discussing details of a death, particularly the gross and grubby ones, such as, "what happens to the body? was there blood? what did she look like?" are difficult, most latency aged children have a need for some detail around these events to help them feel more in control of this. The adults in their life have an opportunity to face these questions with them. By doing this, they are also telling their children that they can face stressful life events together. In contrast, refusal to discuss issues or to give flip answers send the wrong message. "If it's unmentionable, it's unmanageable."

### **Pre-adolescents, 9-12 years**

Pre-adolescents have an adult understanding of death. They view death as final, irreversible and universal. That is, most youngsters this age understand that everyone dies

someday, even them, and it's forever. They may view death as a punishment for bad behavior as they are beginning to explore moral development at this age. They are able to understand the biological aspects of death; such as, what happens if the heart has a blockage or what is the effect of a brain tumor on life function. Furthermore, they can understand the concept of specific cause and effect. That leads them to wonder about what part, if any, they may have played that contributed to a death. They may regard their own behavior, or lack of behavior, as contributory. They may feel guilty; adults need to help them process that complicated emotion. Preadolescents are fascinated with the religious and cultural rituals that surround death and display a curiosity about topics such as cremation, burial, embalming, and the afterlife. Adults in their life may find these questions disarming; however, if approached in a straightforward way, youngsters are reminded that they can trust adults to give them useful information about "difficult to talk about" topics. Sadly, many pre-adolescents stop asking questions of adults by this age, not because they know the answers, but because they are convinced that the adults will be embarrassed or resistant to give them the answers they need.

Many preadolescents respond without a display of emotion or may even be sarcastic when faced with a loved one's death. They intellectualize death as *their thoughts are often more available to them than their feelings*. This bewilders and concerns most adults, who think that their typically sensitive and caring eleven year old has been replaced with an insensitive clone. Feelings are typically buried under a very unattractive demeanor.

The Smiths were vacationing in Florida when they learned from their adult baby-sitter that their four year old child had died while sleeping. Bewildered and overcome with grief, they returned home on the next plane. When twelve-year old Christine faced her parents at the door, she smiled and asked, "What did you bring me from Florida?" This response, although

infuriating to her parents, protected her from a display of overwhelming grief. Christine knew how to handle her parent's anger as she had probably seen it before; she was less prepared to respond to their presumable expression of overwhelming grief. "After all," she reasoned, "if they *fall apart*, then who will take care of me?"

Her angry comments brought more predictable attention and energy from her parents. The preadolescent is dependent on the adults in their life to make life feel safe for them, especially in times of crisis, such as a death. It is critical when helping loved ones to know how to help their children through a loss. Remember to:

- Be authentic. Kids pick up platitudes, gloss-overs and ambivalence like radar.
- Verbalize that, in spite of your grief, you are still able to care for your children. Help them feel that they are safe and that their lives will go on.
- Give them repeated opportunities to discuss the death but don't push too hard. This will take to months to get at feelings.
- Talk about your own grief and how your feelings influence your own behavior.

One winter morning, shortly after her father had died, Terry was removing a gallon of milk from the refrigerator door when it slipped out of her grasp and crashed to the floor. The children, seated at the kitchen table, were shocked to hear their mother scream and then sob. They quickly started to help with the clean-up. When Terry stopped crying, she faced her children and explained, "I'm having a bad morning. I am missing your Grampa terribly." She proceeded to help the children with the clean up and together they sat down to breakfast.

Children can face intensely difficult emotional times if the adults in their life continue to make them feel safe throughout. If mom had run out of the room, leaving them without breakfast and without an explanation, the children may have felt abandoned by her. Explaining her display of

emotion, and continuing to care for them (in spite of her feelings) teaches them that grief and its intense emotions can be faced with the adults in their life.

### **Adolescents (13-18 years)**

This period brings in several new cognitive abilities, emotional processes and developmental processes that touch on the experience of death.

- Adolescents are actively engaged in the normal developmental task of separation from the significant adults in their lives.. A significant death, such as the death of a parent or a sibling, can derail this individual separation individuation process, making this maturational process scary and overwhelming.
- Adolescents typically engage in high risk behavior, almost as though they need to “flirt with death”. They are fascinated with death but may be overwhelmed when it intrudes more closely.
- Paradoxically, they intellectually have an adult’s understanding of death, but behave as though they themselves were immortal. Since many adolescents will, during this period, face the death of a peer, it shatters all their fantasies of immortality.
- Moreover, they are capable of understanding the existential implications of death as they gain the ability to think abstractly. They may not have formed their understanding at this level before it is forced upon them.
- They are interested in exploring society’s attitudes about life and death. They monitor both the proximal and distal groups that respond to a death.

Although they often reject traditional adult rituals surrounding death and create their own with the help of their peers, they do need adults in their life to help them sort out the often colliding feelings of sadness, anger, disbelief and isolation. Adults often feel rejected when

attempting to providing emotional support. However, just their continued presence and availability during the crisis are actually very therapeutic. Adults must interrupt this distancing as developmentally appropriate and respect it while remaining available for reassurance and support.

Adolescent suicide is an increasing phenomenon. In fact, statistics reveal that every day in this country, a young person between the ages of thirteen and twenty-five will attempt suicide. Seventeen young people will succeed every day. Why do so many adolescents attempt to kill themselves? Why, if they have an adult understanding of death, can they see “ending their lives” as an option? Unfortunately, adolescents deny the *physical* consequences of suicide. They often suffer an inability to look beyond the act itself and fail to understand that the consequences of death are final and irreversible.

Seventeen year old Amy was a senior at a prestigious prep school. She was bright, popular and had recently been accepted at her first choice ivy league college. On a particular afternoon, three of her girlfriends betrayed her in a powerful secret. She was humiliated. That evening, she slashed her wrists in an attempted suicide. When the therapist asked her what she was thinking when she was hurting herself she replied, “All I could think was ‘won’t my friends be upset when they walk by the casket and see me lying there.’”

Adults who teach and live with adolescents must help them face the stark reality of the act of suicide:

- It is killing yourself.
- People who commit suicide don’t know how to get help to solve problems.
- You don’t come back.

- It will not glorify your memory.
- It is a permanent solution to a temporary problem.
- Adolescents need to look for help with problem solving.
- No problem is solved by suicide.

### **Childhood Beliefs**

A working knowledge of the developmental framework just described is critical for any health provider. The other predictable interference with a child's understanding of death is magical thinking. Although the psychological literature suggests that magical thinking occurs only during the early childhood years, there is ample empirical evidence to suggest that magical thinking occurs even as late as adolescence.

Bob, aged fifteen, and his older brother, Ted, aged seventeen, were playing basketball against the side of their grandmother's brick apartment building. Several times she opened the window of her third floor apartment and asked them to stop. Finally, she angrily yelled to them, "For the last time, stop. You boys will be the death of me!" Sadly, the next day, grandma suffered an aneurysm and died. In therapy, the boys revealed that they thought that they killed their grandmother.

At any age, magical thinking should be challenged. Simply ask the question, "What made your (mother, father, friend, pet) die? Why do you think he died?"

Another example of magical thinking, not related to a child's understanding of death; rather, his inability to face a situation. Brendan is ten years old:

Brendan became furious when his parents said they could attend the funeral of his beloved teacher in a small school who died suddenly. The parents would have liked to attend the ceremony as they too knew the teacher.

Brendan insisted that he was going with his friends and preferred that his parents not go. That evening he asked to play cards with his mom and just “hang out” at home.

[table 26-1]

## CHILDREN’S GRIEF REACTIONS

Children do not continuously show overt signs of grieving such as seen with adults. This leads some to believe that children do not recognize the loss or understand its implications and therefore do not grieve. Children grieve in spurts, fluctuating between expressions of anger and sadness, anxiety and confusion, and then, in a moment, resume their normal way of going. This is adaptive, since as children they have a limited capacity to tolerate emotional pain and will pull away from it. Adults mistrust the child’s intermittent display of intense feelings and see them as disingenuous. However, children, even very young children, experience intensely painful responses that adults must understand, legitimize and help them through.<sup>7</sup> A child’s grief reaction will relate to:

- the age of the child
- the strength of the relationship of the deceased to the child
- his temperament and capacity to respond to changes
- the availability of a significant adult in his life to model grief
- the availability of an environment safe physically and emotionally to foster his grief work

In fact, the availability of *one* significant adult and a safe physical and emotional environment in which to mourn are the two most significant predictive factors of the child’s successful outcome after suffering a loss. Children will work through their grief over time if they have this emotional space and support to do so.

Contrary to popular thinking, children grieve *longer* than adults. They re-grieve the loss as they develop and make more mature meanings of the significance of the past loss.

Kate was barely five when her mother died of lung cancer. Her only memories of her mother were of her illness. Now, six years later, she and her brother had adjusted to life with dad as the primary caregiver. However, when eleven year old Kate brought home the school notice for the mother-daughter “Learning about our Bodies” evening, she angrily threw it on the kitchen counter and said, “I’m not going!” When her father offered to go with her, Kate began to cry inconsolably. She ran upstairs to her room, slammed her door and refused to talk to her father for the rest of the evening.

As Kate grows through each developmental stage, being a “motherless daughter” takes on a new meaning. Each event that marks her growing up, her first signs of puberty, when other girls are shopping with their mothers for a prom dress, graduation from high school, marriage, pregnancy and birth, also re-stimulates her grief of mother-loss.

Grief is manifest in different ways. Adults often think the child is not grieving following a loss, but notice marked changes in the child’s acting out. Difficulty concentrating, heightened sibling squabbles, inappropriate and aggressive behavior, moodiness, withdrawal, disorganization and temper tantrums are normal symptoms of grieving in childhood. Due to differences in cognitive ability and personality structures, children are apt to use more primitive defense mechanisms than adults, particularly denial and regression.

Common psychosomatic symptoms include headaches, stomachaches, bowel and bladder difficulties and sleep disturbances. Prolonged duration or intensity of these normal behaviors and symptoms may indicate the need for a clinical intervention but brief periods of turmoil are usually evidence of expected grief work. Chronic depression or hostility, longing to join the

deceased, persistent fear or panic, chronic loss of appetite or ability to sleep indicate the need for a professional referral. For the school-aged child, regular communication with the teacher regarding the child's classroom behavior is recommended as this should show gradual normalization after brief period of disruption. Especially during the first several months following a loss, caring adults can help the grieving child significantly by providing a stable environment, well defined behavioral boundaries, all delivered with empathy. Well intentioned teachers who become more permissive do not serve the grieving child, particularly since the school environment is often the only place that feels the same for the child. Similarly at home, the same level of expectation, routine and pattern is more supportive than a more persuasive or lenient approach.

### **Inhibitors**

In order for a child to grieve a loss, he must perceive his world to be safe and "back to normal." Sometimes one loss leads to other secondary losses that may, in effect have a more profound immediate influence on a child's sense of loss; for example, when a parent dies and the surviving parent goes to work full-time or there is a need to move. The deceased parent may be fantasized as away on a trip but the immediacy of moving, etc. goes beyond the child's ability to use denial in coping. Especially during the first few months following a loss within the family unit, family dynamics are apt to change due to explosive emotions, significant depression, financial stress, and new schedules. This is all part of the predictable "grief" landscape and will normalize with time. However, there are factors that can significantly derail the child's mourning process and require a clinical intervention.

- The inability of the significant adult in the child's life to mourn.          Stony silence is devastating to a child's sense of safety.

When Brian's father suicide, his world and his three brothers' changed forever. The day after the funeral, all family photos which included dad were put away; Mom never talked about Dad again. Shortly after Dad died, Mom went to work for the first time; took a computer course at night, and moved the family from the only home that Brian had ever known.

- The significant adult's inability to tolerate the child's expression of grief. "Stiff upper lip" is not to be encouraged.

Julie's eighth birthday would be especially bleak this year because her twin sister had died six month's earlier. When she cried while discussing party plans with her parents, Dad immediately started in with his routine response, "Don't be sad; be grateful that you're alive!"

- Forced hyper-maturity of the child; requirement to adultify behavior, e.g. take care of the siblings; prepare meals.

Fourteen year old Charlie refused free tickets to the Red Sox game that evening; he knew his mom would be alone if he went.

- Overwhelming secondary losses or a history of unresolved losses.

Seven year old David no longer cried when he left his foster family. After all, this family was the third one he had had in two years.

- Ambivalence towards the deceased person or confusion about the details of the death.

Dad's drinking had finally hurt everyone for the last time. He killed the innocent couple in the on-coming lane and himself when he veered over the yellow line. Sixteen year old Paul was flooded with intermittently with rage and relief.

- Inability to make meaning of the loss; lack of ability to accept the finality of the loss. Fantasy ideas beyond a few weeks.

Each time nine-year old Rebecca looked at the video of her family's

vacation on Cape Cod, it assured her that her baby brother would be at her cottage at Cape Cod when the family returned next summer.

### **Religious/Cultural implications**

Clinicians must view a child's conception of death and grief reaction in a religious/cultural context. McGoldrick et al warn that "clinicians should be careful about definitions of 'normalcy' in assessing families' responses to death, [since] the manner of, as well as the length of time assumed normal for mourning differs greatly from culture to culture."<sup>8</sup> It is important for the clinician to learn from the family what the child has been taught to believe about illness, death and mourning and especially rituals surrounding death. It is equally important for the clinician to learn what the child has "caught" with regard to his own idiosyncratic logic about death and the afterlife.

The child in the movie *My Girl* felt comforted when her best friend died from an allergic reaction to a series of bee stings when she reasoned that now her deceased mother who "resided" in heaven would take care of him.<sup>9</sup>

Most bereavement specialists agree that it assists children to attend funerals and other rituals associated with the death of loved one<sup>10</sup>. However an adult (not necessarily a primary care provider but a familiar and supportive person) should prepare the child for the experience directly and without euphemisms, accompany the child and be available to answer questions. A child should be told what her role will be and that she can leave if she needs to do so (this rarely happens). For a child to benefit from this experience, she must be old enough to make sense of the event and be assured of an adult for direct support. Keeping a child separate from the family

and community during this time may be very threatening to the child. His fantasies may be more scary than anything that will happen in reality.

## **SPECIAL SITUATIONS**

### **Pet Loss**

Few, if any children, will grow up without facing the painful experience of “losing” their pet. Some parents, in an effort to shield their children from the pain, mistakenly disallow the child the opportunity to face the grief that is a necessary by-product of affection and connection to their beloved pet. How many adults can remember being told as children that Rover was sent to a “farm in Iowa where he can run and breathe fresh air”! Why did parents think that information would not be equally devastating? No better are all too familiar stories of children returning home from school to learn that while they were gone, Rover was brought to the veterinarian’s and “put to sleep” because he was old and sick. The unexpected and hidden aspect of the event makes it very difficult for a child to profit from this learning opportunity.

In fact, the death of a pet, especially when it is anticipated, provides a rich opportunity for a youngster to strengthen coping skills. With anticipatory guidance provided by parents and the veterinarian, the child can accomplish the psychological task of understanding the what, why and how of pet euthanasia. Furthermore, the family can grieve together, naming the feelings and recognizing and respecting each family member’s individual way of dealing with feelings. Lastly, the family can engage in the rituals involved in saying good-bye: bringing the pet to the veterinarian, listening to his/her explanation of the euthanasia procedure, (emphasizing the lack of pain), burying him, and sharing memories of their pet. Parents and other caring adults serve their children by not trivializing or denying their feelings of grief, but at the same time, not being overwhelmed by them. Death, after all, is part of the lifecycle.

### **Sibling Loss**

The death of a sibling presents an enormous challenge to the surviving child or children in the family. She has weathered the loss of her brother or sister, a contemporary whose loss will continue to be felt throughout the lifecycle. She also has “lost her parents as she knew them, as the complicated mourning parents face is more intense and prolonged than any other”<sup>11</sup>. Marital conflict, depression, guilt, social isolation and possible resentment towards the perceived briefer adjustment for the surviving children exacerbate parents’ grief and may inhibit their ability to be emotionally available to their surviving children. In order to gain affection to ease their parents’ pain, the surviving child may attempt to “replace” a deceased sibling, thereby compromising the youngster’s own identity development. Too often the tendency to idealize the dead also makes it difficult for surviving siblings to deal with their ambivalent feelings (e.g. unresolved sibling rivalry) or anger at the deceased or at their parents (e.g., for not preventing the death or for seeming to care more about the deceased child). Finally, a survivor’s guilt is commonly felt by the surviving sibling and must be challenged. Many times brief counseling is needed to explore these issues, separate from any group family therapy. Sibling/survivor groups may be an additional help.

### **Parental Loss**

It is not clear exactly how many children experience the death of a parent; Kliman<sup>12</sup> estimates that five percent of children in the United States - 1.5 million - lose one or both parents by age fifteen; that proportion may be substantially higher in lower socioeconomic groups. The death of a parent affects the child’s development of a sense of trust and self-esteem. When a young child experiences the loss of that significant relationship, the core of his or her existence is shaken. Trust in the consistency and constant source of support and comfort is disrupted.<sup>13</sup>

In addition to the child's developmental age at the time of death, the next most important consideration is the emotional availability of the surviving parent who has a seemingly impossible task ahead; managing her own grief while providing a consistent, stable and "normal" environment for her children. Children can only do their necessary grief work if and when life feels safe again, at a time when changes abound. The acute grieving period, usually two to three years, is a period of adjustment as each family member feels a real need to be understood and has the least capacity to give understanding.

A month after nine year old Molly's mother died of ALS, she and her dad were at a drive-thru at MacDonald's. When he grabbed for his wallet, he realized that he had left it at home and had no money to pay for dinner that night. Molly became hysterical, thinking that they were poor now that mommy had died.

Children may idealize and overidentify with the deceased parent while distorting their view of the remaining parent. They are particularly concerned about any perceived vulnerability of the remaining parent. Depending on the cause of death, safety or health issues may become exaggerated. A common concern for the surviving parent is whether the very youngest children will remember their deceased parent. Looking at family photos and videos and storytelling is not always welcomed by the children who may fear the surviving parent strong display of emotion. Finding that balance is challenging because it may be different for each individual child. Although the same person died, he or she had a unique relationship with each family member.

### **The Dying Child**

When a child is diagnosed with a serious or life-threatening illness, parents turn to their child's primary care doctor, with whom they already have a trusting relationship. Special care should be taken by the primary care doctor to share updated information regarding the diagnosis

and prognosis. Furthermore, continuing communication with the child and his family throughout the course of the illness and eventual death is recommended. In particular, siblings may benefit from increased communication and/or appropriate referrals during particularly stressful periods of the illness. Prior to the 1970's, a protective approach regarding disclosing information to the dying child was employed by most professionals. However, today most researchers and clinicians agree that an open approach promotes coping skills and adaptive behavior. Children should be given information that allows them to understand, as much as they can, the experience they are undergoing. The child may vacillate between denial and acceptance of the disease. With some, he may practice mutual pretense, and with others he may be open about the seriousness of his illness and his fears and fantasies of impending death. Listening to the child and taking cues from him mitigates his sense of isolation.<sup>14</sup> Spinetta et al<sup>15</sup> suggest five factors that should be considered by caregivers before discussing the illness or death with the dying child:

- The parents' philosophical stance on death; e.g. What are their religious and cultural views about life, death and the afterlife?
- The parents' emotional stance on death e.g. Is one parent or the other in denial about death as an eventuality? Is either parent likely to be stoic or hyper-emotional?
- The child's age, experience and level of development
- The family's coping strategies; e.g. What history of crisis or illness can predict their ability to cope with this illness?
- The child's perception of process over content; e.g. Does the child require detailed information about procedures or treatment? Can she look at "the big picture"?

Today, the child is often actively involved with the treatment team. Since many children will die at home, the parents play a much more active role in their child's treatment as well. When

curative therapy has been replaced by palliative therapy, the treatment team should take special care not to abandon the child or her family. The primary care clinician's ongoing communication with the family at such a stressful time is suggested.

### **Getting Help**

When a child faces a family death or the death of a friend, parents often turn to their pediatrician for anticipatory guidance. She should be aware of the resources available within the community to assist the bereaved child. Developmentally appropriate grief groups are outstanding supports for children and the parent(s) who bring them. After sharing a simple evening meal, four concurrent groups gather in different rooms: children aged five through eight, children aged nine through twelve, teens, and parents. Nothing mitigates the isolation felt by the bereaved child more effectively than other children the same age who have also suffered a loss. Parents share their grief and unique situation of parenting alone or after the death of a child. For the groups to be effective, they should be facilitated by well trained adults and supervised by mental health professionals. Unfortunately, due to the special needs of youngsters to group them by age and stage, few communities offer this wonderful form of support. A popular model allows children to express their grief through individual and group play, artwork, journaling, and "sharing time".

(FIG-1)

Selected books and videos can be particularly helpful to the bereaved child. The Good Grief Program at Boston Medical Center offers an annotated bibliography that catalogs books by the type of loss, the reading level and a summary<sup>16</sup>. Parents should preview the book for its suitability and if the child is very young, read the book aloud with the child. This creates a natural opportunity for parent and child to talk about feelings.

## Summary

Because losses are an inevitable occurrence in the lives of children and their families, and because the pediatric health provider cares for the child in the context of these losses, she has a unique ability to assist the family through the losses over time. The pediatric provider who can offer anticipatory guidance to parents, accompanied by an empathetic ear at the time of an acute loss and at *significant times thereafter* is esteemed. Equally treasured is the pediatric provider who wisely “checks in” with his young patient at pivotal times in his development. Connecting with both parents and young patients around the challenging affective issues embraced by losses can be daunting for the pediatric health provider, but the rewards are plentiful. A parent reflects on her special relationship with her pediatrician, nearly nineteen years after the birth of her second son.

When Dr. Jones came into my room and told me that Michael had Down’s Syndrome, for just a minute I couldn’t remember what that meant. I guess I was in shock. But then, I looked into his eyes and saw that they had ‘filled up’, and I knew that Michael and I were not alone and we would face this together with Dr. Jones. He has been with us every step of the way, acknowledging the grief, the challenges and the joys of having a child like Michael.

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Violence against children can: Result in death. Homicide, which often involves weapons such as knives and firearms, is among the top three causes of death in adolescents, with boys comprising over 80% of victims and perpetrators. Lead to severe injuries. For every homicide, there are hundreds of predominantly male victims of youth violence who sustain injuries because of physical fighting and assault. Violence against children is a multifaceted problem with causes at the individual, close relationship, community and societal levels. Important risk factors are: Individual level - poor parenting practices. family dysfunction and separation. being associated with delinquent peers. witnessing violence between parents or caregivers. All children are tested by negative events. The concept is not intended to present a heroic image of such children when compared with others who meet similar situations with retreat, despair, or disorder. Indeed, to speak of resilience does not necessarily reflect an imperviousness to stress. Rather, it is designed to reflect the capacity for recovery and maintained adaptive behavior that may follow initial retreat or incapacity upon initiating a stressful event. In recent months, such an event was witnessed in the disruption of families by the Persian Gulf War. - stressful life events in the family, and. - large family size. Sameroff et al first observed these children quite intensively in infancy. Ending violence in children's lives and investing in early childhood are first and foremost a question of children's rights, further supported by scientific evidence which shows that a violence-free early childhood matters: the first 1,000 days of a child's life are the foundation for a person's whole future development. Violence in early childhood is a stressful, painful experience for a child in the immediate term, with the further risk of mid-and long-term consequences. The optimum physical, intellectual and socio-emotional potential of children depends on receiving loving care and enjoying