▪ Talking with Children About Death ▪

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Nurses are often asked to respond to children's questions about death and to advise parents and teachers on how to discuss this topic with children. This article reviews the concepts that children must learn to understand and cope with a death. Cognitive limitations of young children that may result in guilt and misinterpretations are reviewed. Advice is provided on how nurses can assist infants, young children, and adolescents in dealing with deaths of significant others or their own impending death. The importance of identifying and addressing the personal needs of the helper are underscored. J PEDIATR HEALTH CARE. (1993). 7, 269-274.

Parents may wish to protect their children from the "harsh reality" of death. But as much as they may wish otherwise, they cannot prevent their children from experiencing the loss of a pet, friend, or family member. Limiting discussion about death will only hinder children's understanding of the loss and interfere with their ability to cope with it. Many health care providers also choose to ignore children's need to talk about, learn about, and come to understand death. But children need caring and knowledgeable adults with whom they can discuss death, both in a general context before a loss and specifically in response to a significant death. Nurses are often asked to respond to the inquiries of children about death and to provide advice to parents and teachers on how this topic can be discussed with children.

To guide the selection of explanations and to structure discussions on the topic with children, nurses must first appreciate what children know about death and what they are capable of learning at various stages of their development. The understanding of death is a developmental process. Similar to the process by which children come to understand physical illness (Schonfeld, 1991), important qualitative differences exist in the very basic ways in which children at different stages of development see, interpret, and understand the phenomena in the world around them.

▪ CONCEPTS ABOUT DEATH

Four basic concepts about death have consistently appeared in the literature: irreversibility, finality (nonfunctionality), inevitability (universality), and causality (Hostler, 1978; Kastenbaum, 1967; Smilansky, 1987; Speece & Brent, 1984; Wass, 1984). Children's lack of comprehension of each of these concepts has direct implications for their ability to successfully mourn a loss.

Irreversibility

Death is permanent. Unlike cartoon and television characters that die and return to life with alarming regularity, no recovery or return from death occurs. Children with an incomplete understanding of this concept may view the deceased as having gone far away on a trip and become angry when the deceased fails to return or contact them. Furthermore, if children do not understand the irreversibility of their loss, then they have no reason to detach or alter their personal ties to the deceased. This is a necessary first step in the mourning process and allows the child to re-establish relationships with other individuals.

Death is a state in which *all* life functions cease *completely*.

Finality (Nonfunctionality)

Death is a state in which **all** life functions cease **completely.** Young children initially attribute life to all objects. This belief in animism is often reinforced by adults who encourage children to talk to their stuffed animals and treat inanimate objects as if they possess life functions or who comment that the television or car "died." As children are more able to correctly identify living functions (such as cognition, respiration, or sensation) they are more likely to realize that these functions must end at death (Safier, 1964; Wass, 1984). Children with an incomplete understanding of the finality of death may wish to bury food with a dead pet. They may comment that dead people only move a little because the coffin is small or cannot see well because it is dark underground. These children may become preoccupied with

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concerns about the physical suffering of the deceased and may, for example, have recurrent nightmares of a dead relative being buried "alive." Horror movies prey on children's limited understanding of the finality of death by creating characters that are "almost dead" (such as zombies) and those that return from the dead to seek revenge (often by attacking innocent children).

Children must be helped to understand the true causes of death.

Causality

Children must be helped to understand the true causes of death. Children who rely instead on magical thinking are apt to assume responsibility for the death of a loved one by concluding that their bad thoughts or unrelated actions were the cause of the person's death. Children's understanding of causality is also influenced by immanent justice, a belief that some form of natural justice exists wherein good is automatically rewarded and bad is punished (Schonfeld, 1991). This may lead children to conclude that the deceased is being punished for some real or perceived wrong-doing. Magical thinking may lead to excessive guilt that is difficult for children to resolve, whereas immanent justice may cause undue shame about the death.

Inevitability (Universality)

Everything that is alive will eventually die. Children with an incomplete understanding of the inevitability of death may view themselves or significant individuals in their lives as immortal. Parents often falsely reassure their children that they will always be alive to care for them. Only when a significant death has occurred do these parents then inform their children of the truth about the inevitability of death. Unfortunately, when a significant death has occurred, children will usually fear that others (if not everyone) close to them will die. This is perhaps the most difficult time to be confronted with the universality of death. Yet if children do not view death as inevitable, they will likely view death as a form of punishment (either for their actions or thoughts or for those of the deceased), leading again to excessive guilt or shame.

On average, children learn these concepts between the ages of 5 and 7 years. But children develop at their own individual rates, and there is wide variability for children of the same age. In addition, children tend to regress under stress, and the death of a loved one is invariably a stressful event. Children therefore are most apt to function as if they had a less developed understanding just at the time when they need a mature understanding of death. Approaching the child with a preconceived notion of what a "typical child" of that age is able to understand about death is not helpful. Instead, given an appreciation of the process of cognitive development in this area, nurses can determine what a particular child understands about a death that has occurred by gently asking simple, but direct, questions that explore the child's understanding of the relevant concepts. Such questions might include: When someone dies, can they come back to life again? (irreversibility) What happens to people after they have died? Can they still see or hear or feel pain? (finality) What causes people to die? (causality) Who dies? Does everyone eventually die? (inevitability) Misconceptions can then be identified and corrected.

Children, even newborns, are capable of reacting to someone's death, even if they do not fully understand what has occurred.

■ INFANTS AND YOUNG CHILDREN

It is never too early to begin discussions about death. Children, even newborns, are capable of reacting to someone's death, even if they do not fully understand what has occurred. Infants can respond to maternal depression with altered feeding patterns and even failure to thrive (Lansky, Stephenson, Weller, Cairns, & Cairns, 1982). Parents should be counseled after a death has occurred within a family that the physical and emotional needs of all family members, even infants, must be met. As much as possible, feeding and care-giving patterns should be maintained. Parents often deny the emotional needs of their young children at the time of a death of a family member or close friend, in part so they may attend to their own grief. Parents may feel so overwhelmed that they question whether they have any resources to attend to the physical, let alone emotional, needs of their children. They often wish to send their children away to be cared for by others until they feel they are coping better with the loss themselves. Nurses should help grieving parents identify supports that will allow the parents to continue in their role as caretakers for their children.

Young infants probably lack a conceptual understanding of death. But with the development of object permanence during the second half of the first year of life, infants begin to become capable of understanding loss. It has been suggested that the game of "peek-a-boo" is one of many games about death engaged in by children. The game involves repetitive separation (and reunion) with important caregivers and may represent an attempt to understand and deal with loss. In fact, the translation for "peek-a-boo" from Old English is "alive-or-dead" (Betz & Foster, 1984; Maurer, 1966).

A father brings his 20-month-old son for counseling regarding the sudden death of the child's mother in a car accident 2 days before; the child was a passenger in the car at the time of the accident but was not injured. Although the funeral has not yet occurred, he is already demonstrating marked distress. He is having trouble with separation, wakes frequently at night shouting "No, No, No," and is fearful of riding in a car. Over the next 2 weeks, he makes such comments as "Head, truck, hurt, neck, eye, Mommy" and refers to "ink" coming out of his mother's head and eye. He then speaks of a "rainbow round [her] head" and concludes that "Mommy [is in] heaven." His play has become more aggressive, and he has been noted to take trucks and smash them together screaming. Despite his young age, he clearly understands what has occurred.

Children in similar circumstances may not be able to express their feelings and concerns as directly. Health care providers must assist parents to identify the needs of their children at the time of a loss and offer support and assistance so that parents can meet the task of responding to them.

Young children's understanding of causality is characterized by magical thinking, which is often unwittingly reinforced by parents.

■ CHILDREN'S BEREAVEMENT AND GUILT

Young children's understanding of causality is characterized by magical thinking, which is often unwittingly reinforced by parents. Parents wish their children to believe that if they eat their vegetables at dinner then Santa Claus, whom they have never met, will somehow be aware of this event and will bring them the present they want for Christmas. These parents should not be surprised when their children conclude that someone died because they had done, or only thought, something bad. In general, when talking with children (and adults) about death, it is best to assume that some underlying guilt may exist regarding the death, even if the child had no possible role to play in the cause of death.

An 8-year-old boy is brought by his parents for counseling regarding the recent death of his brother by sudden infant death syndrome (SIDS). The boy is a bright and engaging child and has received appropriate explanations from his parents; his mother is a child psychologist. He demonstrates precocious insights into the emotional responses of family members (on the first visit he comments: "Did you notice my mother is pregnant? . . . I think she's trying to replace my brother . . . I know you can't do that, but I think that's what she is trying to do"). Yet when asked why he thought his brother had died, he remarks, "because I went to camp that day." Although his parents had made every attempt to explain the cause of his brother's death as best they could, SIDS is fundamentally an unsatisfying explanation even for adults. Left with no other explanation, the boy predictably assumes guilt for the loss.

From early on, children are made to feel guilty for their accidents. They are told: "You should have been more careful . . . You shouldn't have been running in the first place." It is not surprising, then, that both children and adults often assume that whenever an accident occurs, someone is at fault. In a society that supports a major field of law called *accident liability,* there is no such thing as a true accident. When talking with children about death it is therefore often useful to assure them of their lack of responsibility with such comments as, "Many of the children I talk to who have had a (relative) die tell me that they somehow feel it may have been their fault, even when it obviously was not. We all know that thoughts and feelings can't make someone die. I know that there wasn't anything you did to cause your (relative) to die, but I wonder if you ever felt guilty the way those other children did?"

■ CONCRETE THINKING AND LITERAL MISINTERPRETATIONS

Adults must explore children's understanding about death and not be fooled by superficially correct comments. The thought processes of young children are concrete. They may take explanations at face value, leading to literal misinterpretations. For example, children may be afraid to go to a wake after being told the body is placed in a casket, wondering what happened to the head.

Parents of an early elementary school-aged child feel that their son has responded well to his sibling's death by SIDS. Their only concern is that he seems to be unruly in church, but they do not see how this could be related to the death, which occurred several months earlier. When asked, they state that the explanation they gave their son for the infant's death was that "God loved the baby so much, He wanted him back as an angel at His side." They had told the boy that church was "God's home," and the boy had decided to make it quite clear whenever he was visiting God that he was not "angel material" and did not wish to be called to His side.

Children need to be given developmentally appropriate explanations and be asked what they understand.

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Children need to be given developmentally appropriate explanations and then be asked what they understand. As they explain it back to the adults, misconceptions will become evident and can be corrected. Over-generalizations should be anticipated. Children will need to be told that not all illnesses are serious and that not everyone who goes to the hospital dies. Religious explanations can be shared with children but should not be relied on as the only explanation of death. Attempts to place religious concepts in concrete terms are usually ineffective and provide little understanding of both physical realities and spiritual beliefs. Any adult who has been faced by a young child relentlessly asking where in the sky is heaven and can they go there by plane to visit a deceased relative understands the futility of such an approach.

■ CHILDREN'S GRIEF

Children grieve, often deeply, and for long periods. But they may not give this impression to adults. For one thing, they do not sustain strong emotions for extended periods of time. They often use denial or delay the expression of their grief. Adults in their lives may inadvertently communicate to them that the death is not to be discussed. When a young child asks, "I know that Mommy is dead, but will she see me on my birthday?" the surviving parent often responds with tears. Questions such as these are particularly poignant. Unfortunately, the egocentrism of young children may lead them to conclude that they caused their parent to cry by misbehaving. Many children will then quickly state, "Don't worry Daddy, we'll be ok. I know how to cook. I'll do everything Mommy used to do." Often the parent will then tell the health care provider, "Oh, my daughter? She's doing great. I'm falling apart, but she's accepted it." In reality, the child is often left to deal alone with serious concerns and troubling emotions. These may become evident months later or may be indirectly expressed in other settings. After a death has occurred, adults need to encourage questions and to answer them honestly.

Children may express their grief indirectly through their behavior or attempt to work it out through play.

Children may express their grief indirectly through their behavior or attempt to work it out through play. Indeed, many children's games have death as a central theme. "Cowboys and Indians" and "cops and robbers" involve killing and playing dead. After a particularly traumatic loss, children may initiate post-traumatic play, which involves a re-enactment within play of elements of the traumatic event and may take on a ritualistic pattern.

Children grieve in stages over many years. They will reprocess the experience at each new stage in their life, applying new cognitive and emotional insights to try to reach a more satisfying explanation of a significant death. Unfortunately, children have many more sources of misinformation than sources of correct information about death, and this process may be unnecessarily delayed. With proper education, children can learn the concepts about death at a much earlier age (Schonfeld & Kappelman, 1990; Schonfeld & Smilansky, 1989).

■ ADOLESCENT BEREAVEMENT

Although it is a necessary precondition, knowledge about death is not sufficient in and of itself to lead to successful adjustment to a loss. Adolescents, who may comprehend the concepts about death, are still in need of supportive services. Society often perceives that the impact of a death on adolescents is less severe than for young children. Adults often wrongly assume that because adolescents are able to think rationally, they should understand what has occurred and need no further explanations. Adults may feel that because adolescents are able to think and act independently and are often less willing to accept assistance and guidance from adults that they do not need support and outreach services at the time of a death. In reality, adolescents are often left unsupported even when another child in the family dies. Services are extended to the parents, who then often rely on the adolescent siblings to provide comfort and to fill in for needed services, such as caring for younger siblings (Adams & Deveau, 1987). Even less support is offered when the death of a peer is involved (Podell, 1989). Families often underestimate the intensity of adolescent peer relationships or their adolescent children's actual vulnerability to these crises. Nurses within schools may be best suited to begin to address the emotional needs of adolescent students when a death of a peer has occurred (Schonfeld, 1993).

■ FUNERAL ATTENDANCE

Parents may ask whether it is appropriate for children to attend funerals. Although little research has been done on this topic, some general guidelines drawn from the author's clinical experience can be suggested. When a close relative or friend has died, children should, whenever possible, be offered the option to attend the funeral. Children who are denied this opportunity may construct fantasies of what occurs during these ceremonies that are more frightening than the reality. They may also feel cheated and left out of an important cultural and family ritual.

A parent or other adult who has a close relationship

with the child should explain in simple terms what the child can expect at the funeral, including such simple facts as that many people will be crying and appear very sad. Information should be provided about any anticipated rituals, such as a viewing with an open casket or a grave-site ceremony. Questions should be encouraged and answered honestly. If the child chooses to accompany the family to the funeral, then it is preferable that an adult who is familiar with and well liked by the child is assigned to accompany the child, preferably someone who is somewhat removed from the personal tragedy of the death (such as a baby-sitter, a neighbor, or a relative). This adult can monitor the child's reactions to the funeral and answer any questions that may arise.

Children should never be forced to participate in any ritual that they find frightening or distasteful, such as kissing the body of the deceased. They should be told that it is alright for them to leave at any point during the ceremony; the adult accompanying them can then take them for a walk around the block or into the lobby. Children who choose to play quietly in the lobby of the funeral home for the duration of the ceremony may still feel a higher level of participation in the event than if they were forced to remain at home or were sent to stay with neighbors or relatives.

■ THE ROLE OF NURSES

Nurses may be the sole source of correct information about death and one of the few caring adults who feel comfortable talking with children about death. Nurses can help parents to see the importance of discussing this topic with their children and can work with the parents to provide the support that children need at this time.

School nurses can advocate for education about death within the schools in a preventive mental health context.

Nurses within the schools may also act as advocates for children by assuring that crisis intervention services are available within the school (Schonfeld, 1989, 1993) and by serving as a member of a school-based crisis intervention team. (A copy of an unpublished model for school-based crisis intervention is available on request from the author.) School nurses can advocate for education about death within the schools in a preventive mental health context. Such education need not take a strict curricular form but can be incorporated into regular classroom lessons and can utilize teachable moments, such as when the fish in the classroom dies or when the class finds a dead bug out on the playground (Schonfeld & Kappelman, 1990, 1992).

■ THE DYING CHILD

In general, children with a terminal illness appear to have a precocious understanding of the concepts of death and their personal mortality. This occurs even if the adults have decided not to inform the child of the terminal nature of the illness (Greenham & Lohmann, 1982; Spinetta, 1974; Spinetta, Rigler, & Karon, 1973). Many parents are uncomfortable when their children openly acknowledge an awareness of their impending death. The children often perceive that it is their task to provide emotional support to their parents and to carry on the mutual pretense that they are unaware of their health status. At times, nurses are asked to care for children with a terminal illness but are told by the parents (and the health care team) that they must not disclose the nature of the illness. Yet these children will often ask the nurse questions, either directly or indirectly, about their impending death (Kubler-Ross, 1974). This places the nurse in an untenable position.

Adults must act on any opportunity to support a dying child through the process.

It is virtually impossible to lie to a child and preserve a relationship that is built on trust and caring. Parents must be helped to realize that it is the process of dying and not the death itself that is most frightening to children. Adults must act on any opportunity to support a dying child through this process.

■ HELPING THE HELPER

Nurses must come to understand their personal feelings about death to be effective in providing support for children who have experienced the death of a loved one or who are faced with their own impending death. Often this will involve some introspection about prior personal losses. But perhaps most importantly, nurses should remain aware of how continued exposure to deaths of others impacts on not only their professional careers but also on their personal lives.

Death of a patient is one of the most stressful personal and professional experiences faced by health care providers.

Death of a patient is one of the most stressful personal and professional experiences faced by health care providers. In studying the self-reported responses of pediatric residents, Behnke, Reiss, Neimeyer, and Bandstra (1987) found that physicians experience more grief responses than they felt were appropriate for an ideal-

ized physician. This resultant discrepancy between the physicians' actual response to a patient death and that which they feel is appropriate for the ideal physician is likely to create inner turmoil and dissonance that further interferes with successful coping. Similar reactions to patient death can be expected for all health care professionals.

Permission and tolerance for professionals to discuss and to have their personal needs met regarding bereavement is necessary not only so that they may then be more able to serve the needs of their patients and their patients' families, but also so that the personal needs of the professional staff may be met. Psychosocial rounds (especially in intensive care settings), retreats, and other support services dealing directly with professionals' responses to patient death are important aspects of staff development.

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