The Pediatrician and Childhood Bereavement

ABSTRACT. Pediatricians should understand and evaluate children’s reactions to the death of a person important to them by using age-appropriate and culturally sensitive guidance while being alert for normal and complicated grief responses. Pediatricians also should advise and assist families in responding to the child’s needs. Sharing, family support, and communication have been associated with positive long-term bereavement adjustment.

The death of an important person in a child’s life is among the most stressful events that a youngster can experience. Adults in the midst of their own grief often are confused and uncertain about how to respond supportively to a child. When the death involves a parent or a sibling, the potential for an adverse response by the child is compounded. During such a crisis, the pediatrician can be an important source of education and support for a child and family.

By already knowing something of the family interactions and individual coping skills, the pediatrician is in a position to help evaluate and understand a child’s reactions and to advise and assist the family in responding to the child’s needs. Awareness of the child’s temperament and typical responses to stress can help the pediatrician counsel the child and family. Cultural and religious background are important considerations in dealing with the bereaved family. Knowledge of previous significant losses and parent and child responses to them are helpful in understanding and predicting how a death may affect the child and family. Circumstances (eg, prolonged illness, sudden unexpected death, or violent death) are important additional considerations. In instances of disasters with multiple deaths, the pediatrician is likely to be called on as a resource by rescue teams, school personnel, and others. The pediatrician should describe to families and personnel the normal childhood emotional reactions to such an abnormal incident and offer support and counsel to the children and to the adults caring for them.

The child should be told about a death honestly and in language that is developmentally appropriate. When advising an adult about informing the child of the death, the pediatrician needs to be aware that a child’s concept of death varies with age (Table 1) and needs to be able to tailor the specific advice given to a parent. The family can be reassured that their showing of feelings, such as shock, disbelief, guilt, sadness, and anger, is normal and helpful. A bereaved parent or other close family member who shares these feelings and memories (eg, with pictures and stories) with a child reduces the child’s sense of isolation. Children need reassurance that they will be cared for and loved by a consistent adult who attends sensitively to their needs. In addition, they must be assured that they did not cause the death, could not have prevented it, and cannot bring back the deceased. Parents should be encouraged to continue family routines and discipline.

The initial shock and denial of death may evolve into prolonged or severe behavior change that signals the need for more intensive intervention. Children may seem emotionally unmoved, thus causing concern to family members. It is important for the pediatrician to be aware of the range of manifestations of childhood grief (Table 2) and to be alert to prolonged or severe behavior change that signals the need for more intensive intervention. A number of age-appropriate books can be read by or to a child as support for understanding and dealing with the grieving process (Table 3). The pediatrician should remain alert to the resurfacing of the child’s concerns at the anniversary of the death, at holidays, or at times of other losses as the child progresses through subsequent developmental stages.

Recognition of one’s own attitudes and reactions to death is essential for objectively and supportively counseling the family. Pediatricians must realize that grief counseling is an emotionally demanding
Should prompt investigation by pediatrician; mental health referral is probable.

**TABLE 1.** Overview of Children’s Concepts of Death

<table>
<thead>
<tr>
<th>Age Range, Years</th>
<th>Concept</th>
</tr>
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<tbody>
<tr>
<td>0 to 2</td>
<td>Death is perceived as separation or abandonment</td>
</tr>
<tr>
<td></td>
<td>Protest and despair from disruption in caretaking</td>
</tr>
<tr>
<td></td>
<td>No cognitive understanding of death</td>
</tr>
<tr>
<td>2 to 6</td>
<td>Death is reversible or temporary</td>
</tr>
<tr>
<td></td>
<td>Death is personified and often seen as punishment</td>
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<tr>
<td></td>
<td>Magical thinking that wishes can come true</td>
</tr>
<tr>
<td>6 to 11</td>
<td>Gradual awareness of irreversibility and finality</td>
</tr>
<tr>
<td></td>
<td>Specific death of self or loved one difficult to understand</td>
</tr>
<tr>
<td></td>
<td>Concrete reasoning with ability to see cause-and-effect relationships</td>
</tr>
<tr>
<td>Older than 11</td>
<td>Death is irreversible, universal, and inevitable</td>
</tr>
<tr>
<td></td>
<td>All people and self must die, although latter is far off</td>
</tr>
<tr>
<td></td>
<td>Abstract and philosophical reasoning</td>
</tr>
</tbody>
</table>

time-consuming, and potentially frustrating endeavor. The Classification of Child and Adolescent Mental Diagnoses in Primary Care: Diagnostic and Statistical Manual for Primary Care (DSM-PC) Child and Adolescent Version identifies diagnoses and conditions and may help the pediatrician evaluate the degree of severity of the child’s behavior. Use of DSM-PC coding also may help the pediatrician deal with third-party payers. Referral to a mental health specialist or clergy (pastoral counselor) should be considered when the pediatrician believes that progress is not being made or would feel more comfortable having someone else work with the family.

**TABLE 2.** Range of Common Grief Manifestations in Children and Adolescents

<table>
<thead>
<tr>
<th>Normal or Variant Behavior</th>
<th>Sign of Problem or Disorder*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shock or numbness</td>
<td>Long-term denial and avoidance of feelings</td>
</tr>
<tr>
<td>Crying</td>
<td>Repeated crying spells</td>
</tr>
<tr>
<td>Sadness</td>
<td>Disabling depression and suicidal ideation</td>
</tr>
<tr>
<td>Anger</td>
<td>Persistent anger</td>
</tr>
<tr>
<td>Feeling guilty</td>
<td>Believing guilty</td>
</tr>
<tr>
<td>Transient unhappiness</td>
<td>Persistent unhappiness</td>
</tr>
<tr>
<td>Keeping concerns inside</td>
<td>Social withdrawal</td>
</tr>
<tr>
<td>Increased clinging</td>
<td>Separation anxiety</td>
</tr>
<tr>
<td>Disobedience</td>
<td>Oppositional or conduct disorder</td>
</tr>
<tr>
<td>Lack of interest in school</td>
<td>Decline in school performance</td>
</tr>
<tr>
<td>Transient sleep disturbance</td>
<td>Persistent sleep problems</td>
</tr>
<tr>
<td>Physical complaints</td>
<td>Physical symptoms of deceased</td>
</tr>
<tr>
<td>Decreased appetite</td>
<td>Eating disorder</td>
</tr>
<tr>
<td>Temporary regression</td>
<td>Disabling or persistent regression</td>
</tr>
<tr>
<td>Being good or bad</td>
<td>Being much too good or bad</td>
</tr>
<tr>
<td>Believing deceased is still alive</td>
<td>Persistent belief that deceased is still alive</td>
</tr>
<tr>
<td>Adolescent relating better to friend than to family</td>
<td>Promiscuity or delinquent behavior</td>
</tr>
<tr>
<td>Behavior lasts days to weeks</td>
<td>Behavior lasts weeks to months</td>
</tr>
</tbody>
</table>

* Should prompt investigation by pediatrician; mental health referral is probable.

**TABLE 3.** Selected Books About Bereavement for Parents and Children*

- Young Children and Parents Dealing With Death: The Dead Bird, by Margaret Wise-Brown. Addison-Wesley, Reading, MA, 1988 (3 to 5 y)
- Accident, by Carol Carrick. Seabury Press, New York, NY, 1976 (6 to 8 y)
- Old Children and Young Adolescents on Death of a Sibling or Close Friend: A Taste of Blackberries, by Doris B. Smith. Thomas Y. Crowell Co., New York, NY, 1973 (8 to 9 y)
- Beat the Turtle Drum, by Constance C. Greene. The Viking Press, New York, NY, 1976 (10 to 14 y)
- Straight Talk About Death for Teenagers, by Earl A. Grollman. Beacon Press, Boston, MA, 1993 (13 to 19 y)


**RECOMMENDATIONS**

1. The pediatrician should provide support and anticipatory guidance for children and families who face death. The pediatrician is in a position to encourage open discussion of reactions, thoughts, and feelings in the family, thereby increasing the sense of mutual support and cohesion.
2. The pediatrician must use age-appropriate and culturally sensitive guidance while being alert for...
normal and complicated grief responses. The ability to share, reliance on family members, and good communication have been associated with positive long-term bereavement adjustment.

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REFERENCES

ADDITIONAL READINGS
The Pediatrician and Childhood Bereavement  
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