

Chapter 2: Literature Review

2.1 Introduction

The literature review examines International and South African research in the field of childhood bereavement. The focus of the literature review is on children and how they respond to death i.e. how children grieve. Studies on children's understanding of death and the stages or phases of grief are examined. The limited research on African perspectives of death is presented. 'Normal' grief reactions as well as 'complicated' grief are considered and explored. The effect that bereavement has on children and the treatment thereof, is reviewed. Finally, training programmes for volunteers are presented.

2.2 Loss, Bereavement, Grief and Mourning

The terms loss, bereavement, grief and mourning are all associated with one another but have significant differences in their meanings. It is thus important to define these terms to understand their specific meanings.

2.2.1 Loss

As highlighted in the previous chapter, the experience of loss can be both physical and psychosocial in nature (Rando, 1993). When mourning the death of a loved one, one suffers both physical and psychosocial losses, as well as a number of secondary losses. Thus, when an individual is mourning, they are mourning for the specific death, as well as the sum total of all the losses connected to this specific death (Rando, 1993). The experience of these multiple losses has implications on the impact of the grieving process (Rando, 1993).

2.2.2 Bereavement

In terms of the definition of bereavement, Stroebe & Schut (1998, in Curren, 2001 p91) define the term as “the situation of a person who has recently experienced the loss of someone significant through that person’s death.” Goldman (1994) in her definition of the term bereavement suggests that it is the state of having lost something, whether the loss is of a significant person or a significant thing.

2.2.3 Grief

Stroebe & Schut (1998, in Curren, 2001 p91) describe grief as an “emotional reaction to the loss of a loved one through death which incorporates diverse psychological and physical symptoms.” Rando (1993) includes behavioural and social symptoms in the definition of grief. According to these combined definitions of grief, grief may be experienced in the following four ways: psychologically (through effects, cognitions, perceptions, and attitudes), behaviourally (through personal action, conduct, or demeanour), socially (through reactions to and interactions with others), and physically (through bodily symptoms and physical health).

2.2.4 Mourning

Although grief and mourning are associated with one another, they are not the same. Mourning is described by Stroebe & Schut (1998, in Curren, 2001 p91) as the “social expressions or acts of grief which are shaped by the practices of a given society or cultural group.” Similarly, Goldman (1996) defines mourning as taking the inner experience of grief and expressing it outside of ourselves. These external expressions of grief include culturally sanctioned rituals, for example funerals.

To summarise the differences between these terms, bereavement is an event, grief is the emotional process while mourning is the social process (Oliviere et al, 1998, in Curren, 2001).

2.3 Children and death

2.3.1 Helping children understand death: The role of caregivers

Caregivers must try to help children who are suffering loss to comprehend the death as loss, and to perceive their reactions as grief responses. This will help them to better understand their situation, and reduce a sense of helplessness, which will improve the children's coping ability (Rando, 1993).

To help children better understand their situation and thereby improve their ability to cope, Pennells (1995) believes that caregivers should take the following into consideration: Firstly, when talking to children about death, the language used should be clear, simple and appropriate for their age. Caregivers should be aware of the language and words used to give explanations to children. They should try to avoid euphemisms such as, "they have gone to sleep" or "s/he has passed on." The information of the death should be given to them as soon after the death has taken place as possible, to prevent the children hearing inaccurate stories from others. The information about the death should also be truthful. Pennells (1995) notes that while it is important not to make ambiguous remarks and to tell the truth to children, it is as important to be sensitive when talking to the children about death. Secondly, Pennells (1995) emphasises that children need help to express their feelings. Children learn how to grieve from the way that adults around them behave, thus, if an adult explains their own feelings to the children, the children will learn what is acceptable. However, if the feelings are ignored, the children will understand that it is wrong to express emotions and might therefore begin to 'act out.'

Smilansky (1987) believes that children may approach the phenomenon of death from two different points of reference. The first being the cognitive approach: What is death? What is the connection between life and death? Does a dead person lose the properties of life? Will he return to life? The second point of reference is the emotional approach: What do we feel when

someone close to us dies? What do we feel when a person is being buried? What do we feel when a dog dies? Who is to blame for the death?

Thus, the role of the caregiver is to help children deal with death on both the cognitive and emotional levels. The caregiver should help the children to understand death depending on their level of understanding, as well as help the children to feel the implications of death in a natural manner (Smilansky, 1987).

Smilansky (1987) believes that caregivers often miss opportunities to prepare children for more serious and personal confrontations with death. If the caregiver is aware of, and open to addressing 'general' cases of death when they arise, for instance finding a dead bird, then the children could receive a calm, relaxed explanation of what death means because, at this time, their ability to understand death will be greater, since they are not deeply and personally involved. These more emotionally neutral opportunities can help prepare children emotionally for death.

Smilansky (1987 p24) compares preparing children cognitively and emotionally for death, to the immunisation of the body against illness.

“When the body is immunised, it is given a light attack of the illness, which immunises it against a more severe attack in the future.... (Likewise) the child who experiences a 'light dose' of mourning will be prepared to deal more effectively with 'the more severe' cases of personal misfortune”

Smilansky (1987) is not suggesting in such cases that children will be protected from pain and grief when someone close to them dies, but rather that children will find it easier to deal with death if they have had some prior cognitive and emotional preparation of the experiences of death.

2.3.2 Children's understanding of death

Adults may consider that children do not have a real understanding of death and they might therefore think that children do not need to grieve (Holland, 2001). However, this is an inaccurate perception as children do respond to parental loss according to their cognitive developmental stage. Children of diverse ages have different cognitive capacities to understand the meaning and causes of death (Chris et al, 1993, in Borr et al, 1998).

Lord (1992) agrees that children do indeed grieve and that the distinct way in which they handle death is largely determined by how old they are. However, she proposes that children grieve on an intermittent basis for years after the death of a loved one. This is as a result of their developmental stages: as children move through the different developmental stages, they will understand death in a new way and will therefore grieve all over again according to their new understanding or level of maturity. However, she points out that developmental levels and environments differ greatly in individual children, and therefore, a child's specific age is not always a clear indicator of how he/she will grieve and thus these age ranges and developmental stages should be interpreted liberally.

Children under the age of three years have little actual understanding of death because death is an abstract concept to them and is also beyond their level of cognition. Their grief is usually a reaction to separation rather than the death itself (Beckmann, 1990). In terms of Bowlby's theory of attachment, a child under the age of three will pine for and search for the one who has gone. The young child in this age range is in the instinctive emotional phase of development which focuses on the loss (Currer, 2001).

Children between the ages of three and five years tend to view death as temporary. They believe that death is like sleep: you are dead and then you are alive again (Beckmann, 1990). Later in this stage children develop 'magical thinking' whereby they believe they have the ability to make things happen by simply wishing it, or thinking it (Beckmann, 1990). Thus, some

children fear that they have caused a loved one's death because they wished them dead or because they were angry with that person. They also fear the consequences of their 'magical thinking.'

Children between the ages of six to nine years gradually realise that death is final but they may not understand that it is something that will happen to everyone, including themselves (Beckmann, 1990). Not only do children in this age group have the capacity to begin to understand the finality of death, but they also would have grasped the concept that death is irreversible (Kane, 1979, in Holland, 2001).

Children between the ages of ten and twelve years have a more logical and abstract understanding of the concept of death (Beckmann, 1990). Holland (2001 p17) believes that "by the time most youngsters reach the age of twelve years, they will probably have an understanding of death close to that of an adult." By ages ten and eleven years, the causes of death can be understood and death is perceived as final and inevitable (Ostewies et al, 1984, in Borr et al, 1998).

The gradual acquisition of the concept of death reflects the developmental progression of Piaget's theory of epistemology. In Piagetian theory, children move from an animist or 'magical thinking' stage through to the stage of formal operations and later to that of abstract thought (Lovell, 1973, in Holland, 2001). Although Piaget's developmental theory has been much criticised, the notion of developmental change and maturation of cognitive understanding clearly relates well to the changing understanding of death in children. It is therefore perhaps not coincidental that children seem to achieve an adult concept of death at a similar time to when they achieve a more sophisticated way of thinking which approximates that of a mature adult thinker (Wass & Corr, 1984, in Holland, 2001).

Lord (1992) suggests that a child's experience of grief depends on a number of personal attributes and experiences including: the way the child learned to cope with stress in their lives before the death, the quality of the relationship

the child had with the deceased, the circumstances under which the deceased died, the child's religious beliefs and ethnic customs and the emotional support available from friends and family while the child is grieving.

2.4 The African perspective of death

There is scant literature on the African perspective of death, particularly African children's perceptions of death or their particular reactions to death. However, the literature does reveal some insights into the traditional African understanding of death.

In the South African context, studies on the death perceptions of the Xhosa people, was conducted by Jeff Peires (1988, in Pato, 1990). He suggests that the Xhosa people are ambivalent about death. On the one hand the Xhosa people feel that people do not really die but remain with the living. The Xhosa people interpret death as a transition from the state of being a human being to the state of being an ancestor. Onukwugha (2002) suggests that Africans conceptualise death as a transition, which implies that the dead person has not gone, but rather changed form into a spiritual existence. He further suggests that the term 'passed on' is frequently used in the African culture.

Zweig (1983, in Kamerman, 1988) in a study comparing the conceptions of death between middle-class white children and lower-class black children in America, found that black children, less than white children, understood the finality of death. This suggests that an understanding of the finality of death is not related to cognitive understanding of death, but rather to cultural differences or influences.

On the other hand, it is reported in some texts that African people have the notion that death is evil and unnatural. Pato, (1990) and Onukwugha (2002) tell stories from African folklore that demonstrates the unnatural nature of death.

In terms of the Xhosa culture, a folktale relates that:

“in the beginning God sent the chameleon to humanity with the message that they would live forever. But the chameleon was delayed on the road and was overtaken by the evil lizard, which delivered instead a message that human beings would die.”
(Pato, 1990).

From the Nigerian perspective of the origin of death, a folktale reveals that:

“At one time there was no death. People were fascinated by the idea of living forever. They appealed to the gods to guarantee eternal life. The decision was left to the outcome of a marathon race between the frog and the dog. If the frog won, death would come into the world; if the dog won man would gain eternal life. The people were excited about their opportunity, believing the dog would easily win the race. Once the race started, the frog continued at a slow pace, non-stop. The dog ran fast, but stopped often to eat garbage from cans. The frog’s approach of slow and steady won the day, the dog losing the race and thus the genesis of death.”
(Onukwugha, 2002).

Thus, although there is scant literature or research on the African child’s perspective of death, it would seem that there are likely to be cultural differences in understanding and explaining the concept of death. The experience of death between Western societies and traditional African societies is an area of research that is fundamentally important to this kind of study and investigation but is clearly under-investigated.

2.5 Stages or Phases of Grief

2.5.1 The Stages Model of Loss

A model of loss was developed by Elizabeth Kubler-Ross (1969) from her research with terminally ill patients. This model proposes that people experiencing loss associated with terminal illness, pass through various stages and that these stages can be generalised to any person who experiences loss, and is therefore in the process of grieving. The stages of grief that Kubler-Ross identified are: shock and denial, anger, guilt, depression and resolution (Holland, 2001).

2.5.1.1 Shock and Denial

The function of denial is to act as a buffer against unexpected or shocking news, indeed it is a way to cope with bad news (Kubler-Ross, 1969). Within this stage the person who is affected by the news of the death of a loved one may refuse to accept the news or may behave as if it is not true. Also, the person that is affected by the news of the death of a loved one may isolate him/herself from others in an effort to maintain the initial defense mechanism. This is usually a temporary defense and is then replaced by feelings of anger in the second stage of grief (Kubler-Ross, 1969).

2.5.1.2 Anger

Following the first stage of denial is the stage of anger. The feelings associated with this second stage are anger, rage, envy and resentment (Kubler-Ross, 1969). These feelings of anger may be directed at the person who has died, at God, or the people who are closest to the person who is affected by the death of a loved one. While it may be difficult to deal with these feelings of anger, it is important to understand the reason for these angry feelings and to express them.

2.5.1.3 Guilt or Bargaining

The third stage of grief is that of bargaining which may be seen as an attempt to enter into an agreement that may 'undo' that which has happened. Psychologically, these attempts at bargaining and the promises made may be associated with feelings of guilt (Kubler-Ross, 1969). For example, a child may promise good behaviour in return for spending more time with the deceased parent, this may be as a result of the guilt that the child feels that s/he did not spend enough time with his/her parent while they were alive. Within the South African context, African people may make promises to their ancestors in an attempt to relieve their feelings of guilt.

2.5.1.4 Depression

Following a person's feelings of numbness and anger, these feelings are replaced with a sense of great loss that leads to sadness or depression (Kubler-Ross, 1969). These feelings of depression may be evidenced in the person's behaviour following the news of the death of a loved one. For example, the child may easily become irritable, show little interest in their routine daily activities, they might lose weight or demonstrate a loss of appetite, and they might be tearful. Within this stage it is not helpful to try cheer the person up, rather it is important to help the person express their sorrow.

2.5.1.5 Acceptance

When a person has had sufficient time to work through their feelings of shock, guilt, anger and sadness they reach a stage of gradual acceptance. This is not a happy stage but rather a stage void of feelings. Within this stage, the person finds peace and acceptance (Kubler-Ross, 1969). The person within this stage may need time alone to mourn and make peace with the death of a loved before they can accept what has happened.

Thus, the first stage is that of shock and denial, gradually moving through to resolution, and finally to the completion of mourning. It is estimated that this process can take from 18 months to 2 years (Holland, 2001).

It is argued in the literature that many counsellors have over-simplified the work of Kubler-Ross (1969) and consequently interpret her stages of grief as separate stages that follow each other in a strict linear order (Van Dyk, 2001). Parkes (1996, in Holland, 2001) supports the stages of grief theory as laid out by Kubler-Ross (1969) but suggests that they are not necessarily in a fixed or rigid order and that the bereaved person can return to earlier stages of grieving before moving on to a state of resolution.

Ahmed (1992 p157) would tend to agree with Parkes as he states,

“this sequence is by no means cast in stone. People can go back and forth or remain at any one point for weeks, months or years. There is no right or universally appropriate time for healing grief. People also can partially be in several phases at any one point in time”

2.5.2 The Task Model of Loss

Worden (1991, in Curren, 2001) offers an alternative theoretical explanation of the progression of grief. He views the stage model of loss as being too passive or deterministic and as such he proposes that a mourner should take action by completing the four tasks of mourning. The four tasks of mourning are: (1) acknowledge the loss and accept the reality of the death, (2) experience the pain of grief, both physical and emotional, (3) adjust to an environment without the deceased and (4) invest energy elsewhere by withdrawing it from the deceased (Holland, 2001). In other words, the four tasks are to: (1) accept the reality of the loss instead of denying it, (2) work through the pain of grief instead of not feeling, (3) adjust to an environment in which the deceased is missing rather than failing to adapt and (4) emotionally relocating the deceased in one's personal view of the universe and moving on with life instead of refusing to love others (Cox, Bendiksen & Stevenson, 2002). Through his research with bereaved children, Fox (1998, in Holland, 2001) similarly disregards a stage model of loss, proposing instead that children who are grieving should complete four psychological tasks. The four tasks that Fox (1998, in Holland, 2001) identified are: understanding, grieving, commemorating and moving on. The first task is understanding: children need to make sense of the loss at whatever developmental stage they experience it. The second task is grieving: children will experience physical, emotional, cognitive, and behavioural symptoms in normal grief. The third task is commemorating: children need to find concrete ways to make death or other losses meaningful. The fourth task is moving on: this means that the child will not forget about the deceased but will find an inner place for the love for the deceased and will have moved to another level of grief work.

2.6 'Normal' grief reactions

As stated previously, grief is a natural response to loss. When exploring 'normal' grief reactions, it is important to bear in mind that there are certain factors that will influence how a child will deal with grief: (1) the child's chronological age, maturity and psychological understanding of death, (2) the history of the child's relationship with the person who has died. If the child was particularly close to the person, then the loss is naturally greater, (3) circumstances or nature of the death will influence the child's grief, (4) consideration should be given to how many concurrent crises or stressors the child may be dealing with at the same time and (5) the support of the family system will also influence the child's grief (Beckmann, 1990). Gray (1990, in Newnes, 1991) states further that the child's grieving process is also affected by: the gender of the deceased and the child's emotional status at the time of the loss.

Although grief is a natural process and the emotions of grief are readily identifiable, the patterns of grief are seldom simple and straightforward. For children and adolescents, learning to live with a death means re-visiting and re-interpreting its impact on their lives at each stage of their development (Adams, 1998, in Cox et al, 2002). Younger children are vulnerable to grief reactions because: (1) they have a limited ability to conceptualise death and comprehend its meaning, (2) their use of imagination and magical thinking, (3) their difficulty communicating their thoughts and feelings, (4) their dependency on adults for nurturing, role-modelling and protection, especially when adults are grieving, (5) lack of emotional maturity and limited capacity to tolerate uncertainty, ambivalence and vivid death-related stimuli and (6) the tendency to somatise feelings that are overwhelming (Adams, 1986; Rando, 1995 in Cox et al, 2002). Issues around death and grief can be particularly difficult to address with children because of the associated intense emotions. Their understanding of death depends on many factors including: their developmental stage, the degree to which they have been included or excluded from the mourning rituals and the effect the death has had on the family (Cox et al, 2002).

Some theorists such as Beckmann (1990) and Smilansky (1987) do not agree that grief happens in stages or phases, rather they posit that there is a wide range of 'normal' grief reactions. Children may exhibit different grief reactions at different depths and for different lengths of time. A child's grieving is also individual and therefore an individual child might show all of the grief reactions or only a few (Beckmann, 1990). No-one knows for sure how long a child should grieve, how many symptoms s/he will experience or the intensity. For the most part though, it is obvious that grief is a painful experience and it will last for a long time (Lord, 1992). 'Normal' grief reactions include: shock or numbness, denial, panic or alarm, fears, anger, regrets, relief, regression, low self-esteem, depression and apathy, and changes in roles (Beckmann, 1990). Nader (1997) and Stevenson (1995 in Cox et al, 2002 p71) further explain that

"grieving children face fears of their own dreams and even conscious thoughts related to death; apathy and diminished interest in life; changes or detachment from existing relationships; fear; anger; acting out or punishment seeking behaviour; somatic symptoms and sleep disturbances."

Holland (2001) includes recall of events, defensiveness and normality in his understanding of the 'normal' grief reactions. According to Segal (1984, in Papadatou, 1991) bereaved children may exhibit one or more of the following behaviours: (1) denial of trauma, (2) guilt and blame for the tragic event, (3) repressed feelings, (4) internalisation or acting out of anger, (5) obsession with fear of loss of remaining family members and (6) search for immediate ways of gaining control over their life. Smilansky (1987) lists sorrow, longing for the deceased, a sense of lack and incompleteness, guilt and anger directed either at the deceased or at others who 'caused' the death of the deceased, as the painful feelings that the mourning child will experience following the death of a loved one.

Among these reactions, fear, guilt and anger seem to be the ones most commonly experienced by children (Staudacher, 1987 p131). The child who has been personally affected by death will have multiple fears. These might include the following: fear of losing the other parent, fear that s/he will die too,

fear of going to sleep, fear of being separated from a parent or sibling, fear of being unprotected, and fear of sharing his or her feelings with others.

Guilt can arise from virtually any thought or act and it is therefore impossible to enumerate all of the reasons that a child may feel guilt. However, Staudacher (1987 p133) states some of the motivations for guilt in a child: The death is a punishment to me for misbehaving, I wished the other person dead, I did not love the other person enough, and it is not right for me to live when the other person is dead. Guilt and anger are closely linked emotions, the child who thinks s/he is unworthy of being alive, may exhibit aggressive or disruptive behaviour at home or school (Staudacher, 1987 p135). In addition to anger growing out of guilt, it can grow from a range of beliefs that may be held by the child: I have been abandoned and now I must cope with life on my own, I am unimportant that is why my loved one could leave me, my future has been taken away from me, I was looking forward to interacting with my parent and now I have nothing to look forward to and I should have been able to prevent the death and I didn't, I am powerless.

The feelings of fear, guilt and anger are reportedly the emotions most commonly identified among children's grief reactions. As these emotions are very intense, it seems important that children are helped to deal with these emotions in order to facilitate the grief process.

2.7 Complicated grief

Cox et al (2002 p53) argue that a number of issues impact on the grieving process of a child, for example "the unfathomable suicide, the senseless accident, or the mutating virus of AIDS, make death not only less understandable and more fearsome, but also the grieving process much more complex." Children may be more likely than adults to suffer from complicated grief because they are often excluded from family coping rituals. This exclusion can lead to loneliness that in turn can result in the loss of self-esteem (Cox et al, 2002).

The people who are left behind when a loved one dies of AIDS are at significant risk for complicated grief because of certain factors associated with this type of death, namely: lengthy illness, the mourner's perception of the death as preventable and the mourner's perceived lack of social support (Rando, 1993). It is likely that AIDS orphans might suffer from complicated grief. Goldman (1996 p22) defines complicated grief as the situation in which:

“children become stuck in a frozen block of time, they are denied access to the normal and natural flowing process of grief. Thus, all situations that may cause fear, shame and terror cut off the grief process and results in the children being caught unexpectedly in frozen blocks of time.”

The term 'frozen blocks of time' is an important concept underlying complicated grief. Children experiencing complicated grief usually feel unable to break free from overwhelming feelings experienced at the time of the trauma and they will become imprisoned by these fears if they are not given the freedom to work through their own grief (Goldman, 1996). With the apparent lack of resources available to help children work through their own grief or break free from the overwhelming feelings they experience, the aspect of complicated grief may be further compounded.

Social stigma and shame frequently accompany deaths related to AIDS. Children feel too embarrassed to speak of their emotional issues and remain silent out of fear that they will be ridiculed or ostracised. These suppressed feelings may become outwardly projected onto others as rage, and inwardly projected onto themselves as self-hatred. Often these children feel lonely and isolated. They cannot grieve normally because they cannot separate the loss of the deceased from the way the deceased died (Goldman, 1996). Van Dyk (2001) emphasises that grieving openly for a loved one who has died of HIV/AIDS is difficult because of the stigma associated with sexually transmitted diseases, and further suggests that experiencing these painful feelings alone or in secret, often make these painful feelings worse.

In order to help children alleviate complicated grief, and begin to experience the 'normal' process of grief, it is recommended that caregivers or lay

counsellors should: (1) see the child in the present, and see his/her behaviours as a cry for help, (2) create a safe environment for the child and be a guide to walk the child through his/her grief work when they are ready, (3) to become a helper in remembering and (4) provide a space to re-experience denied feelings (Goldman, 1996). To facilitate this process, the caregiver or lay counsellor needs to achieve openness about previously closed topics. It is therefore important that the caregiver helps the child to separate the person who died from the way that the person died and define AIDS and death to the child in simple and direct language to eliminate judgment (Goldman, 1996).

2.8 The Effects of bereavement on children

Studies on the effects of bereavement in children reveal that “the process of recovering from traumatic experiences and significant losses can take months or years, and for some children and adolescents their daily lives can be disrupted by intrusive memories of the trauma, grief reactions, and symptoms of depression” (Fritz, 2003 p9). In his research into the consequences of childhood bereavement, Fritz (2003) suggests that some of the shorter-term effects of bereavement include withdrawal from friends and family, lack of participation in family activities, school truancy, loss of concentration at school resulting in bad marks or grades, preoccupation with death and a diminished interest in social activities and isolation from peers.

Lendrum and Syme (1992) identify the loss of self-esteem as one of the major consequences of childhood bereavement and as such, one of the most important healing processes is to repair esteem. It is common for children to go through a period where they will lose all confidence and think very little of themselves. This low self-esteem may be due to their vulnerability and their perceived lack of control over their situation or because of some unresolved guilt (Beckmann, 1990). However, as the child begins to express his/her feelings, the grief work begins, and the issue of self-esteem is addressed (Lendrum & Syme, 1992).

Other short-term effects of bereavement may include: sleep disturbances, eating disorders, toilet problems, new physical disorders or exacerbation of existing ones such as asthma, anxiety, separation anxiety, mood swings, withdrawal, aggressive behaviours, school phobia, poor concentration, change of motivation, hyperactivity and 'acting out' (Holland, 20001).

Isaacs (1950, in Smilansky, 1987) maintains that a child who has lost one or both parents, could develop depressive patterns of behaviour, a low self-image, self-hate, and a lack of confidence in the future. When investigating the effect of a father's death, Isaacs (1950, in Smilansky 1987) found that orphans in her research population developed a variety of anti-social behaviours. She argued that the orphan may lie more, cheat, disturb lessons, steal and be generally undisciplined and that these negative behaviour patterns may be attributed to the orphan searching for a strong substitute father figure to discipline him/her. With reference to the effects of bereavement with the loss of a mother, Brown and Harris (1978, in Lendrum & Syme, 1992) in a study of depressed woman in Camberwell U.K., showed that one of the four vulnerability factors which predisposed women to suffer from depression, was the loss of their mothers before the age of eleven years. It is argued that the childhood loss of a mother clearly contributed to the depression that these women displayed.

Rutter (1966, in Black, 1998) found a fivefold increase in childhood psychiatric disorders in bereaved children as compared to that of the general population. In terms of the long-term effects of childhood bereavement, studies have shown that if grief is not resolved in childhood, it can have long lasting effects into adult life. The consequences of unresolved childhood grief as identified by Beckmann (1990) include: depression, alcoholism, loneliness, accidents, anxiety, physical diseases and suicide in adulthood.

Through their work with adult psychiatric patients Lendrum and Syme (1992), found that these patient's difficulties often stem from unacknowledged losses in childhood. According to Brown (1971, in Black, 1998) an adult bereaved of a parent in childhood seems to be more vulnerable than the general

population to psychiatric disorders, particularly depression and anxiety.

2.9 Group therapy with grieving children

Pennells (1995) suggests that family work and individual counselling are valid means of helping bereaved children, however these interventions do not specifically address a child's isolation in grief or give them a sense of peer support. One of the main aims of group work should be to create an environment for children in which they can share their feelings with their peers. Other aims of group work with grieving children are: the alleviation of isolation, an increase in self-esteem, giving and receiving reassurance and support, as well as reducing the child's feelings of being powerless and stigmatised (Pennells, 1995). Learning about the experiences of others who are grieving can offer children invaluable insight into their own feelings. A group of peers may be beneficial to children who have difficulty speaking to significant adults (Grollman, 1988, in Papadatou, 1991).

Smilansky (1987) believes that adults play an important role in a child's grieving process, both as models for imitation of grieving behaviour and as a source of help and guidance that will lead to his/her readjustment. The adult may lessen the child's pain through his sympathy, help the child to accept the finality of the loss of his/her parent and guide them both cognitively and emotionally to adjust to the new reality of life without a parent. By talking about the deceased and giving the child the opportunity to express his/her feelings, an adult can help the child to construct this new reality. Smilansky (1987) suggests that this help can be offered by members of the child's family, his/her teachers or professionals with whom the child comes into contact.

Group interventions with grieving children provide them with the skills and support necessary to continue to work toward the resolution of their grief. The group can be both educational and supportive in nature, and each session should focus on a specific topic and encourage discussion (Beckmann, 1990). To enable children to work toward the resolution of grief, Pennells (1995)

suggests that the specific topics to be explored should mirror those of the stages of grief as identified by Elizabeth Kubler-Ross (1969).

To ensure a cohesive group, the chronological age and psychological understanding of death of the children participating in the group, needs to be considered. The ideal would be to have groups of children within the following age ranges: 5-7, 8-10, or 10-12 years (Pennells, 1995). Mixing the different ages so that the very young and older children are in the same group creates problems because the younger ones will not understand what the older ones are saying and the older children might become irritated with the younger children and may have a tendency to make fun of them or tease them (Beckmann, 1990).

It is believed that a child can enter a support group too early, especially if the child is still in shock or denial. In this case, the child has not yet faced the reality of the death and is also not aware of the issues they will have to deal with at a later date. It is therefore recommended that a child not be admitted into the group if it has been less than 3 months since the loss. Ideally, children should join the group when the loss has occurred in the previous 6 – 12 months (Beckmann, 1990).

One of the greatest benefits of a group process for bereaved children is that the children realise that they are all dealing with the same issues and this in turn makes them feel “more normal.” Also, the communication that is opened up in the group process might facilitate open communication in the home environment as well (Beckmann, 1990).

Paramount to the ‘success’ of group work with children, who have lost a loved one, is open and honest communication (Fleming and Balmer, 1989, in Papadatou, 1991). This type of communication extends from the child and counsellor, to the counsellor and/or parent or caregiver in the child’s life. The communication with the child’s parent or caregiver is a priority, before, during and at the conclusion of the groups. The group leaders should provide information regarding the purpose of the group, how the group will be

conducted, the topics to be discussed, and the emotional responses likely to occur (Fleming et al, 1989, in Papadatou, 1991).

Felmim et al (1989, in Papadatou, 1991) describes a number of objectives that counsellors should aim to achieve when working with groups of children who are grieving. The first is to allow for an open, honest and non-judgmental environment where questions may be asked and discussed without fear. The second is to understand the individual experience each child has already had with death and how he/she interprets these experiences. The third is to provide correct and factual information for any misconceptions the children may have concerning death. Fourth, the counsellor should identify a model or overview for the many feelings involved in the process of mourning. And finally, provide alternatives for the children to say good-bye to his/her loved one.

Pennells (1995 p46) also suggests that group work with children who are grieving should have specific goals. Among these are: help the children to express their feelings, increase their sense of the reality of the loss, provide an opportunity for them to voice fears and concerns, create opportunities for them to acquire knowledge, encourage a healthy withdrawal from the deceased, and help them to readjust after the loss.

2.10 Training Programmes with Volunteers

2.10.1 The need for lay counsellors in South Africa

Within the South African context, it is a sad reality that very few HIV/AIDS infected and affected people have access to trained counsellors outside of the pre- and post- test counselling context (Van Dyk, 2001). Therefore it is essential to equip volunteers with the necessary skills to be effective counsellors, including HIV/AIDS counsellors, trauma counsellors and bereavement counsellors.

Due to the scarcity of helpers in the mental health field, the training of paraprofessionals can be an effective and efficient use of the professional's time (Candotti, Mason & Ramphal, 1993). Furthermore, it might even be that the professional has an ethical responsibility to devote a portion of their time to the training of the paraprofessional (Candotti et al, 1993). Studies done on the training of peer counsellors have established that "training and implementation of skills are beneficial to both trainees and the individuals who make use of their services" (Lestsebe, 1984 p31). The advantages of training members of the community as paraprofessionals, are multiple (Candotti et al, 1993). Firstly, paraprofessional workers allow professional people to be better utilised. And secondly, helping others, provides a therapeutic experience for the paraprofessionals themselves, which thereby increases the proportion of well-functioning people in the community (Vermeulen, 1986 in Candotti et al, 1993).

Vermeulen (1986, in Candotti, 1993) recommends that in the search for effective programmes that provide communities with social services, the focus should be on the development of existing resources in the community. These might include self-help groups, non-formal education involving paraprofessionals and volunteers. Vermeulen (1986, in Candotti et al, 1993) further recommends that professional mental health workers should utilise their skills in training others, as a cost-effective way of reaching large numbers of people. The training of paraprofessionals appears to hold great potential for enhancing community mental health. By training people to work within their own communities, professionals will be responding effectively to the needs of the community.

2.10.2 The training of lay counsellors

a. The definition of training

In terms of the training of volunteers to become lay counsellors, Carkhuff (1979, in Letsebe, 1984) suggests that the goal of such a training programme should be to develop within the lay counsellors specific skills in order to

facilitate their being effective helpers. Ouane, Armengol & Sharma (1990) further suggest that the training of lay counsellors should not only involve the acquisition of specific skills, but should rather be an educational process that involves the acquisition of knowledge, awareness and skills related to the role of a lay counsellor. Within this educational process, the lay counsellor should enhance their level of competence in the cognitive domain (knowledge) and also in relation to their awareness of their own attitudes and behaviours (Ouane et al, 1990).

According to Carkhuff (1979, in Letsebe, 1984 p56) the principle ingredients of any training programme include: trainer, trainee, and programme variables.

b. The roles of the trainer and the trainee

The knowledge that the professional has, will obviously be different to the knowledge that those in the community have, or the lay person (Reeves, 1989 in Cassara, 1991). While the professional may have knowledge that might be more objective in nature with a focus on statistical data or case studies, the lay person is likely to have a more intimate knowledge of the context of those facts and figures. Through the exchange of knowledge, the participating community group will learn more about the knowledge of the professional, and the professional will learn more about the perceived needs of the community group and their knowledge (Reeves, 1989 in Cassara, 1991). Thus, it should be acknowledged that the roles of those involved in the training programmes are not always static, rather these roles may overlap and be interchangeable. This means not seeing people in one role only, either as trainer or trainee, but realising that even these roles, at some stage in the training, may be interchangeable.

c. The trainer

Rigby (1982, in Letsebe, 1984) regards the following factors as important attributes of a successful trainer: the trainer should be sensitive to what is happening and how it is happening and s/he should assume a facilitative role

to encourage the expression of opinions within an atmosphere conducive to group reflection. Rigby (1982, in Letsebe, 1984) suggests that the climate of learning depends on the interpersonal relationships that develop in the training group and the expectations of the trainer and trainee. It is thus important that the trainer is aware of his/her own needs and personality and how these personal factors influence the way that the trainer interacts with the trainees. Furthermore, an effective trainer should have the following personal characteristics: self-understanding, congruence, empathy, respect, genuineness and ability for confrontation (Letsebe, 1984).

d. The trainees

With reference to trainees, Johnson (2000 in Van Dyk, 2001) proposes that the most important requirement necessary to be a lay counsellor is to have compassion for another person's struggle and the willingness and commitment to 'walk the walk' with the person and his/her significant others. Dryden & Feltham (1994) include the following attributes as important characteristics within the trainee: self-awareness, an ability to cope with the intellectual and academic requirements of the training, a capacity to cope with the emotional demands of the training course and an ability to form helping relationships.

e. The Training programme

Carkhuff (1979, in Letsebe, 1984) supports the incorporation of concepts of experiential learning as well as the more didactic or pedagogic aspects into the training programme. Brammer (1980, in Letsebe, 1984 p63) also states that there are three basic strategies for learning helping skills. These are: skills practice, experiential learning and didactic knowledge. Therefore, lectures and alternatives such as guided discussions, group assignments and reports, and participative activities such as role-play and simulated exercises and field experiences, should all be part of an effective training programme.

Lendrum & Syme (1992 p178) describes experiential learning as “learning through experience” and suggests that it is an integral part of all counselling training and of learning how to work with the grieving. Within this framework, the experiences of the learners can be expressed and shared with members of the group. The trainer should listen empathically and demonstrate the therapeutic attitudes as well as draw out new learning from individual or group experiences (Lendrum & Syme, 1992). Furthermore, they suggest that the training should include training specific skills and knowledge of at least one counselling model, knowledge about loss and the opportunity for self-exploration, both individually and in groups (Lendrum & Syme, 1992).

If trainees are provided with opportunities to do things by themselves, and not only receive information on how to do them, then the training will be more beneficial to the trainees (Ouane et al, 1990). And by doing so, learning is ensured not only at the cognitive level, but on a practical level as well. Ouane et al (1990) believe that active participation of trainees is essential to their own training. This is due to the fact that the active participation of trainees helps them to generate their own knowledge and allows them to take responsibility for their own learning.

f. The elements of a Bereavement Training Programme

With reference to training lay counsellors in bereavement counselling, the following are deemed necessary elements of a training programme for bereavement counsellors: children’s reaction to loss, the effects of the loss of a parent on a child, the stages of loss, the tasks of the mourning process and factors that impact on the ability to cope with bereavement and loss (Lendrum and Syme, 1992).

g. Evaluation of the training programme

Evaluation of a training programme has important consequences for the effectiveness of the training. Hambling (1974, in Letsebe, 1984 p64) defines evaluation as:

“an attempt to obtain information (feedback) on the effects of a training programme and to assess the value of the training in light of that information. This definition includes investigation before and during training as well as after the training exercise”

Thus, evaluation of the training programme provides feedback from participants about the content and style of the training. Continuous evaluation of the training programme by those involved in the training, including the trainer and the trainees, enables the trainer to judge the relevance of the current training programme as well as give direction for future training programmes. While, evaluation generally tends to focus on the problems and shortcomings of a particular programme, Jones & Barnes (1985) suggest that evaluation can also document achievements and positive outcomes of the particular training programme.

2.11 Conclusion

The number of deaths, both natural and non-natural, is on the increase in South Africa. As a result of these deaths, many children are likely to experience grief, which affects children differently at different stages of their development. There are various stages of grief through which all people who are experiencing loss generally pass. These stages are shock, guilt, anger, depression and resolution. However, there are also a wide range of grief reactions typical to children, among them fear, anger and guilt. Group Therapy with children seems to be highly effective because of the many benefits that the children receive from it, namely children feel less isolated and more ‘normal’ and group work often facilitates communication for the child. However, with the number of deaths increasing and therefore the number of grieving children increasing, the result is a shortage in professionals to work with such children. Thus, it seems vital to train lay people from the community

to aid others within their communities, as an effective way of dealing with the shortage of counsellors in these communities.