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Parental death in young children's lives: health professionals' and kindergarten teachers' contributions in meaning-making

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ABSTRACT

The present study focused on professionals' meaning-making support to young children (1–6 years old) anticipating and grieving the loss of a parent because of a severe, somatic disease. A two-phased interview study with palliative health-care professionals (11) and kindergarten teachers (18) provided data for a comparative analysis of professionals' contribution in making meaning about parental death across the contexts of palliative health care and kindergarten. The analysis focused on forms of interactions and resources for meaning making. Dialogues in the health systems centred on death and dying as natural, biomedical processes and relied on the dead or dying body as a context-specific resource for meaning making. The dialogues in the kindergarten centred on trying to understand the affected child's behaviour and emotional expressions together with the peer group.

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early childhood education; palliative care; parental death; children (1–6yrs); meaning-making

A parent severely ill and dying: children's everyday life contexts

A parent's severe illness and death represent a complex developmental condition. It alters the everyday life of the family, and at the same time the young child's possibilities for participation within and across other development contexts, such as school and kindergarten (Højholt and Kousholt 2018; Lytje and Dyregrov 2019). The present study compares kindergarten teachers' and palliative health-care professionals' ways of interacting with young children (1–6 years old) about parental death.

In Norway and other OECD countries, a majority of children live their life across the two societal institutions of family and kindergarten already from the end of the first year of their life (Bae 2010; Sommer, Samuelsson, and Hundeide 2013). When a mother or father falls ill with an incurable, somatic disease, palliative health care additionally becomes another societal institution in the child's everyday life. These two institutional contexts provide different conditions for children's participation.

The institutional contexts

As a result of medical progress in the late 19th century, death has been professionalized and has moved from being handled by the community to being handled by palliative

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health-care professionals that provide inter-professional care at the location where the dying person is (in palliative wards in hospitals or nursing homes, or palliative care arranged and based in their own homes) (Graven, Lund, and Jacobsen 2013; Madsen, Meldgaard, and Henriksen 2013). Palliative care in principle focuses on the physical, emotional, social and spiritual suffering of both the patient and her relatives (Madsen, Meldgaard, and Henriksen 2013). Recent changes in laws and recommendations for health professionals in Scandinavian countries oblige palliative health-care professionals to focus on patients' minor children by addressing their needs for appropriate follow-up and individually adapted information about prognosis and diagnosis (Danish Health Authority [Sundhedsstyrelsen] 2012; Norwegian Health Personnel Act 1999; Swedish Law of Health and Medicine 2017). However, the patient-centeredness and the medical code ruling within the health care system can seem to make health professionals prioritize medical tasks above psychosocial issues (Karidar, Åkesson, and Glasdam 2016) and limit health professionals' possibilities for involving children (Dencker et al. 2017; Hogstad and Jansen 2020). Several studies point to insufficient support from health professionals to minor children of severely ill patients and their families (Golsäter et al. 2016; Ruud et al. 2015). In addition, health professionals' opportunity to meet the child directly is limited to short visits during home-based care, or on occasions when the child is actively invited to visit in hospital, which is something that not all patients allow (Hogstad and Leer-Salvesen 2020; Karidar, Åkesson, and Glasdam 2016). Kindergarten teachers, on the other hand, are in a position where they have close, everyday contact with the children.

The Nordic kindergarten tradition is founded on social-pedagogical philosophy where free play and social interactions with peers are considered central in learning and developmental processes (Alvestad and Berge 2009). Arranging weekly or daily gatherings in the kindergarten is a common pedagogical practice for educational purposes and to build a sense of community in the peer group. The Framework Plan for the Content and Tasks of Kindergartens (2017), mandates kindergartens to support children in coping with misfortunes, to deal with challenges and become familiar with their own and others' feelings. Still, to the best of our knowledge, there exists to date no peer-reviewed studies that have focused on kindergarten teachers' contribution in supporting affected and grieving children. Two master's degree theses report from small-scale qualitative interview studies with kindergarten teachers in Norwegian kindergartens, and point to the need to give voice to kindergarten teachers' professional theoretical and practical knowledge about children and grief (Røkholt 2010) – a knowledge that seems to be underestimated by other professional collaborating partners (Sandberg 2012).

We need to consider professionals' contribution across contexts in relation to each other, to be able to understand children's possibilities in developing ways of conducting their life, and for the development of policy and practice for professionals. Two research questions will be addressed in this article:

- (1) In which ways do professionals within the two contexts of palliative care and kindergarten interact with children to make meaning of parental death, and which resources do they rely on in their ways of making meaning?
- (2) How does the professionals' meaning making work to shape children's possibilities to participate within and across everyday life contexts when a parent is severely ill and dying?

By conducting a comparative analysis of palliative health-care professionals' and kindergarten teachers' meaning-making practices and related resources, we bring to the fore knowledge about professional practices that, without the contrast created by comparison with the other context, might have remained implicit and taken for granted.

Dialogues that form and expand meaning

Developmental psychology has traditionally considered the universal development of children's concepts about death by age (Hogstad and Wold 2016). However, when a mother or father dies, the child's understanding of parental death involves more than just understanding death cognitively: children's subjective, everyday life experiences of parental death relate to how they together with others actively relate to and continuously *make meaning* of parental death (Hundeide 2003; Højholt and Kousholt 2018).

The present study takes a sociocultural psychological approach and relocates death concepts from the individual child to the *transindividual*: the meaning of death is socially constructed and already embedded in cultural practices, language, and other socioculturally shared symbol systems (Graven, Lund, and Jacobsen 2013). In situated encounters between people, multiple competing discourses of death are resources for making meaning about parental death. These discourses make available different possible ways of talking, thinking, feeling, and acting. A study of concepts and understanding of life and death among Norwegian 8-year-old pupils showed that they alternated between several discourses of death, depending on the conversational context and related to the overarching socio-cultural context (Hogstad and Wold 2016). Two of these discourses were, first, death as a natural, biomedical process that happens to all living things, and that results from the cessation of bodily life functions; and second, death as the loss of – or a fundamental change in – an emotionally significant relationship (Hogstad and Wold 2016).

From a developmental perspective, children gradually, and together with others, develop their ways of drawing on socioculturally shared meanings in their conduct of life (Hundeide 2003; Højholt and Kousholt 2018). Caregivers or professionals contribute as partners in interpretation by taking departure from shared knowledge that is already known to the child and expanding this by building bridges to something novel (Hundeide 2003). Engaging in such meaning-making work could be done through different forms of dialogues and with different aims (Ulvik 2015), but these practices have in common creating distance from the immediate by constructing a representation of the child's immediate experience (Hundeide 2003). To be able to depart from a basis in shared knowledge in dialogues with the young child (1–6 years old), professionals need to be conscious of the child's modes of communication and body language, and to listen, improvise, and interpret singular words or sounds and body language (Bae 2009; Sommer, Samuelsson, and Hundeide 2013).

Method

Participants

The present study focuses on interactions and dialogues in situated encounters where professionals engage as interpretation partners for young children in expanding the

meaning of parental death, and it is part of a PhD project about professional support for young children who have a severely ill and dying mother or father. The PhD project has been approved by the Data Protection Official for Research in Norway, and it consists of two phases of interviews with professionals. Three doctors and eight nurses from six public health institutions took part in the first phase, and the second phase included participation by 18 kindergarten teachers from seven kindergartens. See [Table 1](#) for an overview of participants.

Health professionals within palliative health-care services received written and oral information about the research project through information meetings arranged in the health institutions where they worked, or through a mediator within the health system. Those who volunteered to participate contacted the first author directly by mail or telephone. All participants provided informed, written consent.

In the second phase, kindergarten teachers were recruited through families anticipating or recently experiencing the death of a parent because of a severe, somatic disease and who had at least one child in the family attending or previously attending kindergarten during the illness process. Information about the research project was distributed to families with the help of a university hospital-based bereavement support centre and a national health institution for cancer patients, as well as a municipal public health service.

Eight families with a total of nine children who had attended kindergarten during illness processes (five girls, four boys) contacted the first author by mail. Through written consent, they released the kindergarten teachers from their duty of professional confidentiality for the specific purpose of the interviews and at the same time provided contact information for the kindergartens. All 18 kindergarten teachers and their leaders volunteered to participate and provided their written consent.

Interviews

Both first- and second-phase interviews focused on professionals' experiences in encounters with minor children and their views and considerations regarding children's involvement when a mother or father is severely ill and dying, but the interview guides differed

Table 1. Participants.

Profession (woman/man)	Years of experience	Institutional affiliation
3 doctors (1/2)	3–17 years of palliative care experience	1 in a small hospital 2 in university hospitals
8 nurses (7/1)	2–10 years of palliative care experience	From 2 different hospitals: - 2 palliative wards - 1 ambulant team - 2 ambulant/hospital teams From municipal health services: 2
18 kindergarten teachers (16/2)	4–36 years of experience as kindergarten teacher	From 7 different kindergartens: - 6 administrative leaders - 12 leaders in groups of children: • of mixed age (2) • 1–3 years old (4) • 3–6 years old (6)

from each other. Fundamental differences in the two professional groups' experiences relating to their access and relations to children for the scope of this study made different interview guides necessary. Whereas the kindergarten teachers (with one exception) each had experiences of providing support to only one child or pair of siblings, who all were 6 years of age or below, the health professionals' experience consisted of encounters with several children in a wider age range (0–18 years old). Health professionals' encounters were however more limited in time and closeness in their relations to the children compared to the kindergarten teachers, who followed the children from day-to-day before and throughout the illness process, and continued to follow some children also after the parent's death (five children). The health professionals' interview guide had four main questions; of these, two elicited the most responses relevant for the present study: one asked for stories from practice and the other focused specifically on children of kindergarten age (1–6 years old). The latter asked for these children's needs and understanding of illness and death, and how ideally they should be supported.

As a means to elicit detailed descriptions of interaction practices that would provide knowledge about meaning-making work within the kindergarten, the kindergarten teacher interview guide was developed with inspiration from the life-mode interview (Haavind 2019). The interview started by asking about the time when the kindergarten got to know that the mother or father was severely ill, and continued by alternating between following and developing a picture of the events chronologically, and lingering on specific events to explore and elicit detailed accounts of interaction sequences and justifications for practice. All interviews were conducted in Norwegian, and all except one were conducted in the professionals' workplace. Interviews lasted from 30 to 135 minutes and were audio recorded. The first author transcribed all the interviews verbatim, resulting in 850 pages of text.

Analysis

During the first-phase interviews, the first author became curious about the interactions between health professionals and young children next to the dying or dead body because of the way the body appeared as an essential, but also *context-specific*, resource for making meaning about death. This made us want to further explore and systematically analyse context-specific patterns of forms of interactions. The first and second author then together developed the four-step process of analysis described below.

In the first step, the first author read the 850 pages of transcripts searching specifically for stories about and descriptions of interactions with children in making meaning about parental death. As expected, given the differences between the two groups and the different interview guides, the data from the two groups of professionals differ. Whereas the kindergarten teacher data contain many detailed stories with descriptions of interactions with the child in question, the health professional data contain references to detailed descriptions of practices that they claimed they usually do. These detailed practice descriptions, 'we-usually-do descriptions', were more generalized in their form and were not necessarily tied to specific children. These were not found in the kindergarten teachers' transcripts.

Text sections that consisted of detailed descriptions of concrete practices where the professionals interacted with children in particular ways, or detailed

descriptions of specific interactions between the child and the professional, were marked in the text and given a code (hp for health professional/bl for kindergarten teacher), plus a number. After several rounds of thoroughly considering whether the text sections met the inclusion criteria, we ended up with 98 text sections – 30 extracts from the health professional interviews and 68 extracts from the kindergarten teacher interviews. The codes referring to the text extracts were structured in a table for the second and third steps of the analysis. See a translated example in Table 2.

The second analytic step was descriptive and involved identifying the child's and the professional's initiative and participation in the interaction from each text extract, and structuring it in the table. Body movements and language, singular words or sounds as well as silence and listening were included as forms of participation, in line with Bae (2009). The third step of analysis involved interpreting the interactions described, built upon two analysis questions that were theoretically informed (Kousholt 2018) by Hundeide's (2003) dialogues that expand and form meaning: What is the interaction about? Which resources do they apply for making meaning? Steps two and three were conducted twice: first for the health professionals, and then for the kindergarten teachers, revealing within-group differences and similarities.

The fourth step of analysis involved looking for patterns of forms of interactions and resources for meaning making within and across the professional groups, and it resulted in three main forms of interactions, with the two latter tied to context-specific resources within the institutional contexts. Finally, using the findings in the fourth step as a point of departure, we used Højholt and Kousholt's (2018) concept of participation to analyse how the professionals' various ways of conducting meaning-making work conditioned children's possibilities to participate across the contexts.

Results

Forms of interactions

The three main forms of interactions were *pre-arranged meetings with many involved participants*, *dialogues in encounters with the dying and dead body*, and *therapeutic, psychological dialogues* and are categorizations of the interactions that were most commonly referred to across the interviews. The categories do not apply to all participants within each context, or to all areas of the contexts. For example, even though gatherings to commemorate the dead parent was a frequently mentioned form of interaction, none of the kindergarten teachers in toddler groups (1–3 years old) arranged such gatherings. In addition, four (of 29) professionals did not refer to any instance of meaning-making interactions in their interviews, while others' accounts consisted of up to 10.

Pre-arranged meetings with many involved participants

Both groups of professionals organized well-prepared, structured meetings where information about illness and death was provided. In the health-care context, these took the form of information meetings and involved family as well as professionals from different institutions and of different professions. In the kindergarten, the pre-arranged meetings

Table 2. Systematic description of text extracts.

Code and short description	How does the professional describe: - the child's participation? - the initiative of the professional?	- the professional's participation?	What is the interaction about?	Interpretation: Which resources do they apply for making meaning?
<p>HP-E-6/1 Concrete description of a situation from practice: a child (appr. 5–6 years old) comes along into the room to see her mother just after her death</p>	<p>- the initiative of the child? Listen to the nurse's heart first, then to her mother's heart with the stethoscope. She hears the difference between the beating and non-beating heart.</p>	<p>- the professional's participation? Offers her own beating heart for the girl's listening.</p>	<p>Helping the child in understanding what it means to be dead and that mum is dead now.</p>	<p>Medical equipment: the stethoscope. Bodies/hearts: the dead body of the mother and the healthy body of the nurse.</p>
<p>BL-V-37/4 Story from one of the regular weekly gatherings in the kindergarten where the boy's (appr. 2 ½ years old) mother recently died. They listen to music – accidentally the instrument that the mother used to play.</p>	<p>- the child's participation? Responds by saying 'Mum, mum' repeatedly. Sits down together with V and looks at the picture of the instrument mum played on the iPad.</p>	<p>- the professional's participation? Answers the boy: Yes, mum played music, do you want to come up here?'" Continues by talking about his mother. Searches for a picture of the instrument she played (that they listen to) on the iPad and shows the children.</p>	<p>The boy seems to associate the sound of the music with his dead mum. V contributes to strengthen this association when she acknowledges it and expands it by adding another sensible element – a picture of the instrument she played – and by talking about what she interprets as the background of the child's association: that mum played music.</p>	<p>Language Music iPad: picture, iconic representation of an object that is associated with mum. V's knowledge about mum as a musician.</p>

were memory gatherings after the parent had died and gatherings informing the children's group that one of the parents of a kindergarten child was severely ill and might die. The gatherings involved the peer group and sometimes the remaining parent, and candles and a picture of the dead parent decorated the room. The purpose of the meetings within both contexts seemed to be to inform the child or children, and to help them understand that the parent was going to die or had died. Nurse 'Jenny' told of an information meeting with two siblings of kindergarten age who were informed that their mother's disease was incurable and that the mother was going to die within a short time:

I had brought a little teddy and a suitcase with doctor equipment, and I told them, "You know that mum has been sick for a while". I then opened the suitcase and picked up the hypodermic syringe and showed on the teddy, "She has gotten medicines". I let them try the syringe, before continuing, "If someone has been sick for a very long time, and the doctor has no more medicines to give . . ." and I showed them the book *Chemoman Casper*,¹ and further built on that story to explain how the chemotherapy eventually stops working and the illness grows in the body. Moreover, the children asked, "Will mum die?" "Yes, she is going to die. Everybody dies eventually, we just do not know when. But your mum is not going to live very much longer."

The kindergarten teachers in the gatherings used very similar explanations to Jenny, about how doctors try to heal the parent, but that sometimes no medicine is working. Even though the purpose of the meetings within both contexts was to provide information, there was a difference regarding who was familiar with the knowledge before the information meeting. In the health-care context, the purpose was to provide the child with knowledge that was previously unknown to him or her, and in the kindergarten, the information was known to the bereaved (or anticipating) child but not necessarily to the other children in the group. Hence, whereas in the health-care context the information target was the child or siblings, in the kindergarten the peer group was as much the target as the bereaved child.

Dialogues in encounters with the dying and dead body

The most frequently referenced forms of interaction between health professionals and young children (of approximately 8 years and below) were dialogues next to the dying and dead parent, where the professional supported the child in interpreting what they heard and saw. The professional used plain, concrete descriptions of physiological processes. For instance, nurse 'Lavrans' recalled saying the following:

"Your mother's breath sounds like this because she has water in her lungs. We will try to relieve her of this water."

They also had similar dialogues *prior* to encounters with the dying or dead body, where the nurses and doctors prepared the child for the fact that the dead body would be cold, about how the death process possibly could proceed, and how the breath sounds and changes in the death process. No kindergarten teachers told about engaging in this form of interaction. However, kindergarten teacher 'Maria' related that when the recently bereaved boy in her group (same-aged children, 4 years old) came back to the kindergarten after visiting hospital, he told about having felt his dead father and that 'he was cold, but not white'.

Therapeutic, psychological dialogues

The doctors and nurses told about interactions with adolescents categorized as therapeutic, psychological dialogues, because they provided individual psychological support and comfort, but this type of dialogue did not happen with the youngest children. However, the kindergarten teachers did have such dialogues, some in private and some within the child group, like in this example from Maria:

We have had a lot of good conversations, even though he doesn't say much. However, he can initiate it by just a sentence, and I will talk around it while he listens. Recently, he was lying on his tummy across my lap. His mate complained about him having done something, and I said to his mate, "Maybe it is not so easy to be him these days; maybe he is angry or sad within. Maybe he misses his dad really much and is sad because of that." Several children started asking, "Why did he get cancer?" and "Will he never ever come back?" We talked for a long time. He said nothing himself, just lay there on my lap listening. I was very well aware that he was listening.

Maria's example is a conversation with the group that carries an individual therapeutic effect for the bereaved child. In addition, the kindergarten teachers referred to engaging in play situations as a narrative-dramatic form of therapeutic dialogue.

In private therapeutic dialogues, the kindergarten teacher took the child away from the children's group to be alone in a private space. In one kindergarten, a picture of the deceased mother of a 3-year-old boy was placed in the staff's break room, and the kindergarten teacher 'Vilde' brought the boy there to talk about and commemorate the mother when he initiated talking about mum. In another kindergarten, when a 5–6-year-old boy anticipating the death of his mother showed signs of being emotionally overwhelmed while in the group of children, the kindergarten teacher 'Belinda' immediately and discretely invited him out of the situation to the staff's break room where he could cry in private.

Resources

The body and medical equipment in the health-care context, as well as *peers* in the kindergarten context, stood out during the analysis as context-specific resources. Again, not all health professionals seemed to utilize the possibilities for meaning making available through the medical context. Even though kindergarten teachers' accounts abounded with references to peers, peers as a resource were not equally evident in cases where the children attended groups for 1–3 years olds. The kindergarten teachers in these groups did not tell about the same types of conversations, and the dialogues seemed mainly to concern the child painfully calling for or merely asking for the dead parent, and the professional replied that he or she was dead or in heaven. The other children in the group were not part of these interactions. In addition to these context-specific resources, we present *discursive resources* that have the potential to span across contexts.

Context-specific resources: the body and peers

The dying or dead body was a resource for meaning making exclusive for the health care context. Nurse 'Lavrans' encouraged a pair of siblings to tickle their dead father under the feet to see that he did not respond. Nurse 'Elisabeth' allowed children to borrow her

stethoscope to listen for heartbeats, first in her own chest, and then in the dead mother's chest to see that her heart did not beat any more. Nurse 'Jenny' reported, from the same meeting as quoted from above, that she showed the children how the mother's hair was gone as an indication of severe illness. In these examples, the dying or dead body became objects of shared knowledge. In addition to the body, nurses and doctors applied medical equipment as interpretative resources, as with Elisabeth's stethoscope or Jenny's use of a syringe to visualize and expand on the children's knowledge about illness and medicines.

Kindergarten teachers made explicit references to peers as helpful and welcoming partners in joint meaning making. None of the health professionals did so. During the memory gatherings in kindergartens, peers asked questions about cancer as a cause of death and the irreversibility of death, and commented with their own death-related experiences. The everyday life of the kindergarten offered situations where the bereaved or anticipating child stood out for peers as different, for example the pick-up-situation at the end of the day. Peers contributed with statements that made death explicit, by stating that (name)'s mum or dad is dead or going to die; for instance, as kindergarten teacher 'William' related, an older child said while 3-year-old 'Carl' was present, 'Carl's mum is dead'.

Discursive resources

Even though the health professionals exclusively own the access to the body as a material resource in making meaning of death as a biological process, the related biomedical discursive resource is available for both groups of professionals. The kindergarten teachers draw on a biomedical discourse of death in their explanations within gatherings when explaining why the parent's illness might lead to or led to death. However, there are fundamental differences in the two groups' ways of approaching the emotional aspect of death experiences. The health professionals tended to explain death as a concept by drawing comparisons to other biologically similar instances of death that the child might be familiar with, like dead flies and animals. They generalized death as a naturally occurring phenomenon happening to all living things, regardless of the emotional significance of this specific death. The kindergarten teachers, on the other hand, tended to highlight the difference between a dead parent and a dead fish in the grocery store fish counter or a beloved dead pet. In the memory gatherings, candles and white tablecloth created an emotional atmosphere that contributed to convey the emotional meaning of death, in addition to deliberately showing facial and bodily expressions of grief, such as gentle weeping and sad faces. This meaning-making work seemed to draw on discourses of loss and bereavement and involved a dimension of socializing the peer group into socioculturally appropriate ways of behaving, such as comforting, showing sadness, and displaying a sense of care.

Discussion of possibilities for participation within the two contexts

In the following, we apply empirical examples to analyse how professionals' contribution in meaning-making dialogues may condition children's possibilities to participate across contexts when a parent is severely ill and dying (Højholt and Kousholt 2018). First, it is a theoretical point that involving children in dialogues at the same time is to acknowledge

them as participants, which in itself contributes to equipping them with possibilities, for example of rejecting and resisting (Øksnes and Samuelsson 2017), as well as to express themselves in the dialogues (Bae 2009).

Involving children in gatherings also opens an arena for participation, regardless of whether the aim of the gathering is to deliver information or to commemorate, and of whether the child participates verbally or just with their embodied presence. Even very young children may feel the emotional significance of parental death by merely being present. Towards this background, it is worth noting that the youngest children (1–3 years old) in mixed age-groups had different possibilities for participating than young children in same-aged groups, where gatherings were not conducted.

Second, involving children in dialogues may increase their ability to apply discursive resources to talk about their experiences, which further opens up the possibility to share their experience with other people in other contexts of their everyday life. Maria's example, where the 4-year-old boy was able to tell the peer group and Maria back in the kindergarten about the feeling and vision of his recently deceased father, nicely illustrates this. Guidelines for support to children experiencing parental death recommend that professionals provide clear and concise factual explanations in concrete language about causes of death, using the words 'death' and 'dying' and avoiding euphemisms (Willis 2002), which is similar to how the health professionals in the present study contributed as interpretation partners in encounters with the dead and dying parent.

For health professionals, the dying or dead body permits the use of sensory cues (tactile, visual, smell) as shared knowledge to expand the meaning of death as a biomedical process and biological phenomenon. Plain, concrete descriptions of visual and tactile impressions are discursive resources that create a distance to the immediate, intense experience of encountering the dead or dying body. Previous studies of children's developing understanding of death show that presenting visual cues in explanations of death support children's understanding of death as involving cessation of all body functions (Hogstad and Wold 2016), and that increased biological understanding of death seems to decrease the fear of death in young children (Slaughter and Griffiths 2007).

Third, peers' behaviours, reactions, utterances, and engagement in processes of making meaning of parental death can either limit or open up possibilities, and in this way they become part of the anticipating or bereaved child's developmental conditions. When peers hear that a parent has died or is ill and going to die, the other children start their process of adjusting to, and figuring out how to understand, deal with and live with, the threat from parental illness and death. However, peers' contributions are conditioned by the kindergarten teachers' regulation of the peers' opportunities to take part (Højholt and Kousholt 2018), and in our study, the kindergarten teachers' ways of approaching and responding to initiatives by peers varied. William told about talking in a friendly manner to the boy who spoke of the death of Carl's mum, pointing out that it might affect Carl that he said so. Further, he talked about what it means to be dead. An important aspect here is that William implicitly acknowledged the peer as trying to come to terms with what it means that someone's mum is dead. Still, there appeared to be an element of moral judgment in William's way of talking to this boy, probably tied to sociocultural

norms for behaviour when someone is dead, as he commented in the interview, 'It is the unfiltered mind of the child talking'.

The same correction of behaviour was not visible in the example from Maria. She responded to the efforts of the children's group in coming to terms with what it means that someone's dad or mum is dead, while simultaneously taking care of the boy's individual psychological needs. Hence, she conducted parallel dialogues with multiple purposes, both made possible by the mere presence of peers. Her way of incorporating into the peer group her understanding of the boy's behaviour as expressions of grief seems to have the potential to facilitate the boy's bereavement processes in the kindergarten group by making the peers understand him better. Belinda's responses, on the other hand, when she on one occasion 'froze' and remained silent upon a peer's mention of the anticipated death of the boy's mother, because she was fearful of saying something wrong, potentially contributed to making death a taboo topic within the kindergarten. Creating or upholding taboos limits the peer group's opportunities to take part and to understand – not only what the anticipated death means to the child in question, but also what the anticipated death means to the peer group members, in their relationships and their everyday lives.

Discussion

The present study points to ways of making meaning accessible to professionals within the contexts of kindergarten and palliative care. It is a strength that it involves data from both kindergarten teachers and health professionals, primarily for two reasons. First, to our best knowledge, this is the first study to focus on kindergarten teachers' contribution in joint meaning-making work with children experiencing parental death because of a severe, somatic disease. With some exceptions (Bugge et al. 2014), previous studies within the field of childhood bereavement have focused on parentally bereaved children above 6 years old (Duncan 2020; Hanna, McCaughan, and Semple 2019). Second, involving two professional groups allows a comparison that could not be done in previous studies involving only health professionals.

The recruitment strategies of this study limit the generalizability of the results. The sample of health professionals may skew towards those professionals with above-average dedication to supporting children as next of kin, and it may therefore contain an unnaturally high amount of meaning-making interactions compared to a more representative sample. The process of recruiting kindergarten teachers involved difficulties in obtaining consent from the families, which may indicate a sample skewed towards kindergartens where the parent–kindergarten collaboration functions more satisfactorily than in other such situations.

Another aspect affecting the generalizability of the results is that only the kindergarten teachers were temporarily released from their adherence to strict confidentiality. The health professionals' abundant experience during years of clinical work made it possible for them to anonymize their stories, but in their efforts to anonymize their patients and their children they probably withheld details and made the stories more impersonal and general. The fact that the health professionals gave more 'we-usually-do' descriptions, while the kindergarten teachers gave more detailed descriptions, might derive from this, and this might have resulted in deeper insight into the meaning-making dialogues within

the kindergarten. Some of these differences may however derive from actual differences on the basis of experience between the groups. A point of particular significance here is that *time* is a resource that the health professionals are in continual shortage of, overall and in encounters with children (Karidar, Åkesson, and Glasdam 2016), while kindergarten teachers follow the children in their everyday life during illness processes. More time with the child enables closer relations and results in a situation where the kindergarten teacher and the child share more background knowledge necessary for successful communication (Hundeide 2003).

An additional strength is that the research methodology involved in-group analysis, which allowed for insights regarding differences within the two contexts on how the professionals contributed to open or limit the child's possibility to engage in meaning-making dialogues. Worth noting is that these differences do not have to be tied to the individual professional but could relate to other circumstances, for instance communication patterns in the family system that affect the professional's possibilities to engage in meaning-making dialogues with the child, such as parents withholding information about illness and death from their child (Hogstad and Leer-Salvesen 2020). Further research is needed to better understand the conditions contributing to limiting and opening up possibilities to participate within and across everyday life contexts for children experiencing parental death.

Concluding remarks

The international literature provides guidelines for professionals directing them to support children experiencing parental death by engaging in open communication about illness and death (Duncan 2020; Hanna, McCaughan, and Semple 2019). The present study's findings show that such open communication may involve very different ways of engaging in dialogues with young children, depending on the availability of resources and the purposes of engaging in meaning-making work, tied to the societal institutions. Health professionals engage in meaning-making dialogues centred on death as a biological phenomenon and dying as a biomedical process, while kindergarten teachers mainly engage in meaning making centred on parental death as an emotional and relational phenomenon. Hence, the two groups of professionals have different perspectives on the development of children, resonating with their formal mandates (for example through the Health Personnel Act (HPA) and The Framework Plan for the Content and Tasks of Kindergartens (2017)). Their roles, responsibilities, and tasks in relation to these children, keeping in mind the knowledge of professionals' fundamentally different ways of attending to their obligation to support children in making meaning of death, should be considered by developing interprofessional collaboration.

Health professionals could take steps to involve the kindergarten staff when new information about prognosis and diagnosis is shared, and with that they would signal a responsibility as well as provide a possibility for the kindergarten staff to engage in dialogues, with this information as background knowledge. In the present study, there were few references to interactions between health professionals and kindergarten teachers. Sharing information across the different contexts about what a child has experienced enables the professionals' interpretation of the young child's singular words or sounds to expand on their meaning. For example, the information that a child

has felt the coldness of a dead body in the hospital, provides kindergarten teachers with the necessary background information so that they base their interactions in shared knowledge – even though the concrete, physical meaning-making resource of the dead body is not present. This is especially important with the youngest children, who might not have the possibility to share this information themselves. Our findings point to the need for paying extra attention to the possibilities of toddlers, and especially toddlers in same-aged groups, to participate in meaning-making dialogues.

Note

1. Chemoman Casper [Norwegian title: Kjemomannen Kasper] is a children's book about chemotherapy, published by the Norwegian Cancer Society.

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