THE DEVELOPMENT OF THE CONCEPT OF DEATH IN CHILDHOOD

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In 1973 Claire Mulholland published a book of poems written to and about her daughter who had died of leukaemia. The shortest said simply:

Worst of all was the agony
Of not knowing
What you knew.

In many ways that brief cry sums up the central reason for studying the development of the concept of death in children. If we can understand what they know, we may be able to communicate with them at an appropriate and therefore effective level. And it is not only children facing their own death who need such communication; many children are touched by the death of a sibling, a school friend, a parent or grandparent or a pet. (Let us not minimise the death of pets; I worked with a boy once who had been deeply affected by the demise of his goldfish).

In the 19th century, when child death was far more common an occurrence, there was a general assumption that children would know about and possibly expect death. A clergyman then could write as follows:

> My dear children, the whooping cough is spreading fast; several little ones have died of it. Day after day I hear the bell tolling, and one little child after another has been buried here; as I walk out into the villages and the lanes and go into the schools, I see your little faces swelled and hear you coughing; but I am pained to think how few of you would be found ready were you children to die of it.
>
> **"The Children's Friend".**

This quotation raises an immediate point of context. The well brought up five year old Victorian was likely to be taught about death, and heaven or hell directly or indirectly. Today the Indian child is taught that we will be reborn; the British child learns, if anything, that our spirit goes to heaven. But the British child may learn that talking about real death is not quite nice. Most of the work I shall be quoting in this paper is based on work done in America or Europe; I know of only one study carried out elsewhere.

The Awareness of Death

There is ample evidence that children under the age of five are aware of death. Kastenbaum[6] reported that a 16 month old was observed to watch in alarm as an adult trod on a caterpillar. The child studied the remains and after a pause said "No more". Last year I worked with the parents of a boy who died of cancer just before his fifth birthday. Shortly before his death he told his parents that he did not want to be an angel and go to Jesus, and he went on as follows:

> "People do die, don't they Mummy?"
> "Yes, everybody dies sometime."
> "Doctors can't save all the people, can they?"
> "No, but doctors try very hard."
> "The doctors can't make me better, Mummy, and neither can you, can you? But Jesus can make me better. Jesus will make me better with love and kisses because Jesus doesn't give pricks. And then he'll send me home."

Just a few weeks before he died, he told his mother that he did not like going to sleep because he dreamt about horrible things.

> "I dream about dying."
> "About you dying?"
> "Yes."
> "Does that frighten you?"
> "Yes, I know I'm going to miss you and Daddy."

At a less anecdotal level Kane[5], studying 122 mainly middle class children in America, reported that all the three years olds she interviewed were able to distinguish a picture of a dead rabbit from one merely sleeping. Maurer[10] is one of several writers who have argued that experimentation with an awareness of alternating states of being and not being can be dated from the infant's first game of "peek-a-boo".

So far, then, we can be reasonably sure that children are familiar with the word 'dead' before they enter school. We know that some of them may associate it with immobility and with separation. But we are still a long way from understanding in detail what it is that a child understands.

The concept of life has to be studied before we can understand children's concepts of death. Piaget has noted that up to the age of six or seven children often attribute life to inanimate objects. This is hardly surprising when they hear adults talking of a live wire or a dead telephone.

By six or seven, though, most children have a clearer idea of life and are well on the way to developing a full concept of death. The notion of a full concept is important: we do not go to bed one day with no concept and wake up next morning with one. Rather we develop the concept bit by bit. Sylvia Anthony (in Britain) and M. Nagy (in Hungary), studied the components of the concept, but a recent full account is that of Barbara Kane who, in a 1979 article delineated 10 components. She assessed 122

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How to help children cope with the death of a parent must be the concern of all of us who work in the field of bereavement care, not only for compassionate reasons but because today's children are tomorrow's citizens and a history of unresolved grief in childhood we now know is found commonly in depressed adults. Depression is one of the commonest psychiatric disorders and is the cause of most suicides as well as great individual and family distress—to say nothing of lost work hours and cost to the Health Service and therefore the tax-payer.

In this issue we have three papers directly relevant to childhood bereavement. Richard Lansdown's original work on the development of a child's concept of death is important to counsellors and parents who are trying to help a child to understand what happened to his dead parent. Judy Hildebrand has down-to-earth tips on how to understand what children are telling us and how to help the whole bereaved family—wise words from an experienced and sensitive family therapist.

Finally our article on Parents' Circles describes a way of helping children by supporting their widowed parents—an original contribution by Cruse to the care of bereaved families, which deserves to be more widely emulated.

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American children aged 3 to 12 and assigned ages at which each component emerged, as shown in Table 1.

Table 1

COMPONENTS OF THE CONCEPT OF DEATH

		Average age attained
1.	Realisation	all 3 year olds
2.	Separation	5
3.	Immobility	5
4.	Irrevocability	6
5.	Causality	6
6.	Dysfunctionality	7
7.	Universality	7
8.	Insensitivity	8
9.	Appearance	12
10.	Personification	—

From: **B. Kane** (1979). Children's Concepts of Death. *Journal of Genetic Psychology 134* 141-153.

Several subsequent studies have supported the general notion of a gradual accumulation of components and a move from the concrete to the abstract. Working once more with middle class children, in India, Misra and Mewara[11] asked children aged 6 to 13 a series of eleven questions similar to those used by Koocher. They classified responses by age, with a steady increase in generalisation and abstraction and, at 9 years, a notable increase in an interest in ghosts. (This is discussed further below).

The most recent general studies are those of Reilly et al[14] (in America) and myself and Benjamin[8] (in England). The former, working within a Piagetian framework, asked questions of 60 children aged 5 to 10, mostly from middle income families. Children's understanding of personal mortality, judged by their response to the question: "Do you believe that some day you will die?" was related to their general cognitive level, assessed by a conservation task. The positive replies found by age are given in Table 2.

Table 2

DECLARED BELIEF IN PERSONAL MORTALITY

In answer to the question: "Do you believe that some day you will die?":

Percent replying yes:

Age	5	6	7	8 - 10
	50	73	82	100

From: **T. P. Reilly et al** (1983). Children's Conceptions of Death and Personal Mortality. *Journal of Pediatric Psychology 8* 21-31.

My own study, carried out with my colleague, Gail Benjamin, used a story about an old lady who died as a basis for discussion, with a heavy emphasis on probe questions. The responses of 83 children aged 5 to 8 have so far been analysed in a preliminary fashion and these results suggest that 7-8 remains the nodal point in conceptual development. However, of 17 children aged 5, almost one third of the age group had a virtually complete concept, that is they gave several causes of death, they did not see it as reversible and, perhaps most surprising in the light of Kane's work, they had a good idea of the appearance of the dead person. Clearly it would be most unwise slavishly to follow the conclusion that 8 or 9 is the key age at which one can discuss death.

It is often argued that a child's own experiences will affect the development of the concept. The most obvious experience to take into account is death itself: it could be predicted that children who have themselves experienced the death of a relative, close friend or a pet would have an accelerated concept. Kane[5] found this to be so for children up to the age of 6 only, and Bolduc[4] also supported this notion when children aged 9 to 14 were considered. Tallmer et al[16] looking at 3 to 9 year olds, did not find the same effect.

Closely related to family or pet deaths is experience of war or civil war. McWhirter[9] studied children in Northern Ireland and found that a more advanced definition was indeed given by 4 or 5 year olds living in the areas of the troubles.

Little attention has been paid to social class as such. One study by Tallmer[16] found that children from lower social classes had a more advanced concept, possibly because they have more contact with death on the streets or because they are in greater danger themselves. This study was carried out in America.

Religious belief has been shown to have some influence; Blum[3] found that Roman Catholics believed more in the after life than did Jews. Swain[35] and Zweig[17] however, found no difference between the religious groups they studied; the latter asserted that the media teach more than families or the church.

The implications of all the above for those dealing with children who are themselves facing death is that one must consider whereabouts on the developmental sequence the child is. And developmental stage can refer also to the sequence of the child's concept of illness as much as death. Myra Bluebond-Langner[2] considered such stages and postulated five as shown in Table 3.

Table 3

SELF CONCEPTS OF THE DYING CHILD

1. Seriously ill.
2. Seriously ill and will get better.
3. Always ill and will get better.
4. Always ill and will never get better.
5. Dying.

From: **M. Bluebond-Langner** (1978). *The Private Worlds of Dying Children.* Princeton University Press.

While I do not disagree with Bluebond-Langner I would like to consider five more sequences, shown in Table 4.

Table 4

STAGES IN THE CONCEPT OF ILLNESS

1. I am ill but I will get better.
2. I am very ill but I will get better.
3. I have an illness that can kill but I will get better.
4. My illness can kill my contemporaries.
5. I may die very soon.

The crucial stage, in my experience, is number 4. Healthy children tend to use death references as a metaphor: "I could kill you" is rarely meant literally. When they hear their parents say that they must take their tablets or they will die, I suspect they take this threat in the same metaphor-like way. But when they hear of the death of someone of their age, or younger, perhaps a child they had seen up and about only recently, the full realisation of the possibility of their own impending death comes home. I remember telling a 13 year old that another child on the ward, a boy of 7, had died the night before. She burst into tears, saying over and over again "I didn't want him to die." What she was also saying was, "I don't want to die".

Following this outburst I went on, not surprisingly, to talk with this girl about her own death. She made me promise to tell her when it was imminent.

Given that she was 13 years old I was happy to do this. I was less happy when confronted with the obvious distress of a 3 year old, dying in hospital, with no family to support him. His mother knew how ill he was, but was unable for various reasons to be with him. I did not talk to him about his death; I reflected that for a child of this age the greatest fear is separation and so I stroked him and told him that there would always be someone with him. If I were not there (and I am rarely on the ward for

more than a couple of hours) then a playleader would be, or a nurse, or a doctor, or the ward clerk, or someone. Fortunately the organisation of psychosocial support on our ward is such that I could promse this, knowing that it would be arranged.

The three year old and the thirteen year old are easy. Much harder is the 6 to 8 year old and I hope that the research outlines in this paper have both emphasised the difficulties and outlined some guidelines.

This paper is based on a talk given to the 1985 Cruse Conference of Branches.

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WIDOWED PARENTS' CIRCLES

By Dr. DORA BLACK, MB, FRCPsych, DPM

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"I was describing to a friend that being widowed so suddenly was like being shipwrecked on a wild, stormy, black sea. Thinking further on this feeling, I decided that discovering Cruse was like finding a patch of calm water and the Parents' Circle a landlocked harbour from which to take short journeys out to sea again, knowing you can return time and time again to gain more courage and strength from the strength and courage that comes from the group itself. Gradually the journeys get longer and one can go further afield. It is lovely to be ab'e to relax, have coffee and talk in pleasant, warm surroundings, knowing the children are being entertained by caring, understanding people".*

*From Maidstone Cruse Parents' Circle leaflet, with permission.

In the early days of Cruse Parents' Circles were started by Margaret Torrie, Cruse's founder, with the help of her husband, Dr. Alfred Torrie, because they recognised that widowed mothers might now have no one with whom to share the joys and sorrows of child-rearing and to talk over the problems that inevitably arise in family life. In this article I will discuss the patterns that have evolved in these groups and try to put forward guidelines for their establishment and conduct which may be useful to Cruse Branches and others working with bereaved families.

Bereaved children can sometimes be forgotten. The reasons are understandable when we appreciate the pain involved for a child in losing a parent. People may need to defend themselves against recognising this pain by ignoring the needs of the child, passing them off as insignificant or in some cases by becoming hostile. It is important for any organisation which aims to counsel bereaved people to make sure that the children in the family are not forgotten. Children have special difficulty in grieving and in expressing their feelings of deprivation and usually need help to do so and to come to terms with their situation. There are two ways in which help can reach them—directly through individual or group counselling or therapy and indirectly through helping their widowed parent either alone or in groups, so that she or he can then respond more appropriately to his/her child's needs. All these services should be available to orphaned children but in this article I am going to concentrate on group meetings for widowed parents.

Child rearing is not an easy task and most parents have mixed feelings about their children: at times feeling loving and proud, at others hateful, ashamed, guilty and incompetent. When there are two parents, the chances are that they will not both feel angry or loving with a child at the same time or to the same degree so that the intensity of emotion can be modified by the other. This acts as a protection for children which goes when only one parent rears them. Parents have a special interest in their children. Grandparents are interested too but in a different, less intense way, as are other relatives, friends and teachers. So that the sharing of joys and sorrows between parents is unique.

A Parents' Circle can help by providing a safe setting where widows and widowers can talk about their children, and ventilate and alleviate some of their feelings. For the setting to be safe and therefore helpful certain principles need to be observed. Attention must be given to the physical setting, the membership, the leadership and the organisational details. The content of meetings and how they are structured and led is in the hands of the leaders and will be discussed later.

Physical Setting

Meetings should be held regularly in the same place and at the same time. The room should be warm, softly lit with comfortable chairs arranged in a circle, and there should be facilities in a separate room for making coffee. Such rooms can be found in health centres, probation and social services offices, child guidance centres and many other places and may often be loaned free of charge or for a small fee. It is important

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