Sibling Death in Childhood: An Evaluation of the Literature Regarding Inclusion of Minority Cultures, 1990–2002

Joyce Kay L. Cherry

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SIBLING DEATH IN CHILDHOOD:  
AN EVALUATION OF THE LITERATURE  
REGARDING INCLUSION OF MINORITY CULTURES  
1990 – 2002  

by  

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ABSTRACT

SIBLING DEATH IN CHILDHOOD:
AN EVALUATION OF THE LITERATURE
REGARDING INCLUSION OF MINORITY CULTURES
1990 – 2002

Joyce Kay L. Cherry
Old Dominion University, 2003
Chairman, Dr. Colin Box

This evaluation seeks to determine the extent to which the professional literature concerning bereaved children in the United States includes African American, Hispanic American, and Asian American children whose siblings have died in childhood.

A literature search identifies 58 articles, published between 1990 and 2002, concerning children under age 19 living in the United States whose siblings have died. Articles are sorted by time frame and classified by type. There are 31 descriptive articles consisting of five literature reviews, five commentaries, five case studies, and 16 narratives; there are 27 research articles. Analysis determines the extent to which race, culture, and ethnicity are included in article comments and discussions, and in research samples.

The 31 descriptive articles include 11 brief discussions or comments regarding race, ethnicity, or culture. Changes in the descriptive literature over time are calculated using the ratio of the number of comments/discussions as compared to the number of articles per time period:

- 1990 to 1993: 1 comment / 12 articles (1:12)
- 1994 to 1997: 5 comments / 10 articles (5:10)
- 1998 to 2002: 5 comments / 9 articles (5:9)
The 27 research studies contain 28 samples; 17 identify race/ethnicity of participants. Seven studies have samples of 10% or more minority children. In only two studies, published in 2001 and 2002, are results reported concerning race or ethnicity.

Caucasians are included in 21 samples, African Americans in seven samples, Hispanics in five samples, and Asian Americans in two samples. Changes in research articles over time are examined by comparing the ratio of samples containing 10% or greater of identifiable minority participants to total samples in the time period:

1990 to 1993: 2 samples / 14 total samples (2:14)
1994 to 1997: 2 samples / 8 total samples (2:8)
1998 to 2002: 3 samples / 6 total samples (3:6)

The number of articles published regarding childhood sibling death changed over the three time periods, decreasing from 26, to 18, to 14. Research articles exhibited the greatest change, decreasing from 14, to 8, to 5.

Recommendations are made for future research.

Members of Advisory Committee:  Dr. Lindsay Rettie
                                 Ms. Susan Hunter
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CHAPTER 1
INTRODUCTION

Children are profoundly affected by the death of a brother or sister (Martinson & Campos, 1991; Shooter, 1997; Davies, 1999, pp. XV-XVIII). The degree to which children are affected has only been recognized recently (Martinson & Campos, 1991). When a child dies, friends, as well as society at large, hasten to comfort the parents. Surviving brothers and sisters may be reminded to help take care of their parents, or to be good girls and boys. Visitors, and sometimes bereaved parents, do not recognize the symptoms of grief of the surviving children (Applebaum & Burns, 1991). Consequently, bereaved siblings are often neglected or forgotten mourners, and their needs are often not identified and met (Shooter, 1997; Kemp, 1999).

Grief is an emotion experienced by everyone; it is “a country we all must visit” (Lynn & Harrold, 1999, p. 180). Grief suffered from the loss of a loved one can be so painful that even the mature mourner may try to ignore or suppress it. Grief is difficult to discuss; there are fewer words and clichés regarding grief and bereavement than for other emotions. Grief is accompanied by a wide range of feelings that can swing rapidly from one extreme to the other, including pain, anger, loneliness, relief, guilt, sorrow, and depression (ibid, pp. 179-191). It is difficult for adults, especially parents, to see children experiencing all of the painful emotions that grief brings. Moreover, children’s grief may not be recognized, because, not having the experiences of life that adults have, they grieve differently from adults.
When Children Grieve

Children express their grief differently, depending upon their age, and, sometimes, their sex (McCown and Davies, 1995). When young children mourn, they exhibit their grief through behavior (Davies, 1995). Preschool children to middle teenagers whose siblings have died have been found to exhibit aggressive types of behavior problems consisting of arguing, demanding attention, disobedience, and/or stubborn/sullen/irritable mood. Children, especially the younger in the group, often have nightmares. The aggressive behaviors by this age group are believed to be efforts to elicit attention from parents who are deeply involved in their own grief.

A study of adults who had lost siblings before the age of 19 reveals that many had developed high levels of anxiety, depression, and fear, including significant fears of death that lasted into adulthood (Fanos, 1996, pp. 80-83, 91-100). Some had experienced persistent nightmares. Many as adolescents withdrew from close relationships, apparently fearing repeated loss and feeling hidden anger. They expressed fears of losing their parents. Their fear of intimacy, learned in adolescence, was manifested, according to researchers, by their fear of commitment in marriage (Fanos & Nickerson, 1991). Of the eight participants in the study who had lost their siblings as adolescents, 1 had married. Of the 12 adults who had lost a sibling during their latency years, 9 through 12, 6 had married.

Bereaved adolescents have difficulty with concentration, problems with study habits, and lowered school grades (Balk, 1991). Four years after the death of a sibling, one group of adolescents exhibited poorer physical health than non-bereaved children.
Females demonstrated poorer indicators of physical health and higher measures of anxiety.

When a brother or sister dies, surviving children must cope with enormous life changes (Jarratt, 1982, 1994, p. 15). The surviving siblings lose their place in the birth order. They may suddenly become the oldest child, the youngest child, or even the only child. Their present and future are irretrievably altered. “They have lost a playmate, companion, and rival, and all the familiar interactions and expectations that were connected to those relationships.” This loss can lay the foundation for pain that may remain through adulthood (Van Riper, 1997).

The Problem

The study of children and adolescents who have lost a sibling to death is important because such children are at high risk for a poor outcome (Opie, 1992). In order to learn what interventions might prevent or decrease poor outcomes, bereavement research is required regarding specific populations, appropriate interventions, and the timing of those interventions. In the United States, there is a scarcity of research and commentary in the academic literature regarding childhood sibling bereavement (Reed & Greenwald, 1991; Opie, 1992; Davies, 1999, pp. 24-28).

Moreover, while the professional literature regarding sibling death is inadequate, there is less information available regarding the inclusion of African American, Hispanic, and Asian American children in that literature. Opie’s (1992) review article of nursing research concerning childhood and adolescent bereavement concludes, “...examination of the samples demonstrates a significant lack of ethnic and minority variability among the subjects.” Graham (1997) concurred, stating that few works published in the United
States include minority children regarding sibling death and bereavement. Another author reported that, in the field of dying, death, and bereavement generally, there are few studies in the professional literature that include and discuss minority populations (Oltjenbruns, 1991, 1998).

The purpose of this literature evaluation is to determine the extent to which the professional literature regarding sibling death includes African American, Hispanic, and Asian American children. To do this, it is important to understand something of life and death in minority cultures.

Children of Minority Cultures and Death

Although members of minority cultures live in all sections of the United States, minorities, especially African Americans and Hispanic Americans, frequently live in neighborhoods with a concentrated ethnic population (LeClere, Rogers, & Peters, 1997). Consequently, minority children often live in urban areas affected by higher rates of unemployment and with fewer resources within a poorer urban community (PDIA newsletter, September, 2000). Young people in urban inner cities experience death, often sudden and violent, as part of daily life, and often find no listeners to hear their stories or to share their feelings. The Project on Death in America newsletter reported that there are far-reaching issues related to losses sustained by children so affected. For these children, "the consequences of loss can be devastating without intervention... America's children are grieving, yet few adults recognize the depth and extent of their grief (PDIA, September, 2000)."

The PDIA newsletter continues, noting that children will lose siblings and other relatives due to violence, drugs, and AIDS. Consequences of these multiple losses can be
“depression, suicide, school failure and/or drop-out, teenage pregnancy, substance abuse, and violence” (Project on Death in America, PDIA newsletter, September, 2000).

On a daily basis, according to the Children’s Defense Fund (2002), children in the United States under the age of 20 are subject to five suicides, nine homicides, and 34 deaths from accidents. In addition, in the year 1999, gunfire killed more children in the same age group than did cancer, pneumonia, influenza, asthma and HIV/AIDS combined. In cases of child murder and fatal illness, surviving siblings are often forgotten mourners (Shooter, 1997).

Cultural issues become more complicated for some children who live in the United States but whose families adhere to markedly different cultural norms. For example, there are thousands of members of the Hmong culture of Laos in the United States. Hmong use animals for sacrifice in order to improve the health of family members (Fadiman, 1997). This custom most likely arose from the need to slaughter livestock in order to feed relatives who came to visit the sick. Sacrificial animal slaughter is usually deemed unacceptable, or at least bizarre, by mainstream America, whether or not the family consumes the remains. This view exists even though Americans consume animals daily, they being slaughtered away from the view of the general public.

In China, the cultural norms differ from those in the United States regarding family structure. In the United States, the family unit is “husband-wife” dominated. In China, the family is “parent-child” dominated (Martinson, Liu-Chiang & Yi-Hua, 1997). This refers to the life-long relationship in which, even as adults, children and their elderly parents maintain an interdependent, supportive relationship. The culture also encourages
repression of emotional expression, deeming it not seemly. The Chinese have been found to express their stress through physical symptoms, which is more socially acceptable.

Conversely, the traditional culture of the African American community fosters emotional expressiveness (Roark, 1999). Health care professionals from more reserved backgrounds may have little cultural competence regarding how those from an expressive culture cope with the tragedy of death.

Cultural traditions in the Hispanic community include interdependency with an extended family, some members of which may be in another state or in the country of origin (Roark, 1999). Decision-making may have to wait until a family member held in high esteem or considered more knowledgeable can travel to those in need.

Rosen (1998, pp. 155-182) discusses the need for culturally knowledgeable and sensitive approaches in providing care for the dying and for their bereaved families, as cultures differ in dealing with the experiences of death and bereavement. Rosen observes that dynamics between family members will vary depending upon cultural mores. Culture will define what is appropriate behavior for men and for women, for boys and for girls, and for siblings, according to their birth order.

Davies (1999, 209-210) addresses the importance of recognizing and working within a cultural framework when dealing with sibling bereavement. She indicates that childcare professionals must attend to the factor of ethnic identity in any approach to grief work, because families operate from the context of their culture.

If professionals in the field of grief and bereavement understand the importance of inclusiveness of minorities in their practice, why might minorities not be adequately represented in research?
Minority Groups and Medical Research

Many researchers note the difficulty of including minority subjects in research studies because of the reluctance of minorities to participate (Kaplan, 1997). According to information provided by the National Cancer Institute at a symposium, 9% of patients who volunteer for cancer trials are African American. Kaplan reports that the origin of the problem of minority participation is acknowledged by researchers to rest with the history of the Tuskegee syphilis study, and what it represents to minority communities. Tuskegee was the location of a government-run study from 1932 to 1972 wherein 399 African American men were observed but left untreated for syphilis. This has left the African American community reluctant to participate in medical research. Sterling and Peterson discuss the results of Tuskegee, with references from Gamble, 1997; The AIDS "Plot" Against Blacks, 1992; and Bates, 1990.

The legacy of the Tuskegee syphilis study and other negative practices of injustices and discrimination have contributed to persistent fears and mistrust of those who provide medical treatment and conduct research. In recent times, investigations such as the 1989 vaccine study in Los Angeles, programs to screen for sickle cell disease, and projects to address AIDS and birth control have been hypothesized as plots of genocide by many in the African-American community (Sterling and Peterson, 1999).

In 1994, the National Institutes of Health implemented requirements for inclusion of women and minority participants in research that is conducted in concert with NIH clinical grants and cooperative agreements. (Sterling & Peterson, 1999). This has caused
many professionals to review and rethink their approach to recruiting minorities, and to seek solutions to the challenge.

It is important for health care professionals, who treat clients of various racial and ethnic groups, to be sensitive and understanding of their cultures (Mazanec & Tyler, 2003). This requires cultural competence. Those who take part in bereavement research involving children must be especially culturally competent in order to foster minority participation (Sterling & Peterson, 1999). Until this happens, the health related needs of minority communities cannot be adequately met.

Being a member of a minority group neither increases nor decreases the emotional response to the death of a sibling. Bereaved children of all cultures and ethnicities feel the effects of childhood grief. Oltjenbruns (1998), in her study of Mexican American and Anglo American college students, indicates the need for increased inclusiveness of minority groups in bereavement studies:

> It is crucial that we come to understand common grief responses of various ethnic groups. Without this knowledge base, we may inadvertently come to inappropriate conclusions about what is abnormal, pathological, or unhealthy for a given minority population by using information about the majority population as the basis for our judgments (Oltjenbruns, 1998).
**Purpose**

This evaluation seeks to determine the extent to which the professional literature regarding bereavement of children in the United States includes African American, Hispanic, and Asian American children who have been bereaved by sibling death.

**Research Questions**

What currently exists in peer reviewed journals regarding sibling death among minority children?

To what extent is each of the ethnic/racial groups of African Americans, Hispanics, and Asian Americans represented in research studies?

Has the representation of minority children in the literature changed over the time span included in this study, from 1990 to 2002?

**Definitions**

1. Affectional bond – “A relatively long-enduring tie in which the partner is important as a unique individual and is interchangeable with none other…”, the loss of which results in grief (Ainsworth).

2. Bereavement – “literally, to be deprived by death” (Moseby International). Clinically, bereavement is the reaction, including grief, mourning, and recovery/adaptation, to the loss of a close relationship (Raphael, p.33).

3. Child or children – persons under the age of 19.

3. Sibling – for the purposes of this study, bereaved siblings will include both biologic and adopted siblings, as well as step and half siblings.
Usage of Terms

Researchers and federal agencies such as the U. S. Census Bureau and the U. S. Department of Commerce are inconsistent in the usage of terms for racial and ethnic groups. Terms for racial and cultural groups have been standardized throughout this paper to provide consistency, except when a direct copy of a statistical report or a direct quote from a narrative report was utilized. In addition, because the term “Hispanic” denotes ethnicity, it sometimes includes Black and Caucasian Hispanics. When there is the possibility of misrepresentation of a cited author’s intent, terms utilized by that author will be used.

Terminology used includes:

1. African American
2. Asian American
3. Caucasian
4. Hispanic

If an article uses a specific term, such as “Anglo”, that original term will be preserved. Anglo, for instance, often differentiates between Anglo Caucasian and Hispanic Caucasian. When an author uses this term, it will be preserved in this study.

Limitations

Though every effort was made to provide a balanced view of the problem, the perspective is that of the author. Additionally, while all relevant articles were sought across the disciplines that work with death and bereavement, articles could have been inadvertently missed. All reviews, this one included, however carefully made, have the potential to miss commendable articles.
Generalizability

Results can be generalized only insofar as the types of literature analyzed. The analysis did not include dissertations, works in non-peer reviewed journals, or the popular literature. Results can only be generalized for the ages and ethnic/racial groups included in the analysis.
CHAPTER 2
REVIEW OF THE LITERATURE

The purpose of this evaluation is to determine the extent to which the professional literature published in the United States between 1990 and 2002 regarding childhood sibling bereavement includes certain minority populations. In order to do this, it is necessary to establish the importance of the sibling relationship, and to place it in a biologic, an historic and a cultural/societal context.

**Siblings in Great Literature**

The sibling relationship has held an important place in history and fable (Treffers, 1992, pp. xi-xii). The Egyptian goddess Isis loved her brother, Osiris, and, as the tale unfolds, their relationship was subsequently responsible for the birth of the lineage of Egyptian pharaohs. Music and poetry relate stories of brotherly and sisterly affection, as do authors such as Tolstoy and Chekhov. Another story tells of sibling rivalry that has become the archetype of sibling jealousy, the story of Abel, slain by his brother, Cain. The book of Genesis relates that, when confronted by God, Cain asks the question that has become timeless: “Am I my brother’s keeper?” (The Holy Bible, Revised Standard Version).

Jealousy and rivalry are emotions frequently used to define the sibling relationship, particularly of the very young (Dunn & Kendrick, 1982, pp. 86-99). Jealousy and rivalry are the observable reactions of children seen in competition for parental attention. In the past, studies have focused on child-parent relations, not sibling relations. Studies of sibling relations indicate that, even with small children, the relationship contains a broad spectrum of behaviors, including concern and affection.
However, while classic works abound with writings concerning the complexities of the sibling relationship, current research literature does not (Treffers, 1992, p. xi; Davies, 1999, pp. 1-10). Moreover, there is little in the literature regarding the deaths of minority children and the subsequent impact of those deaths upon surviving siblings (Opie, 1992). This information is reported by numerous authors of books and articles published about either sibling relationships or sibling death (Davies, 1995, 1999; Boer & Dunn, 1992; Fanos, 1996; Lamb & Sutton-Smith, 1982).

The Sibling Relationship in Society

The sibling relationship is a unique one in human society, as it is the only relationship that endures throughout the life span (Cicirelli, 1982, 1995; Boer & Dunn, 1992). This is the closest genetically of all relationships, with siblings sharing fifty percent of their genetic makeup, the greatest proportion of common genes of any relationship (Ainsworth, 1989). If gene survival is a biologic imperative, survival of a sibling and the sibling’s offspring becomes survival of the gene pool. Siblings also share a bond of mutual experience of family, a shared history, in a kinship role. These bonds of affection, or affectional bonds, that siblings establish with one another can endure throughout the life span.

In addition, the relationship tends to be the most egalitarian in the family structure, even allowing for variations in power levels consistent with age and family position (Cicirelli, 1982). About 90% of children in the United States have siblings. Most spend the largest part of the waking hours of early childhood in the company of siblings. Parents treat children differently based upon each child’s sex and birth order.
The parenting practices of mothers and fathers, coupled with interactions between siblings, mold each child’s intellect and personality.

The sibling bond is one of the first formed in a person’s life. The next section will discuss how bonds are formed.

**Theories of Human Bonds of Affection**

Researchers in the field of sibling bereavement have cited attachment theory as one explanation for the sibling relationship (Davies, 1999, pp. 1-2). Attachment theory was developed by John Bowlby and Mary Ainsworth in the 1950’s, and was a radical departure from accepted scientific thought of that era (Bretherton, 1992). John Bowlby, a psychotherapist who began his practice in Great Britain in the 1940’s, became interested in the effects on children of maternal separation, that is, being left in strange places with strange people. Bowlby found psychoanalytic principles “unsatisfactory” in laying a foundation for his studies (Bowlby, 1980, pp. 38-43). He eventually conceived an approach to his work that incorporates links to cognitive psychology, neurophysiology and developmental psychology. His theses regarding human bonding were built upon what he termed attachment theory.

Bowlby introduced attachment theory and affectional bonds in three seminal papers published between 1958 and 1960 (Bretherton, 1992). A primary tenet of attachment theory is that attachment behaviors comprise a specific, successful behavior system rooted in the genetic makeup of a species. Attachment responses maximize species survival by assuring that others are attracted to, and will provide care for, the young. Attachments are often life-long (Bretherton, 1992; Ainsworth, 1989). The
sibling relationship is one of the first relationships developed through this behavioral system.

Attachment behavior is considered as any behavior in which a person achieves and maintains proximity with another preferred individual (Bowlby, 1980, pp. 39-43). Bowlby asserts that attachment behaviors are separate from and equal in importance to the other primary behaviors of eating and sexual activity, and are as important to the survival of the species. The goal of attachment behavior is to create and maintain bonds of affection with another specific person, the resultant bonds providing security to the child and pleasure to the other person. The first person to whom the behaviors are directed is the primary care giver, historically the mother. The attachment behavior system is instinctive and, for the infant, self-correcting. When successful, it promotes the safety and well being of the child. If the person to whom a human infant becomes attached vanishes or is not responsive, the infant will follow, call, cling or cry. Infants and children develop the ability to perceive subtle cues from the figure of attachment, and also learn to give cues in return, exchanging communications. Further, infants develop internal models regarding these affectional bonds, which are maintained throughout a lifetime. Later in life they are altered only with great effort.

Ainsworth was interested in the issues of security and infant-mother attachment (Bretherton, 1992). After working with Bowlby in England, Ainsworth lived in Uganda in the mid-1950’s and worked with 26 Ganda families for 9 months. She recorded extensive material regarding mother and infant interactions, and their similarities and differences. Ainsworth determined that secure attachment was directly correlated with maternal sensitivity to the child. Ainsworth’s study was the first empirical study of
attachment. She followed this in 1963 with “a second observational project whose thoroughness no researcher has since equaled” (Bretherton, 1992). Ainsworth, working in Baltimore, observed behavioral interactions of 26 families, primarily mothers and infants, beginning in the child’s first month, and ending at age 54 weeks. She collected approximately 72 hours of data from each family. Her results indicated that patterns of behavior regarding parent sensitivity to infant needs and bonding originated in the first 3 months of the child’s life.

Affectional bonds endure throughout the life span (Bowlby, 1980, pp. 39-43). The early affectional bonds lay the foundation for later bonds that will be established with others. When the early bonds are secure, the child, and later, the adult, is secure. When bonds are threatened, a person experiences anxiety. When bonds are broken, as with death or abandonment, a person experiences grief and sorrow. Healthy attachment behaviors are to be desired, and are not signs of dependency or regression. Disturbed patterns of attachment can give rise to anxiety, or conversely, deactivation of the behavior system. The death of a primary attachment figure leads to intense grief (Raphael, 1994, p. 6).

Another theorist has expanded upon, and has offered additions and corrections to, Bowlby’s and Ainsworth’s works, advancing the premise that the complexity of relationships must receive greater consideration in the study of the development of children (Dunn, 1993). Dunn noted that the variations of interactions for even one child are enormous when considered in light of the number of people with whom the child interacts, and that children are able to modify their behaviors with different people at a very early age. In addition, relations with siblings will change as each child matures,
possibly negating the existence of Bowlby’s “internal working model” (Dunn, 1993). Dunn pointed out that temperament of both child and parents, interactions within the family at large, and interactions of the culture within which the family operates have significant impact on children and their relationships. Further, Dunn reported that studies by Bornstein and Zukow indicated that by age three, children can refer to the social expectations of the culture and world in which they live, and relate these to their relationships with family members, which differ from culture to culture.

Another study conducted by Cornell Medical School emphasized that the family itself is key to the physical and emotional health of its members, concluding, “The family is the unit of illness because the family is the unit of living” (Richardson, 1948). The importance of sibling interaction within the family cannot be overemphasized.

Regarding sibling relations, it was only in the early 1980’s that studies began to be reported in the literature (Dunn, 1993, pp. 43-57). The relationships of siblings are complex and often contradictory. Siblings may experience attachment, rivalry, cooperation, and conflict within the same relationship. Siblings appear to establish positive relationships when their temperaments, which are largely hereditary, are similar. In addition, negative life events often bring siblings closer together.

The sibling relationship is impacted, as is the parent-sibling relationship, by dynamics among and between all family members (Bryant, 1992). There are no dyadic relationships that exist in a vacuum. Siblings can have both positive and negative influences on one another. Research indicated that siblings, themselves, describe cooperation existing along with conflict, though cooperation is predominant. (Graham-Berham, 1994).
Siblings are active participants in sharing a common culture (Bryant, 1992). They set standards, serve as role models, and provide supervision, support, and affection. When mothers are absent or less available, sibling relationships are generally enhanced. Children go to siblings to discuss problems, sometimes because the mother and/or father are negative in acceptance of their children's feelings. Sibling emotional support cannot, however, supplant or serve as a substitute for parental support.

The relationship siblings share for the first three years of life has a significant impact on their socialization (Abramovitch, Pepler, & Corter, 1982). They interact with a full range of behaviors and emotions. While there may be jealousy and aggression, there is also affection, cooperation, and imitation. The relationships and interactions may well mirror those of later life, and prepare – and pattern – children for their expectations and responses as adults.

The sibling role is important to the family. Because the family is a building block of society, the integrity of the family is important to society as a whole. When the family is viewed as a system, the sibling relationship is one of three major subsystems, the others being the spousal subsystem and the parental subsystem (Lamberti & Detmer, 1993). The daily interactions within and among the three subsystems become the interactions of life within the family. Brothers or sisters are usually the first and most frequent playmates of childhood. Though their relationships may include ambivalence, children often provide emotional support to each other during times of distress (Bryant, 1992). As the family provides the framework for the life of the individual, the culture provides the framework within which individuals and families live and function.
Cultural Implications Regarding Sibling Relations

A person's subjective experience of culture will vary, depending upon the type of culture from which he or she comes (Triandis, 1989). The concept of self will differ, depending upon whether the culture is collectivist in nature or individualistic. In a collectivist culture, persons refer more to themselves as members of groups. Parents tend to place higher value on obedience, reliability, and proper behavior. In an individualistic culture such as the United States, parents generally tend to value self-reliance, creativity, and self-actualization, at least in professional social classes.

While many people in the United States hold the predominant cultural view that each person is an individual seeking autonomy and success, many others in the same country, reared in different households operating from non-Western cultural bases, hold different views (Markus and Kitayama, 1991). The Chinese, Africans, Asian Indians, Hispanics, Filipinos, Japanese, Balinese and Moroccans hold beliefs that place a greater value on interdependence and responsiveness to others than do traditional Westerners and European Americans. The authors noted that these cultures are widely disparate in many other ways, but hold the same views regarding the importance of one's obligations to others in the family and to larger society.

However, though cultural settings will differ, siblings in every society are the ones with whom a child will spend thousands of hours, who are present when thoughts and behaviors become part of a child's inner self (Weisner, 1989, pp. 11-22). Siblings are present whether the setting is in the United States, where a child's central task is literacy training, or in Mexico or Hawaii, where the tasks also include help with child care and shopping for food.
Death, Grief, and Bereavement as Related to Culture

This paper presents an evaluation and analysis of the academic literature of dying, death, and bereavement as it includes minority children bereaved of a sibling. In order to do this, the relationship between culture and death must be examined.

One researcher indicated that culture prepares people to experience death in a particular manner, and that when death occurs, people are guided by those concepts in their actual responses (Catlin, 1993). Funerals in the twentieth century began to, as Walter (1994-1995, p. 245) stated, "celebrate an individual life on earth rather than transport a soul into heaven" (Klass & Goss, 1999). However, in the United States, professionals in the field of death and bereavement currently emphasize a model that assumes there is a continuing bond between the living and dead, and "the purpose of grief is to construct a durable biography of both the survivor and the deceased" (Klass & Goss, 1999).

There are certain situations, particularly in present day America, in which it is extremely difficult for bereaved persons to move through the bereavement process without professional care (Rando, 1992-93). The rites and rituals that have provided comfort to the bereaved in past generations, such as funerals and visitations, are often ignored. Rapid social change, the breakdown of the nuclear family, parental absence from the home, and the loss of extended social support have complicated the process of healthy grieving. Other significant trends that contribute to what Rando called complicated mourning are the increase in sudden, violent death; death from excessively lengthy chronic illness; and deaths of children. This is especially true when a child's
death is due to a potentially preventable cause, such as an accidents, a homicide, or a suicide.

In addition, Rando observed that mourners have fewer emotional and societal resources, and may have sustained multiple losses such as poor parenting, divorce, or unemployment, prior to the immediate death. Mourners in society often are unrecognized. Children, Rando continued, are among the unrecognized mourners.

In order to understand some of the cultural differences that exist among groups regarding views and responses to death, grief, and bereavement, a study was performed with 397 California adolescents and their parents (Reimer & Templer, 1996). Death anxiety and death depression were measured. Results indicated that Hispanics reported highest death anxiety/depression; Afro-Americans reported next highest; Asian reported third highest; and Euro-Americans reported lowest. The most significant differences were found between the experiences of Hispanics and Euro-Americans regarding death anxiety, death depression, death distress, and death discomfort. This same study found that American family groups of all origins differed from family groups in the Philippines regarding intra-family attitudes toward death. The Philippine families shared greater similarities in death anxiety and depression than did American families, leading the authors to conclude that such attitudes are influenced by society, as well as other factors.

There are a wide variety of beliefs and practices in the United States in dealing with death and dying (Koenig & Gates-Williams, 1995). Asian cultures have traditionally shielded dying family members from the knowledge of a terminal diagnosis or impending death. When this pattern is practiced in the United States where full disclosure of medical status is valued, it has been a concern to physicians and other health
care providers. In addition, fewer minorities use advance directives regarding end-of-life medical care. In Koenig and Gates-Williams (1995) discussion of the 1993 work of Caralis, Davis, Wright, and Marcial, "Substantially more African Americans and Hispanics 'wanted their doctors to keep them alive regardless of how ill they were, while more... whites agreed to stop life-prolonging treatment under some circumstances'".

A 1994 paper by Frank, Blackhall, Murphy and Michel stated that 80% of Hispanics and Korean Americans approved the statement: "'Life-sustaining machines should never be stopped because even if the patient appears to be dying, there is always the chance of a miracle'" (Koenig & Gates-Williams, 1995). Less than one-third of European Americans agreed with the statement. In addition, both the majority of Korean Americans and Hispanics indicated that discussing death with the patient would be harmful.

Corr, Nabe, and Corr (2000, pp. 103-128), with a caution to avoid stereotyping, discussed cultural influences on minority groups with the United States. African Americans, the authors related, have historically had a frequent association with death due to the harshness of slavery and the disadvantages of socio-economic conditions. The high rate of death among infants, and the disproportionate number of African Americans with AIDS, among other issues, served to continue this pattern. African Americans tended to have a support network of friends, neighbors, and church members who help them during death and bereavement. The family is probably most central to the support system. Cultural practices at the time of death usually involved much visiting of the family, and a funeral ceremony that is emotionally expressive.
Hispanic Americans originate from many diverse cultural backgrounds, coming from Mexico, Cuba, and the countries of Central and South America (Corr, Nabe, & Corr, 2000). The Hispanic communities are often more readily absorbed into the surrounding community than are some minority groups. Hispanic Americans have differing histories regarding causes of death. Chronic disease, violence, and, more recently, HIV/AIDS have been factors. Hispanic Americans are younger as a group than other cultures. In matters of death and bereavement, religion plays a major part, as many Hispanics are members of the Roman Catholic Church. Last rites and funerals lend themselves to profound expressions of grief. Funerals may last for several days, and the family often observes a formal mourning period (Corr, Nabe, & Corr, 2000).

Asian Americans often have the lowest death rates among both minority and majority cultures (ibid.). There are many communities and cultures of Asian Americans, reflecting the number of countries of origin. Death is usually caused by chronic disease, though this varies markedly in some cases. For instance, the infant mortality rate for Chinese Americans is quite low, while the rate for Filipino Americans is much higher. Death and funeral practices are met with controlled emotions. In many Asian American cultures, the living maintain a close relationship with the dead, believing that the dead continue to watch over them. Funeral ceremonies can be important occasions in the life of the family and of the community (ibid.).

While the body of evidence grows that culture shapes the experience and expression of grief, some disciplines will find greater interest in the internal experience of the individual following the death of a loved one (Catlin, 1993). In a study of perceptions of bereavement of undergraduates from both the United States and Spain, the author
concluded that culture does inform bereavement, and that grief may well be a “hard-wired”, biologically based, and universally shared experience. Further, the nature of a relationship may have as much bearing as culture when it is disrupted by death. Culture may influence bereavement in lesser relationships, but suffering after loss of a “relationship of attachment” may be similar across cultures.

**Special Issues of Children in Minority Cultures**

This evaluation seeks to determine the extent to which the professional literature regarding childhood sibling bereavement includes certain minority populations. Consequently, issues that impact minority health, morbidity, and mortality are relevant.

**The Population of Children in the United States**

As Table 1 indicates, there are over 72 million children in the United States under the age of 18. Of these, (all approximate numbers) 44 million are non-Hispanic White, 11 million are Black (African American), 12 million are Hispanic (Black and White), and 2.5 million children are Asian/Pacific Islander (United States Census Bureau, 2001).

This study will not address the special needs of other minority children such as American Indians and Alaskan Natives, who are often included in population and health care data. Their populations are smaller in size and are impacted by cultural, economic, and political issues not discussed in this paper.
Table 1: Selected Demographic Characteristics for Children in the United States

<table>
<thead>
<tr>
<th>Race</th>
<th>United States</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population under age 18</td>
<td>72,293,812</td>
<td>-</td>
</tr>
<tr>
<td>Children of one race</td>
<td>69,436,926</td>
<td>96.0</td>
</tr>
<tr>
<td>White children</td>
<td>49,598,289</td>
<td>68.6</td>
</tr>
<tr>
<td>Black or African American children</td>
<td>10,885,696</td>
<td>15.1</td>
</tr>
<tr>
<td>American Indian or Alaska native</td>
<td>840,312</td>
<td>1.2</td>
</tr>
<tr>
<td>Asian children</td>
<td>2,464,999</td>
<td>3.4</td>
</tr>
<tr>
<td>Native Hawaiian/other Pacific Islander</td>
<td>127,179</td>
<td>0.2</td>
</tr>
<tr>
<td>Children of some other race</td>
<td>5,520,451</td>
<td>7.6</td>
</tr>
<tr>
<td>Children who marked two or more races</td>
<td>2,856,886</td>
<td>4.0</td>
</tr>
</tbody>
</table>

**Hispanic Origin Status**

| Population under age 18                   | 72,293,812    | 100.0   |
| Hispanic children                         | 12,342,259    | 17.1    |
| Non-Hispanic children                     | 59,951,553    | 82.9    |
| Non-Hispanic white children               | 44,027,087    | 60.0    |
| Non-Hispanic, other races                 | 15,924,466    | 22.0    |

Hispanics, who can be of any race, are included in the racial figures shown above in “Race”.

Source: Population Reference Bureau, analysis of data from U.S. Census Bureau, 2000 Census Summary File 1 and Summary File 3, as cited in Kids Count Census Data Online.
The Death Rates of Children in the United States

In the United States, approximately 1.8 million children ages 18 and under experience the loss of a sibling each year (U. S. Department of Commerce, 1991). Losses of this order result in problems not just for the surviving children and their families but also for the greater society. In the United States, the greater society includes significant populations of minority ethnic and racial groups. The population of the country's children reflects this diversity. Health statistics for the United States indicate, however, that these losses are not distributed proportionately throughout the population.

A review of Tables 2 and 3, the death reports for children for the year 2000, reveals that African American children of all age groups have higher total death rates than do Caucasian or Hispanic children. Hispanic children of all age groups except the 10 to 14 years age group have higher total death rates than do Caucasian children. As Table 3 indicates, the causes of death and age groups with the greatest disparity between ethnic and racial groups are the homicide rates in the 15 to 19 years age group. Analysis indicates that Hispanic American children are murdered at a rate over six times and African American children are murdered at a rate over twelve times that of Caucasian children.

Statistics for the year 2000 do not differ substantially from those of other years. They are reflective of mortality rates of minority children over the course of a number of years (Nickens, 1991; National Center for Education in Maternal and Child Health, 2001).

Statistics for Asian American children are included in the table for “White, non-Hispanic”. However, the single data element of “All Causes” does contain the actual
rates for Asian American children. (Note regarding national statistics and age groupings: reports of the Bureau of Census provide census tabular data for children ages 18 and below. Reports of National Vital Statistics provide death rate tabular data for children ages 19 and below.)

Table 2: Child Death Rates per 100,000 Population, Four Highest Ranking Causes
Ages 1 – 4 and 5 – 9

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>ALL CAUSES</th>
<th>ACCIDENT</th>
<th>ASSAULT/HOMICIDE</th>
<th>CONGENITAL MALFORM.</th>
<th>CANCER²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Non-His.</td>
<td>58.8</td>
<td>19.1</td>
<td>6.9</td>
<td>5.9</td>
<td>3.2</td>
</tr>
<tr>
<td>Hispanic</td>
<td>31.0</td>
<td>10.9</td>
<td>2.0</td>
<td>3.9</td>
<td>2.7</td>
</tr>
<tr>
<td>White Non-His.³</td>
<td>27.9</td>
<td>10.9</td>
<td>1.5</td>
<td>2.5</td>
<td>2.7</td>
</tr>
<tr>
<td>Asian/PacIs⁴</td>
<td>19.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>ALL CAUSES</th>
<th>ACCIDENT</th>
<th>ASSAULT/HOMICIDE</th>
<th>CONGENITAL MALFORM.</th>
<th>CANCER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Non-His.</td>
<td>25.7</td>
<td>11.4</td>
<td>1.4</td>
<td>1.5</td>
<td>2.4</td>
</tr>
<tr>
<td>Hispanic</td>
<td>15.2</td>
<td>6.1</td>
<td>0.7</td>
<td>1.0</td>
<td>2.7</td>
</tr>
<tr>
<td>White Non-His.³</td>
<td>14.8</td>
<td>6.4</td>
<td>0.6</td>
<td>0.9</td>
<td>2.5</td>
</tr>
<tr>
<td>Asian/PacIs</td>
<td>9.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from National Center for Health Statistics (2001)

¹ Congenital malformations, deformations and chromosomal abnormalities
² Malignant neoplasms
³ Includes Asian/Pacific Islander children
⁴ Asian/Pacific Islander data for “All Causes”: National Center for Health Statistics (2002)
Table 3: Child Death Rates per 100,000 Population, Five Highest Ranking Causes
Ages 10 – 14 and 15 – 19

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>ALL CAUSES</th>
<th>ACCIDENT</th>
<th>ASSAULT/ HOMICIDE</th>
<th>HEART DISEASE</th>
<th>CANCER</th>
<th>SUICIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Non-His.</td>
<td>29.1</td>
<td>9.6</td>
<td>2.7</td>
<td>1.5</td>
<td>2.5</td>
<td>1.3</td>
</tr>
<tr>
<td>Hispanic</td>
<td>19.3</td>
<td>6.2</td>
<td>1.8</td>
<td>0.7</td>
<td>3.7</td>
<td>0.9</td>
</tr>
<tr>
<td>White Non-His. ² ³</td>
<td>19.6</td>
<td>8.0</td>
<td>0.7</td>
<td>0.7</td>
<td>2.5</td>
<td>1.7</td>
</tr>
<tr>
<td>Asian/PacIs. ⁴</td>
<td>14.1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>POPULATION</th>
<th>ALL CAUSES</th>
<th>ACCIDENT</th>
<th>ASSAULT/ HOMICIDE</th>
<th>HEART DISEASE</th>
<th>CANCER</th>
<th>SUICIDE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Non-His.</td>
<td>92.3</td>
<td>24.9</td>
<td>35.0</td>
<td>4.3</td>
<td>4.7</td>
<td>5.9</td>
</tr>
<tr>
<td>Hispanic</td>
<td>68.5</td>
<td>31.0</td>
<td>16.7</td>
<td>1.7</td>
<td>4.3</td>
<td>6.2</td>
</tr>
<tr>
<td>White Non-His. ³</td>
<td>63.3</td>
<td>36.9</td>
<td>2.7</td>
<td>1.6</td>
<td>3.4</td>
<td>8.9</td>
</tr>
<tr>
<td>Asian/PacIs</td>
<td>38.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: Adapted from National Center for Health Statistics (2001)

---

1 Congenital malformations, deformations and chromosomal abnormalities
2 White Non-Hispanic, Ages 10-14; 4th ranking cause: Congenital Malformations – 1.0
3 Includes Asian/Pacific Islander children
4 Asian/Pacific Islander data: National Center for Health Statistics (2002)
Projected Growth of Child Populations in the United States

It is important to understand statistical characteristics of populations, including changes in population size, in order to help determine the relevance of any population based problem (Fos & Fine, pp. 2-12). As Table 2 indicates, the death rates of minority children are generally higher than death rates for White children (National Center for Health Statistics, 2001). This being so, it then becomes important to understand the future trends in child population. Information from the Office of Juvenile Justice and Delinquency Prevention (Snyder & Sickmund, 1999) indicates that trends in the growth of child populations in the United States will bring about a population shift.

In the United States, the Hispanic population doubled between 1980 and 2000. (Hobbs and Stoops). Between 1900 and 2000, the number of non-Southern states having at least ten percent of the population other than White increased from two to twenty-six. By the year 2000, the populations of California, Hawaii, and New Mexico were predominantly “minority” populations. Therefore, children who were once members of minority groups have, and will increasingly become, members of the majority population. As Table 4 indicates, by 2015, the population of children may shift substantially.

Table 4: Projected Increase in the Population of Children in the U.S. by Year 2015

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>White children</td>
<td>3%</td>
</tr>
<tr>
<td>Black or African American children</td>
<td>19%</td>
</tr>
<tr>
<td>Asian/Pacific Islander children</td>
<td>74%</td>
</tr>
<tr>
<td>Hispanic children</td>
<td>59%</td>
</tr>
</tbody>
</table>

(Adapted from Snyder & Sickmund, 1999)
Review of Table 4 reveals that the populations of children of minority groups will increase at substantially greater rates than the population of White children. As stated previously in this paper, the National Center for Education in Maternal and Child Health has reported that morbidity and mortality statistics regarding minority children have exceeded those of mainstream America as a general trend. This is a factor to consider as the population of minority children begins to exceed that of the current mainstream culture.

As Tables 2 and 3 indicate, there are multiple problems regarding minority cultures that impact child health and death. The death rate for minority children is generally higher than for Caucasian children in the United States. Depending upon age groups, the difference is noteworthy. The Federal Interagency Forum on Child and Family Statistics (2002) has established the Key National Indicators of Well-Being, and publishes an annual report of the indicators. These indicators measure children's economic security, health, behavior and social environment, and education. Selected indicators are presented here.

**Key National Indicators of Well-Being**

**Family structure and living arrangements:** Children in families with two parents (biological, step, or adoptive) are significantly more likely to have income above the poverty line. As Table 5 shows, minorities have fewer children living with two parents.
Table 5: 2001 – Children Living with Two Parents

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White-non Hispanic</td>
<td>78%</td>
</tr>
<tr>
<td>Black-non Hispanic</td>
<td>38%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>65%</td>
</tr>
</tbody>
</table>

**Access to Health Care:** This indicator is one measure to determine family ability to provide preventive or medical care for a sick child. Table 6 indicates that a greater percent of minority families than White families do not have health insurance.

Table 6: 2000 – Health Insurance Coverage

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White-non Hispanic</td>
<td>93%</td>
</tr>
<tr>
<td>Black-non Hispanic</td>
<td>87%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>75%</td>
</tr>
</tbody>
</table>

**Low-Birthweight Babies:** Babies are termed as having a low-birthweight if they weigh less than 2,500 grams at birth (Federal Interagency Forum on Child and Family Statistics, 2002; Kids Count, 2002). These babies have a 24 times higher death rate than normal weight babies, and will, most likely, have greater developmental problems. Minority mothers from across all socio-economic levels, except for Hispanic, have higher rates of low-birthweight babies. One factor that may partially account for higher rates is living in isolated neighborhoods, apart from mainstream medical or social support.

Table 7: 2000 – Low Birthweight Babies

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White-non Hispanic</td>
<td>6.6%</td>
</tr>
<tr>
<td>Black-non Hispanic</td>
<td>13.1%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>6.4%</td>
</tr>
<tr>
<td>Asian/Pacific Island</td>
<td>7.3%</td>
</tr>
</tbody>
</table>
**Children Living In Poverty:** The Indicator report noted that the number of children living in poverty increases in minority populations when there is a female-householder family (Federal Interagency Forum on Child and Family Statistics, 2002).

The Anna E. Casey Foundation states that “children living in poverty” is a universally accepted measure regarding the status of children in physical, social, and legal domains (2002 Kids Count Data Book Online). This indicator for the United States is one of the highest in the industrialized world. The rate is growing in this country because of the increase in the number of families of the working poor, rather than an increase in families on welfare. The number of families totally dependent on welfare has decreased by 1.7 million to 1.1 million between 1976 and 2000. The rates of poverty have decreased for most minority cultures, but still remain higher than for Non-Hispanic Whites.

**Table 8: 2000 – Children Living in Poverty**

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White-non Hispanic</td>
<td>9%</td>
</tr>
<tr>
<td>Black-non Hispanic</td>
<td>30%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>27%</td>
</tr>
<tr>
<td>Black-non Hispanic-Married Couple</td>
<td>8%</td>
</tr>
<tr>
<td>Black-non Hispanic- Female Householder</td>
<td>49%</td>
</tr>
<tr>
<td>Hispanic Married Couple</td>
<td>21%</td>
</tr>
</tbody>
</table>

Source: Kids Count Data Book Online, Figure 3, “Poverty Rates by Race and Hispanic Origin: 1959-2001

---

1 Comparative information regarding White married couples and White female householders was not included. However, in the author’s opinion, the information presented appeared important.
However, the rates of children living in poverty are greater than for the general population. In the year 2000, 13% of Non-Hispanic White children were living in poverty. For Asian children, the rate was about 14%. The rates for Black and Hispanic children was about 26%, nearly twice the rates for White and Asian children, (OJJDP Statistical Briefing Book).

**Infant –Child – Adolescent Mortality:** This information was provided in Tables 2 and 3. In addition, the Indicator report notes that, while infant mortality has decreased across all ethnic and racial groups since 1983, disparities remain (Federal Interagency Forum on Child and Family Statistics, 2002). Most unintentional injuries among children are a result of traffic accidents. While safety systems such as seat belts and restraints have reduced deaths, almost half of child occupant deaths (ages one to four) occurred with children who were not restrained. Regarding adolescent deaths, injuries from motor vehicle accidents, homicide, suicide, and firearms were primary causes.

**Minority Children, Crime, and Violence**

The purpose of this analysis is to determine the extent to which children of selected minority groups are represented in the literature of dying, death, and bereavement published in the United States. As the foregoing tables have indicated, minority children and youth in several age groups have high rates of death due to violence. Minority children are victims of a disproportionate number of violent crimes (Snyder & Sickmund, 1999, p. 18). In regard to murder of juveniles, between the years of 1988 and 1995 the rate of juvenile homicide for Black children was four times that of white children. This was during a time when Black children comprised 15% of the
juvenile population. Between 1980 and 1997, over 90% of children were killed by members of their own race, when the killer was known.

**HIV and AIDS in the Minority Community**

African American and Hispanic minority groups experience significantly higher death rates from AIDS than mainstream society in the United States (Leavitt, Morrison, Gardner, & Gallagher, 1996). Statistics indicated in 1996 that between 80,000 and 125,000 children would lose a parent to AIDS within five years. African American and Hispanic women would make up 80% of those parents who die (Michaels & Levine, 1992). In 1997, African Americans comprised 13% of the nation’s population, but were diagnosed with 45% of the nation’s cases of AIDS (Moore, 1999). The National Center for HIV, STD and TB Prevention reported in 1998 that 60% of women and 62% of children with AIDS were African American (Moore, 1999).

Many urban minority AIDS orphans have suffered multiple physical, emotional, and social trauma and impairment, and have experienced cumulative and repetitive traumas (C/R T), as reported by Gallagher, Leavitt, and Kimmel in 1995 (Leavitt et al., 1996). Children may have lost a parent and/or other relatives to AIDS. Much care and attention must be given to any therapy provided to such children, who are emotionally fragile.

In the African American community, the church, often a major resource center, has had difficulty in accepting that traditional role for those affected by HIV/AIDS (Moore, 1999). However, certain New York City churches have begun developing programs that are “culturally sensitive and relevant to meeting the needs of AIDS grievers”, and providing education to lay leaders.
**Cross Cultural Issues**

The problem of failure to understand cross-cultural practices has led to numerous breakdowns in individual and societal communications (Tharp, 1991). As an example, it would be expected that the use of different languages would hinder communication. However, differences are profound in use of even a common language such as English. There are cultural differences in rapidity of speech; in when to talk, when to pause, even how long to pause; in rhythm of speech; and in a myriad other linguistic details. Two fields, those of child mental health and education, have made inroads in verbal communications designed to improve provision of services to minorities. Studies have been made of language structure and “courtesies and conventions of conversation”, and efforts have been instituted to modify technique. Use of language is vital in both the practice of psychology and of teaching; consequently, work with language development for minority children has been a first-order goal.

While there are some limitations to results, one study indicated that quality of life diminished with experiences of race-related stress (Utsey, Chae, Brown, and Kelly, 2002). Often, the predominant culture maintains the view that the traditions and beliefs of others are invalid and inferior. African Americans, Latinos, and Asian Americans experience various degrees of race-related stress resulting from rejection by the larger culture.

Certain propensities within cultures have been observed that also contribute to problems with inter-cultural communications. A study of 57 patients with advanced HIV infection explored reasons patients and physicians fail to discuss end-of-life care. The population was 65% Non-Hispanic Caucasian, 16% African American, 11% Hispanic,
and 4% Other. The non-Caucasian patients indicated at a higher level than Caucasians the reluctance to discuss issues involving death, fearing that such talk would make death more imminent. They also stated the preference not to discuss the medical care they would want if they became very sick. The authors postulated that there are possibilities of improving communications through several approaches (Curtis, Patrick, Caldwell and Collier, 2000)

Psychologists in the United States who provide treatment to children have reported that Western systems of theory, diagnosis, and treatment lack validity across cultures (Tharp, 1991). For instance, in the United States, the concept of mourning differs markedly from that of the Indochinese. The greatest problem in providing therapy to children of differing ethnic backgrounds appears to be that clinicians don't have sufficient information to provide “culturally responsive forms of treatment”.

Tharp discusses problems in communicating across cultures, which he indicates has been further recognized in provision of psychological services in a study by Sue, Allen, and Conaway. Of 13,450 clients in community mental health facilities, a study revealed no disparity in treatment provided to Hispanic or Native-American clients as compared to Anglo American clients. But the dropout rates for clients were: Hispanic, 42%; African American, 52%; Asian American, 52%; and Anglo, 30%. In reviewing these cases, the researchers faulted the appropriateness of the service and the quality of professional interactions (Tharp, 1991).

In another study that utilized the Grief Experience Inventory scale, there was a significant difference identified between Mexican American and Anglo American college students regarding several manifestations of grief (Oltjenbruns, 1998). Mexican
Americans had higher scores in measurements of loss of control (the tendency to show signs of grief outwardly), and somatization (experiencing physical symptoms, such as dry mouth). This result was interpreted as indicating a more powerful response to the loss. The author observed that, admonitions in the professional literature notwithstanding, many individuals, "at least subconsciously pass judgment as to what may be the 'right' way to grieve, with the implication, then, that there is a 'wrong' way to grieve".

**Conclusion**

"Siblings always matter" (Weisner, 1989). Though the cultural setting may change, there are some elements of sibling relationships that share common features across cultural boundaries. As children and adults deal with high divorce rates, blended families, and social change, siblings in roles of support may become more important to each other in the United States, not less.
CHAPTER 3
METHOD

A review of the literature was performed to identify articles discussing or
evaluating child survivors of sibling death published in the United States between
January 1, 1990 and December 31, 2002. Literature was selected to include those
professions involved with bereaved children. These included the field of dying, death,
and bereavement (interdisciplinary in nature, but specific as a field of work); medicine,
nursing, and allied health professions; social work; education; psychology; and pastoral
care.

Procedure

Articles were selected which were published in English in professional journals
between January 1, 1990 and December 31, 2002 and were related to the death of a child
who had a surviving sibling or siblings age 19 or under at the time of the death.

Articles were identified through searches of Internet databases recognized as
authoritative in their respective disciplines: Medline/Pubmed, PsychInfo, CINAHL,
Expanded Academic ASAP, Cambridge Sociological Abstracts, Social Services
Abstracts, Eric, and Education Full Text.

Scholarly books, academic articles, and reference and bibliography lists were
utilized in the search. Manual search was performed of Death Studies and Omega
through 2002.

Articles were excluded that did not relate to children living in the United States.
Keywords utilized in the Internet search, in either title or text, were “sibling AND (death OR bereavement).

The intent of the evaluation was to determine the status of the existing professional literature regarding inclusion of minority children; consequently, the search criteria were interpreted so as not to exclude an article that would assist in this effort. If, for example, an article dealt primarily with parental reaction to a child’s death, but contained relevant information regarding surviving siblings, the article was included in the evaluation.

**Organization of Data**

Articles were classified according to article type: literature review, commentary, case study, narrative, or research report. Articles were placed in one of three time frames: 1990 to 1993, 1994 to 1997, or 1998 to 2002. Data were retrieved from articles and entered into a database using the fields noted in Figure 1.

<table>
<thead>
<tr>
<th>Author</th>
<th>Date</th>
<th>Journal</th>
<th>Article Title</th>
<th>Article Type</th>
<th>Sample Source</th>
<th>Ages of Sample Participants &lt;19</th>
<th>Race/Ethnicity Stated?</th>
<th>Race/Ethnicity Discussed?</th>
<th>Race/Ethnicity of Sample Participants</th>
</tr>
</thead>
</table>

**Review by Article Type for Inclusion of Minority Children**

Literature reviews, commentaries, case studies, and narrative (non-research) articles were analyzed to determine if there was any mention of race, ethnicity, or culture. If there was a sentence or two regarding either or all of these, this was recorded as a “Comment”. If there was substantive discussion, this was recorded as “Discussion”.

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Research articles were analyzed to determine if there was comment or discussion regarding race, ethnicity, or culture. They were also analyzed to determine the race and/or ethnicity of the participants, and the numbers of each group, if provided.
CHAPTER 4

RESULTS

This evaluation of the literature sought to determine answers to three questions. First, what currently exists in professional journals regarding sibling death among minority children? Second, to what extent are African American, Hispanic, and Asian American/Pacific Islander children included in research studies regarding survivors of sibling death? Finally, has the representation of minority children in the literature changed over the time span included in this evaluation? In order to answer these questions, articles published between the years 1990 and 2002 were reviewed and analyzed for content concerning race and ethnicity.

The search of individual databases identified articles as follows: MedLine/PubMed, 262; PsychINFO, 107; CINAHL, 40; Expanded Academic Index ASAP, 63; Cambridge Sociological Abstracts, 15; Sociological Services Abstracts, 9; ERIC, 7; and Education Full Text, 79. Of the 596 total articles identified in the databases, 58 met the research criteria.

The 58 articles were first reviewed individually, and then placed by date into the category of work they represented, either literature review, commentary, case study, narrative, or research article.

All articles were reviewed to determine if they commented upon or discussed issues of race or ethnicity. In addition, research articles were reviewed to determine the racial and ethnic backgrounds of participants in each sample.
The results of each category were reviewed to determine if any changes had occurred in the frequency of inclusion of minorities in the literature during the thirteen years the review encompassed.

Additional articles were found that did not meet the criteria for the evaluation, but which provide insight regarding the issues explored in this report. Those articles are listed in the Supplement category.

The results are classified in Table 9 by ascending order of date of publication (the oldest first) and according to the time frame in which one of three time frames.

Table 9: Organization of Results

<table>
<thead>
<tr>
<th>Category</th>
<th>Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Literature reviews</td>
<td>5 Total</td>
</tr>
<tr>
<td>1990-1993</td>
<td>3</td>
</tr>
<tr>
<td>1994-1997</td>
<td>1</td>
</tr>
<tr>
<td>1998-2002</td>
<td>1</td>
</tr>
<tr>
<td>2. Commentaries</td>
<td>5 Total</td>
</tr>
<tr>
<td>1990-1993</td>
<td>0</td>
</tr>
<tr>
<td>1994-1997</td>
<td>4</td>
</tr>
<tr>
<td>1998-2002</td>
<td>1</td>
</tr>
<tr>
<td>3. Case studies</td>
<td>5 Total</td>
</tr>
<tr>
<td>1990-1993</td>
<td>3</td>
</tr>
<tr>
<td>1994-1997</td>
<td>1</td>
</tr>
<tr>
<td>1998-2002</td>
<td>1</td>
</tr>
<tr>
<td>4. Narratives</td>
<td>16 Total</td>
</tr>
<tr>
<td>1990-1993</td>
<td>6</td>
</tr>
<tr>
<td>1994-1997</td>
<td>4</td>
</tr>
<tr>
<td>1998-2002</td>
<td>6</td>
</tr>
<tr>
<td>5. Research reports</td>
<td>27 Total</td>
</tr>
<tr>
<td>1990-1993</td>
<td>14</td>
</tr>
<tr>
<td>1994-1997</td>
<td>8</td>
</tr>
<tr>
<td>1998-2002</td>
<td>5</td>
</tr>
<tr>
<td>6. Supplement</td>
<td></td>
</tr>
</tbody>
</table>

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Five reviews of the literature were located. The results are provided according to the time frame in which they were published.

Table 10: Literature Reviews

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Number of Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Literature reviews</td>
<td>5 Total</td>
</tr>
<tr>
<td>1990-1993</td>
<td>3</td>
</tr>
<tr>
<td>1994-1997</td>
<td>1</td>
</tr>
<tr>
<td>1998-2002</td>
<td>1</td>
</tr>
</tbody>
</table>


2. Opie (1992), “Childhood and Adolescent Bereavement”, reviews nursing research articles published between 1983 and 1990 regarding childhood and adolescent bereavement. Opie identified 11 articles, 9 from the 1980’s and 2 from 1990. Of the 11 articles she reviews, Opie notes that 9 relate to sibling loss. Of her observations regarding samples utilized in the studies, Opie writes:

Nurse researchers included subjects from the lower SES groups in 10 studies; however, examination of the samples demonstrates a significant lack of ethnic and minority variability among the subjects. In one study 11% of the sample was Hispanic. Generally, the samples were white and lower to middle class. Due to the small number of
studies and the frequent sampling bias, it can be concluded that no single population has been adequately studied.

Opie reports that only two authors “acknowledged the limitations inherent in their studies”. Opie’s recommendations for future research include the need for more inclusiveness in samples and for studies that would explore bereavement issues in various cultures and ethnic groups.

3. Walker (1993), “Sibling Bereavement and Grief Responses”, reviews literature concerning grief of children ages 19 and younger who have lost a sibling. She notes that the purpose of this article is to “expand on those reviews (by Eugenia Waechter and C. L. Betz) by focusing on bereavement and grief responses of siblings with analysis pertinent to nursing implications”. Walker discusses or reviews over 60 articles, 27 of which are in her literature review, but which are also discussed critically. Of these 60, Walker reviews 28 articles from the 1980’s, and 10 articles from 1990 to 1993. There is no mention of race or ethnicity in observations or discussion.

4. Huntzinger (1995), “A Selective Review and Discussion of the Literature on Early Sibling Loss”, reviews loss in early childhood, with the focus on developmental and mental health outcomes of the survivor. Her discussion concerns early works written by Freud (citation not provided); Cain, Fast, and Erickson in the 1960’s; Bowlby in the 1980’s, and others. Also mentioned were a 1992 unpublished manuscript by Joan Fanos, and work by Carolyn Walker (citation not provided). Race and ethnicity are not mentioned.

5. Kemp (1999), “Grieving the Death of a Sibling or the Death of a Friend”, explores disenfranchised grief and the professional literature. Kemp reviews over 25
books and articles regarding sibling death, most of which apply to children and adolescents. At least 10 of these that concerned child or adolescent sibling bereavement were published in the 1990’s. Kemp addresses situations in which the survivor’s grief is often unrecognized by the larger culture. Siblings are in this category, as are those who are not often acknowledged by the family of the deceased, such as friends and gay partnerships. There is a discussion of loss of friends during time of war and on the battlefield. There is no discussion of race or ethnicity.

**COMMENTARIES**

There were 5 articles located that were classified as commentaries. Of these, 4 critically examine or comment upon other articles, and one is a reply by the authors.

<table>
<thead>
<tr>
<th>Table 11: Commentaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time Frame</td>
</tr>
<tr>
<td>------------------</td>
</tr>
<tr>
<td>Commentaries</td>
</tr>
<tr>
<td>1990-1993</td>
</tr>
<tr>
<td>1994-1997</td>
</tr>
<tr>
<td>1998-2002</td>
</tr>
</tbody>
</table>

Articles 1 through 3 are commentaries that address Hogan and DeSantis’s (1994) article, “Things That Help and Hinder Adolescent Sibling Bereavement”. Article 4 is a “Response by the Authors”, Hogan and DeSantis (1994), to the commentaries. Article 5 is a commentary by Davies on a work by Van Riper.


Cowles indicates that the study sample was not representative of the general population, and questioned whether a sample with fewer two-parent homes, different socio-economic levels, and greater variety in ethnicity would have a different outcome.

Demi notes issues with the convenience sample, participants of which were located through their attendance at bereavement groups held by the Compassionate Friends. Families were largely White, two-parent, and middle income. Demi indicates it would be beneficial to conduct the same study with participants “from other cultural groups, other economic classes, and from single-parent families.”


Ross states that more information regarding the sample would be helpful, specifically, whether both parents worked to maintain what was a “fairly high” income; whether the study excluded families who would only discuss grief within the family, or who bore grief stoically and silently. Ross questions how the sample might respond to questions if its members were from different cultures.

4. Hogan, N. S. and L. DeSantis. (1994). Things that help and hinder adolescent sibling bereavement. The authors respond to the foregoing commentaries:

Hogan and DeSantis note the questions regarding the sample. They indicate that they had obtained the sample

…from a mutual support organization for bereaved parents and siblings.

Going to an expert source (those who have experienced the phenomenon) is a necessary condition of qualitative research to ground the phenomenon in question in the language and meaning of the participants and to understand it from their point of view.
The authors state that qualitative research is not generalizable beyond the sample without first applying other sampling and analysis.

Hogan and DeSantis respond to the issue of two-parent families being less than representative of the population. Upon request by the Institutional Review Board, they write, instructions to the participants had included the request that, if possible, both parents sign the consent form. They state that this may have confused single parents, who then did not participate.


Davies provides comments on an article written by Van Riper, one of five sisters who, as children, were bereaved by the death of a younger sister in an automobile accident. There is no mention in the commentary (or in the original article) concerning race or ethnicity.

**CASE STUDIES**

Five articles were identified and located which were classified as case studies. There was no mention of race or ethnicity in any of the case studies.

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Number of Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case studies</td>
<td>5 Total</td>
</tr>
<tr>
<td>1990-1993</td>
<td>3</td>
</tr>
<tr>
<td>1994-1997</td>
<td>1</td>
</tr>
<tr>
<td>1998-2002</td>
<td>1</td>
</tr>
</tbody>
</table>

1. Grogan’s (1990) article, “Grief of an Adolescent When a Sibling Dies”, presents the story of two brothers who lost an 11-year-old sister from a stroke when they
were 17 and 18. Information regarding how the study participants were identified was not included.

2. Heiney (1991) authored “Sibling Grief: A Case Report”. The 9-year-old subject was selected because he was the only child who attended more than once in a series of family/sibling support groups. His baby brother had died of cancer about three months prior to the group meetings.

3. Donders (1993) presents 3 cases of children between the ages of 3 and 9 in “Bereavement and Mourning in Pediatric Rehabilitation Settings”. One case involves death of a brother; a second involves death of mother and sister; the third involves death of a mother. In each case, the child-subject sustained either severe traumatic brain injury or anoxic encephalopathy due to the event that took the life of his family member(s). Regarding selection of cases, the author noted that there are limited numbers of children with brain injuries to perform a large-scale study concerning their understanding of death, and their experience of bereavement and mourning. These cases were selected to provide further understanding of the experiences of children with brain injuries.

4. Cain and Lohnes (1995) write of “Identificatory Symptoms in Bereaved Children: A Diagnostic Note”. The 7 cases present 2 children who are bereaved of siblings and 5 children who are bereaved of parents. Cases were selected from children who had received care in a variety of psychiatric settings following family death.

5. Batten and Oltjenbruns (1999) term their work an exploratory study in “Adolescent Sibling Bereavement as a Catalyst for Spiritual Development: A Model for Understanding”. The authors present the results and analysis of interviews with 4 adolescents, ages 15 to 18, who had lost a sibling between 3 and 19 months prior.
Hospice and the Compassionate Friends had served as sources for participants. The adolescents had been enrolled in the study following their response to a mailing.

**NARRATIVES**

There were 16 articles identified and located which were classified as narrative. The results are provided according to the time frame in which they were published. Articles published within the same year are entered alphabetically.

<table>
<thead>
<tr>
<th>Table 13: Narratives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Time Frame</strong></td>
</tr>
<tr>
<td>1990 – 1993</td>
</tr>
<tr>
<td>1994 – 1997</td>
</tr>
<tr>
<td>1998 – 2002</td>
</tr>
</tbody>
</table>

**NARRATIVES PUBLISHED BETWEEN 1990 – 1993**

1. Romond (1990), ‘’It’s Sad and You Hurt a Lot’: Letters from Bereaved Brothers and Sisters’; is authored by a nurse whose 7 year old son died, leaving her three-and-a-half year old bereaved. No mention is made of culture, race or ethnicity.

2. Smith (1991), “Preschool Children ‘Play’ Out Their Grief”; is the story of the Dougy Center in Portland, which provides bereavement services to children and parents. There is no mention of race or ethnicity.


4. Panchal (1992), “Beware a Child Suffers”; in the discussion of children’s perceptions of death, this article speaks about family, social class, and socioeconomic level, with the observation from a 1974 study by Tallner, Formaneck, and Tallner that
children in lower classes are more exposed to violence, and are conscious of death at an earlier age than are children of other classes. There is no mention of race or ethnicity.

5. Davies (1993), “Sibling Bereavement: Research-Based Guidelines for Nurses”; includes discussion of the family environment and intellectual, cultural, and social orientation. There is no mention of race or ethnicity.

6. Heiney, Hasan, and Price (1993), “Developing and Implementing a Bereavement Program for a Children’s Hospital”; describes the efforts of an interdisciplinary team from all pediatric services within a medical center in South Carolina to create a bereavement program. There is no mention of race or ethnicity.

NARRATIVES PUBLISHED BETWEEN 1994 – 1997

1. Wilson (1995), “Differences Between Identical Twin and Singleton Adjustments to Sibling Death in Adolescence”; presents the problems peculiar to siblings whose twins die during adolescent years. No mention is made of race or ethnicity.

2. DeMaso, Meyer, and Beasley (1997), “What Do I Say to My Surviving Children?”; discusses how families can help siblings whose brother or sister has died, including a paragraph regarding family functioning, and family “cultural and religious/spiritual beliefs”, as well as support systems. No direct mention is made of race or ethnicity.

3. Robinson and Mahon (1997), “Sibling Bereavement: A Concept Analysis”; this exploration of sibling bereavement seeks to add to the knowledge base in the field of death and bereavement by determining who should be deemed a sibling. The article seeks to cast light upon this issue due to the needs of many adults whose siblings are and will be dying of AIDS. The authors note that religious groups, fraternal
organizations, and minorities sometimes consider close friends/associates to have sibling status. The authors indicated that, in the literature review of sibling bereavement studies, "diversity was sought in the variables of age and cause of death... to gain the broadest possible understanding of how sibling bereavement is manifested". No other mention is made of race or ethnicity than use of the term "minorities".

4. Van Riper (1997), "Death of a Sibling: Five Sisters, Five Stories"; the author and four adult sisters tell of the impact their baby sister's death had on their lives when they were children. There is no mention of race or ethnicity.

**NARRATIVES PUBLISHED BETWEEN 1998 – 2002**

1. Juhnke and Shoffner (1999), "The Family Debriefing Model: An Adapted Critical Incident Stress Debriefing for Parent and Older Sibling Suicide Survivors". This article describes how Critical Incident Stress Debriefing has been utilized to develop the Family Debriefing Model. At the conclusion, the authors note that the model has been utilized with 11 families, 10 of which were Caucasian, and suggested future work with other ethnic or religious groups to build empirical data.

2. Committee on Psychosocial Aspects of Child and Family Health (of the American Academy of Pediatrics), (2000), "The Pediatrician and Childhood Bereavement". The abstract and guidelines noted that pediatricians should use "...culturally sensitive guidance" in assisting children who have lost a sibling. The article included an observation that "Cultural and religious background are important considerations in dealing with the bereaved family."
3. Hilden, Watterson, and Chrastek (2000), "Tell the Children".

This article provides information regarding the need to provide honest information to children whose siblings are dying. A mention is made of studies regarding children "(in Western cultures)" as well as dealing with issues "in a culturally and individually sensitive way".


This author, herself a sibling survivor of suicide, discusses the devastation of families by a child's suicide. Recommendations to other therapists include understanding the influence "ethnic and religious background" has on family beliefs and dynamics.


Three oncology centers in South Carolina hosted a three-day camp experience for bereaved siblings, ages 6 through 19. Criterion for attendance was that children must have lost a brother or sister to cancer or a blood disorder in the previous three years. Summary and evaluation of the session are presented. There is no mention of race or ethnicity.

6. Stuber and Mesrkhani (2001), "What do we tell the children?".

Vignettes of the death of a mother, a grandparent, and a brother, as well as a parent with cancer, are used to illustrate how to communicate the news of death to young children. Included is information concerning how some cultures (Japanese, Indian, Armenian, and Iranian, for example) advocate not discussing bad news due to harmful effects. In other cultures, the loss of a grandparent can be a significant loss to a child, and extremely distressing. The authors note that religious rituals provide structure for
mourning in many cultures, but may need to be modified for small children to participate. The authors report that in many Latino and Asian cultures, a child may be supported by extended family and friends, or religious organizations.

**RESEARCH ARTICLES**

There were 27 articles identified and located which were classified as research articles. The results are provided according to the time frame in which they were published. Articles published in the same year are entered alphabetically.

<table>
<thead>
<tr>
<th>Time Frame</th>
<th>Number of Articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990 – 1993:</td>
<td>14 articles</td>
</tr>
<tr>
<td>1994 – 1997:</td>
<td>8 articles</td>
</tr>
<tr>
<td>1998 – 2002:</td>
<td>5 articles</td>
</tr>
</tbody>
</table>

**RESEARCH ARTICLES PUBLISHED BETWEEN 1990 – 1993**


   This study utilized a sample of 61 children between the ages of 4 through 16, representing 37 families. Participants were predominantly Caucasian with 5 families reporting a minority member. No mention is made in the results or discussion regarding race or ethnicity.

2. Balk (1990), “The Self-Concepts of Bereaved Adolescents: Sibling Death and Its Aftermath”. This study had a sample of 42 adolescents between the ages of 14 and 19 years, recruited through Compassionate Friends and the CandleLighters. The participants were all White. The discussion contained no mention regarding race or ethnicity.
3. Hogan and Balk (1990), “Adolescent Reaction to Sibling Death: Perceptions of Mothers, Fathers, and Teenagers”. This study had a sample of 14 families, with a mother, father, and one teenage from each. The teenagers were part of a larger sample from a previous study by Hogan (1987). The parents were randomly selected from the larger sample. The participants were contacted through the Society of Compassionate Friends. Of the 42 total number in the sample, 76.2% were White, 11.9% were Hispanic, and 11.9% were other racial/ethnic identify. The results and discussion contained no information regarding race or ethnicity.

4. DeFrain, Martens, Stork and Stork (1990-91), “The Psychological Effects of a Stillbirth on Surviving Family Members”. This descriptive study had an interview sample of 22 families, including mothers, fathers, siblings and some grandparents. The sample source and demographics are unknown. An additional sample of 304 completed questionnaires was obtained through a news story in 100 large and small newspapers throughout the United States. The sample was composed of mothers and fathers of all ages who had experienced a stillbirth from two weeks to forty years prior. According to the article, composition of the sample included: African American, Caucasian, Hispanic, Asian American, and Native American. A distribution was not included. The results and discussion included no information regarding race or ethnicity.

5. Applebaum and Burns (1991), “Unexpected Childhood Death: Posttraumatic Stress Disorder in Surviving Siblings and Parents”. There were 20 families in this study, with one sibling and one parenting from each family participating. The families were recruited as follows: 2 from the Family Bereavement Center of Wayne Count, MI; 18 from Compassionate Friends and from Parents of Murdered Children.
Death was to have occurred in the last seven years. The siblings were between 3 and 23 years of age; 14 were age 19 or younger. Of the sample, 16 were White, 1 African, 1 Hispanic, 1 of mixed ethnicity, and 1 Korean (who had been adopted by a White couple). There was no report or discussion of race or ethnicity.

6. Balk (1991b), "Sibling Death, Adolescent Bereavement, and Religion. The sample in this study was composed of 42 youth between the ages of 14 and 19. Subjects were recruited thorough the CandleLighters and the Compassionate Friends. All participants were Caucasian. There was no mention of race or ethnicity in the discussion.

7. Davies (1991), "Long-Term Outcomes of Adolescent Sibling Bereavement”. The sample for this study was composed of 12 persons between the ages of 25 and 75 who had lost a sibling when between the ages of 11 and 15 years. The study requirement was that the loss had to have occurred prior to the subject’s 17th birthday. Participants had been recruited through postings on university, community center, and church bulletin boards. All subjects were white. The discussion noted limitations of the study, which affect generalizability, including limitations of the sample regarding ethnic groups.

8. Demi and Howell (1991), “Hiding and Healing: Resolving the Suicide of a Parent of Sibling”. This study has a sample size of 17, ages 26 to 50. The mean length of time since the parent/sibling suicide was 17 years. Study criteria stated that the suicide had to have occurred before the participant’s thirtieth birthday. Of the 17 suicides, 11 were parental and 6 were sibling. Of the sample, 15 were whites and 2 were blacks. There was no mention of race or ethnicity in the results or discussion.
9. Fanos and Nickerson (1991), “Long-Term Effects of Sibling Death During Adolescence”. This study sample was chosen because each participant had lost a sibling to cystic fibrosis, “the number one genetic killer of Caucasian children in the United States today”. The sample contained 25 survivor siblings who had lost a brother or sister before they were 19 years of age. The sample was recruited through letters mailed in 1984 to families who had lost a child between 1963 and 1982 at one of the CF clinics in metropolitan areas in the United States. This article contains no further mention of race or ethnicity.

10. Flogan and Greenfield (1991), “Adolescent Sibling Bereavement Symptomatology in a Large Community Sample”. The sample of 127 adolescents was recruited through a mailing to 408 chapter officers of The Compassionate Friends. The participants were from 13 through 18 years old. The sample was 97% Anglo. The discussion notes that more research is needed “across a wider spectrum of ethnic groups…”.

11. Martinson and Campos (1991), “Adolescent Bereavement: Long-Term Responses to a Sibling’s Death From Cancer”. This nonrandom sample of 31 adolescents, ages 10 through 19 at the time of death of the sibling, was taken from a larger study of home care patients/families in the Midwest. The majority of the sample members were Caucasian. There is no mention of race or ethnicity in the results or discussion.

12. Hogan and DeSantis (1992), “Adolescent Sibling Bereavement: An Ongoing Attachment”. This research study was utilized to develop a taxonomy of the adolescent sibling bereavement process. The final sample size was 141, ages 11 through
18, a convenience sample recruited through Compassionate Friends. Of the participants, 135 (96%) were Anglo, and 6 (4%) were Other. There is no further mention of race or ethnicity in the article.

13. Leder (1992), “Life Events, Social Support, and Children’s Competence After Parent and Sibling Death”. This descriptive correlational design study had a sample of 37 families, with 37 parents/guardian and 37 children ages 6 through 11 at time of death and 7 through 15 at the time of the study. The deceased family members were 18 parents and 20 siblings (one child had lost a parent and a brother). The participants were recruited through a children’s hospital, The Compassionate Friends, attendance at a family bereavement conference, and individuals know to the investigator. Sample race and ethnicity were not provided. There was no discussion of race or ethnicity in the article.


The study sample was of 25 surviving siblings of 20 adolescent suicide victims. A control group matched by geographic cluster sampling of housing tracts similar in demographics was also chosen. The control group had no exposure to suicide. The mean age of the sample was 17.4 (SD:2.8). Interview was about 6 months after the suicide. The sample was chosen from a consecutive survey of adolescent suicide victims in Western Pennsylvania. The sample was 100% white. There was no mention of race or ethnicity in the discussion.

1. Finke, Birenbaum, and Chand (1994), “Two Weeks Post-Death Report by Parents of Siblings’ Grieving Experience”. This is a secondary analysis from an earlier study. In this study, the sample numbered 43 siblings ages 19 and under, from 31 families. Both parents of each sibling were participants in the study. “All families, from three major medical centers and six private practice physicians, whose children were known to be in the terminal phase were recruited for the study.” Demographic figures indicated that mothers and fathers were about 85% Caucasian, about 5% Black, and about 10% Other. Study results did not include race or ethnicity.

2. Hogan and DeSantis (1994), “Things That Help and Hinder Adolescent Sibling Bereavement”. This information for this study comes from an earlier study regarding bereaved adolescents. Sample size was 140 participants, ages 13 to 18 at the time of the study. The participants were recruited through the Compassionate Friends. The sample was 96% White (134 participants). Three commentaries and a response by the authors are appended to this article. Study results did not include race or ethnicity.

3. Mahon (1994), “Death of a Sibling: Primary Care Interventions”. A study, contained within this narrative article, had as its stated purpose, “to explore whether the experience of sibling death from trauma affected a child’s development of an accurate concept of death”. The sample was solicited from a metropolitan area medical examiner’s listing of non-natural consecutive deaths of children over a 15-month period. From letters sent to families, a sample of 29 children from 23 families was established. Ages of children were from 5 to 12 years. A matched comparison group was also established. No information was provided regarding race or ethnicity in the article.
4. Martinson, McClowry, Davies, and Kuhlenkamp (1994), “Changes Over Time: A Study of Family Bereavement Following Childhood Cancer”. This study is a longitudinal follow-up of 7 to 9 years of an earlier study of home care patients/families in the upper Midwest. In this study, the sample included 48 families, of which, there were 46 mothers, 33 fathers, and 71 siblings. The mean age of the siblings was 18.7 years; the mean age of siblings interviewed was 18.8 years. No information was provided in the article regarding race or ethnicity. [A previous study reported by Martinson and Campos (1991) using this sample indicated a majority of the sample was Caucasian.]

5. McCown and Davies (1995), “Patterns of Grief in Young Children Following the Death of a Sibling”. This study is the result of a combining of two sets of data previously reported upon by the authors, singly, in 1982, 1983, 1987, and 1988. The sample size was 90 children from 61 families, with subjects ages 4 through 16 years. Subjects came from the western United States and Canada. The methods of recruiting the sample were not provided. The participants were 90% White and 10% Hispanic, Asian, or Black. Results did not mention race or ethnicity.

6. Brent, Moritz, Bridge, Perper, and Canobbio (1996), “The Impact of Adolescent Suicide on Siblings and Parents: A Longitudinal Follow-Up”. This follow-up study provided summation of the three sets of interviews over a three-year period. The initial sample of 25 was taken from a listing of consecutive suicides in Western Pennsylvania. All subjects were White. No mention was made of race or ethnicity in the results.

7. Nelson and Frantz (1996), “Family Interactions of Suicide Survivors and Survivors of Non-Suicidal Death”. This is a study of child and adolescent death, and
parent and sibling survivors. The sample included 41 parents and 39 siblings who were recruited from bereavement support groups in New York State, and from flyers and newspaper notices. At the time of death, the siblings’ average age was 16. Of the parents, 39 were Caucasian, and 2 were Black. Of the siblings, 35 were Caucasian, 1 was Hispanic, 2 were Black, and 1 was Asian. There was no mention of race or ethnicity in the results or discussion.

8. Tonkins and Lambert (1996), “A Treatment Outcome Study of Bereavement Groups for Children”. This study had a sample of 16 participants who were ages 7 through 11. Of these, 14 were bereaved of a parent and 2 were bereaved of a sibling. Six of the subjects were assigned to a control group but were given therapy after the control period. Participants were recruited through advertisements and brochures. The groups were held at three established clinic sites, each with a different population. Site one clients were mostly Caucasian, site two were predominantly Hispanic, and site three were primarily Caucasian. Results were not reported by race or ethnicity. A statement is made in the discussion that the improvement in children recorded in this study were consistent across sources, suggesting that the changes were noted across situations and methodologies.

**RESEARCH ARTICLES PUBLISHED BETWEEN 1999 – 2002**

1. Worden, Davies, and McCown (1999), “Comparing Parent Loss With Sibling Loss”. This study combined two study samples obtained by the authors for previous studies, published in earlier years (1992, 1993, and 1996; and 1983, 1988, and 1998). The first study sample of 125 school-aged children from 70 families was from the Child Bereavement Study at the Massachusetts General Hospital, and was “identified
from communities selected for their varying demography in the greater Boston area”.

The second study sample of 75 children from 50 families came from studies by Davis and McCown, and were from the western United States and Canada. Of this sample, 90% of the participants were White, and 10% were Hispanic, Native American, Asian or Black. No further mention was made of race or ethnicity.

2. Birenbaum (2000), “Assessing Children’s and Teenagers’ Bereavement When a Sibling Dies from Cancer: A Secondary Analysis”. This study is part of a secondary analysis of a longitudinal study first published by the author in 1987. The sample for this study included 61 children ages 3 to 19 years, from 37 families. The participants were predominantly Caucasian; five families reported minority members. The literature review cites Opie's (1992) article, which calls for “more representative samples”. There is no other mention of race or ethnicity in the study.

3. Salloum, A., Avery, L., McClain and R. P. (2001) “Group Psychotherapy for Adolescent Survivors of Homicide Victims: A Pilot Study”. The sample for this study was composed of 45 youths ages 11 through 19, who had lost a family member through murder. Nine each of the children had lost a parent, sibling, cousin, or friend. Eight had lost an uncle or aunt; one indicated loss of other. The sample was obtained through social workers participating in a special community-based therapy project for at-risk youth in four public schools in New Orleans. All participants were African American. The methods and discussion sections provided information regarding African American children in this setting relative to loss, grief, and bereavement, as well as safety.
4. Lohan and Murphy (2001-2002), “Parents’ Perceptions of Adolescent Sibling Grief Responses After an Adolescent or Young Adult Child’s Sudden, Violent Death”. This study was part of a larger study that dealt with parental loss of a child through violent death. The sample of parents was recruited through public death records. The author refers the reader to earlier published articles for any further information regarding recruitment. In this study, the surviving children were ages 10 through 19. A total of 34 fathers answered questions about 47 children. A total of 73 mothers responded to questions about 87 children. There is no mention of the race or ethnic origin of the sample. There is no mention of race or ethnicity in the article.

5. Pfeffer, Jiang, Kakuma, Hwang and Metsch (2002), “Group Intervention for Children Bereaved by the Suicide of a Relative”. This study has a sample of 75 children, ages 6 to 15 years, from 52 families. Fifty children were bereaved of a parent and 25 children were bereaved of a sibling. The intervention group contained 39 children; the non-intervention group contained 36 children. Names were obtained from medical examiners’ lists of consecutive suicide victims. The sample was recruited from families who responded to letters about the study. The children in the sample numbered 52 White, 12 African American, and 11 Hispanic. The tables provided depict the number of each group that was assigned and then retained in the study by gender, race/ethnicity, and social status. The authors report a high rate of posttraumatic stress symptoms in nonwhite families. The authors state that the high percentage of white male suicide victims who had used firearms indicate this is representative of suicide in the general population.
Table 15: Summary of Results for Descriptive Articles

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td># Articles</td>
<td>Discussion</td>
<td>Comment</td>
<td></td>
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<tr>
<td>Literature Reviews</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Commentaries</td>
<td>0</td>
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<td>-</td>
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<tr>
<td>Case Studies</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Narratives</td>
<td>6</td>
<td>0</td>
<td>2</td>
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<tr>
<td></td>
<td>31</td>
<td>5</td>
<td>6</td>
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</tr>
</tbody>
</table>

SUMMARY OF RESULTS FOR DESCRIPTIVE ARTICLES:
Regarding Content of Discussion or Comments Concerning Race or Ethnicity.
Recorded by Time Frame and Category.
<table>
<thead>
<tr>
<th>1990-1993: 14</th>
<th>Date</th>
<th>Sample</th>
<th>White</th>
<th>AfAm</th>
<th>Hisp</th>
<th>Asian/PI</th>
<th>Other</th>
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<tbody>
<tr>
<td>Balk</td>
<td>1990</td>
<td>42</td>
<td>42</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Birenbaum et al</td>
<td>1990</td>
<td>61</td>
<td>Predomin.¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DeFrain et al</td>
<td>1990</td>
<td>326²</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hogan &amp; Balk</td>
<td>1990</td>
<td>42</td>
<td>76.2%(32)</td>
<td>11.9%(5)</td>
<td>11.9%(5)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Applebaum &amp; Burns</td>
<td>1991</td>
<td>20↑</td>
<td>16</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Balk-b</td>
<td>1991</td>
<td>42³</td>
<td>42</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Davies</td>
<td>1991</td>
<td>12</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Demi &amp; Howell</td>
<td>1991</td>
<td>17</td>
<td>15</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fanos &amp; Nickerson</td>
<td>1991</td>
<td>25⁵</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Hogan &amp; Greenfield</td>
<td>1991</td>
<td>127</td>
<td>97%(6) (123)</td>
<td>(3%-4)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Martinson &amp; Campos</td>
<td>1991</td>
<td>31</td>
<td>Majority</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hogan &amp; DeSantis</td>
<td>1992</td>
<td>141</td>
<td>135⁷</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leder</td>
<td>1992</td>
<td>37⁸</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brent et al</td>
<td>1993</td>
<td>25</td>
<td>25⁹</td>
<td></td>
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</tr>
</tbody>
</table>

¹ Predominantly Caucasian; 5 families had minority member
² Diversity of race/ethnicity; numbers not stated
³ Families
⁴ Same population as 1990 study
⁵ Race/Ethnicity not stated; cystic fibrosis family
⁶ Anglo
⁷ Anglo
⁸ Families; race/ethnicity not provided
⁹ Sample from consecutive listing of suicide victims
<table>
<thead>
<tr>
<th>Date</th>
<th>Sample</th>
<th>White</th>
<th>AfAm</th>
<th>Hisp</th>
<th>Asian/PI</th>
<th>Other</th>
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<td>1994-1997: 8</td>
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<td></td>
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<tr>
<td>Finke et al 1994</td>
<td>43</td>
<td>85% (37)</td>
<td>5% (2)</td>
<td></td>
<td>10% (4) L</td>
<td></td>
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<tr>
<td>Hogan &amp; DeSantis 1994</td>
<td>140</td>
<td>134</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mahon 1994</td>
<td>29</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Martinson et al 1994</td>
<td>48</td>
<td>Majority</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>McCown &amp; Davies 1995</td>
<td>90</td>
<td>90% (81)</td>
<td></td>
<td></td>
<td>10% (9)</td>
<td></td>
</tr>
<tr>
<td>Brent et al 1996</td>
<td>25</td>
<td>25s</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nelson &amp; Frantz 1996</td>
<td>41 parents</td>
<td>39</td>
<td>2</td>
<td>39 sibs</td>
<td>35</td>
<td>2</td>
</tr>
<tr>
<td>Tonkins &amp; Lambert 1996</td>
<td>16</td>
<td>2 groups</td>
<td></td>
<td></td>
<td>1 group</td>
<td></td>
</tr>
<tr>
<td>1998-2002: 5</td>
<td></td>
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<td></td>
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<tr>
<td>Worden et al 1999</td>
<td>125</td>
<td>75</td>
<td>90% (67)</td>
<td></td>
<td>10% (8)</td>
<td></td>
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<tr>
<td>Birenbaum 2000</td>
<td>61</td>
<td>Predomin.8</td>
<td></td>
<td></td>
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<tr>
<td>Lohan &amp; Murphy 2001</td>
<td>34/47</td>
<td>73/879</td>
<td></td>
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<td>Salloum et al 2001</td>
<td>45</td>
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<td>Pfeffer et al 2002</td>
<td>75</td>
<td>52</td>
<td>12</td>
<td>11</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1 Sample- 43 siblings/43 parents; race/ethnicity given for parents
2 Race/ethnicity not stated
3 Families; is reanalysis of 1991 study, majority Caucasian
4 10% Hispanic, Native American, Asian or Black
5 Follow-up of a 1993 study, listing of consecutive suicides
6 Race/ethnicity not stated; sample selected for varying demographics
7 10% Hispanic, Native American, Asian or Black; samples combined from previous studies
8 Follow-up of previous study; sample predominantly Caucasian; 61 siblings from 37 families participated; 5 families reported a minority member
9 Fathers/children and Mothers/children; race/ethnicity not stated
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Caucasian, White, Anglo</td>
<td>11 studies (442 subjects)</td>
<td>7 studies (351 subjects)</td>
<td>3 studies (119 subjects)</td>
</tr>
<tr>
<td>2. African American, Black</td>
<td>3 studies (3 subjects)</td>
<td>2 studies (6 subjects)</td>
<td>2 studies (57 subjects)</td>
</tr>
<tr>
<td>3. Hispanic</td>
<td>2 studies (6 subjects)</td>
<td>2 studies (1st study-1 subject; other study number not given)</td>
<td>1 study (11 subjects)</td>
</tr>
<tr>
<td>4. Asian American/Pacific Islander</td>
<td>1 study (1 subject)</td>
<td>1 study (1 subject)</td>
<td>Ø studies</td>
</tr>
<tr>
<td>5. Other</td>
<td>3 studies (12 subjects)</td>
<td>2 studies (13 subjects)</td>
<td>1 study (8 subjects)</td>
</tr>
<tr>
<td>6. Miscellaneous explanatory information provided by articles</td>
<td>1 study-“diverse”, no specifics</td>
<td>1 study-“majority Caucasian”; 1 study-ethnicity reported by group-no #</td>
<td>1 study-“predominantly white”.</td>
</tr>
<tr>
<td>6. Information not provided</td>
<td>3 studies</td>
<td>2 studies</td>
<td>2 studies</td>
</tr>
</tbody>
</table>

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Supplement

Articles included in the Supplement did not meet criteria for inclusion in the analysis, but are worthy of note for those interested in childhood sibling death and/or minority children.


N.B. Of special note is Shadows in the Sun, a book by Betty Davies (1999) included in the Bibliography. This volume provides an overview of the author’s clinical insights and published articles, as well as works of others in the field of sibling death.
CHAPTER 5
CONCLUSION

Summary

The goal of this literature evaluation was to determine the extent to which children of selected minority groups who have been bereaved of a sibling have been described in the literature of dying, death, and bereavement. The evaluation has addressed three questions:

- What exists in the literature published in the United States between 1990 and 2002 regarding sibling death among children from selected minority groups?
- To what extent is each minority group represented in research studies?
- Has there been a change over time in the literature regarding the inclusion of minority children?

Specific answers in terms of numbers of comments, discussions, and the numbers of minority children included in research samples are provided in Chapter 4. The following conclusions are based on the data in Chapter 4:

- The 31 descriptive articles include 11 brief discussions or comments regarding race, ethnicity, or culture; four call for increased inclusion of minority children.
- Changes in the descriptive literature over time can be calculated using the ratio of the number of comments/discussions as compared to the number of articles per time period:
  
  1990 to 1993: 1 comment / 12 articles (1:12)
  1994 to 1997: 5 comments / 10 articles (5:10)
  1998 to 2002: 5 comments / 9 articles (5:9)
The change in the ratio indicates that, for each succeeding time frame, the number of articles containing mention of either race, ethnicity, or culture increased when compared to the total number of articles reviewed.

- The 27 research studies contain 28 samples; 17 identify race/ethnicity of participants. Seven studies have samples of 10% or more minority children.
- Caucasians are included in 21 samples, African Americans in seven samples, Hispanics in five, and Asian Americans in two.
- Changes over time in research samples and articles are depicted by the ratio of samples containing 10% or greater of identifiable minority participants to total samples in the time period:
  
  - 1990 to 1993: 2 samples / 14 total samples (2:14)
  - 1994 to 1997: 2 samples / 8 total samples (2:8)
  - 1998 to 2002: 3 samples / 6 total samples (3:6)

  This change indicates that, for each succeeding time frame, the number of samples containing 10% or greater of minority participants increased when compared to the total number of samples.

- A further change was found in research articles with the publishing of one article in 2001 that had a sample of African American children, and one article in 2002 that contained a representative sample of Caucasians, African Americans and Hispanics. Prior to these articles, no research article discussed findings of race or ethnicity.
- All of the minority groups appear to have been underrepresented in articles and research samples. Asian Americans are almost absent from the literature.
• A decrease was found in the number of articles published regarding childhood sibling death during the 13-year time frame.

Discussion

Several issues were noteworthy. First, of the five literature reviews included in the analysis, only one mentioned race, ethnicity, or culture. That article, published in 1992, called for greater minority representation in research.

Second, of the five commentaries evaluated by the analysis, three were written about a single research article published in 1994. All three suggested that the article could be enhanced by inclusion of cultural or ethnic diversity. The information in the article was representative of other articles published during the time period (1994-1997). Neither of the other two commentaries discussed race or ethnicity.

Third, though it would be difficult to compare the 27 research articles statistically as the purposes and methods of the studies differed, an examination of the combined demographic characteristics regarding race and ethnicity is of interest. Of the studies for which numbers could be determined, participants in the samples number 887 Caucasians, 66 African Americans, 18 Hispanics and 2 Asian Americans.

The intent of this literature evaluation was not to imply that every article regarding childhood sibling death must have race, ethnicity, or culture as either a primary or a secondary topic. For instance, Donder’s (1993) article discussing bereavement among children with traumatic brain injury; Van Riper’s (1997) recount of the death of her sister, and Davies’ (1997) accompanying commentary; and Cain’s (1995) presentation of identificatory symptoms contribute relevant information to the literature published. An observation by one of these authors relating the theme of the article to
culture or ethnicity might be workable. It might also change the author’s focus and message.

Many notable books and articles from the field of dying, death, and bereavement contain little or no mention of race or ethnicity. There are research studies that do not or are unable to include a racially or ethnically diverse sample, such as studies that relate to a geographic area or a particular condition. Brent’s (1993, 1996) articles regarding suicide indicate that the sample, all Caucasian, came from consecutive death records of suicide victims in Western Pennsylvania. This sample represents a population bounded by both geography and demographics.

Nonetheless, the results of this literature evaluation describe a pattern, that professionals would want to amend given the tools and resources. Corr, Nabe, and Corr (2000, pp. 105-108) underscore this with the observation that little is known of African American, Hispanic, and Asian American cultures in the United States regarding death and bereavement except from a few studies in various places. While a perceptible change in the inclusion of minority children in the literature has been noted in this evaluation, the measure of the change is not remarkable. Between 1998 and 2002, one narrative article and two research articles were found that contain discussions or representative samples of minority children. The contents of these few articles will not provide the information for the framework upon which professionals in the field must build in order to provide services and care for children of minority cultures. If, in 2003, mortality statistics for all causes of death follow the current trend, 27,000 non-Hispanic Caucasian, and over 24,000 African American, Hispanic, and Asian American/Pacific Islander children will die (extrapolated from the National Center for Health Statistics Report, 2002).
If, however, the problem of under representation of minority children in the literature is issue that has been reported in at least four instances in the early and middle 1990’s, why has there not been a genuine change?

Sue (1999) addresses this problem in the discipline of psychology. Sue states that research that includes minorities has suffered from an over-emphasis on internal validity at the expense of external validity. As an example, Sue points to the common practice of using undergraduate college psychology students as samples for research, often for financial or academic reward. Such studies have internal validity, but limited external validity, and are hardly representative of the general population.

The problem of increasing the number of minority children in the literature stems from several circumstances. Hogan & Greenfield (1991) have observed that minority families are often not participants in certain organized bereavement groups active nationwide that are used for numerous research studies. These convenience samples are not racially or ethnically diverse.

Second, seeking a sample that is more representative is time consuming, which means it is also much more costly (Sue, 1999). Lack of time and resources are primary reasons that practitioners give for not performing research at all (Sandberg, Johnson, Robila, & Miller, 2002). In addition, as explained previously in this paper, professionals of the majority culture are often not skilled in communicating with persons of minority cultures. Other researchers have written about the difficulty of obtaining minority participants in their studies (El-Sadr & Capps, 1992; Kaplan, 1997; Sterling & Peterson, 1999; Adams, 2003). The failure to include minority subjects in research led to action by the federal government.
Patti Homan, Bereavement Section Leader with the National Council of Hospice and Palliative Professionals, has concluded that the narrow focus of sibling death, especially within minority communities, is a factor in research (personal communication, June 19, 2003). Like other areas of research, she continues, this one will "wax and wane", and may be a pattern that appears in other disciplines at the same time.

The narrow focus of childhood sibling death is also cited by Peter Gutierrez of Northern Illinois University (personal communication, June 23, 2003). Dr. Gutierrez indicated that the sample size is a problem when studying very narrow topics. It is even more difficult when seeking a population in one geographical area. The problem is compounded when trying to be culturally inclusive, continued Gutierrez. The gatekeepers within the communities, such as clergy and funeral directors, can be approached, and relationship building can begin. Gutierrez noted that relationship building must be genuine and reciprocal, otherwise it is merely a means of taking advantage of someone else’s goodwill.

All people view the culture in which they were raised as the “norm”; they may consider those of other cultures as outside of this norm (Corr, Nabe, & Corr, 2000, p. 128). Professionals in the field of death and bereavement mirror the same attitudes as others in the general population. One Jewish physician describes his efforts to understand how his minority patients, many of whom are well educated, feel about the cultural divide (Adams, 2003). He reports, “There are times when they are in the exam room when they feel like they’re being treated by the enemy”.

The last issue to be discussed is the finding that the number of articles published in the professional literature regarding childhood sibling death has decreased during the
time frame examined by this evaluation. There was a total of 26 articles located for 1990-1993, 18 articles located for 1994-1997, and 14 articles located for 1998-2002. The number of narrative articles remained fairly constant; other non-research articles were too few in number to assess. A decline was seen in the number of research studies, which decreased over the three time frames from fourteen, to ten, to five.

Reasons for the decrease, especially in research studies, could include issues cited by Sue (1999) in his discussion of minority research in the field of psychology. Sue notes that tools and treatments have rarely been validated cross culturally. This reflects the problem those in the field of hospice care have identified concerning few adequate tools of measurement (Wass, 2001). Other problems also impact obtaining “empirical” evidence of the effectiveness of hospice. Lack of adequate funding, difficulty in accessing the program/population, and an insufficient theoretical framework in the field all serve to curtail research. Some of the elements important in Wass’s article are applicable to sibling death and minority children generally. Also, as Wass (2001) notes, hospice has had a patient population that has tended to be “homogeneous”, and now has the need to “achieve cultural, ethnic, and religious diversity in patient populations”.

Wass’s observations also embrace issues pertinent to this analysis, not generally discussed in hospice because hospice provides care for the terminally ill and their families, not for sudden death. Wass points to the issue of homicide and horrendous death: murders and crimes committed by and affecting children and adolescents. She cites the necessity for thanatologists to work in a multidisciplinary team to alleviate the pain of these losses.
Wass, who was a child in Germany during World War II, speaks to the need for bringing grief support to children. She discusses the cultural differences among the young, and the spiritual needs that they have. Wass calls for research regarding children and young people, and for commitment to death education.

**Recommendations for Future Research**

This literature evaluation has asked important questions regarding the status of African American, Hispanic, and Asian American/Pacific Islander children in the literature of sibling death and bereavement. It has provided qualitative and numeric data that reveal the extent to which these children have, and have not, been included in both theoretically and research based articles. However, it would be futile to simply recommend that theoreticians write about minorities and that researchers include minority children in their samples. Recommendations must point toward how these two measures can be effected. There are two broad avenues of thought that must be considered. First are the issues of recognition and acceptance of the problem. Second are the issues regarding concrete steps that can be taken.

First, at a fundamental level, the professional community should undertake discussions within the literature regarding the need to broaden the base of inquiry to include matters concerning race, ethnicity, and culture in the field of sibling death. For most people who practice within the fields related to bereavement of children, this would not be a controversial issue. A few might state that the rationale for confronting inclusion of minorities is to avoid being marked as politically incorrect (Sue, 1999). However, most would agree that a discipline that could not include a significant portion of the population in much of its literature was not meeting either the standards of scientific
inquiry or the standards of the profession. Thus, the issue is larger than simply trying to obtain a racially or ethnically representative sample for a research study. As has been stated previously, care and concern must be genuine.

Additionally, practitioners who are not comfortable with their level of cultural literacy might attempt to become engaged with members of the minority communities within their own geographical areas. There are organizations that are either partially or wholly composed of minority members that could be approached to offer end-of-life, death, and bereavement education. The members of these organizations might never have been approached and offered an opportunity to participate in mainstream research, especially research regarding their culture.

The issue here is, after all, not merely to meet federal regulations, but to become proficient in the provision of care to all children who have lost a brother or sister. To do this, there must be sufficient skill in the professional community, and sufficient trust in the minority communities. This leads to the second avenue, that of learning what steps to take to increase minority participation in the field.

Sterling and Peterson (1999) have synthesized strategies found successful in both improving cultural literacy and in establishing trust to improve the participation of minority families and children in research. These strategies include several points that have been mentioned in this evaluation:

- Increasing the knowledge base of those on the research team regarding aspects of the lives of the minority populations, which includes how the families obtain health care and the method of transportation they use;
• Including individuals important to the minority community in the planning and implementation of the project;
• Addressing fears and concerns about possible racism and bias directly;
• Establishing trust through conveying genuine interest and concern.

These measures, coupled with ideas, concepts and philosophical perspectives of Sue, Wass, Oltjentbruns, Opie, Davies, and others presented here can form the basis of a new approach to childhood sibling bereavement.

**Conclusion**

This literature analysis has provided an examination of professional literature published in the United States between 1990 and 2002 regarding sibling death in childhood. The findings indicate that African American, Hispanic, and Asian American children are not adequately represented in this literature.

In Chapter 2, a literature review regarding sibling death and children in minority communities was presented. It sought to outline the importance of the sibling bond, the cultural importance of the sibling relationship, and the enormity of the loss of a sibling in childhood. The literature review was composed largely of articles that, according to the findings of this analysis, may not provide information concerning death, dying, and bereavement of minority children. How, then, can we speak with any degree of confidence about the needs, the approaches, or the interventions that children of minority cultures require when their brothers or sisters die? This evaluation suggests that we can do this only when we have heard the voices of these children speaking through our own literature.
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