Brain Tumour Australia Information

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Kids Corner cont.

Guidelines for speaking to Children

The Cancer Council of NSW has published a book called "When a parent has cancer: how to talk to your kids". Free copies are available by calling the Cancer Council Helpline, 13 11 20

Toddlers

This age group cannot understand the concept of a brain tumour or cancer. It cannot be seen or touched. Their concerns are more about having their primary need met. They will be worried if separated from a parent; worried or frightened about medical procedures (especially injections or having blood taken) and may cry, run away or have nightmares.

Up to Age 2

Be truthful when speaking about either trips to the doctor or hospital. If injections or a procedure may hurt then explain this clearly and honestly. Allow them to cry. Don't insist they be `brave' or a little `soldier', but do praise them after the procedure to show them, how proud you are. Honesty and praise builds up a trusting relationship.

2 to 7 year old

This age bracket has a better understanding. They are reasonably ego-centric- the entire world evolves around them, so it is important to explain that actions do not `cause' the diagnosis eg. Being naughty did not cause the brain tumour and being good will not make it automatically go away.
Reassurance is necessary with this age group, and honest explanations about procedures, tests and discomforts need to be clearly explained. Remind the child that the treatment or tests are being performed to make them or a family member feel better.

Use language specific to their stage of development - the terms 'good' and 'bad' can be used when explaining how brain tumours develop from faulty cells. However as these terms are also used to describe behaviour, the use of the term faulty, damaged, defective or imperfect can be used with reliable, stable, trusty etc.

If a child or a family member is taking medications then use the name of the medication rather than using the word `medicine'.

If something that they take is spoken of as `medicine' and it makes them or a family member sick eg. Chemotherapy, then when the child needs to take something to stop them vomiting (another type of `medicine') they will become confused.

Also if a child at sometime in the future requires cough and cold `medicine' they may resist taking it as previous `medicine' made them or a family member ill.

By using the correct name allows children to form associations that can be positive and negative, however they will have more control and understanding, and take their cues from the significant adult in their life.

Being more attention seeking, clingy, teary, demanding extra physical contact from parents or reverting to bed wetting, all common in this age group

7-12 years old

While this age bracket are still limited by their own needs and life experiences, they are approaching in their development the ability to understand relationships between events.

Symptoms can be identified as part of the brain tumour diagnosis and they may have a better understanding that their behaviour did not cause the diagnosis. They are also better able to understand the connection between medications and procedures leading to a positive outcome.

This age group may also follow instructions more readily or easier and they may be more cooperative with the treatment plan. Always use language specific to a child's development stage and again use the correct terminology.

Some children in this age group will make a connection between the diagnosis of a brain tumour and dying. Television has impacted on this age group and their understanding may be also be tainted by the experience of peers who may have had a family member or neighbour die from a 'cancer'.
If the diagnosis has a less than favourable prognosis; possibly death, or if the child may lose their independence or behaviour changes or mood swings may be experienced, then at some stage in the journey it may be advisable to have the support of a trained counsellor when raising these issues.
Treatment centres should have the services of a social-worker and or a psychologist available as part of the treatment team. Try to be prepared to discuss difficult questions when they arise. Your child may miss out on talking about some very strong and frightening feelings and the reassurance that may be needed

12 years and over

This age group has the ability to understand relationships between diagnosis and events. They will think more and may ask more questions. They will still want to know when the tiredness or fatigue will abate; when will they have the energy to resume their sporting activities or hobbies and continue with their school and social life. Having a much clearer understanding of death they need to be reassured of the developments and progress made in the treatment of brain tumours.

Always maintain honesty throughout treatment, even if the questions are complex and confronting. Use the treatment team to assist with explanations if you feel overwhelmed. It is natural to want to protect children from hurt, fear and pain, but good communication is essential to help built up trust and understanding. Children may attempt to hide their own feelings if they are concerned that they cannot be truthful or treated truthfully.

Questions that a child may ask

- ***What is a brain tumour?*** A brain tumour is a mass of extra, unnecessary cells that grown in the brain. Often these cells are abnormal as opposed to normal cells that form when a child is growing and developing or when new cells are needed to repair damaged cells.

- ***Why did I get a brain tumour?*** Children need to be reassured that their behaviour (or a family members behaviour) did not cause the brain tumour. They need honest communication - 'not even the doctors know why a brain tumour occurs'

- ***What happens to me with the treatment?*** Keep a calendar and a diary of appointments, tests, and medication with the child to let them remain in control of their treatment plan. If it is necessary to alter the schedule then inform the child of the changes and why. It may prove difficult for the child to understand the necessity to take 'medications' to assist with their treatment plan if they do not actuality feel 'sick'. Try simple age appropriate explanations of the medication or treatment finding the damaged, defective or imperfect cells and hopefully destroying them before they can get any bigger.

- ***Will I (or a family member) die from the brain tumour?*** Children may come straight out and ask this question or they may be afraid to ask in case the answer is something that they do not want to hear. They need to be assured that every possible step; surgery, radiation therapy and or chemotherapy is being used to help fight the brain tumour. They need to know that all the treatment team will also do their best to help treat the brain tumour. While attending a treatment centre the child may see other children or adults who are extremely unwell. They may ask questions in front of the other person or they may be afraid to even talk about their fears and observations. The best approach is, prior to visiting a centre to explain some of the things that a child may see in a treatment centre; sick people; people attached to machines or intravenous devices; blood, injections etc.

- ***What about other people finding out about my brain tumour or my parents brain tumour?*** If the child attends a school or other extracurricular activities then the care-givers in these environments need to be aware of the family crises in order to provide maximum care and support. Schools are communities were 'gossip' can get out of control and if communication about a diagnosis and treatment has not been discussed with the children in the family, frequently another child in the school will make it 'their mission' in life to explain to a child all they 'know' about the health crises (eg. My mummy said that your daddy is sick and that he is going to die; or if you have radiotherapy for your `cancer' then you will die.) Children can be worried about how their peers or classmates will react especially if the treatment the child may be receiving has an impact of physical changes to the body (eg. Shaved head, dexamethasone effects of weight gain, large scars, seizures or a loss of function in various parts of the body). Many health professionals are more than willing to visit a school to speak with the staff, a class or a school assembly about brain tumours. This can de-mystify all the perceptions that many in this environment may have. Encourage the child to speak openly about their diagnosis and treatment, however the child needs to know that not all adults have a good grasp on the cancer/brain tumour concept, so it is understandable that many children may also have a limited knowledge.

- ***Can you catch a brain tumour?*** Children need to be reassured that a brain tumour is not 'catching'.

Questions that a child may ask cont.

- ***Can I still do the things that I used to do?*** The answer to this question will be linked to the type of brain tumour and any changes that the child may be experiencing as a result of the diagnosis. They may experience fatigue, have poor concentration and poor hand-to-eye coordination. Noise or strong lights may worry them, and balance may be effected. Therefore bike riding, playing computer games, even drawing if the right side of the body experience's some deficits may all require adjustment or putting on hold for a while. Any out side activity may require a hat to protect the treatment area or it may be advised that exposure to the sun be avoided whilst receiving treatment.

- ***Does the chemotherapy treatment make people sick?*** Children should be told about all aspects of the treatment so that if they become unwell that side effects can be managed as soon as possible.

- ***Does the radiation therapy make a person radio active or shine in the dark?*** With TV Shows and comic books colouring a child's perception they may have some unusual ideas about the treatment and its effect on them or a parent (if the parent has a brain tumour). Assure them that, no they will not shine in the dark; they will not be radio-active and they can still play, hug and kiss family members with no worries at all.

- ***Will the hair grow back again?*** Depending on which area of the brain is treated, the radiation therapy may affect hair growth in a couple of regions on the head. Sometimes the hair grows back , sometimes it is thinner and sometimes it may not all grow back. Different chemotherapy treatments can make the hair fall out but after chemo the hair re-grows. This is a question for the consultant that is in charge of your child's treatment plan

- ***Why did Daddy or Mummy get a brain tumour?*** No one knows why people get brain tumours `not even the doctors know why a brain tumour occurs' Children need to be reassured that their behaviour (or a family members behaviour) did not cause the brain tumour. They need honest communication.

- ***What will happen to me if mummy or daddy dies?*** If it is a parent who has the brain tumour, the child will frightened that they may lose both parents. Children of all ages require continual reassurance that they will be 'looked after'.

Discipline of the child with a brain tumour

Discipline is an important part of growing up in a family. Many parents find it very difficult to maintain discipline with their child who has been diagnosed with cancer. Having seen your child very ill, in pain, knowing that their future is uncertain and that some children may die makes it difficult for parents.

It may also be tempting to over protect your child, which often denies him the opportunity to participate in normal activities necessary for his/her growth and development. If you are unsure how much to discipline your child, or when to limit or restrict certain activities then ask your doctor, Social Worker, psychologist and/or discuss it with other parents.

- Know what to expect in regards to how much the illness/ medication is affecting him/her both physically and psychologically. Find out what he/ she is and isn't allowed to do, and then you will be able to treat him/her as you would any other child

General Issues when a Child has a Brain Tumour

Let children know it is OK to cry and be sad. It is also OK to be frightened. Let the child see you cry, they need to be given the opportunity to provide you with comfort.
On occasion, when an adult is upset they my not want to `upset', frighten, or worry the child, but children are perceptive and are frequently aware of your personal pain and fears. Explaining to children why you are sad, and that it is nothing that they have done to create your sadness or your tears, gives them permission to communicate what may also be happening for them at this time.

Effect on the extended family, peers and friends

Be mindful that even though the diagnosis of a child with a brain tumour has its greatest effect on the immediate family, other people, whether it be grandparents, other relatives, family friends or their school peers can also be affected. Support and practical assistance may be offered by the above group. However, this assistance may be time limited due to personal commitments making them feel helpless and anxious too.
Grandparents worry about both generations in the family, the grandchild and the parent (their own child-you). Family meetings with the treatment team may assist in the sharing of medical information to help them understand.

Effect on the extended family, peers and friends cont.

Just clarifying that radiation therapy does not make a child radio-active may debunk some of the myths surrounding treatment.

Each individual family will deal with relatives, friends and neighbours in their own way (and in particular, sticky-beaks who may intrude). For those who really want to assist it may be difficult not knowing how or what is best and not wanting to intrude.

So it can be helpful to disclose what you are feeling, what your needs are and what assistance you may need.
It may also be necessary to set boundaries in relation to spoiling or over indulging your child with family members. Normality and routines assist both the child and the family at a time of heightened stress.

Effects on siblings

Other children in the family may feel resentment and believe they are being neglected; in some cases this is actually true. The demands of a sick child on parents may result in less time to allow for the needs of other children in the family. This may be an area when friends, relatives or neighbours can assist with transporting children to after-school activities.

It is normal for siblings to feel jealousy as the child with a brain tumour is receiving more parental attention. They may begin to act out in negative attention seeking ways such as temper tantrums and increasing their demanding behaviours. They may develop somatic symptoms such as headache, abdominal pain, even bedwetting. Siblings often develop these symptoms as part of a sick-role which they see as similar to their ill sibling. School refusal, disobedience, aggression, withdrawal and unhappiness are other emotional and behavioural problems that often result.

Supporting the siblings

Encourage siblings to have as much contact as possible with their ill sibling. Phone calls, letters and hospital visits are a good idea. Attempt to minimize exposing siblings to extremely distressing situations.

Facilitate information sharing regarding the child with the brain tumour, and encourage siblings to join (where appropriate) meetings that you may have with the treatment team.
Organise regular family meetings which provide opportunities for siblings to ask questions and a forum to acknowledge their feelings and enlist their personal strengths in solving any family problems. Maintain a relatively normal routine at home. Try to keep up your normal methods of boundary setting and discipline.

Children less than 5 years may not have the cognitive capacity to understand the situation and may interpret the prolonged removal of one parent as a punishment for their own behaviour. Organising for these children to have some individual time may be a good way to deflect their concerns and fears.

Continually monitor siblings throughout the child's diagnosis and treatment. Be aware of changes in appetite, sleep, mood, behaviour. Also check their school progress regularly with their teachers. If family issues and relations are causing concern , assistance can be obtained from the treatment team through a Social Worker or Clinical Psychologist who can advise you or refer you to a local agency for ongoing support.

Be open and honest with all children in the family. Let them know that feelings of resentment are natural. Providing them with opportunities to share and participate in the family's crisis will encourage healthy growth and maturity. Open communication gives them the opportunity to respond in helpful ways, giving them a sense of belonging and usefulness.

During periods of extended stays in hospital, the family at home may like to keep a diary of activities at home, so that they can send it to the parent and hospitalised child as a way of including them in the events at home.

However, do not in a time of crises expect a child to be `too-adult' or expect them to take on too many of the adult roles/jobs. This will only add to a sense of frustration and resentment, alienating the child even more.

Try and set time limits on any new roles or responsibilities that the child may be undertaking eg. Doing laundry, putting the garbage out etc. and reinforce their worth by respecting that the crises is also impacting on many aspects of their life and development as well as their sense of security.

Inform the school or the year advisor/deputy principal of the family crises as changes in behaviour in the classroom/playground are often the first sign that the diagnosis or attention given to the child with the brain tumour is impacting.

Effect on the extended family, peers and friends cont.

Other attention seeking behaviour may occur including headaches, tummy upsets, withdrawal, temper tantrums, bed wetting or not wanting to attend school.

Talk with the Hospital Social Worker to discuss fears and other feelings the siblings are experiencing

Points to keep in mind when a brain tumour is diagnosed in a family

Reassure the child that a brain tumour diagnosis or treatment is not punishment for anyone's behaviour.

Be honest in your communication with the child.

- Explain treatments and tests realistically.
- Never be afraid to tell your child that you do not have all the answers. (However reassure them that if possible you will endeavour to find information for them.)
- Allow the child to speak to you about their fears and ask questions if you sense they are too frightened to raise any subject.
- Let the child know that it is OK to cry and to be frightened and angry.
- Set boundaries. Children always push the boundaries and they need consistency while coping with a brain tumour.
- Involve the child in the treatment plan, let them have some control (unless it harms or interferes with the treatment plan or outcome)
- Introduce the concept of family talks. That way other children in the family can feel included and not resent the extra attention that a child with a brain tumour may be receiving.
- Realize that everyone, children and adults, have good and bad days or periods in their life.
- Maintain normalcy as much as possible with routines (and don't forget all those kisses and hugs) including school.
- Use the health professionals who are members of the treatment team. They can be an excellent resource and support.

Helpful hints for parents

- Buy a notebook/diary and note down any questions you or the children may have.
- List any information that is provided in relation to diagnosis, treatment, tests and results.
- This will help empower your role as a parent in advocating for your child.
- Talk to other parents/families on the ward that have been on the brain tumour journey. You cannot underestimate the support you may gain from this experience.
- Ask for patient education literature.
- Try to maintain a typical lifestyle, as far as is possible.
- Treat the child as normally as possible.
- Keep in mind the needs of other children in the family, they still need special time, and attention.
- Keep all avenues of support open, you never know when you may need them for both your child and your selves.
- Allow time to talk with your partner/spouse or if you are a single parent with someone close to you.
- Allow yourself time just for yourself.
- Don't allow all discussions to revolve around the child with the brain tumour diagnosis, make time to do things you enjoyed doing together before your child became sick.
- Pursue strategies to reduce frustration or boredom when you're waiting around for procedures eg. Reading, puzzles. etc
- Ask your Social Worker to link up with other parents/ families
- Develop a roster or system whereby you and your spouse can share and alternate the care of your child at the hospital. This allows an opportunity to spend time with the hospitalised child and other siblings and to also have a rest or time to yourself. This also provides both parents an opportunity to become familiar with the hospital, the staff and the routines.
- If you are a single parent, perhaps another family member or friend who is close to the child, may be able to stay at the hospital occasionally to give you a break.
- Utilise the services/resources at the hospital for support.
- There are outside professionals, agencies and organisations who can offer a variety of support, information and assistance, just ask your Social Worker for this information.
- Encourage family and friends to visit the hospital but explain to them what to expect so they can prepare themselves for things like the drip attached, bald head, and other sick or dying children.
- If the visits become too lengthy and noisy restrict visitors in number or the length of time that they stay with the child, both at home and at hospital. Too much noise, activity and too many conversations at the one time can be confusing or of concern to the child especially just after surgery or during treatment.

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Helpful hints for parents cont.

- Also depending on the location in the brain of the tumour, the child's concentration or tolerance may be affected adding an extra dimension to the crises if there are too many visitors, or too much activity surrounding them.

School issues

Maintaining regular school attendance (when possible) is essential by:

- Keeping routines as normal
- Reinforcing a sense of well being.
- Allowing the diagnosis to be a 'small' part of the child's life not all the child's life.
- Preventing the child falling behind with their peers in the school environment and the learning process.
- Assisting self esteem and self worth.
- Allowing social contact with peers and reducing social isolation.

You may also want to liaise with the teacher about issues regarding home tutoring, correspondence, and lessons whilst in hospital etc.

Note: a Request for Special consideration

For older students and senior school students who may be undertaking assessment tasks and obligations, request that the 'Board of Studies' (in NSW, or its state equivalent) be notified of the family health crises. A request for special consideration may allow for an average mark to be allocated to a students submitted work, or for an extension to be offered to an assignment deadline. Performing at optimum level may prove too difficult when a brain tumour diagnosis has been received in a family.

Practical support issues

There may be aspects of your life that suddenly become disrupted/disorganised.

Financial changes may occur [a parent not being able to work] or extra expenses being incurred by the family for petrol, travel, accommodation etc.

The Child Disability Allowance, a fortnightly allowance is given by the Centrelink and may be applicable to the care needs of your child. Approval of this fortnightly allowance is based on the extra care and attention you provide for your child due to their brain tumour diagnosis and treatment. Once the Child Disability Allowance has been approved (approval make take 6 to 8 weeks), the child will also receive a Health Care Card which you can present to a pharmacy making the cost of medications less expensive.

- **Treatment transport assistance.**

Each state in Australia has their own application form [the name of the scheme varies]. In NSW families who live more than 100 kms (as of July 1st 2006) from the treatment hospital with a child requiring treatment, are eligible for an allowance through the Department of Health allowance called the **Isolated Patients Travel & Accommodation Assistance Scheme (IPTAAS),** a reimbursement for one parent's (escort's) travel and accommodation expenses while their child is receiving treatment

A separate form must be completed for every return trip that the child and the escort parent makes to the hospital for treatment. It is important to be aware that reimbursement of expenses may take a lengthy period (approximately 6-8 weeks).

Other financial assistance may be possible through a number of charitable organisations including: The **RedKite** Organisation (Formally known as the Malcolm Sargent Cancer Fund) and the **Children's Cancer Institute of Australia**.

Application for financial assistance for a family will need to be made by the Hospital Social Worker.

Families may experience difficulties with their present housing situation due to their child's diagnosis and treatment. If your family is experiencing these difficulties, the Department of Housing may be able to assist. Some major treatment centres offer special limited term on-campus accommodation for a child/families when a child is receiving treatment.

If you or other family members require letters or telephone liaison with organisations, advocating your particular circumstances, do not hesitate to contact your Social Worker; eg. letters to employers, the Department of Housing, schools, Centrelink etc are required during your child's treatment. Agencies such as Home Care may be able to as families with specific needs and eligibility for these Services is based on strict criteria and fees are means tested.

There are community support agencies including : **Camp Quality, Canteen, Starlight Foundation, Make-A-Wish Foundation,** that provide a child with a serious illness with a special wish .

Kids Corner cont.

Canteen also has a support program for children age 12 to 24 called **`Offspring'** for children with a parent who may have a Brain Tumour diagnosis.

A referral to any of these organisations can also be made by the Social Worker.

Resources and Links for Children

Books and the use of specially chosen web sites can provide a valuable resource for parents to help their children gain a better understanding when a diagnosis of a brain tumour is received in the family.
However, in order to use these resources in the most effective manner, it is important to give careful consideration to several factors.

- Books or websites will not magically answer all questions
- Books or websites will not answer or solve problems
- Insight gained from using resources will not substitute for the work that adults and children must do together in order to help children reach a rounded understanding
- Resources can introduce topics and provide a structure and some guidelines that can stimulate discussion
- However, personal interaction is essential
- A child's age and developmental stage is important to consider (not just their chronological level).
- Be honest and straightforward with children
- Provide explanations based on reality
- Language should be in simple terms that children can easily understand
- Check out a website or book first before introducing it to a child
- Considered ways to approach any parts that may cause distress or anxiety
- Stimulate a discussion after using the resource.
- Be honest
- Reinforce that expression of emotion is normal and healthy

Children and Grief

In the past, children were thought to be miniature adults and were expected to behave as adults. It is now understood that there are differences in the ways in which children and adults mourn.
Unlike adults, bereaved children do not experience continual and intense emotional and behavioural grief reactions. Children may seem to show grief only occasionally and briefly, but in reality a child's grief usually lasts longer than that of an adult. This may be explained by the fact that a child's ability to experience intense emotions is limited. Mourning in children may need to be addressed again and again as the child gets older. Since bereavement is a process that continues over time, children will think about the loss repeatedly, especially during important times in their life, such as going to camp, graduating from school, getting married, or giving birth to their own children.

A child's grief may be influenced by his or her age, personality, stage of development, earlier experiences with death, and his or her relationship with the deceased. The surroundings, cause of death, family members ability to communicate with one another and to continue as a family after the death can also affect grief. The child's ongoing need for care, the child s opportunity to share his or her feelings and memories, the parents ability to cope with stress, and the child's steady relationships with other adults are also other factors that may influence grief.
Children do not react to loss in the same ways as adults. Grieving children may not show their feelings as openly as adults. Grieving children may not withdraw and dwell on the person who died, but instead may throw themselves into activities (for example, they may be sad one minute and playful the next). Often families think the child doesn't really understand or has gotten over the death. Neither is true; children's minds protect them from what is too powerful for them to handle.
Children's grieving periods are shortened because they cannot think through their thoughts and feelings like adults. Also, children have trouble putting their feelings about grief into words. Instead, his or her behaviour speaks for the child. Strong feelings of anger and fears of abandonment or death may show up in the behaviour of grieving children. Children often play death games as a way of working out their feelings and anxieties. These games are familiar to the children and provide safe opportunities to express their feelings.

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Grief and Developmental Stages

In society, many grieving adults withdraw and do not talk to others. Children, however, often talk to the people around them (even strangers) to see the reactions of others and to get clues for their own responses. Children may ask confusing questions. For example, a child may ask, "I know grandpa died, but when will he come home?" This is a way of testing reality and making sure the story of the death has not changed.

Other Issues for Grieving Children

Children's grief expresses 3 issues:
1.Did I cause the death to happen?
2.Is it going to happen to me?
3.Who is going to take care of me?

Did I cause the death to happen?

Children often think that they have magical powers. If a mother says in irritation, "You'll be the death of me" and later dies, her child may wonder if he or she actually caused the mothers death. Also, when children argue, one may say (or think), "I wish you were dead." Should that child die, the surviving child may think that his or her thoughts actually caused the death.

Is it going to happen to me?

The death of another child may be especially hard for a child. If the child thinks that the death may have been prevented (by either a parent or a doctor) the child may think that he or she could also die.

Who is going to take care of me?

Since children depend on parents and other adults to take care of them, a grieving child may wonder who will care for him or her after the death of an important person.

Planning memorial ceremonies

When a death occurs, children can and should be included in the planning and participation of memorial ceremonies. These events help children (and adults) remember loved ones.

Children should not be forced to be involved in these ceremonies, but they should be encouraged to take part in those portions of the events with which they feel most comfortable.

If the child wants to attend the funeral, wake, or memorial service, he or she should be given in advance a full explanation of what to expect. The surviving parent may be too involved in his or her own grief to give their child full attention, therefore, it may be helpful to have a familiar adult or family member care for the grieving child.

References and resources for grieving children
There are many helpful books and videos that can be shared with grieving children:

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11. Viost J: ***The Tenth Good Thing About Barney.*** New York: Atheneum, 1971.
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Kid’s Corner

Children’s Grief and Developmental Stages

Children at different stages of development have different understandings of death and the events near death.

Infants

Infants do not recognize death, but feelings of loss and separation are part of developing an awareness of death. Children who have been separated from their mother may be sluggish, quiet, unresponsive to a smile or a coo, undergo physical changes (for example, weight loss), be less active, and sleep less.

Age 2-3 years

Children at this age often confuse death with sleep and may experience anxiety as early as age 3. They may stop talking and appear to feel overall distress.

Age 3-6 years

At this age children see death as a kind of sleep; the person is alive, but only in a limited way. The child cannot fully separate death from life. Children may think that the person is still living, even though he or she might have been buried, and ask questions about the deceased (for example, how does the deceased eat, go to the toilet, breathe, or play?). Young children know that death occurs physically, but think it is temporary, reversible, and not final. The child’s concept of death may involve magical thinking. For example, the child may think that his or her thoughts can cause another person to become sick or die. Grieving children under 5 may have trouble eating, sleeping, and controlling bladder and bowel functions.

Age 6-9 years

Children at this age are commonly very curious about death, and may ask questions about what happens to ones body when it dies. Death is thought of as a person or spirit separate from the person who was alive, such as a skeleton, ghost, angel of death, or bogeyman. They may see death as final and frightening but as something that happens mostly to old people (and not to themselves). Grieving children can become afraid of school, have learning problems, develop antisocial or aggressive behaviours, become overly concerned about their own health (for example, developing symptoms of imaginary illness), or withdraw from others. Or, children this age can become too attached and clinging. Boys usually become more aggressive and destructive (for example, acting out in school), instead of openly showing their sadness. When a parent dies children may feel abandoned by both their deceased parent and their surviving parent because the surviving parent is grieving and is unable to emotionally support the child.

Ages 9 and older

By the time a child is 9 years old, death is known to be unavoidable and is not seen as a punishment. By the time a child is 12 years old, death is seen as final and something that happens to everyone.

Grieving Children: Treatment

A child’s grieving process may be made easier by being open and honest with the child about death, using direct language, and incorporating the child into memorial ceremonies for the person who died.

Explanation of death

Not talking about death (which indicates that the subject is off-limits) does not help children learn to cope with loss. When discussing death with children, explanations should be simple and direct. Each child should be told the truth using as much detail as he or she is able to understand. The child’s questions should be answered honestly and directly. Children need to be reassured about their own security (they often worry that they will also die, or that their surviving parent will go away). Children’s questions should be answered, making sure that the child understands the answers.

Correct language

A discussion about death should include the proper words, such as cancer, died, and death. Substitute words or phrases (for example, passed away, he is sleeping, or lost him) should never be used because they can confuse children and lead to misunderstandings.

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