

Children's  
Encounters With  
Death, Bereavement,  
and Coping

**Charles A. Corr, PhD, CT**, is a Professor Emeritus at Southern Illinois University Edwardsville and is a member of the Association for Death Education and Counseling (1978–present; Board of Directors, 1980–1983); the International Work Group on Death, Dying, and Bereavement (1979–present; chairperson, 1989–1993); the ChiPPS (Children’s Project on Palliative/Hospice Services) Leadership Advisory Council of the National Hospice and Palliative Care Organization (1998–present); the Board of Directors of the Suncoast Institute, an affiliate of the Suncoast Hospice (2000–present); and the Executive Committee of the National Donor Family Council of the National Kidney Foundation (1992–2001, 2006–present). Dr. Corr’s publications include more than 30 books and booklets, together with more than 100 chapters and articles in professional journals, on subjects such as death education, death-related issues involving children and adolescents, hospice principles and practice, and organ and tissue donation. His most recent books are the sixth edition of *Death and Dying, Life and Living* (2009), coauthored with Clyde M. Nabe and Donna M. Corr, and *Adolescent Encounters With Death, Bereavement, and Coping* (Springer Publishing, 2009), coedited with David E. Balk.

**David E. Balk, PhD, FT**, is a Professor in the Department of Health and Nutrition Sciences at Brooklyn College of the City University of New York, where he directs graduate studies in thanatology. He is an Associate Editor of *Death Studies* and serves as that journal’s Book Review Editor. His work in thanatology has focused primarily on adolescent bereavement. He is the author of *Adolescent Development: Early Through Late Adolescence* (1995), and with Carol Wogrin, Gordon Thornton, and David Meagher, he edited *Handbook of Thanatology: The Essential Body of Knowledge for the Study of Death, Dying, and Bereavement* (2007). With Charles Corr, he coedited *Handbook of Adolescent Death and Bereavement* (Springer Publishing, 1996) and *Adolescent Encounters With Death, Bereavement, and Coping* (Springer Publishing, 2009). Dr. Balk serves on the Mental Health Advisory Board for National Students of AMF, a program begun by bereaved college students to assist one another.

# Children's Encounters With Death, Bereavement, and Coping

**CHARLES A. CORR, PhD, CT**  
**DAVID E. BALK, PhD, FT**

*Editors*

 **SPRINGER PUBLISHING COMPANY**

New York

Copyright © 2010 Springer Publishing Company

All rights reserved.

No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without the prior permission of Springer Publishing Company, LLC, or authorization through payment of the appropriate fees to the Copyright Clearance Center, Inc., 222 Rosewood Drive, Danvers, MA 01923, 978-750-8400, fax 978-646-8600, info@copyright.com or on the Web at www.copyright.com.

Springer Publishing Company, LLC  
11 West 42nd Street  
New York, NY 10036  
www.springerpub.com

*Acquisitions Editor: Sheri W. Sussman*  
*Project Manager: Mark Frazier*  
*Cover Design: Mimi Flow*  
*Composition: Apex CoVantage, LLC*

E-book ISBN: 978-0-8261-3423-3  
09 10 11 12/ 5 4 3 2 1

The authors and the publisher of this work have made every effort to use sources believed to be reliable to provide information that is accurate and compatible with the standards generally accepted at the time of publication. Because medical science is continually advancing, our knowledge base continues to expand. Therefore, as new information becomes available, changes in procedures become necessary. We recommend that the reader always consult current research and specific institutional policies before performing any clinical procedure. The authors and publisher shall not be liable for any special, consequential, or exemplary damages resulting, in whole or in part, from the readers' use of, or reliance on, the information contained in this book. The publisher has no responsibility for the persistence or accuracy of URLs for external or third-party Internet Web sites referred to in this publication and does not guarantee that any content on such Web sites is, or will remain, accurate or appropriate.

---

**Library of Congress Cataloging-in-Publication Data**

Children's encounters with death, bereavement, and coping / Charles A. Corr,  
David E. Balk, editors.

p. cm.

Includes bibliographical references and index.

ISBN 978-0-8261-3422-6 (alk. paper)

1. Children and death. 2. Grief in children. 3. Bereavement in children.
4. Adjustment (Psychology) in children. I. Corr, Charles A. II. Balk, David E., 1943-

BF723.D3C555 2009

155.9:37083—dc22

2009037535

---

Printed in the United States of America by Hamilton Printing.

*This book is dedicated to  
Dr. Richard J. Blackwell,  
teacher, scholar, mentor,  
and long-time family friend,  
with respect, admiration, and gratitude*

*And to  
Janet Renee Balk,  
My daughter, my child,  
Whose joy for life,  
Sense of humor, steadfast loyalty,  
Desire for social justice,  
Courage in the face of wrong,  
And loving heart  
Fill her parents with pride and admiration*



# Contents

*Contributors* xv  
*Foreword* xix  
*Preface* xxiii

## **PART I: BACKGROUND 1**

- 1 Children, Development, and Encounters With Death, Bereavement, and Coping 3**  
**Charles A. Corr**  
Childhood Development 4  
Encounters With Death During Childhood 9  
Encounters With Bereavement During Childhood 13  
Conclusion 18
  
- 2 Children’s Emerging Awareness and Understandings of Loss and Death 21**  
**Charles A. Corr**  
Early Inklings 22  
Direct Encounters With Loss and Death During Childhood 24  
Understanding Death: Developmental Stages 25  
“Staging” Children and Their Understandings of Death Is Not Desirable 27  
Thinking About Death Is a Complex Matter 29  
Listen to the Individual Child 32  
Some Guidelines for Helping Children Cope With Their Emerging Awareness and Understandings of Death 34

- 3 Ethical Issues in Counseling Bereaved and Seriously Ill Children 39**  
**Heather L. Servaty-Seib and Sara J. Tedrick**  
Professional Competence 40  
Autonomy, Informed Consent, and Child Assent 46  
Confidentiality 50  
Touch 55  
Conclusion 55
- 4 Ethics, Research, and Dying or Bereaved Children 61**  
**Andrea C. Walker**  
Children in Research 62  
Ethical Issues in Research 64  
Design Issues in Research 70  
Conclusions and Recommendations for Research 74
- PART II: DEATH 81**
- 5 Infant Deaths 83**  
**Beth A. Seyda and Ann M. Fitzsimons**  
Infant Death Defined 84  
Infant Deaths and Death Rates in the United States 84  
Leading Causes of Infant Death 84  
Trends in Infant Mortality 86  
Efforts to Prevent or Mitigate Infant Deaths 89  
Impact of Infant Deaths on the Family 91  
Grief and Bereavement Support After an Infant Death 95  
Conclusion 102  
Additional Resources for Health Care Professionals  
and/or Patient/Family 103
- 6 Children, Unintentional Injuries, and Homicide 109**  
**Edith Crumb and Amy Griffith Taylor**  
Unintentional Deaths: Epidemiology and Types 109  
Unintentional Injury Prevention Summary 115  
Homicide 115  
Conclusion 126

- 7 Children and Infectious Diseases 131**  
**Craig Demmer**  
 Burden on Children in Developing Countries 132  
 Main Types of Infectious Diseases Causing Child Deaths 133  
 Lack of Research on Bereavement Associated With  
 Infectious Disease Deaths in Children 139  
 Conclusion 143
- 8 Children Living With Life-Threatening or Life-Limiting  
 Illnesses: A Dispatch From the Front Lines 147**  
**Michael M. Stevens, Rhondda J. Rytmeister, Marie-Thérèse Proctor,  
 and Patricia Bolster**  
 The Walking Wounded: Families of Seriously Ill Children 148  
 Awareness of Death in Well Children 153  
 Awareness of Death in Seriously Ill and Dying Children 154  
 The Sick Child's World 156  
 Looking to the Ill Child's Spiritual Welfare 160  
 Children's Funerals and Beyond: We Will Remember Them 162  
 Coping With Recovery: Reflections From Long-Term Survivors 163  
 The Temperament of Families 164  
 Caring for Oneself and for One's Colleagues: Tours of Duty 165
- PART III: BEREAVEMENT 167**
- 9 Children Bereaved by the Death of a Parent 169**  
**Grace H. Christ**  
 Impact of Developmental Level on Children's  
 Manifestations of Grief 170  
 Type of Death: Anticipated Versus Traumatic Loss 175  
 Factors That Impede or Facilitate Reconstitution Over Time 180  
 Issues Regarding Development and Implementation  
 of Interventions 186  
 Conclusion 190
- 10 Sibling Bereavement in Childhood 195**  
**Katrina Koehler**  
 The Sibling Relationship 196  
 A Roller Coaster of Emotions 197  
 Other Common Grief Reactions of Sibling-Bereaved Children 208

- Over Time Children's Grief Can Stretch Out, Intensify,  
or Come in Waves 211
- Factors That Can Complicate Children's Grief Responses  
to Sibling Bereavement 212
- Conclusion 217
- 11 Death of a Friend During Childhood 219**  
**Diane Snyder Cowan**
- On Friendship 220
- Friendship Quality 221
- Death of a Friend 222
- Disenfranchised Grief and Secondary Losses 226
- The Role of the School 228
- The Funeral 232
- What Can Help 232
- Conclusion 235
- 12 Children's Bereavement Over the Deaths of Pets 237**  
**Tamina Toray**
- Experiencing Pets Outside of the Home 238
- Pets' Influences on the Lives of Children 239
- Pets and Physical Health 239
- Death of a Pet and Children's Grief 240
- Explaining Pet Sickness and Death to Children 242
- Attachment and Loss: Two Ends of the Spectrum 243
- Pets as Members of Children's "Second Family" 244
- Children With Special Needs 244
- The Traumatic or Sudden Death of a Family Pet 245
- Terminal Illness and Family-Present Euthanasia 246
- After-Death Rituals and Commemorating a Pet's Life 248
- Body Care Options 249
- Should We Get Another Pet? 250
- Supporting Children's Grief 250
- Conclusion 254
- 13 Children and Traumatic Deaths 257**  
**Donna L. Schuurman and Jana DeCristofaro**
- Core Definitions 259
- Some Implications of These Definitions 261
- Complicated Grief/Traumatic Grief/Mourning 263
- Risk Factors for Traumatic Reactions 263

- The Intersection of Trauma and Death 266  
 What Types of Interventions Are Appropriate  
 for Children Who Are Experiencing Trauma  
 Symptoms After a Death or Deaths? 269

## **PART IV: INTERVENTIONS 275**

- 14 Talking to Children About Death-Related Issues 277**  
**Jane Moore and Clint Moore III**  
 Be Real 278  
 Use Appropriate and Simple Language 281  
 Have an Open Agenda 283  
 Listen and Observe 287  
 Conclusion 290
- 15 Educating Children About Death-Related Issues 293**  
**Kathryn A. Markell**  
 Early Advocacy and Subsequent Developments 293  
 Objections to Death Education for Children and  
 Counterarguments 295  
 Teacher and Parent Attitudes Toward Death and  
 Death Education 300  
 Death Education in the Schools 303  
 Conclusion 307
- 16 Helping Families Help Bereaved Children 311**  
**Katrina Koehler**  
 A Message for Parents, Caregivers, and Advocates  
 of Bereaved Children 311  
 The Legacy of Equating Surviving With Moving On 312  
 The Natural Grief Process 313  
 Parents (and Other Adults) as Role Models for  
 Bereaved Children 314  
 Allowing Children to Be Children 315  
 Other Ways to Help Bereaved Children 316  
 Grief Support Groups and Grief Counseling 326  
 Teachers and Schools 328  
 Special Circumstances That Influence Childhood Bereavement 328  
 Support for Parents and Primary Caregivers 334

- 17** Supporting Resilience in Bereaved Youth in Sub-Saharan Africa Who Have Lost a Parent to HIV/AIDS 337  
**Melissa J. Hagan and Irwin N. Sandler**  
Parental Death in the Context of the HIV/AIDS Epidemic in Sub-Saharan Africa 337  
Factors That Influence Children's Adaptation Following AIDS-Related Bereavement 339  
Meeting the Needs of Children and Adolescents Bereaved by HIV/AIDS 342  
Helping Families Care for AIDS-Bereaved Children and Adolescents: "Walking the Road" From a Contextual Resilience Perspective 350  
Case Study 351
- 18** Principles and Practices of Peer Support Groups and Camp-Based Interventions for Grieving Children 359  
**Donna L. Schuurman and Jana DeCristofaro**  
A Brief Retrospective 359  
Philosophical Framework 361  
Guidelines for Best Practices 362  
Four Operating Principles 362  
Group Structure 364  
Group Format 365  
Effective Group Size 367  
Type of Death and Developmental Factors 367  
Which Children Are Suitable for Grief Support Groups, and Should They Be Screened? 367  
What About the Adult Caregivers? 368  
Bereavement Camps 368  
Evaluating Program Effectiveness 370
- 19** Using Expressive Arts When Counseling Bereaved Children 373  
**Dayna D. Wood and Rebekah Lancto Near**  
History of the Arts as Healing 374  
Creative Arts Therapies and Grief 375  
The Creative Arts and Other Disciplines 377  
Expressive Arts Therapy 378  
Family Arts Programming and Children's Bereavement Groups 388  
Concluding Thoughts 391

- 20 Children With Developmental Disabilities, Death, and Grief 395**  
**Marc A. Markell and John H. Hoover**  
Developmental Disabilities 396  
Developmental Disabilities and End-of-Life Concepts 400  
Disenfranchised and Complicated Grief 405  
Parental Grief in Developmental Disabilities 408  
Recommended Programs and Treatment Modalities 409
- 21 Pediatric Palliative and Hospice Care 413**  
**Stacy F. Orloff and Susan M. Huff**  
Background 414  
Defining Palliative and Hospice Care 415  
Children Who May Benefit From Palliative Care 419  
Models of Care 422  
Conclusion 432
- 22 Psychotherapeutic Approaches for Children  
With Life-Threatening Illnesses 435**  
**Michelle R. Brown and Barbara Sourkes**  
Individual Psychotherapy 436  
Themes of Loss That Often Arise in Psychotherapy  
With Children 438  
Psychotherapeutic Techniques 441  
Anticipatory Grief 446  
Family Psychotherapy 448  
Siblings 450  
Cultural Considerations 451  
Future Directions 452
- Appendix: Selected Books to Be Read by or With Children 455**  
**Charles A. Corr**  
Coloring and Activity Books 455  
Confronting Difficult Feelings 457  
Deaths of Pets 458  
Coping With Illness and Approaching Death 460  
Picture Books About Loss and Grief 461  
Picture Books With Animals Telling About Loss  
and Grief 465

Books Designed to Educate or Guide Children 467  
Storybooks About Death, Loss, and Grief 468

**Name Index 477**

**Subject Index 485**

## Contributors

**Patricia Bolster, RSM, DHCE, MEd, MTh**, is Chaplain in the oncology unit of the Children's Hospital at Westmead, Sydney, Australia.

**Michelle R. Brown, PhD**, is a Clinical Assistant Professor in the Division of Child Psychiatry, Stanford University School of Medicine, and a Pediatric Psychologist with the Pediatric Psychiatry Consultation-Liaison Service at Lucile Packard Children's Hospital at Stanford in Stanford, California.

**Grace Christ, DSW**, is a Professor in the School of Social Work, Columbia University, New York City.

**Diane Snyder Cowan, MA, MT-BC**, is Director of the Elisabeth Severance Prentiss Bereavement Center, Hospice of the Western Reserve, in Cleveland, Ohio.

**Edith Crumb, LCSW**, was Grief Intake Counselor at Alive Hospice and Emergency Department Social Worker at Monroe Carell Jr. Children's Hospital at Vanderbilt in Nashville, Tennessee, at the time of her contribution to this book. She is currently a teaching assistant in the bachelor's of social work program while pursuing her doctorate in social work at the University of Louisville.

**Jana DeCristofaro, MSW**, is the Coordinator of Children's Grief Services at the Dougy Center for Grieving Children in Portland, Oregon.

**Craig Demmer, EdD, PhD**, is a Professor in the Department of Health Sciences, Lehman College of the City University of New York.

**Ann M. Fitzsimons, MBA**, is a bereaved aunt and the Cofounder/Associate Director of Compassionate Passages, Inc. She lives in Farmington Hills, Michigan.

**Melissa J. Hagan, MPH, MA**, is a Prevention Research Fellow at Arizona State University, Tempe, Arizona.

**John H. Hoover, PhD**, is Associate Dean of the College of Education, St. Cloud State University, St. Cloud, Minnesota.

**Susan M. Huff, RN, MSN**, is the Director of Pediatrics at Home, a company of Johns Hopkins Home Care Group and Johns Hopkins Medicine in Baltimore, Maryland.

**Katrina Koehler, BA**, is the Executive Director at Gerard's House, in Santa Fe, New Mexico.

**Kathryn A. Markell, PhD**, teaches at Anoka-Ramsey Community College in Coon Rapids, Minnesota.

**Marc A. Markell, PhD, CT**, is a Professor of Special Education at St. Cloud State University, St. Cloud, Minnesota.

**Clint Moore III, MDiv, PhD, BCC, FT**, is an ordained Episcopal priest in the Diocese of Chicago and a Clinical Ethicist at Advocate Lutheran General and Advocate Lutheran General Children's Hospitals, Park Ridge, Illinois. He is also a part-time faculty member in the Philosophy Department at Loyola University Chicago.

**Jane Moore, EdD, FT**, is an Associate Professor at National-Louis University, Chicago, Illinois, and a part-time faculty member in the Thanatology Program at King's University College, the University of Western Ontario, London, Ontario, Canada.

**Rebekah Lancto Near, CAGS, MS, LCAT**, is a consulting licensed expressive arts therapist for Friends of Karen, Inc., in Brooklyn, New York.

**Stacy F. Orloff, EdD, LCSW**, is Vice President of Palliative Care and Community Programs at Suncoast Hospice in Clearwater, Florida.

**Marie-Thérèse Proctor, BA Psych and Rel Studies, BA Psych Hons, PhD**, is a Psychologist and Project Research Officer with the Life-Limiting Conditions Project in the Oncology Unit of the Children's Hospital at Westmead, Sydney, Australia.

**Rhondda J. Rytmeister, BA (Hons), MCLinPsych**, is Senior Clinical Psychologist in the Oncology Unit at the Children's Hospital at Westmead, Sydney, Australia.

**Irwin N. Sandler, PhD**, is Regents' Professor and Director of the Prevention Research Center, Arizona State University, Tempe, Arizona.

**Donna L. Schuurman, EdD, FT**, is Executive Director of the Dougy Center for Grieving Children in Portland, Oregon.

**Heather L. Servaty-Seib, PhD, HSPP**, is an Associate Professor of Counseling and Development in the Department of Educational Studies, Purdue University, West Lafayette, Indiana.

**Beth A. Seyda, BS**, is a bereaved parent, Board Past-President of the Pregnancy Loss and Infant Death Alliance, and cofounder and Executive Director of Compassionate Passages, Inc. She lives in Chapel Hill, North Carolina.

**Barbara Sourkes, PhD**, is an Associate Professor of Pediatrics and Psychiatry at Stanford University School of Medicine and the Kriewall-Haehl Director of the Pediatric Palliative Care Program at Lucile Packard Children's Hospital at Stanford in Stanford, California.

**Michael M. Stevens, AM, FRACP**, is Senior Staff Specialist in the Oncology Unit of the Children's Hospital at Westmead, Sydney, New South Wales, Australia.

**Amy Griffith Taylor, LMSW**, is the Counseling Supervisor at the Victim Intervention Program (VIP) of the Metropolitan Police Department of Nashville and Davidson County in Nashville, Tennessee.

**Sara J. Tedrick, BA**, is a graduate student in the Counseling Psychology Doctoral Program in the Department of Educational Studies, Purdue University, West Lafayette, Indiana.

**Tamina Toray, PhD**, is a Professor in the Psychology Division at Western Oregon University, Monmouth, Oregon, and Adjunct Faculty at Oregon State University College of Veterinary Medicine, Corvallis, Oregon.

**Andrea C. Walker, PhD, LADC**, is an Associate Professor of Psychology at Oral Roberts University, Tulsa, Oklahoma.

**Nancy Boyd Webb, DSW, BCD, RPT-S**, is Distinguished Professor Emerita of Fordham University's Graduate School of Social Service, where she served as the founding director of the Post-Master's Certificate Program in Child and Adolescent Therapy in Westchester County, New York.

**Dayna D. Wood, EdS, NCC, LMHC**, is a bereavement counselor for the Visiting Nurse Service of New York Hospice Care program in New York City.



## Foreword

All adults know that everyone will die sooner or later, but until confronted with an actual death, or with a situation of a serious health condition, most of us prefer to push the idea of death for ourselves and our loved ones into the distant future. It is the ultimate loss experience, and it is an event over which we have no control. When someone close to us becomes terminally ill or dies, we feel devastated, and this may be one of the most powerful emotions we have ever known. Even the strongest and the mightiest bow down to the power and finality of death. Some people never “get over” their loss. In view of this reality, it is no wonder that adults have great difficulty talking with children about death and in trying to help bereaved youth with their questions and confused emotions. Adults who themselves feel helpless and overwhelmed when confronted with death are ill-equipped to answer children’s questions and to help them process their feelings about it.

Thankfully, the field of death education has stepped in to offer assistance in the form of guide books and manuals intended to help professionals assist bereaved individuals of all ages. In the past decade a virtual flood of bereavement books has been published, and these have been eagerly welcomed by the broad range of helpers who find themselves in a situation of having to comfort a bereaved child or young person. No longer can the topic of death be ignored as the general public in this country watches daily television or news accounts about homicides, terrorist attacks, and wartime deaths. The media give extensive exposure to this subject, and all professionals who interact with children, whether pastoral counselors, medical personnel, nurses, school counselors, social workers, teachers, or parents, must be prepared to encounter children who are trying to deal with their emotions related to deaths in their families, in their schools, and in their communities.

I learned this many years ago in my own experience as a child therapist counseling children and families who were dealing with a variety of problematic situations. The death of a grandmother in a family that was

trying to adapt to a boy with severe attention deficit problems taught me that stresses between the generations over the management of a terminally ill elderly woman can seriously complicate and negatively impact the family's ability to focus on their child, who was struggling with other problems (see Webb, 1993). Because of this case, and several others in which death emerged as a complicating factor in a child's therapy, I realized that it was necessary to acknowledge and focus on the child's and family's reaction to a significant death, in addition to helping with other troublesome issues. Over time I have worked with children who have experienced a variety of death experiences, including the loss of a close friend in a car accident, a mother who had terminal AIDS, a father who died suddenly in a house fire, and a father who perished in the attacks of September 11, 2001, to mention a few. Because there was a paucity of professional literature covering traumatic events such as these, I decided to edit a book about helping bereaved children in order to share my clinical experience with other therapists, counselors, and students. Over the course of 15 years, that book (*Helping Bereaved Children*) has been published in two updated and distinct editions with a third edition currently in press, thereby confirming my original impression that the subject was one that was greatly needed.

The invitation to write the foreword to the present book, *Children's Encounters With Death, Bereavement, and Coping*, provided me with another welcome opportunity to express my own commitment to help the helpers who are helping bereaved children. Charles Corr and David Balk have assembled a very comprehensive group of topics and authors in this volume that can serve as exemplars for assisting in a variety of bereavement circumstances. The extensive coverage includes a review of children's reactions to various types of deaths and chapters that present a variety of helping interventions. These include chapters focused on death education, on the use of expressive arts therapies, on peer groups, and on the role of hospice and palliative care, as well as on family and individual psychotherapy. The appendix, containing a rich selection of books for children about loss and grief, will serve as a wonderful resource for professionals and parents who will welcome having this annotated listing of books to read with bereaved children.

We know that death comes in many forms, from the anticipated decline and eventual demise of an elderly grandmother, to the sudden, completely unexpected accidental death of a sibling in a skiing accident. Deaths may be peaceful and quiet or violent and mutilating. They may occur singly or in groups. They may involve close family members,

school friends, or unknown, but famous, rock stars such as Michael Jackson. Several factors will determine children's bereavement responses. I have grouped these into an assessment formulation that I refer to as the "Tripartite Assessment of the Bereaved Child" (Webb, 2002). These include Individual Factors such as the child's age, past experience with death, and ability to comprehend the meaning of the loss. Another important factor is the nature of the child's relationship with the person who died. It seems understandable that the closer the relationship, the deeper will be the pain of the loss, and the more complicated will be the child's bereavement. Corr's two opening chapters cover many of these issues. A second group of factors that I refer to as "Death-Related Factors" includes what the child has been told about death in general terms and also what has been communicated to the child about the current death event.

Family, Social, Religious, and Cultural Factors constitute the third part of the tripartite assessment of the bereaved child. It is important to know the degree to which the child has been included in the family rituals surrounding the death, including the funeral. Children benefit from having the opportunity to say goodbye in an age-appropriate manner, if the culture approves of this. We know that religious beliefs, which can be such a comfort to adults, sometimes confuse and anger the young child who does not comprehend the abstract distinction between the body and the soul and whose literal thinking may wonder why God chose to take away his or her mother or father. Children need repeated and patient explanations, given in small doses in simple terms. Readers will find some very helpful suggestions about doing this in several chapters in part 4 of this book.

This book is a wonderful resource that can be consulted repeatedly by professionals and used as a text in thanatology courses. Unfortunately, none of us can take away the pain of bereaved children that will come and go at significant milestones in the child's growing life when he or she misses the absent loved person. However, it is possible to keep that grief from becoming disabling and to foster children's resilience so that they can incorporate their bereavement and carry on with their lives. The concept of the "transformative" power of grief (Peterson, Park, D'Andrea, & Seligman, 1995; Tedeschi & Calhoun, 1995) refers to the ability of some individuals not only to move beyond the pain of their loss, but also to use it in a positive way. One might think that this would be an unrealistic expectation for young children, but I cite several examples of children's positive experiences with death in my latest book, *Helping*

*Children and Adolescents With Chronic and Serious Health Conditions.* Readers who want an inspiring example should check out the autobiographical account of Mattie Stepanek, who at age 12 had experienced the deaths of several siblings from a rare disease and who, himself, had a terminal condition (Stepanek, 2001). This boy's young life is a beautiful demonstration of the power of resiliency and hope that transformed a situation of sadness and doom to one of possibility and positive thinking. In a similar manner, Corr and Balk's book will help adults find many ways to lead bereaved children to a hopeful belief in their future, despite their considerable losses. This book is a real contribution to the growing literature in this field.

*Nancy Boyd Webb, DSW, LICSW, RPT-S  
Distinguished Professor of Social Work Emerita,  
Graduate School of Social Service,  
Fordham University*

## REFERENCES

- Peterson, C., Park, N., D'Andrea, W., & Seligman, M. E. (2008). Strengths of character and posttraumatic growth. *Journal of Traumatic Stress, 21*(2), 214–217.
- Stepanek, M. J. T. (2001). *Journey through heartsongs*. New York: Hyperion.
- Tedeschi, R. G., & Calhoun, L. G. (1995). *Trauma and transformation: Growing in the aftermath of suffering*. Thousand Oaks, CA: Sage.
- Webb, N. B. (Ed.). (1993). *Helping bereaved children: A handbook for practitioners* (2nd ed., 2002; 3rd ed., in press). New York: Guilford Press.
- Webb, N. B. (Ed.). (2009). *Helping children and adolescents with chronic and serious medical conditions*. Hoboken, NJ: Wiley.

## Preface

Children who are struggling with death-related issues deserve caring and competent assistance from the adults around them. These are issues that have staggered many adults. When provided with timely and appropriate support, children are resilient in many ways, but encounters with loss, death, and bereavement challenge their abilities to cope.

Unfortunately, children's experiences and endeavors in this field have not always received the full-scale, in-depth exploration they deserve. There are many reasons for this deficiency. All too often, issues involving children and adolescents are run together as if there were no important differences between these two developmental groups. In addition, on their own, children are diverse in many ways, and it has often seemed to many adults that children's encounters with death and bereavement are few in number, with perhaps little impact on their lives in the long run.

We disagree. On the contrary, we believe there is need for a robust and ongoing focus on issues related to death, bereavement, and coping during childhood. Such a focus needs to include, but go beyond, investigations of familiar topics, such as parental or sibling bereavement as experienced by children. We offer this book as part of a new effort to provide a broad resource to guide care providers, such as nurses, counselors, social workers, educators, and clergy, as well as parents, family members, and other concerned persons, who seek to understand and help children as they attempt to cope with death-related issues.

Writing separately and together, we have attempted over the years to contribute to the literature on death-related topics as they involve children. One of us has coedited three prior books in this subject area. Those books included *Helping Children Cope With Death: Guidelines and Resources* (1982; 2nd ed., 1984), coedited with Hannelore Wass; *Childhood and Death* (1984), also coedited with Hannelore Wass; and *Handbook of Childhood Death and Bereavement* (Springer Publishing, 1996), coedited with Donna M. Corr.

Together, the two editors of the present volume coedited *Handbook of Adolescent Death and Bereavement* (Springer Publishing, 1996) and *Adolescent Encounters With Death, Bereavement, and Coping* (Springer Publishing, 2009).

We agreed to undertake a new book on death-related issues and children, the one you now hold in your hands, because we recognized that a great deal has transpired since the 1980s and 1990s in terms of theoretical understandings, research advances, and clinical management. For example, our knowledge of the development of children's understandings of death has been increasing and becoming more sophisticated, sensitivity to both cultural differences and the individual voices of children has been enhanced, appreciation of diverse populations around the world has grown, new insights have been gained about children's resilience following bereavement, and multiple attempts have been made to bridge the gaps that often separate researchers and practitioners. At the same time, the availability of pediatric palliative and hospice care has expanded greatly, as have grief support programs for bereaved children and their families. In addition, we have learned a great deal in recent years about effective ways to talk to and teach children about death-related issues, and the resources available to help us in these endeavors have greatly expanded, as shown by the 125 titles that are identified and described in the appendix to this book.

In developing this book, we approached individuals who could draw on a wide variety of expertise and invited them to contribute. We asked them to make every effort to synthesize contemporary scholarship, to link practice and current research, and to examine topics with more than mainstream American culture in mind, insofar as that was possible. We greatly appreciate the generosity with which so many fine authors took time from their busy schedules to join in this project. The contributors to this book come from multiple professional backgrounds and disciplinary perspectives, including psychology, education, counseling, health sciences, nursing, social work, medicine, philosophy, and pastoral care. Several contributors work in pediatric palliative care and hospice programs, as well as in children's bereavement support programs.

As we received initial manuscripts from these contributors, we were continually impressed by the quality of the information, insights, and lessons they contained. We also appreciated the willingness of contributors to work with us to sharpen and polish their chapters so as to make them as instructive and as useful as possible for readers of this book. New evidence, scholarly research, practical wisdom, and exciting interpretations

came together in important ways. As a result, we believe *Children's Encounters With Death, Bereavement, and Coping* provides an overarching framework for understanding these topics, offers persuasive syntheses of specific areas of inquiry, initiates scholarly discussion on subjects not previously examined, and offers practical guidance for helping children. We trust you will share our judgment once you have had an opportunity to examine the contents of this book.

*Charles A. Corr*  
*David E. Balk*



Children's  
Encounters With  
Death, Bereavement,  
and Coping



# Background

## PART I

The four chapters in part 1 provide essential background for understanding and helping children in their encounters with death, bereavement, and coping. Chapter 1 addresses a series of topics related to childhood development and typical encounters with death and bereavement in both the United States and other countries around the world. The goal of this chapter is to provide a broad overview of both child development and death-related encounters during childhood, while also suggesting some of the many ways in which the two interact. Many of the topics introduced in this chapter, such as leading causes of death both in the United States and elsewhere around the globe, and typical patterns in children's grief and mourning, will be developed in greater detail in later chapters in this book.

Chapter 2 explores children's emerging awareness and understandings of death. The journey from early inklings about separation and loss to full-blown concepts of death is a complex one, navigated in different ways by different children. Chapter 2 describes the typical journey of well children from a young child's first awareness of themes and events related to separation and loss through direct encounters with death during childhood. The chapter also explains a well-known, stage-based theory of the development of children's understandings of death, offers some critical remarks about such stage-based schemas, and points out the complexity of the concept of death. In conclusion, the chapter offers

advice about listening actively and carefully to children's concerns about loss and death, and sets forth 17 guidelines for adults who are interacting with or seeking to help children cope with sadness, loss, and death-related events.

Chapters 3 and 4 explore ethical principles and issues that are likely to arise when adults engage in counseling or research with seriously ill, dying, or bereaved children. Both chapters stress the importance of professional competence, whether in counseling children or in the design and implementation of child-related research projects. In each case, the chapters emphasize the need to respect autonomy, informed consent or child assent, confidentiality, and the legitimate role of parents and other family members.

A basic lesson that reappears throughout these and subsequent chapters in this book is the need to listen actively and carefully to each child as he or she shares descriptions and accounts of his or her death-related experiences. It is also important to realize that adults who read this book are not immune to encounters with death, loss, and bereavement. For that reason alone, while we seek to help children who are coping with similar death-related encounters, we can also learn from them at the same time.

# 1

## Children, Development, and Encounters With Death, Bereavement, and Coping

**CHARLES A. CORR**

This chapter addresses four fundamental subjects that underlie everything else that appears in this book: (1) typical developmental processes in childhood; (2) broad patterns of encounters with death during childhood in the United States and in selected examples from other parts of the world; (3) typical patterns of encounters with bereavement during childhood; and (4) children's coping with death-related challenges. Specific topics examined include (1) the meaning of the terms "child" and "childhood"; (2) the difference between normative and non-normative life events and transitions within childhood; (3) developmental tasks that are likely to confront children during four distinct eras in childhood; (4) some complications in childhood development; (5) numbers of deaths, death rates, and leading causes of death in three age groupings during childhood in the United States, along with the key variable of race; (6) distinctive encounters with death during childhood in some other areas of the world; and (7) examples of loss and death during childhood, what we currently know about children's grief and mourning, and some suggestions about needs of bereaved children. The goal of this chapter is to introduce these topics as important in their own right and as preparation for more detailed explorations in the chapters that follow.

## CHILDHOOD DEVELOPMENT

### Childhood and Its Four Principal Eras

Ever since medieval times, the term *child* has designated the offspring of human parents, that is, the unborn or newly born human being, “originally always used in relation to the mother as the ‘fruit of the womb’” (Simpson & Weiner, 1989, vol. 3, p. 113). Such offspring may be young children, adolescents, or even the adult children of their parents, but the word “child” most properly refers to an individual below the age of puberty. The related term *childhood* normally identifies the portion of the life span from birth to puberty or the beginning of adolescence.

Within childhood as it is typically experienced in most developed societies in the world today, an interval including approximately the first 10–12 years of life, it has become customary to think of four basic developmental eras (sometimes called “ages,” “periods,” or “stages”): infancy, toddlerhood, early childhood or the preschool years, and middle childhood or the school-age years (see Table 1.1). Although the justifications for these divisions are generally obvious, there may be some arbitrariness

Table 1.1

#### PRINCIPAL DEVELOPMENTAL ERAS DURING CHILDHOOD

ERA	AGE <sup>a</sup>	PREDOMINANT ISSUE	VIRTUE
Infancy	Birth through 12–18 months	Basic trust vs. mistrust	Hope
Toddlerhood	Infancy to 3 years of age	Autonomy vs. shame and doubt	Will or self-control
Early childhood; sometimes called play age or the pre-school period	3–6 years of age	Initiative vs. guilt	Purpose or direction
Middle childhood; sometimes called school age or the latency period	6 years to puberty	Industry vs. inferiority	Competency or skill

<sup>a</sup>All chronological ages are approximate.  
Source: Adapted from Erikson (1963).

in the number of eras identified during childhood and in their precise boundaries. For example, some might wish to draw a further distinction between children in the early primary school years and pre-teenagers. In addition, some authors (e.g., Newman & Newman, 2005; Papalia, Olds, & Feldman, 2005) advocate the prenatal period, extending from conception to birth, as being the very first era in the human life course. For our purposes here, it is enough to consider the standard division of four basic developmental eras in childhood.

Clearly, children differ among themselves in many ways. In addition to differences arising from their developmental status, children differ as unique individuals; as males and females; as members of different racial, cultural, religious, or economic communities; as a result of divergent life experiences; and in other salient ways. When generalizations about children are offered, it is helpful to keep these many variables in mind and to be extremely cautious (as suggested in the footnote in Table 1.1) about linking developmental eras with chronological ages or confounding the two as if there were no real distinction between them.

## **Normative and Non-Normative Transitions and Life Events**

Throughout the human life span, it has become commonplace to distinguish between normative and non-normative life events and transitions (e.g., Baltes, Reese, & Lipsitt, 1980). A normative life event is one that is expected to occur at a certain time, in a certain relationship to other life events, with predictability, and to most if not all of the members of a developmental group or cohort. Because normative life events follow familiar patterns or standards, they lead to expected transitions or turning points in individual development. Entering the primary school system around the age of six is a familiar example of a normative life transition in the United States and many other developed countries. This transition is the basis for the previously noted distinction between preschool and school-age children or early and middle childhood.

As the language itself indicates, non-normative life events are those that are unexpected or unforeseen. Unlike normative life transitions, these events occur atypically or unpredictably, with apparently random relationship to other life events and to some but not all members of a developmental cohort. Because non-normative life events are characteristically unanticipated, they usually catch children and adults unprepared.

A child's discovery that he or she is a musical prodigy who has the ability to play an advanced piece of classical music or a child experiencing the accidental death of a pet during childhood are both examples of non-normative or distinctively personal life events. Such events obviously do occur from time to time in the lives of some children, but there is no reliable basis for predicting if, and much less when, they will happen in the life of a specific child.

Most of the death-related events discussed in this book are, or involve, situational occurrences or non-normative life experiences. Events such as the death of a youngster during childhood or a child's encounter with the death of a parent, sibling, other relative, or friend are best thought of as unanticipated life crises. These events do not rise to the frequency or predictability of normative life transitions during childhood.

Normative life transitions and unanticipated or situational life events do share some common characteristics. Both may confront the children who experience them with life crises, and both may evoke coping processes from such children. Events that are properly described as life crises or turning points in a child's life present "dangerous opportunities." That is, they offer opportunities for growth and maturation if a child copes with them effectively, but they also represent danger in the form of possible psychological harm to the child and distorted or unsatisfactory development if the coping response is inappropriate or inadequate. As a result, it is useful to understand both the nature of normative life transitions in childhood and the potential implications for children of unanticipated life events—especially those that may be distressing in character. In the case of events related to death and bereavement, it is also helpful for adults to learn how to foster constructive coping processes in childhood, how to minimize unproductive or counterproductive coping, and how to support children while they are engaged in the work of coping.

## **Developmental Tasks Within Four Principal Eras in Childhood**

Throughout the human life span, normative life transitions are usually described in association with developmental tasks. Within childhood, these tasks represent the work children need to undertake in order to navigate successfully the developmental challenges that confront them. In his well-known analysis of life-span development within childhood (summarized in Table 1.1), Erikson (1963, 1968) described each era within childhood in terms of a predominant psychosocial issue or central conflict and in terms of a leading virtue that would be achieved through

the normal and healthy development of an individual ego. Erikson meant that in each era of their development, children (and other human beings) are confronted by a pair of opposed tendencies or orientations toward life, the self, and other people. The way in which each of these basic tensions or conflicts is resolved successfully has its outcome in a transformed quality of ego functioning that Erikson calls a “virtue,” such as the virtue of hope or the virtue of self-control. Successful resolution or integration results in growth or maturation; unsuccessful responses to developmental challenges may stunt or harm maturation and leave unfinished work for later in life.

In his account of infancy, Erikson depicted the central conflict as one between basic trust and mistrust. The developmental task in this era of childhood is to develop a sense of basic trust upon which the virtue of hope can be founded. In this context, trust and hope mean that children believe they can rely on people and the world to fulfill their needs and satisfy their desires. A view of the world as unfriendly or unpredictable might lead to mistrust in children and a self-protective withdrawal.

In toddlerhood, Erikson described the central conflict as being autonomy versus shame and doubt. This conflict is a tension between self-regulation and external control. According to Erikson, the primary developmental task for toddlers is to establish their own legitimate autonomy or independence in making decisions and to develop the virtue of will or self-control.

During early childhood, Erikson identified the central conflict as one between initiative and guilt. The developmental task for children in this era is to cultivate their own initiative or desire to take action and pursue goals and to balance that with the healthy moral reservations that they may have about their plans—a combination of spontaneity and responsibility. Developing this sort of self-regulation promotes the virtue of purpose or direction in a child’s life.

Finally, for Erikson, children in middle childhood are confronted with a developmental conflict between industry and inferiority. These children face the challenge of developing their capacities to do productive work. The virtue that results from successful resolution of this crisis is competence, which reflects the child’s sense of self-esteem rooted in a view of the self as able to master skills and carry out tasks.

## **Complexities in Childhood Development**

It needs to be kept in mind that human development is complex and multifaceted and that it extends over a relatively long period of time.

Beginning from the successful fertilization of an ovum by a sperm, child development characteristically proceeds through a fairly well-recognized set of physical processes related to biological (or anatomical and physiological) development. After birth, physical development includes mastery of large motor and other skills. For example, normally-developing children learn to reach out to toys and other objects; to hold their bottles; to roll over, crawl, and walk; and eventually to perform other activities that involve complex coordination skills.

At the same time, most children also experience psychological, social, and spiritual development. In these areas, greatest attention has been given to personality and social development in childhood (represented by the work of Erikson and many others), to intellectual development (represented by the work of Piaget & Inhelder [1958] and others), and to spiritual development (represented by the work of Coles, 1990). However, no aspect of child development is a simple process occurring in isolation. For example, in some children development is delayed, obstructed, or even prevented for various reasons. An infant may not start walking as expected, or a child may be handicapped by a range of disabilities. Perhaps that is why Erikson (1963) spoke of the need for “triple bookkeeping,” by which he meant that one must take into account social context, ego process or identity, and somatic process or constitution in any satisfactory explication of human development. Elsewhere, Erikson (1975, p. 228) described these variables as the “history, personality, and anatomy” of a developing individual.

The full scope of human development during childhood and all of the variables that might affect it cannot and need not be explored here in all of its complexities. For example, whereas most non-normative events occur to some but not all members of a developmental cohort, others seem to be different in their character and implications. Thus, singular events that are relatively limited in the timing of their occurrence, such as the bombing of Hiroshima, the terrorist attack on the World Trade Center and the Pentagon on September 11, 2001, or Hurricane Katrina in the New Orleans area, had a momentous quality, with a wide and enduring impact both on persons who were directly affected and on others across populations. Other powerful events, such as the Holocaust or the situation of children and families forced to live in great poverty or situations of violent conflict for year after year, have lasting, perhaps permanent, influence on human development.

These few examples—and there must be many more—remind us of the complexities of human development during childhood in relationship

to both normative and non-normative life events and transitions. With that in mind, this chapter focuses on ways in which developmental processes (and other factors) can play important roles in affecting encounters with death during childhood and how encounters with bereavement arising from the deaths of significant others may influence a child's subsequent development.

## **ENCOUNTERS WITH DEATH DURING CHILDHOOD**

Children do die. This section offers a broad overview of the frequency of children's encounters with death and an analysis of the principal features of those encounters to heighten appreciation of the general patterns of childhood deaths. This examination includes numbers of deaths, death rates, and leading causes of death during different eras of childhood in the United States, as well as some comments on the important variables of race. These patterns of childhood encounters with death are reasonably typical of those in many developed areas of the world. (Note that the mortality figures for 2005 cited in this chapter are the most recent final data available from the National Center for Health Statistics [NCHS] as this chapter is being written; also, because the presentation of those data follows NCHS terminology [e.g., for racial and cultural groupings] and format, it may not always be identical with our earlier usage and our discussion of four eras during childhood.)

### **Numbers of Deaths and Death Rates Among Children in the United States**

For several years, numbers of deaths and death rates during childhood in the United States have remained relatively stable with a slight downward trend. General patterns can be summarized in the following ways (Kung, Hoyert, Xu, & Murphy, 2008):

- A total of 36,033 children between birth and 9 years of age died in our society in 2005.
- The largest number of child deaths (18,514) occurred among White Americans (who represent the largest portion of the total population).
- More male children died than females in every age grouping during childhood.

- More deaths (28,440) occurred during infancy (children less than 1 year of age) than in any other segment of childhood.
- The highest death rates during childhood occurred among Black Americans for children under 1 year of age (1,311.2 deaths per 100,000 children) and for children from 5 to 9 years of age (21.1 deaths per 100,000); highest deaths rates for children 1–4 years of age occurred among American Indians and Alaskan Natives (59.2 deaths per 100,000).
- The highest infant mortality rates in our society occurred among Black Americans (13.7 per 1,000 live births versus 5.7 for White Americans and 8.1 for Hispanic Americans).

## **Leading Causes of Death During Childhood in the United States**

This section describes the five leading causes of death for all races and both sexes in the United States in 2005, according to three age groups: infants; children between the ages of 1 and 4; and children between the ages of 5 and 9. It is useful to examine these data with special attention to causes of death that are associated with developmental problems.

### *Infants*

The leading causes of death among infants in the United States have remained basically stable for many years (see chapter 5 in this book for a more detailed analysis of infant deaths). Approximately 54% of all infant deaths in 2005 resulted from five principal causes: congenital anomalies; disorders relating to short gestation and unspecified low birth weight; Sudden Infant Death Syndrome (SIDS); newborns affected by maternal complications of pregnancy; and newborns affected by complications of placenta, cord, and membranes (Kung et al., 2008). (The sixth-ranking cause of death in this age group in 2005 was accidents or unintentional injuries.) An unfortunate portion of these deaths are associated with an absence of effective prenatal health care, injurious maternal behavior (e.g., smoking, using alcohol, or taking illicit drugs during pregnancy), and lack of adequate health care for all segments of American society. Congenital anomalies, an increasing population of low birth-weight infants, and SIDS all point to problems associated with a child's development before birth, during the birth process, or not long after birth.

The prominence of Sudden Infant Death Syndrome—typically involving the sudden death of an apparently healthy infant less than 1 year

of age with no advance warning—as the leading cause of death among infants from 1 month to 1 year of age across all economic, ethnic, and cultural groupings is particularly relevant to our interest in child development. Although its underlying cause is unknown, SIDS is a recognizable constellation of events that can often be diagnosed with some precision by a thorough postmortem and circumstantial investigation. Recent research has pointed to brainstem abnormalities and preliminary neurochemical evidence as possibly helping to understand some infants' vulnerability to SIDS (Paterson et al., 2006). Even without definitive information on this point, during the early 1990s, new research (e.g., Dwyer, Ponsonby, Blizzard, Newman, & Cochrane, 1995) led the health systems in the United States and many other countries to recommend that infants might be at less risk for SIDS if they were placed on their backs for sleep, rather than on their stomachs (e.g., American Academy of Pediatrics, 1992, 2005). Then in June 1994 the U.S. federal government initiated a “Back to Sleep” campaign that has led to dramatic and sustained reductions in SIDS deaths—numbers fell from approximately 5,400 deaths in 1990 to 2,230 in 2005, a reduction of nearly 59%.

### *Children 1–4 Years of Age*

As children move from infancy to toddlerhood, they typically become more mobile and more independent of their parents and other caretakers, both within and outside the family home. This growing autonomy results in accidents becoming the leading cause of death among children 1–4 years of age and accounts for approximately 40% of all deaths in this age group in 2005 (Kung et al., 2008). Unintentional injuries of this type involve such causes as motor vehicle accidents, drowning, burning, ingesting harmful substances, choking, falling, and misadventures with firearms (see chapter 6 in this book for a more detailed discussion of unintentional injuries during childhood).

Other leading causes of death for this cohort of children include so-called natural causes of death, such as congenital anomalies, cancer (malignant neoplasms), and heart disease, as well as homicide (called “assault” in the international classification system).

### *Children 5–9 Years of Age*

In this age group, the leading cause of death—accidents—is again by far the most critical. Accidents—in or near motor vehicles, on playgrounds, or in activities such as cycling—caused nearly 38% of all deaths among

school-age children in the United States in 2005 (Centers for Disease Control and Prevention [CDC], 2008).

Other leading causes of death for children between 5 and 9 years of age include cancer (malignant neoplasms), congenital anomalies, assault (homicide), and heart disease.

## **Race as a Key Variable in Deaths of Children in the United States**

The realities of death during childhood are not the same for all children in the United States. Race is the most notable variable.

As previously noted, there are obvious differences in numbers of deaths and death rates for White and Black children in the United States. This disparity applies to all three age groups that we are considering during childhood. For example, among infants problems with disorders related to short gestation and low birth weight are the principal cause of death for Black infants (versus its ranking as the third leading cause of death for White infants). In fact, more Black infants died from this cause in 2005 (2,025) than did White infants (1,926) (Kung et al., 2008). This inequality likely reflects a number of contributing factors, such as a higher incidence of early pregnancy, inadequate prenatal care, and premature birth among Blacks than Whites.

For children 1–4 years of age, variances in death rates between White children and Black children are a bit less dramatic than those for infants, but still substantial (27.0 deaths versus 41.8 per 100,000 in the population), and disadvantages for American Indians and Alaskan Natives are even more dramatic, with a death rate of 59.2 per 100,000 in this age group (Kung et al., 2008). Homicide also ranks higher as a leading cause of death for Black children versus White children in this age group.

Among children 5–9 years of age, death rates are again markedly different: 13.3 deaths per 100,000 for White children, 21.1 for Black children, and 17.4 for American Indian and Alaskan Native children (CDC, 2008).

## **Some Examples of Encounters With Child Death Elsewhere in the World**

Infant mortality is often regarded as an important benchmark in evaluating quality of life and the health care and social services systems in societies. Here, more than two dozen countries around the world have

lower infant mortality rates than those in the United States. This poor record is a notable black mark against our society. There are, however, other ways in which the United States and other developed countries such as Canada, France, Germany, Italy, Japan, and the United Kingdom are far more fortunate in encounters with child death than countries elsewhere in the world.

Developing countries are generally thought of as those that have relatively low standards of living and a limited degree of industrialization relative to their populations. It is in these countries that the highest numbers of child deaths are typically found. For example, the World Health Organization (WHO, 2004) has reported that 75% of all child deaths under the age of 5 years occur in the African and Southeast Asian regions of the world. In terms of causality, WHO reports, “Six causes of death account for 73% of the 10.4 million deaths among children under the age of five years worldwide” (p. 14). These causes are acute respiratory infections (mainly pneumonia), diarrheal diseases, prematurity and low birth weight, neonatal infections such as sepsis, birth asphyxia and trauma, and malaria. Among these six causes, WHO adds that “the four communicable disease categories above account for one half (50%) of all child deaths. Undernutrition is an underlying cause in an estimated 30% of all deaths among children under five” (p. 14; see chapter 7 in this book for a more detailed analysis of infectious diseases during childhood). Some of these causes of child death, such as malaria, have been virtually eradicated in developed countries. Poverty and malnutrition are often widespread in countries where infectious diseases are prominent. One striking example is a cholera epidemic in Zimbabwe in 2009, a country that once was a leading exporter of food, but has more recently been plagued by a breakdown in government services, rampant inflation, and shortages of food.

In contexts such as these, as well as areas marked by ongoing acts of genocide, violent conflict, and disruption of populations, encounters with child death are all too typical, and child development is harmed. Indeed, simple survival is often at risk.

## **ENCOUNTERS WITH BEREAVEMENT DURING CHILDHOOD**

### **Losses and Deaths Experienced by Children**

Losses of all types are an unavoidable part of children’s lives. Many, perhaps most, of these losses have nothing to do with death. For example,

a child's favorite toy may be broken, misplaced, or stolen; parents may divorce; the family may need to move to a new city or location resulting in a loss of familiar routines, school settings, or playmates. These and other types of losses can bring sadness and grief into a child's life.

Deaths of significant others are also a reality in the lives of children. For example, grandparents, parents, and other important adults—such as a beloved aunt or uncle, a dear neighbor, a favorite teacher or coach, or even a familiar school janitor who brightens a dark, scary room by changing a light bulb—may die (see chapter 9 in this book). Sisters and brothers also sometimes die (see chapter 10 in this book), especially during the first year of their lives, when more than 28,000 babies and infants die each year in our society (see chapter 5 in this book). The death of a friend or classmate during childhood can also be an important event, though its impact on a child may not always be properly appreciated by adults (see chapter 11 in this book). And the deaths of some animals—pets, companion animals, or service animals, sometimes even a favorite figure in a zoo—can have an important effect on a child who had become attached to them (see chapter 12 in this book).

## Grief in Childhood

Encountering any significant loss or death can be an important experience for a child. It is likely to generate a *grief reaction*, one that is typically distinctive for each individual child and may have special meaning for that child's subsequent development. Children experience and express grief in many ways, some of which are distinctive of their developmental situations. They may experience a roller coaster of emotions, including such feelings as numbness, sadness, anger, confusion, fear, worry, regret, loneliness, guilt, and self-blame. Sometimes, children's grief involves fatigue and turning within themselves, whereas at other times it can lead to agitation, irritability, lashing out, or getting into trouble. Young children may regress to thumb sucking, bed wetting, and attention-seeking behaviors. Difficulties in sleeping are common. Many bereaved children lose interest in favorite activities or experience a decline in school performance, whereas others strive to be the so-called perfect child, suppressing their grief and trying to take care of others in their families. Quite often, bereaved children have a sense of themselves as being different or alienated from other children, thinking that no one understands how they feel. In short, children's grief may have psychological (emotional or cognitive), physical, behavioral, social, and spiritual dimensions and may be expressed in a variety of ways.

In their grief, children frequently ask questions like the following: Did I cause this to happen? Is it going to happen to me? And very importantly, Who is going to take care of me? The egocentricity associated with such questions is obvious. When a child does not correctly understand the causality involved in a loss, perhaps because of ignorance or magical thinking, it is not surprising that issues of origin and endangerment should present themselves. Children who do not understand that death is final may want to know what sort of activities are undertaken by the deceased, who is thought to be somehow alive in a different way or place, and children who do realize that death is irreversible may ask concrete questions about what happens to a dead body when it stops working. (See chapter 2 in this book for further discussion of these subjects.)

However, it should be kept in mind that children do not always articulate their grief in words. Many bereaved children express their grief through physical activities, such as crying, play, sports, or art. It is also common to cling to sources of comfort and security, for example seeking nurturance and reassurance by cuddling with stuffed animals or pets or wanting to be hugged and held by someone a child loves.

Generally, children's grief comes in waves or recurs at different times, often in relationship to new events or developmental milestones in their lives. Also, children are likely to grieve not only the primary loss, but also secondary losses that follow, such as changes in routines, schedules, and family dynamics, alterations in family finances, and having to move house or change schools. Each of these and other implications of a significant death can be important to a bereaved child.

## **Mourning in Childhood**

There once was a scholarly debate about whether children are able to mourn after a death (see, e.g., Furman, 1973). Partly, this debate depended on claims about children's inability to understand the concept of death, but it also arose from theoretical models of mourning drawn almost wholly from studies of bereaved adults. These models assumed that mourning involved universal patterns (e.g., a group of normative stages or phases) that were thought to lead to goals such as resolution or completion (Doka, 2007). In recent years, this way of thinking about mourning has been challenged, both for adults and for children.

Worden (2009) proposed, instead, that mourning involves active processes in the form of tasks in coping with loss and grief. Worden (1996) identified four tasks of mourning for bereaved children: (1) to accept the reality of the loss; (2) to experience the pain or emotional

aspects of the loss; (3) to adjust to an environment in which the deceased is missing; and (4) to relocate the dead person within one's life and find ways to memorialize that person. Worden was careful to note that these tasks "can only be understood in terms of the cognitive, emotional, and social development of the child" (1996, p. 12). As a result, mourning tasks may need to be addressed throughout childhood again and again in appropriate ways at different developmental points in a child's life and in different contexts. For example, a child might mourn the death of his or her mother at the time of the event, her absence in the months and years that follow, what that may mean afterward for being different from schoolmates who have a living mother, and the child's inability to draw on the absent mother's support or to share achievements with her in later school years. Reworking losses and grief reactions through shifts in the focus and significance of mourning tasks is quite consistent with maturational processes.

As they try to cope with their losses and their grief reactions, bereaved children typically find themselves looking both backward, to the death event itself and what they have lost, and forward, to what all these events will mean for their present and future lives. Each child is likely to cope in his or her own ways and in different ways at different times in his or her life. Quite often these coping processes will be aided by efforts to maintain an ongoing connection to the individual who has died (Klass, Silverman, & Nickman, 1996). These connections involve continuing bonds with an internal representation of that individual. Such bonds depend on new, altered relationships with the deceased, who remains a transformed, but ongoing presence in the life of a bereaved child. At their best, dynamic bonds of this type can provide comfort, solace, and support, a kind of enriched remembrance that helps a child move on in constructive living. Continuing bonds are often supported by linking objects, such as photographs or other mementoes, through which children keep alive the memory and the legacy of the person who died.

In the Harvard Child Bereavement Study (see Worden, 1996), the most extensive research project on child bereavement that we have (in this case, involving the death of a parent), two things became evident. First, instead of simply withdrawing and becoming preoccupied with thoughts about the person who died, many bereaved children immerse themselves in activities of everyday life, such as play and school. This behavior pattern appears to reflect a temporary defense against being overwhelmed by the implications of the loss. In so doing, children seem

to engage in a kind of dosing themselves with grief and mourning, allowing themselves to experience their grief reactions and their efforts to cope for a while, but then turning away when that becomes overwhelming or when other concerns attract their attention. As a result, children's grief reactions are often more intermittent in character than those of many adults, and their overall bereavement may be longer in duration.

Second, in the Harvard Child Bereavement Study, Worden (1996) also noted a late effect of bereavement in which a significant minority of the school-age children being studied were found to be encountering more difficulties at 2 years after the death of a parent than they were at 4 months or 1 year after the death. This fact about the bereavement of many children suggests that it is important to be sensitive to the possibility of both ongoing issues for a bereaved child and those that may arise only at a later point in the child's life. Of course, much of a child's coping depends on the family context of the child and especially on the functioning of a surviving parent or other adult care provider.

From his research, Worden (1996) offered a list of lessons about the needs of bereaved children. They need:

- Adequate information—clear and comprehensible information about an impending death (whenever that is possible) and certainly after a death has occurred
- Fears and anxieties addressed—to know that they will be cared for and to experience consistent discipline
- Reassurance that they are not to blame
- Careful listening—in the form of someone who will hear them out and not minimize their concerns
- Validation of their feelings—including respect for and safe ways to express individual reactions in their own ways
- Help with overwhelming feelings—especially when sadness, anger, anxiety, and guilt are intense
- Involvement and inclusion—both before and after a death, with preparation and without being forced to join in
- Continued routine activities—in the form of age-appropriate activities, such as play and school
- Modeled grief behaviors—through adults who can share their own grief and mourning and show how to experience and express these in constructive ways
- Opportunities to remember—both after a death and throughout life

## CONCLUSION

Children have important work to do as they face the many challenges of life. For some, problems in development arise that can threaten a child's life and cause his or her death. For others, the death of an important person or loss of a significant relationship can have a powerful impact on a child's subsequent development. Although not predictable in their specifics, it is inevitable that many children will be confronted by these events and by challenges related to loss and death. Such challenges are grounded in the very human and personal contexts within which children live their lives.

To ignore or turn a blind eye to these challenges is to abandon children and put them at risk of much harsher futures than they need experience. This essentially leaves children alone without help and support just when they most need assistance from the adults around them. As Katzenbach (1986, p. 322) has written, "Children can adapt wonderfully to specific fears, like a pain, a sickness, or a death. It is the unknown which is truly terrifying for them. They have no fund of knowledge in how the world operates, and so they feel completely vulnerable."

That is the positive message of this book: adults can bring experience, insight, skill, and caring presence to the aid of children who may feel vulnerable and alone in the terrifying face of the unknown. In some cases, skilled adults can eliminate or minimize challenges that confront children. In many cases, thoughtful adults can guide children and help them cope more effectively with challenges arising in their lives. In all cases, wise adults can offer support while children are addressing meaningful events in their lives.

In order to be available to children in these ways, it is essential for adults to be aware of the realities of death-related events in the lives of children and to appreciate the many ways in which coping with tasks arising from death and bereavement can interact with coping with normative developmental tasks.

## REFERENCES

- American Academy of Pediatrics (AAP), Task Force on Infant Positioning and SIDS. (1992). Positioning and SIDS. *Pediatrics*, 89, 1120–1126.
- American Academy of Pediatrics (AAP), Task Force on Sudden Infant Death Syndrome. (2005). The changing concept of sudden infant death syndrome: Diagnostic coding

- shifts, controversies regarding the sleeping environment, and new variables to consider in reducing risk. *Pediatrics*, 116, 1245–1255.
- Baltes, P. B., Reese, H. W., & Lipsitt, L. P. (1980). Life-span developmental psychology. *Annual Review of Psychology*, 31, 65–110.
- Centers for Disease Control and Prevention (CDC). (2008, June 16). Unpublished data from the National Vital Statistics System, National Center for Health Statistics, Mortality Statistics Branch. Retrieved on February 6, 2009, from [http://www.cdc.gov/nchs/data/dvs/LCWK1\\_2005.pdf](http://www.cdc.gov/nchs/data/dvs/LCWK1_2005.pdf)
- Coles, R. (1990). *The spiritual life of children*. Boston: Houghton Mifflin.
- Doka, K. J. (2007). Challenging the paradigm: New understandings of grief. In K. J. Doka (Ed.), *Living with grief: Before and after the death* (pp. 87–102). Washington, DC: Hospice Foundation of America.
- Dwyer, T., Ponsonby, A.-L., Blizzard, L., Newman, N. M., & Cochrane, J. A. (1995). The contribution of changes in the prevalence of prone sleeping position to the decline in sudden infant death syndrome in Tasmania. *Journal of the American Medical Association*, 273, 783–789.
- Erikson, E. H. (1963). *Childhood and society* (2nd ed.). New York: Norton. (Original edition published 1950)
- Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: Norton.
- Erikson, E. H. (1975). *Life history and the historical moment*. New York: Norton.
- Furman, R. A. (1973). The child's capacity for mourning. In E. J. Anthony & C. Koupernik (Eds.), *The child in his family: Vol. 2, The impact of disease and death* (pp. 225–231). New York: Wiley.
- Katzenbach, J. (1986). *The traveler*. New York: Putnam.
- Klass, D., Silverman, P. R., & Nickman, S. L. (Eds.). (1996). *Continuing bonds: New understandings of grief*. Washington, DC: Taylor & Francis.
- Kung, H.-C., Hoyert, D. L., Xu, J. Q., & Murphy, S. L. (2008). Deaths: Final data for 2005. *National Vital Statistics Reports*, 56(10). Hyattsville, MD: National Center for Health Statistics.
- Newman, B. M., & Newman, P. R. (2005). *Development through life: A psychosocial approach* (9th ed.). Belmont, CA: Thomson Wadsworth.
- Papalia, D. E., Olds, S. W., & Feldman, R. D. (2005). *A child's world: Infancy through adolescence with LifeMAP CD-ROM and PowerWeb* (10th ed.). Boston: McGraw-Hill.
- Paterson, D. S., Trachtenberg, F. L., Thompson, E. G., Belliveau, R. A., Beggs, A. H., Darnall, R., et al. (2006). Multiple serotonergic brainstem abnormalities in sudden infant death syndrome. *Journal of the American Medical Association*, 296, 2124–2132.
- Piaget, J., & Inhelder, B. (1958). *The growth of logical thinking from childhood to adolescence* (A. Parsons & S. Milgram, Trans.). New York: Basic Books.
- Simpson, J. A., & Weiner, E. S. C. (Eds.). (1989). *The Oxford English dictionary* (2nd ed., 20 vols.). Oxford, England: Clarendon Press.
- Worden, J. W. (1996). *Children and grief: When a parent dies*. New York: Guilford.
- Worden, J. W. (2009). *Grief counseling and grief therapy: A handbook for the mental health practitioner* (4th ed.). New York: Springer Publishing.
- World Health Organization (WHO). (2004). *The global burden of disease: 2004 update*. Retrieved on January 29, 2009, from [http://www.who.int/healthinfo/global\\_burden\\_disease/2004\\_report\\_update/en/index.html](http://www.who.int/healthinfo/global_burden_disease/2004_report_update/en/index.html)