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# Pastoral Counseling with the Dying Child and his Family

Kenneth Doka

*Concordia Seminary, St. Louis*, [kndok@aol.com](mailto:kndok@aol.com)

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PASTORAL COUNSELING WITH THE DYING CHILD  
AND HIS FAMILY

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Paper Submitted to:  
Dr. William Danker  
For Research Paper (P 299)

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by  
Kenneth J. Doka

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## TABLE OF CONTENTS

Chapter	Page
INTRODUCTION . . . . .	1
I. MINISTRY TO THE CHILD. . . . .	4
II. MINISTRY TO THE FAMILY DURING THE COURSE OF ILLNESS . . . . .	17
III. MINISTRY TO THE FAMILY AT THE POINT OF DEATH AND BEYOND . . . . .	24
IV. CONCLUSIONS. . . . .	27
BIBLIOGRAPHY. . . . .	30

## INTRODUCTION

"To give light to those who sit in darkness and in the shadow of death." Luke 1:79.

Perhaps there is no greater affront to the sense of justice of most Americans than the death of a child. In this culture, with the great value and emphasis placed on the young, and with the rarity of the occurrence, the death of a child brings forth a particularly strong mood of pathos. For while death is unnatural and fearful to man, the death of a child seems to defy logic. Yet children do die.

And, because children do die, there is a need for pastoral care to both the dying child and his family. Such care is different from that given to dying adults, not in theology, but in the fact that the subject is a child, that the total family will be more involved, and, most importantly, in the intensity of the impact upon the child, his family, and their pastor.

This paper hopes to explore the area of pastoral counseling to the dying child and his family. The paper views such a ministry as having three major facets. First is the ministry to the dying child himself. While this seems elementary, it is often neglected, often because of the minister's own difficulty with the death of a child. It must be

realized that childhood is not a homogeneous unit but that there are sharply differentiated stages within childhood. The five-year-old reacts to death in ways considerably different from the adolescent. Thus research along these lines, along with its pastoral implications will be reviewed. Secondly there is ministry to the family during the course of illness. Then there is ministry to the family at the point of death and beyond. The word emphasized in these two latter facets is family. For the death of a child affects not only his parents but most certainly his siblings and possibly others in the family constellation. In addition no such paper could be complete without a consideration of the minister's role and problems. Finally such a paper must enunciate a theology of death, as must all such counseling with the dying. It is hoped that such a theology will permeate the pages of this report, so that the concluding summation is just that. It should also be stated that one major goal of this paper is to disseminate the information we can glean from nontheological sources, often without pastoral comment. Such is justifiable when one realizes that a prerequisite of any counseling is a firm knowledge of the field.

At this point the limitations of the paper should also be mentioned. First, this paper arises from two sources. One is the writer's own experience as a chaplain in the pediatrics ward in a large cancer research hospital. While the writer became quite interested in the area during his sojourn there,

he cannot by any standards claim any expertise. The other source is the literature available within the field, most of which is written from a social scientific perspective.

Research and interest in the area of dying is relatively new, and research and interest in the dying child is particularly fragmentary and of uneven quality. Thus this paper is limited by its sources.

Secondly, it is limited in scope. With the conquest of most acute diseases in this nation, the death of a child usually occurs with the dramatic suddenness of trauma, or at the end of a chronic, debilitating disease. The implications for pastoral ministry of these forms are different. As suggested by the outline, this paper focuses on the latter, and in doing so it must consider such aspects of chronic illness as frequent hospitalizations and the financial and social psychological burdens of a slow death trajectory. In particular it focuses upon leukemia, one of the most common forms of chronic and terminal childhood disease, and the one primarily focused upon in the literature as well as one that predominates in the writer's experience. Leukemia is particularly problematic; in its recurrence of remission and relapse prediction becomes difficult and hope may become unrealistic. Thus this paper does not attempt to offer a comprehensive account of the phenomena of childhood death, but limits itself to chronic disease.

## CHAPTER I

### MINISTRY TO THE CHILD

Before discussing the ministry to the dying child, it is first necessary to consider the child's reaction to his illness and dying. Only then can ministry be meaningful. Such a discussion naturally must begin with the experience of hospitalization, for this will often present the focal point of the child's experience and the milieu in which or around which pastoral counseling will take place.

An initial comment is in order. The hospitalization procedure often has the effect of diminishing the child's faith in his parents.<sup>1</sup> When the child is hospitalized the parents are both unable to offer the child protection from hospital procedure which he might find painful, and they are often unknowledgeable as to the procedures themselves. One parent expressed to me the new relationship very succinctly:

. . . you stop being parents, you become visitors.  
. . . You give her to science. It's the doctors who call the shots now. Sure you can say no. As parents you have the final say, but they really call the shots.

Children too soon realize this and hence will often

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<sup>1</sup>Friedman, et. al. "Behavioral Observations on Parents Anticipating the Death of a Child" (Pediatrics, 32: 610-25, 1963).



bypass parental authority and appeal directly to the medical staff who in fact exercise control over their lives. The pastor must be aware of this important distinction in the parent-child relationship for two main reasons. First he must be sensitive to it as it may enter into the dynamics of the relationship he is counseling, even in situations in which parental participation is stressed. Secondly, this lessening of faith in parental authority may also involve a more general questioning of all parental knowledge. For as the infallible parent is shown to be surely fallible, so may all he has passed on to the child be so questioned. Thus a faith crisis may be precipitated.

Another factor involved in the hospitalization process is the trauma of separation of the child from his social world, particularly from his familiar surroundings and his parents. In the infant and toddler this fear of separation can be more intense and immediate than the fear of death.<sup>2</sup> Various hospitals have attempted to deal with this by allowing parents to participate,<sup>3</sup> even to live in. Nonetheless, this can never be totally satisfactory as the hospital can never provide the full range of contacts that the child had on the outside. It will be most effective with the youngest

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<sup>2</sup>Mary Nagy, "The Child's View of Death," in H. Fiefel (ed.), The Meaning of Death (N.Y.: McGraw-Hill, 1959).

<sup>3</sup>An excellent description of an initial experiment in this concept is found in M. Hamovitch, The Parent and the Fatally Ill Child (Duarte, California: City of Hope Medical Center, 1964).

child, and least with the adolescent who is just losing the important peer ties that have begun to mean much to him.<sup>4</sup>

This is not to suggest that the child is totally isolated within the ward. Often they will form peer groups within the hospital. This, too, has important implications. For very often the child will learn from peers the facts of his disease, the routines of the hospital that signify the beginning of a dying trajectory and other types of inside knowledge. Hence the child will often know through this process far more than he has been told or has been assumed to know.<sup>5</sup>

This ought be remembered in any consideration of the issue as to whether to tell or not to tell a child he is dying. Perhaps no issue in the field has been more debated. On one hand, there is a view offered by some<sup>6</sup> that as we really can never be certain of death one ought hold out hope to the child right to the end. Such a view is well expressed by author John Guenther in his account of the death of his fifteen year old son:

But it was impossible not to support his optimism, because any discouragement would have been a crushing blow. All he now had was his will to live. We

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<sup>4</sup>Wm. Easson, The Dying Child: The Management of the Child or Adolescent Who is Dying (Springfield, Ill.: Charles C. Thomas, 1970), p. 53.

<sup>5</sup>Easson, p. 46.

<sup>6</sup>H. Bissonnier, "The Fatally Ill Child: A Pastoral Approach" in A. Godin's Death and Presence (Brussels, Humen Vitae Press, 1972) and L. Salk, What Every Child Would Like His Parents to Know (N.Y.: McKay, 1972).

had to keep that up at any cost. The cord of life was wearing very thin and if we took away hope it would be bound to snap.<sup>7</sup>

In one study a majority of doctors also responded that they would not answer accurately a direct inquiry from the child regarding prognosis.<sup>8</sup>

Others<sup>9</sup> have argued that such questions must be answered truthfully, although in a comforting manner. For example, they would hold that the question "Will I die?" may be answered directly with an addition to the effect or "We will care for you till then."

It should be realized that the question is often moot. The counselor should be watching closely for cues in regard to what the child does know, and he should not presuppose that the state of knowledge (or ignorance) that his parents or the staff assume to be, is in fact. As stated earlier the child often has other accesses to information, including his own observations. A failure to do so may result in a state of what Glaser and Strauss describe as mutual pretense awareness, a situation in which each party (in this case pastor and child) knows but pretends to the other that he does not know.<sup>10</sup> Such a relationship is not ideal for counseling.

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<sup>7</sup>J. Guenther, Death, Be Not Proud (N.Y.: Harper Row), p. 159.

<sup>8</sup>J. Wiener, "Response of Medical Personnel to the Fatal Illness of a Child," in Schoenberg, et. al. (ed.) Loss and Grief (N.Y. Columbia U. Press, 1970).

<sup>9</sup>J. Vernick and M. Karon, "Who's Afraid of Death on a Leukemia Ward?" Amer. Journal of Diseases of Children, 109: 393-397, 1965). And Easson.

<sup>10</sup>Awareness of Dying. (Chicago, Adeline, 1965).

And the child may often test the person by asking such a question. A blatantly false response may cause the child to question the minister's veracity at other points as well. A better response would simply be to turn the question on the child, to ask him his perception of his prognosis and of death in general and to move from there. One should not be surprised that the child may not choose to engage in such conversation at this time, that his question may not reflect intense concern but only mild curiosity. Nonetheless, such a response on the part of the counselor does open up lines of communication. On the other hand, the child may be quite willing to discuss his fears and thoughts. The counselor must also be willing to do so, for the pastor may be the only one willing to discuss such with the child. And, the alternative is that the child may die very alone, with the failure of others to discuss his anxieties only increasing them. For a child's concept of death must in part reflect the attitudes of the others around him.<sup>11</sup>

As stated in the introduction, to treat childhood as a homogeneous unit would be a mistake. Hence it is necessary to discuss how various ages view their death and illness. It seems evident from research that an infant has neither knowledge nor fear of death.<sup>12</sup> It is, of course, problematic as to

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<sup>11</sup>A point well brought out by Bissonnier (op. cit.).

<sup>12</sup>John Schwalter, "The Child's Reaction to His Own Terminal Illness," in Schonberg, et. al. (ed.), Loss and Grief (N.Y.: Columbia Press), pp. 52-69.

whether he at this point conceives of himself as an entity separate from his environment, particularly his mother. Thus while death may not be a conception and hence concern, the separation, particularly in a strange world in which people constantly jab and stick you is a frightening experience. Hospital programs which stress parental participation, or even allow the parents to live in, as many hospitals do now, help to allay the immediate needs of the infant.

The preschool child begins to develop some concept of death. However research indicates that while he can accept the reality he has not yet conceptualized its permanence.<sup>13</sup> Death is a temporary departure, much like sleep. If skillfully pursued such a concept could provide an effective opening for pastoral consolation and comfort. Nonetheless, this should be approached gingerly. The child at this age has just begun to establish a separate identity, any challenge to it may be quite anxiety provoking. Thus as Easson points out, he is apt to be angry at a response that he will be happier in heaven.<sup>14</sup> It seems best then to recognize the child's sense of loss, to empathize with it, but to point out that while it is a separation from a world he knows and is beginning to enjoy, from people who love him, it is not a

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<sup>13</sup>Nagy (op. cit.)

<sup>14</sup>Gasson, p. 17.

permanent one. The child will also need support. He will need to know that despite the inevitable incapacitation and disfigurement, despite his own behavior which is apt to become regressive or aggressive, he will be cared for.

The child may have another need too. Often children at this age develop a great sense of cause and effect. They hit their brother, Mommy hits them. Hence they often believe in some direct sense that by their misbehavior or disobedience, they have brought this disease upon themselves. Thus effective counseling will have to reassure them that they are not being punished for any particular event. The pastor should be sensitized to possible guilt feelings which may be expressed in numerous obscure ways. For example, in one incident which the writer experienced, the child spoke of a pet who constantly ran from the yard until one day she was hit by a car. The question of the child, whether the pet deserved her fate, seemed to indicate, and did lead to a much wider concern. In discussing the child's condition with him, one additional aspect should be realized. The child at this time has a limited conception of time. Thus any definiteness in terms of time should be avoided. Telling the child he will die in six months is like telling him he will die tomorrow. Hence it ought to be avoided.<sup>15</sup>

During the grade school years, the ages of around six

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<sup>15</sup>Esson, p. 15.

through ten, the child begins to develop independence and self concept. At this point the child has begun school, and the peer group is beginning to replace parents and other adults as the most significant models. And as he begins to hear varying opinions, he begins to learn to make up his own mind. Mastery, in sports, in all events, becomes a key word.

The child at this time begins to develop a sense of death's reality and permanence.<sup>16</sup> The child also can begin to conceptualize the unnaturalness of death<sup>17</sup> and can become aware of the fact that it does not always come when "it ought"; that young people, even children die. The child at this age, while he can accept the reality of death, can also be at a stage where he can understand and accept alternatives to death. The child brought up in a religious family can exhibit a great faith and strength. Easson's<sup>18</sup> comment that the child at this age is able to face the prospect of death and to reach out and aid his family in acceptance is well verified by the writer's own experience. For instance, one eleven-year old boy responded to the news of his diagnosis with: "Leukemia, wow, that's a rough one to take! It's fatal, isn't it?" This child had been quite anxious prior to his

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<sup>16</sup>Nagy, Schwalter (op. cit.).

<sup>17</sup>Schwalter (op. cit.).

<sup>18</sup>p. 48.

parents sharing this information. Once this was shared, he was quite able to adjust. This does not mean that the child can handle death alone. He still needs reassurance and support. He will need his parents. He will experience feelings of guilt, depression and anger. Easson, quoting Psalm 23, sums it up well:<sup>19</sup>

"Yea though I walk through the valley of the shadow of death, I will fear no evil: For Thou art with me; Thy rod and Thy staff they comfort me." Psalm 23

This verse was written by a believer. These words could have been said by a grade school child. A child of this age believes in parents and in God. The grade school child knows that death means a final separation from this life. He knows now what he will miss. He must mourn this loss as he leaves. He is sad and bitter because he does not want to go. He is lonely because he is traveling this journey alone. In this difficult time, the grade school child can use his parents, his family, his buddy or best friend and his classmates to help him live through this final experience. The grade school child always uses the support of those whom he trusts. In his final days and hours, he should pass through death in the comfort and security of his family.

While mastery is the key word for the grade school child, independence is the key word of the adolescent. At this point the adolescent is beginning to assert his independence from his parents and, more and more, he is becoming attached to his peer group. Severe illness then strikes the adolescent in two ways. First it inverts this natural process of independence. The adolescent, after tasting independence, becomes

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<sup>19</sup>pp. 48-49.



dependent again. Secondly, it separates him from his peers. Adolescents like any other age group will avoid the dying patient.<sup>20</sup> And his own physical deformity, at a time when physical appearance is particularly important, can increase that sense of isolation. A pattern of mutual avoidance between the adolescent and his friends will often develop. Thus death and chronic illness can bring on feelings of intense bitterness, resentment and anger. Of all stages of childhood, the impact of death on the adolescent and relations between the adolescent and others will be most difficult. In a time of questioning, the "unfairness" of his death may lead to an intense faith crisis. Answers may be demanded where answers cannot be given. Throughout this period it is important for both family, pastor and staff not to desert the child, no matter how difficult his behavior may become. Despite his exterior, he still needs care and support, even while he may at the time resent his dependence on it. In the end he may well appreciate and accept that support and comfort. The following case that the writer was familiar with may serve as an illustration:

E. W. was a fourteen year old girl with spinal cancer. During her previous visits to the hospital she was quite friendly and open with the staff. At her last visit she became unco-operative and demanding. She stayed in her room, which she kept dark, and constantly brooded. After about two weeks of this she again came out of her

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<sup>20</sup> Esson, p. 54.

shell and was most responsive to staff and family. Before she died she asked that they not blame God.

Thus it is important that at this age period particularly the pastor must be supportive, empathetic and responsive no matter how impossible the demands of the child may become.

A few things then ought to be said in summary about the child's religious state and his needs. First, care to the child should be regular and consistent. The minister should make an effort to follow the child, at hospital and at home throughout the course of the illness. Anything less may not only be ineffective but positively harmful, both in relationship to the child and his family. For example in the case of one seven-year-old suffering from leukemia, the family priest, a tremendously busy man, could only visit the case when it became critical. Hence his visits were an unwelcome reminder of the seriousness of the child's state. He became a harbinger of disaster. Particularly toward the end of the child's life, the mother became quite upset at the priest's visit, at one point describing him as "a vulture waiting to administer last rites." The minister ought to avoid such a trap. A visit at such crisis points will be meaningless to the child and may be sorely resented by his parents.

It should also be realized that the prime task of the ministry to the child will be to convey God's love to the child even in the midst of His judgement. In doing so he

must be able to accept and deal with the child's anger. Easson reports the comment of one seventeen-year old: "If God is as understanding and powerful as they say He is, He can understand and put up with my anger -- for I am mad enough to explode. If God is too weak to tolerate my anger or too stupid to understand, then He is not God!"<sup>21</sup> Rather than a lack of faith, this can be read as a powerful confession. The minister's God cannot be any smaller. The judgement and the anger it elicits has to be accepted by the counselor before he can offer a message of grace which will ring true rather than trite. The message of forgiveness in sin, of grace in judgement, of life in death can be understood by the child, provided it is placed on the child's level. This too is a difficult and sensitive task, for he must be aware of the dual dangers of talking down or above the child. In language the child can understand he must explain the paradoxes of Christianity. He must be open with his own incomprehension. The child can accept an "I don't really know why you; we'll miss you. But I guess God has a reason," more than "God wants you with him." In all this, prayer and devotions may be important to the child. But these should always serve as a supplement and support to counseling. Finally it should be realized that the child will often use symbolic language. Thus play, art and all

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<sup>21</sup>p. 91.

sort of other activities may serve as vital openings and aids in the counseling process. The pastor should not be reluctant to use them. Ministry then to the dying child is time consuming and difficult. It is, no doubt, one of the more difficult situations in which a minister may find himself. And while the difficulty may be conceded, that task of ministry may not.

## CHAPTER II

### MINISTRY TO THE FAMILY DURING THE COURSE OF THE ILLNESS

In order to minister effectively to the parents during the course of chronic illness it is necessary to have some concept of the feelings and behaviors that they will be experiencing and manifesting during that time. The initial reaction, is understandably, one of shock, followed by denial.<sup>1</sup> While this denial will often quickly subside, and realistic efforts to cope be instituted, it may continue and lead to consistent searches for different doctors with more optimistic prognoses. Such a path may go beyond the medical profession to quacks, sacred shrines or miracle workers.<sup>2</sup> In better hospitals it may take the form of a revived and optimistic hope. "If anyone can save my child, this place can."<sup>3</sup> In most types of chronic diseases, the gradual deterioration of the child will make continued denial impossible in all but the most disturbed. Such is not the

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<sup>1</sup>Friedman, et. al. "Behavioral Observations on Parents Anticipating the Death of a Child." Pediatrics, 32 (1963) 610-25.

<sup>2</sup>Kubler-Ross, On Death and Dying (N.Y.: MacMillan Co., 1969), pp. 40-41.

<sup>3</sup>Friedman (op. cit.).

case in leukemia, however. Here, the constant pattern of remission and relapse, the experience of the rapid recovery of a near dead child, the constant talk of breakthrough, make continued denial, at least of the possibility of death, quite viable. One parent for example turned to me after the check-up of a child who had been diagnosed with leukemia for a year and said: "He's fine. All counts are normal. Dr. K\_\_\_ always said that if anyone made it, it would be J\_\_\_." The pastor's role then is a difficult one, to help the parents draw the line between realistic and unrealistic hope, even while he is holding out to them a hope of grace, of forgiveness, of eternal life that is also, by this world's standard, unrealistic.

Once denial subsides it is usually followed by guilt reactions.<sup>4</sup> Guilt takes two forms. The first is simply guilt over the medical condition itself. Did they misperceive earlier symptoms? Is the condition in any way the result of their negligence? Is it hereditary? Could it have been cured if diagnosed earlier? Most of the time reassurance from their doctor will assuage any guilt feelings of this type. The second type of guilt reaction involves a larger question often with strong religious overtones. Why my child? What have we done to deserve this? Here the minister's reassurance can be as comforting to the parents as the doctor.

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<sup>4</sup>Friedman, et. al. (op. cit.).

While the pastor can't answer the question of "why my child" any more than the doctor can, he can give them what are not answers. He can tell them of Job's unsuccessful struggle for the same answer. He can also expect the same anger, the same doubts that Job had. Even C.S. Lewis, at the agonizing death of his wife expressed such feelings: "Not that I am (I think) in much danger of ceasing to believe in God. The real danger is of coming to believe such dreadful things about Him. The conclusion I dread is not: 'So there's no God after all' but 'So this is what God's really like.' Deceive yourself no longer."<sup>5</sup> Thus the parents will need constant reassurance throughout the course of the illness. This reassurance that it is not their fault, may lead to anger and challenge of God (and the minister). The minister should respond to this with continued concern. He may find, as the writer did, that sometime after the death of the child, they may be desirous to rediscuss their theological debates in a less heated fashion.

These two sources of guilt may not be the only ones observed during the course of illness. Guilt may take many forms. For example, in one case in the writer's experience the mother of a seven-year-old child dying of cancer felt guilty they had not leveled with the child over the seriousness

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<sup>5</sup>A Grief Observed (N.Y.: Seabury Press, 1961), pp. 9-10.

of his illness. As the child became sicker, he became more withdrawn and distrustful. The mother compared his reaction to his seven-year-old roommate, who had been informed of his diagnosis and prognosis and who responded with what one staff member called a "rare courage." Again the counselor must be around to explore and to communicate forgiveness for all types of guilt as they develop.

Another common reaction in parents is a search for information and other realistic efforts to counter and understand the disease.<sup>6</sup> Thus parents may become almost as knowledgeable as staff about the disease. The child, if he is old enough (even if he does not know the diagnosis with certainty), may also participate in such a search.

The parents may also experience feelings of helplessness. They have, to a great extent, conceded responsibility for the child to the medical staff. As one parent expressed it: "Well, you give her to science." Parental participation programs may help but they don't change the reality of who is in charge of the child's welfare.

Other family difficulties may arise. For example, there may be problems with role identity.<sup>7</sup> The mother who has built her life around her child may lose the role which she found most fulfilling, and thus life may become meaningless

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<sup>6</sup>Friedman, et. al. (op. cit.).

<sup>7</sup>Vernon, Sociology of Death (N.Y.: Ronald Press, 1970), p. 133.



to her. In addition, the constant hospitalization will often force a separation with one parent taking responsibility for the sick child and the other taking responsibility for the other child. Each parent, under the pressure of the illness, may feel that the other has it easier, and communication may be impaired. Cobb's research<sup>8</sup> seemed to indicate that in marriages which were "good" prior to the onset of illness, the illness did not seem to have ill effects upon the marriage. Those who were having difficulties prior to the illness found these difficulties exacerbated by the disease. Both Cobb<sup>9</sup> and Hamovitch<sup>10</sup> reported problems with siblings who often felt neglected during the illness.

Finally the minister may find that once death nears, hope begins to ebb and the family can accept the death. A number of researchers speak of a process of anticipatory grief.<sup>11</sup> In this process, by the time the child is in his final stages, the family has worked through its grief. Thus

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<sup>8</sup>"Psychological Impact of Long Illness and Death of a Child on The Family Circle," Journal of Pediatrics (1956), 49: 746-51.

<sup>9</sup>op. cit.

<sup>10</sup>op. cit.

<sup>11</sup>Easson, p. 18. J. Davis, "The Attitudes of Parents to the Approaching Death of Their Child," Developmental Medicine and Child Neurology (1964), 6: 286-8. R. & J. Fulton, "A Psychosocial Aspect of Terminal Care: Anticipatory Grief," Omega (1971), 2: 91-100.

the end may be virtually void of feelings. Or, there might be a sense of release that the ordeal, both theirs and the child's has ended. The parents have begun to reinvest their feelings and emotions. A few things ought be said about this process. First, it is a necessary one. If it does not occur the loss may be abrupt and shattering. Secondly, it should be realized that if it occurs too soon it may have the effect of isolating the child from his family. The child may be "socially dead" before biological death. If the minister feels this is occurring and decides to intervene he ought be aware of the consequences of his action for family adjustments following the child's death.

The question may be asked as to what support religion and the ministry offer to parents of dying children. Research here is contradictory. Bozeman and associates reported that few of the mothers they interviewed reported support or comfort from religious belief.<sup>12</sup> Cobb<sup>13</sup> and Friedman<sup>14</sup> reported that their samples did derive support from religious beliefs, although Friedman also found that their sample did not find any particular support from their clergy. Thus it seems that

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<sup>12</sup>Psychological Impact of Cancer and Its Treatment: III The Adaptation of Mothers to the Threatened Loss of their Children Through Leukemia -- Part I." Cancer, (1955), 8:1-33.

<sup>13</sup>op. cit., p. 750.

<sup>14</sup>op. cit., p. 620.

if the parents had faith prior to the child's illness, they did not lose it despite doubts they may have experienced during the course of the illness. However, in their struggle, they did not seem to derive any significant support from their clergy.

The essence of pastoral care to the dying child's family is in caring. The pastor must be around, constantly showing concern, accepting the parents in their anger, in their doubt. He may feel free to confess his own belief but he should avoid preaching and moralizing. Despite the challenges the parents may fling at him, he ought not debate. Later these parents may be ready to ask about these questions they once threw around so heatedly. Often little acts of kindness, giving blood, offering to take care of the child's siblings for a while, will mean more than anything he might say. He must also keep in mind the situation, the final prognosis. Thus he may rejoice when they rejoice, but he must not falsely build up their hope. His constant presence, his continued concern, his consistent confession will be important, provided they are constant, continued and consistent.

## CHAPTER III

### MINISTRY TO THE FAMILY AT THE POINT OF DEATH AND BEYOND

Effective ministry to the parents and family of the dying child cannot stop at the child's death but must go beyond. This will involve a number of phases. First, it will involve efforts at the time of death. The parents will probably be requested for permission for an autopsy and the minister may be requested to advise. In any case he should be around and available in these first numbered minutes. It is often helpful to ask the parents' aid in planning the funeral service. And he in turn should help the parents as they plan. He should realize the effect of this death on the parents: their guilt, powerlessness and ambiguous feelings. Thus they might desire a lavish funeral. This may be a worthwhile investment for the family and the pastor should not necessarily discourage it.

However, ministry must not stop at the funeral but continue beyond it. Hopefully the continued worship life of the congregation will be an aid to the family. Again, the continued concern of the pastor will probably be important to their adjustment. As discussed earlier, they may want to reflect theologically on their experience. C. S. Lewis, for instance, speaks of his initial reaction to the dying of his

wife: "Meanwhile, where is God? . . . But go to Him when your need is desperate, when all other help is vain, and what do you find? A door slammed in your face, a sound of bolting and double bolting on the inside. After that, silence."<sup>1</sup> Yet later after her death has occurred, his reflections take a different turn: "I have gradually been coming to feel that the door is no longer shut and bolted. Was it my own frantic need that slammed it in my face."<sup>2</sup> Then too the minister may review the life of the child, his role and importance in the family, reassuring the family that his life, though perhaps unfulfilled, had been worthwhile. Yet, he must point out that immortality does not rest upon man's achievements. Even the most famous are soon forgotten. Thus their hope lies not there but beyond. We can then point out that through Christ their child has an immortality far more permanent than the fleeting achievements he may have accomplished in a longer life.

Ministry to the family must also include ministry to the child's siblings. The minister might make himself available when the news of the child's death is broken to and discussed with the other children. This is the parents' job, but the minister should play a supportive role if so desired. Often the death of a child may provoke two reactions in his

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<sup>1</sup>op. cit., p. 9.

<sup>2</sup>op. cit., p. 38.

siblings. First, there may be feelings of guilt. The other children probably resented the attention given the child, even when they were aware of the seriousness of the condition. Thus ambivalence may breed guilt. Secondly, they might be anxious that they may be next. Thus the minister may be able to provide reassurance and forgiveness. Again, his ministry to the siblings will be most worthwhile where it has followed a history of concern.

## CHAPTER IV

### CONCLUSIONS

In conclusion, I think it can be stated that the dying child taxes the resources of his pastor as few other cases will. In dealing with a dying child the minister must first be well aware of his own feelings. Carlozzi points out various defenses (such as busyness, ritualized action and special language, set-apartness) that pastors use to avoid the dying patient.<sup>1</sup> Their work thus takes on a highly mechanized quality. Often the patients they work with will quickly sense this and respond in a compatible fashion. Children, though, are more likely to act out their feelings. They are less likely to respect the aloofness that the minister may wish to characterize the encounter. Thus the minister is forced either to withdraw almost totally from the child (and perhaps from their parents who are also likely to be less inhibited), or else to be intensely involved. The minister must have a firm conception of his own feelings, his counseling goals, the methods he wishes to use and the intermeshing of his own feelings with his work.

Finally the minister must be well aware of his own theology.

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<sup>1</sup>Death and Contemporary Man: The Crisis of Terminal Illness (Grand Rapids, Mich.: 1968).

Lutheran theology sees death in much the same fashion as the parent and child regard it. Death is an unnatural and terrifying intervention in life. It is not natural, nor a joyous occasion. It is the result of man's alienation from God, the source of all life. Death may be natural in its universality, but it is unnatural in its cause. How can men not rebel against it, or be unafraid?

But this alone is grim and morbid. The Christian theology of death does not simply end with an analysis of the unnatural end to life but goes beyond to the unnatural end of that end. God did not allow this alienation to stand. Instead He sent His Son to die in our place. Thus he is able to forgive us and to resurrect us. This is the essential core of the Gospel message that we can bring to these parents and children. For just as death is real and personal, so is the resurrection. And, the forgiveness we seek is free, it is not an immortality that must, in some way or another, be earned but rather one that is freely given and has only to be accepted by accepting Christ as Savior from death and judgement, and Lord of life. Thus our theology of death is, as Carlozzi states: "We will win even when we lose."<sup>2</sup> Thus the theology the Lutheran pastor offers is one that fully recognizes the tragic loss which parents and child face. It does not minimize or fantasize. But it does not despair,

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<sup>2</sup>Ibid., p. 65.



either. For it recognizes that this, however tragic, is not the end. It recognizes that beyond this judgement there is grace. It knows of the saving action of Christ. And with this knowledge we hope to impart and share with both parent and child the confession that Lutherans like Thieliicke can make: "I walk into the night of death, truly the darkest night; yet I know who awaits me in the morning."<sup>3</sup>

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<sup>3</sup>Death and Life (Philadelphia: Fortress Press, 1970), p. 198.

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