THE THERAPEUTIC RELATIONSHIP OF EDUCATIONAL PSYCHOLOGISTS WITH BEREAVED CHILDREN

by

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To all those who have contained this therapist, my grateful thanks.

Especially to Melvyn, Alon and Stacey.

"For as far as we know only man faces life with the certain knowledge of having to die. This knowledge. . .can lead him to the edge of the abyss and threaten all his actions with meaninglessness and futility. Or he can seek a bridge that will span the chasm and affirm those things that really give him life - friendship, honour, a desire for justice, love, dignity, family, friends, country, mankind. And to this end he must also help his child" (Grollman, 1967:242).

FOREWORD

I thank the Rand Afrikaans University for their financial assistance with this research.

Opinions expressed and conclusions arrived at in this study, are not necessarily to be attributed to the Rand Afrikaans University.

SUMMARY

This study investigates the therapeutic relationship of educational psychologists with bereaved children. The professional and personal ramifications of this relationship in the life-world of adult therapists, are explored.

The bereavement counselling relationship is viewed as a particularly difficult one for therapists. The therapists' primary focus is the creation of a contained therapeutic environment, one in which young clients can slowly begin the process of coming to terms with their losses. It would appear however, that within this particular therapeutic encounter, therapists may be professionally and personally affected by their clients' traumatic material.

Vicarious traumatization is a term used to describe the therapists' parallel reactions to the clients' trauma and the affect that this can have on therapists in their professional and personal capacities. Therapists who work with children under conditions of extreme stress have the dual responsibility of caring for the therapeutic relationship, whilst at the same time, maintaining their own professional and personal well-being in the face of their clients' trauma.

This study examines the specific vulnerabilities of adult therapists in bereavement counselling situations. The manifestation of stress in its various forms is examined, and prevention and coping mechanisms discussed. The emphasis throughout is on educational psychologists whose client base is mainly children.

This study describes the process of data analysis and reduction and identifies the main themes that emerge from three data sources. These themes are discussed within the framework of existing theory.

This study concludes by discussing specific suggestions for the maintenance of the professional and personal well-being of educational psychologists, who work with bereaved children, specifically within the South African context. Possible suggestions for the selection and training of educational psychologists as bereavement therapists are also made.

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CONTEXTUALIZATION AND ORIENTATION OF RESEARCH

1.1 INTRODUCTION

This study focuses on adult therapists, specifically educational psychologists, in therapeutic relationships with bereaved children, and the ramifications of these relationships on the therapists (refer to section 1.6). This introductory chapter presents the context and rationale of the study. A discussion of the theoretical background of this field of inquiry is given, and the participants are briefly described. The research question, from which the aim of the study is drawn, is formulated, and the aim and objective of the study is given. The research methodology of the study is explained. A brief overview of the structure and sequence of the study is given. Terminology is briefly referred to. The chapter concludes with a review of the researcher's personal assumptions and presuppositions, including the motivation for the study.

1.2 THE CONTEXT AND RATIONALE OF THE STUDY

"When children experience the death of someone they love, we react more strongly than when adults go through such a situation" (Dyregrov & Mitchell, 1992:1). Bereavement counselling or therapy (refer to section 1.6), is generally a challenge for therapists, this is especially true when the bereaved are children. Adult therapists identify with children, making the children's grief theirs, and find it particularly difficult to stop thinking about the children and their tragedy or trauma.

Therapists who work with bereaved children have the dual task of creating a safe therapeutic environment for children, one in which they may slowly begin the process of healing, as well as the task of maintaining their own professional and personal well-being in the face of trauma. These are situations where therapists are particularly vulnerable (Dyregrov, 1991:111).

There has been a plethora of literature on loss and bereavement in the field of thanatology in recent years. There has been a growing focus on children's experience of, and understanding of, death. The understanding of the permanence of death, the conception of death in terms of cognitive maturity and levels of development, and the enormity of the trauma in the child's life have been described (Bowlby, 1980; Grollman, 1967; Wass & Corr, 1984; Worden, 1983; Webb, 1991; 1993; Figley, 1985; Dyregrov, 1991; Furman, 1974; Papadatou & Papadatos, 1991; Rando, 1993).

Several authors give valuable advice on crisis intervention and therapy with children in an attempt to take care of the short term and long term needs of children in crisis (Grollman, 1967; Dyregrov, 1991; Webb, 1991; 1993; Papadatou & Papadatos, 1991; Pynoos & Eth, 1996).

There appears to be a paucity of literature however, that focuses specifically on therapists, including educational psychologists, who in the course of their work with children, enter into therapeutic relationships with children who are bereaved, or whose parents or siblings are terminally ill.

The questions that arise are:

* How does this traumatic event in the life-world of children influence therapists, both within these therapeutic relationships and in their own life-worlds?

* How do the therapists' personal experiences of loss, terminal illness and bereavement influence the therapeutic relationship, specifically when working with children?

* Do therapists have the specific knowledge, skills and tools for this type of work with children?

* Are therapists who are specifically trained, better able to deal with trauma and grief-work?

* How can therapists maintain their personal well-being in the face of such trauma?

Educational psychologists, whose focus in therapy is primarily children and adolescents, are the specific area of interest of this particular researcher, who will refer to herself henceforth, in the first person.

1.3 THE RESEARCH QUESTIONS

In light of the above explanation the research questions of this investigation are:

* How are psychologists in general, and educational psychologists in particular, affected professionally and personally within the therapeutic relationship with bereaved children?

* What knowledge and specific skills are necessary for educational psychologists' to have, in grief-work with children?

* What strategies do educational psychologists have to assist them in dealing with their own personal vulnerabilities associated with grief-work with children?

* What suggestions can be offered to educational psychology students, to prepare them for the specific demands of childhood bereavement counselling?

1.4 THE AIM AND OBJECTIVE OF THE STUDY

The overall aim of the study is to examine the professional and personal ramifications of the therapeutic relationship with bereaved children, on adult therapists, particularly on educational psychologists.

The sub- aims are:

* To conduct a literature review that focuses on the bereavement counselling relationship, and the professional and personal ramifications of this relationship, on grief-workers.

* An identification and description of those factors that make therapists or counsellors vulnerable when dealing with children who have experienced loss.

* The formulation of suggestions for self management and care of educational psychology students in this sensitive area of grief-work with children.

1.5 RESEARCH METHODOLOGY

A literature study will be undertaken to construct a theoretical framework of definitions, concepts, ideas and approaches within the area of grief counselling. The therapeutic relationship between bereaved children and adult therapists will be the focus. Emphasis will be placed on the effects of this relationship on the therapists.

Thereafter an in-depth qualitative study in the form of an interview, a semi-structured background questionnaire, and focus group interview, will be undertaken. The participants of this study will be a clinical psychologist, who in the course of her work, deals with children whose lives have been affected by trauma, including the loss of a significant caregiver. The study will then be extended to include "trainee" educational psychologists. These Educational Psychology Masters' students will be respondents in a questionnaire and focus group interview, aimed at examining the ramifications of the bereavement counselling relationship on therapists, specifically educational psychologists in training. There will also be an attempt to ascertain the needs of educational psychologists in this type of work. The experiences and

responses of the respondents will be described and interpreted. The themes will be described in the form of a narrative.

These themes, as well as information derived from the literature, will then be used to draw up suggestions, specifically for self management and care of educational psychology students, who, in the course of their daily work with children, may be faced with children who are recently traumatized by loss, or who may have unresolved issues associated with death and dying, and whose adjustment and progress may be affected. The implications of these suggestions may then be considered in the training of Educational Psychology Masters' students.

1.6 TERMINOLOGY

In order to be clear as to the meaning and definitions of the concepts used in this study it is necessary to briefly clarify the following terms. More detailed definitions exist in Chapter Two.

* **Ramification:**

  Throughout this study the term "ramification" has been used to describe that, *which arises*, from the bereavement counselling relationship with children and which could impinge on therapists, both professionally and personally. The choice of this particular term, is based on the definition as derived from The Oxford Dictionary (1990:667). The noun "ramification" is defined as "part of a complex structure, something arising from it". In this regard the term per se, has neither positive nor negative connotations, and remains value free. It suggests however that what arises, *is part of a complex structure.*

* **Personal pronouns:**

  Where possible, children, therapists and students will be referred to in the plural which obviates the necessity for gender discrimination. If not possible, the terms he or she will be used interchangeably to refer to therapists and their clients.

* **Children and Adolescents:**

  The term "children" is used as an umbrella term to denote offspring in general. It includes individuals who are chronologically at an age where they should be referred to as adolescents. When behaviour refers specifically to the adolescent population however, the term adolescent will be used.

* **Therapists and Counsellors:**

The literature distinguishes between two main sources of support, namely therapists and counsellors. In terms of the difference between **professional counsellors or therapists**, "this distinction may be superficial in that both processes have similar objectives and techniques" (Thompson & Rudolph,1992:18).

The distinction between **lay bereavement counsellors** and **professional bereavement counsellors or therapists** is however significant. Bereavement counsellors may be lay people, who, because of their own personal loss experiences, become facilitators or counsellors in support group situations, such as The Compassionate Friends or Hospice. These people are not registered with any professional controlling body, although they have usually undergone some basic skills training. **Registered counsellors, therapists or psychotherapists** are psychologists or social workers who have a particular interest in bereavement counselling and bereavement therapy, but who need not have experienced loss.

* **Bereavement Counselling and Bereavement Therapy:**

For the purposes of this research project, the terms bereavement therapy and bereavement counselling **as regards children** have been used interchangeably. The terms apply to the support given by qualified, registered counsellors, therapists or psychotherapists who counsel, or are involved in therapy, with children who are bereaved. There is some debate in the literature as regards the use of these terms. This is discussed in more detail in Chapter Two.

* **Grief-workers and Caregivers:**

The literature refers to the collective group of people known as grief-workers or caregivers. This group includes doctors, nurses, physical and occupational therapists, the clergy, social workers, psychologists and lay counsellors who work with the bereaved.

* **Psychologists and Educational Psychologists:**

The Interim South African Medical and Dental Council differentiates between the following categories of registered psychologists viz. clinical psychologists, counselling psychologists, educational psychologists and industrial psychologists. The primary focus of educational psychologists, is children in need.

* **Grief, mourning and bereavement:**

Grieving is the acute, emotional response to a recognized loss which can begin before death and continue for survivors long after death. Grief can make a person feel acutely sad, angry, exhausted, physically ill, frightened and emotionally vulnerable.

Mourning is a socially sanctioned expression of grief and includes crying, acute or sustained depression, an inability to summon energy and sleeplessness.

Bereavement is the "perception of death by those who suffer loss" (Wass, 1979:265) (refer to section 2.2).

* **Terminal illness, dying and death:**

Implicit in the definition of **terminal illness** is that the person has a life threatening illness that will, in time, lead to death. Thus **dying**, in the case of terminal illness, occurs as a process. **Death** may also be rapid and unexpected, as in the case of a disaster or accident. In this case there is no preparation for death, and bereavement may be complicated by trauma.

* **Vicarious traumatization:**

This is a term used to describe therapists' reactions to their clients' traumatic material. The terms **vicarious traumatization, secondary traumatization, compassion fatigue** and **emotional fatigue** are used interchangeably to describe the manifestations of burnout experienced by caregivers, that may be physical, psychological, social, occupational or interpersonal, and which may impinge on the professional and personal well-being of the caregiver.

1.7 THE STRUCTURE AND SEQUENCE OF THE STUDY

What follows is a short overview of the stages of inquiry as set out in the research report.

Chapter One	:	Contextualization and orientation of the research.
Chapter Two	:	A review of the literature.
Chapter Three	:	The research methodology - A description of the design and process of the inquiry.
Chapter Four	:	The presentation and interpretation of the data of the study, conclusions and suggestions .

1.8 THE RESEARCHER'S PRESUPPOSITIONS AND ASSUMPTIONS

A personal paradigm is formulated in terms of one's own life-world experiences, context, religion, nuclear family composition, extended family etc. In this study I am the primary investigative tool. This research report thus reflects my personal values, beliefs and frame of reference. My personal point of departure is that therapists, and in this specific case educational psychologists, are people with humane qualities, which manifest to a greater or lesser extent in all therapeutic relationships, but especially those with children in need. The therapist and the client interact in a specific type of relationship viz. a therapeutic relationship, which is both mutual and reciprocal. Therapists and children are affected by this relationship.

It is my contention that therapists identify, empathize strongly and sometimes sympathize with children in need. As a result, issues such as personal disclosure, immediacy, transference, countertransference, projection, unfinished business, unresolved losses and personalizing become critical issues which, because of the delicate nature of the interaction, have to be dealt with in an appropriate fashion.

It is also my contention that therapists may have personal issues associated with their own losses that have never been dealt with. These issues, if left unchecked, may cloud and interfere with the therapeutic process and may ultimately affect the well-being of their clients. Worden (1991:134) states that "If the loss is not adequately resolved in the counsellor's life, it can be an impediment to a meaningful and helpful intervention. If it has been adequately integrated, the counsellor's experience with a similar loss can be beneficial and useful when working with the client".

The "idea" for this research developed from a personal observation made during a lecture on 'Bereavement' presented by The Compassionate Friends - an organization of bereaved families - to a class of Educational Psychology Masters' students, of which I was a member, in August 1996. This lecture, together with a written presentation, fulfilled the course requirements on 'Bereavement', one of the subjects required for Psychopathology, a core course for the Master's Degree in Educational Psychology.

The responses and reactions of these student psychologists to the expressed loss of the bereaved mothers, could best be described as emotional flooding or overload. It seemed at the time, that personal histories of loss and issues associated with loss in any form had neither been adequately confronted, nor dealt with, by these educational psychologists-in-training. There were clear indications of countertransference as the trainee psychologists absorbed the pain of the mothers and responded, as if it were their own. Some thoughts recorded in my professional diary at the time were the following:

* Pain and loss are part of the history, life-world and context of people who are future therapists.

* Pain and loss, if left unchecked, could influence future counselling situations.

* Unresolved loss or death issues, are but one of a number of personal issues that, if left unchecked, could negatively affect future counselling relationships.

* The person of the therapist is affected by these relationships.

* The question of skills training to deal with specific situations such as bereavement had never really been addressed as part of training.

* Trauma therapy training, as well as specific knowledge of the bereavement process, is imperative in the area in which we intend working.

* The personal well-being of therapists is vital in this type of work and needs to be actively maintained.

On further reflection I felt that because educational psychologists deal mainly with children, bereavement issues in the field would more than likely involve children who had experienced losses. Thus the contextual framework within which the research question was to be formulated, had been established.

1.9 CONCLUSION

This chapter has outlined the context as well as the rationale for the study that focuses on therapists, specifically educational psychologists, within a therapeutic relationship with bereaved children. The research problem has been presented and the aim of the study stated. The method of data collection has been alluded to. Certain key terms have been briefly defined. Finally it has been stated that the researcher's personal paradigm, life experiences and philosophy of life, forms the framework for the presentation of this research inquiry.

CHAPTER TWO

LITERATURE REVIEW

2.1 INTRODUCTION

A review of the literature assists researchers to construct a framework of theory within which they are able to define and capture a particular broad area of interest, and to then examine specific ideas, concepts and approaches within the aforementioned area. This literature review begins with a general examination of the areas of bereavement, grief and mourning. It then examines the therapeutic relationship between therapists and clients with special reference to counselling children who are bereaved. The effects on the therapist within this therapeutic relationship are examined. The manifestations of stress and burnout are discussed, and prevention and coping mechanisms examined. Key terms and concepts are defined and explored.

2.2 BEREAVEMENT, GRIEF AND MOURNING

The **bereavement** role is defined as a cultural, ritualized, socially sanctioned and temporary one which allows bereaved individuals to temporarily exempt themselves from social responsibilities, and to be taken care of by others. "The event is characterized by changes in the social context of living and employs rights of passage as an appropriate means of coping with the loss" (Wass, 1979:257). Bereavement may be confined to an individual family at one end of the spectrum, or may be a national response to a loss, at the other end. The national and international response following the death of Diana, Princess of Wales, on 31 August 1997, is an example in point.

Grieving is generally viewed as a more intense process of strategies used by people, in an attempt to cope with the acute pain of the loss of personally significant relationships.

Mourning is seen as the gradual acceptance and coming to terms with a life, that excludes the deceased. According to Engel (1961; as quoted in Van der Walt, 1996:2), the process of mourning is a process of healing and of regaining physical as well as emotional equilibrium. There are however instances where acceptance and healing are not easily achieved and where bereavement exceeds the norm. In these instances mourning is viewed as **complicated** (Rando, 1994: 225; Worden, 1983: 65-78).

There is thus a distinction between grief and mourning. With **grief** viewed as the acute reaction to loss, including intense sadness, anxiety and disorientation, and **mourning**, as the gradual acceptance and coming to terms with a life that excludes the deceased. **Bereavement** may be viewed as the response to the loss of a significant relationship through death, which manifests itself, and is finally resolved, via both grief and mourning. When bereavement remains acute,

unresolved or complicated, the following definition of a condition that may be the focus of clinical attention, is found in the Diagnostic and Statistical Manual IV (1993:299), as an Axis 4 classification: "This category can be used when the focus of clinical attention is a reaction to the death of a loved one. As part of their reaction to the loss, some grieving individuals present with symptoms characteristic of a Major Depressive Episode (e.g. feelings of sadness and associated symptoms such as insomnia, poor appetite, and weight loss). The bereaved individual typically regards the depressed mood as normal, although the person may seek professional help for relief of associated symptoms such as insomnia or anorexia".

Uncomplicated i.e. resolving **adult grief and mourning** is usually described in terms of phases or stages. Parkes (as quoted by Wass, 1979:175), describes five specific but overlapping phases of grief each with a number of related feelings. These phases are described as numbness; yearning; disorganization; despair; and reorganization. The related feelings range from shock and denial; disbelief and disorganization; through anger and guilt; loneliness and fear; helplessness and depression; to an eventual acceptance and relief (Kavanaugh, 1972; as quoted by Leming & Dickson, 1990:270). These phases of grief correspond in some way to Kubler-Ross' five emotional stages of the dying process namely: denial; anger; bargaining; depression; and the culminating response of acceptance (Kubler- Ross, 1969; as quoted by Worden, 1991: 35).

Worden (1991:10-18), describes four tasks or phases of **mourning** which must be accomplished before re-establishment can take place and mourning is completed. These are the acceptance of the reality of the loss; experiencing of the pain and grief; the adjustment to an environment in which the deceased is missing; the withdrawal of emotional energy; and the reinvestment of this energy in another relationship.

Rando (1994:255) describes the "Six R" processes of uncomplicated mourning that are necessary for the **healthy accommodation of loss**. These are:

* Recognizing the loss.
* Reacting to the separation.
* Recollecting and experiencing the deceased and the relationship.
* Relinquishing the old attachments.
* Revising one's assumptive world - developing an altered relationship with the deceased.
* Reinvesting in a new relationship, or a life without the deceased.

This description is the framework within which one can understand **complicated mourning**. According to Rando (1994:254), the symptoms of complicated mourning are "any psychological, behavioural or social manifestation of compromise, distortion or failure of any one or more of the "Six R" processes of mourning that would then require different interventions on the part of the

therapist". It is within this category of complicated mourning that one may look at children who are bereaved.

There appears to be a difference of opinion in the literature as to whether the accepted phases for adult grief and mourning apply to **children** who are bereaved. This argument is represented by Bowlby (1980:27) and Leming and Dickson (1990:264) on the one hand, who argue that children and adolescents understand death and can mourn in a similar way to healthy adults. Webb (1993:13), on the other hand, postulates that there are distinct differences. Children are able to experience feelings of sadness, rage and longing which qualify as grief reactions, but until they have a mature understanding of the finality of death and the meaning of an irreversible loss, and are able to let go, they have not dealt with their loss via mourning.

This argument is extended by differentiating the grief responses of children from those of adults in terms of the following:

* **Children's cognitive development**

  Children's understanding of object permanence is directly related to their phase of cognitive development as explained by Piaget and Inhelder (as quoted by Louw, 1991:77). Although a young child may appear to understand death he has no cognitive understanding of the irreversibility, universality and inevitability of death (Webb, 1993:14).

  Children may "mourn" to the limits of their developmental capacity, at a particular time and then discontinue mourning, only to resume the function as a higher level of cognitive or emotional integration is achieved (Webb,1991:239).

* **Children's limited capacity to tolerate pain**

  Children have a limited capacity to tolerate pain and may thus choose to ignore a situation, or to manifest their pain on an intermittent basis for a long period of time. The importance of this in grief-work with children cannot be undermined (Webb, 1993:12).

* **Children's inability to verbalize feelings**

  Whereas adults are usually able to rationalize and talk through issues, children have a limited ability to deal with feelings verbally and often do so in a displaced or disguised manner, through their play. It is for this reason that Play Therapy may help the bereaved child deal with his pain (Webb,1993:13).

* **Children's sensitivity about being different to their peers**

The child's, or more specifically, the adolescent's developmental task of gaining support and acceptance in the peer group is paramount in this regard (Louw, 1991:423). The loss of a parent differentiates the child forever from his peer group, as does the overt manifestation of grief (Webb, 1993:13). This is especially significant for adolescents in therapy.

Children may seem to have the capacity to function well in the external, interpersonal world but this does not mean however, that they are without intrapsychic conflict (Webb, 1991:238).

* **Complex family processes and intense family disorganization**

These are more than likely at work at the time of parental death and these may influence and interfere with the grieving process and hence the children's ability to mourn (Webb, 1991:238).

* **Post-traumatic stress reactions and complicated mourning**

The trauma associated with a loss, especially in circumstances where the loss is sudden or violent, needs to be addressed before the child is able to grieve or mourn. This trauma often stands in the way of the process of mourning and resolution of the loss, and needs to be addressed before mourning can begin (Rando,1996:66-70; Pynoos & Eth, 1986: 306-319).

Thus children's bereavement needs to be conceptualized in terms of the above, all of which can in some way impinge on the therapeutic relationship between therapists and children.

2.3 THE THERAPEUTIC RELATIONSHIP

Joubert (1995:15) quotes Holmes and Lindley (1989), who define psychotherapy in terms of a **relationship** between therapist and client aimed at producing changes in the latter in the areas of cognition, feeling or affect, and/or behaviour.

Research is consistent in indicating the central elements necessary in this relationship viz. a **trained therapist or counsellor, a client or patient** (be it an individual, a group or a family), a **therapeutic relationship**, and a **context or setting**. The therapeutic interaction may be characterized by a variety of treatment approaches or models, be they Psychodynamic, Play

Therapy, Gestalt Therapy, Transactional Analysis, Family and Systems Therapy, Narrative Therapy etc.

Each of the components of the therapeutic interaction will briefly be discussed.

Four main groups of **helpers** are identified in the literature (Nelson-Jones, 1988:1; Worden, 1991:139):

* The first group, identified as **helping professionals**, are people specializing in helping others with their problems. This category includes qualified counsellors, psychologists, psychiatrists and social workers, all of whom have undergone formal skills training, and have fulfilled the academic requirements of their programmes. They are registered with various controlling professional boards and are certified helpers. They need not have any personal experiences with bereavement. This group of people are identified in the literature as counsellors, psychotherapists or therapists.

* The second group are **voluntary counsellors** or helpers. These are people who may have been trained in basic counselling skills, and who work on a voluntary basis in settings such as Hospice or The Compassionate Friends. They have no formal certification. These people may have experienced loss themselves and are identified in the literature as grief-workers or counsellors.

* The third broad group are those who use **counselling and helping skills as part of their daily lives and jobs**, but who may have no skills training. This group includes medical and religious personnel who may also be identified as grief-workers.

* The fourth group of helpers are the **informal helpers** who have the opportunity to assist others, be they relative or friend, to come to terms with a loss.

It is important for the purposes of scientific research to distinguish between the various categories of helpers. Within the context of South Africa however, where there are so few trained and qualified personnel to meet the mental health needs of the population, it is realistic to expect the contribution of the trained lay helper to be of equal value to that of the professional (Joubert, 1995:5). None the less, the terms helping professional and voluntary counsellor, or those as described by Worden (1991:139), which differentiates between therapist as professional, and lay counsellor, may be useful in creating a distinction between professional and non professional helpers.

Of prime importance within this situation are the **skills** of the therapist. Joubert (1995:9) and Baldwin and Satir (1987:86), refer to four essential types of skills required by therapists:

* **External skills** - The actual behaviour of therapists as they engage their clients in therapeutic dialogue during therapy. These include their empathy, genuineness, congruence and unconditional positive regard. Counselling skills such as those described by Egan (1994) are a prerequisite in this regard.

* **Internal skills** - The personal integration of therapists allows them to use their "self" as a therapeutic instrument. In this case the feelings, behaviour, cognition, history of life-world experiences, personal paradigm and context of the therapists, are as much part of the therapeutic relationship, as are those of their clients.

* **Techniques and skills derived from theoretical models** - The various theoretical models or treatment approaches within the helping profession provide a conceptual framework which forms the basis of, and directs, the therapeutic relationship.

* **Co-operative or collaborative skills** - These refer to the ability of independent therapists to co-ordinate their own activities with those of other professional bodies or workers, who may also be rendering assistance to the client e.g. the school or other therapists.

I acknowledge that as part of the course requirements and training in educational psychology, there is an emphasis on the training in external and theoretical skills and techniques as stressed by Rogers (as quoted by Baldwin & Satir, 1987:45) and Egan (1994:108f.). These are vital in the therapeutic encounter. I am equally concerned with the incorporation of internal skills i.e. the positive use of the integrated "self" of the therapists in relation to, and interaction with clients, and with the effects of this interaction on therapists.

This is not a new debate within the field of psychology, including educational psychology. There are proponents within the field, such as Minuchin and Freud, who emphasize external and technical skills, and others, such as Baldwin and Satir and the existential therapists, who stress internal and personal skills (Baldwin & Satir, 1987:7-15). This argument is further extended by Michael White and the narrative therapists (White,1990; Anderson, 1995), who argue that therapists and clients are inextricably bound in a relationship, and that the lives of both are continuously touched and enriched through this interaction.

It would appear that few training programmes for therapists at universities, simultaneously integrate therapists' conceptual theoretical framework and technical skills, with their personal skills and integration of self (Baldwin & Satir, 1987:154).

The choice of **techniques** or **therapeutic models** used in **counselling children** differ from traditional adult therapeutic discourse. Whereas counselling with adults usually involves therapeutic discourse or dialogue, the choice of therapeutic techniques with children is complicated by the age of the child and the stated reason for referral.

Two alternative broad forms of classifying therapeutic techniques with children exist. The first focuses on the involvement of the therapist in directing the course of therapy. These techniques are described as Non Directive, Indirective and Directive. The second type of classification, as suggested by Thompson and Rudolph (1991:23), distinguishes counselling models in terms of the dominant intervention area viz. affect/feeling; cognition/thought; and/or behaviour; or a combination of categories, referred to as eclectic. This classification is helpful for the therapist in allowing him to assess the dominant need of the child, and to design a therapeutic intervention programme bearing this in mind. This will be described in more detail further forward.

The **context** or **setting** within which the therapeutic relationship occurs varies from the therapist's office or playroom, to a hospital or hospice. It depends primarily upon the age of the client, the presenting problem, the participants and the therapeutic technique of choice.

2.4 BEREAVEMENT COUNSELLING

Bereavement counselling, as an umbrella term, implies a therapeutic relationship between two or more people. On the one hand, the client who has experienced the loss of a loved one through death, and on the other hand the qualified helper(s). The loss experienced by the client may be sudden or expected i.e. timely, or unexpected i.e. untimely. It is however irreversible.

The literature distinguishes between **grief counselling** and **grief therapy**, especially with regard to adult bereavement and loss (Worden, 1991:79; Webb, 1993:45). This particular distinction depends on whether grief is viewed as uncomplicated i.e. "normal", or complicated i.e. "pathological". In the case of the former, counselling would be aimed at helping the survivor to say good-bye by completing "unfinished business". In the latter, therapy would be aimed at identifying and resolving the conflicts of separation, which preclude the completion of the mourning task in the person whose grief is absent, delayed, excessive or prolonged. In the case of terminal illness, grief counselling or terminal care may begin before death and is regarded as preparation for living with a terminal illness, as well as preparation for dying and death.

Dyregrov (1991); Webb (1993); Wass and Corr (1984); and Lendrum and Symm (1992), all refer to the unique group of children, who by virtue of parental or sibling death or terminal illness, become **bereaved children in counselling**.

As therapists in these situations "We do what we can to pick up the pieces, but life will never be the same again. The therapist/counsellor in this situation has to face and accept the limits of his/ her ability to help" (Webb, 1993:56). Therapeutic intervention with these children is initially often akin to the little boy in children's tales, who attempted to stop the dikes in Holland overflowing, by using his fingers to stop the flood of water. But life can never be the same again.

As has already been discussed above, there are a number of factors which can impinge on the resolution of loss via mourning, and hence the therapeutic relationship with bereaved children. Amongst these are the issues of ongoing developmental phases, as well as the child's understanding of permanence, finality and irreversibility. The fact that developmentally, children may need to retain a relationship with the deceased person in fantasy, so that developmental tasks may be completed, is also significant. Childhood mourning, per se, may be delayed as a result of trauma, the child's inability to verbalize, and the child's desire to be the same as his peers (refer to section 2.2).

These factors are significant for grief therapists or counsellors who work with children, for a number of reasons. These include that they cannot expect more from the child than that which is developmentally appropriate. Children may be unable or unwilling to verbalize their feelings, thus the "object of attachment" as conceptualized by Bowlby (1980:299), may be mourned over years after the loss. Children may have a deep spiritual investment with deceased parents, which could delay the mourning and resolution of loss, indefinitely. There are other unconscious processes at work. Childhood bereavement triggers an array of defenses including denial, repression, projection and splitting which complicate the process. Furthermore, when bereavement is complicated by **trauma**, the child may not be able to mourn, before the trauma has been addressed.

All the above may complicate the timing of the process and affect the therapeutic relationship in some way. Grief therapy needs to occur bearing the above in mind and may thus need to be seen as ongoing (Webb, 1993:43).

Whatever the timing, death in the life world of children is viewed as a crisis situation or "worst possible scenario" and the children as traumatized victims (Dyregrov & Mitchell, 1992:2; Webb, 1991:30; Webb, 1993:43). The crisis may manifest itself at the time of death and require crisis intervention. It may manifest as a form of post-traumatic stress, especially when the loss occurs under traumatic circumstances (Rando,1994:257). In this instance there may be a clinical combination of a Posttraumatic stress disorder and mourning. Therapists thus need an understanding of the psychodynamics of what may be considered "normal" regressive reactions, as well as dysfunctional or pathological reactions. If unresolved, the crisis may occur some years later in a disguised or masked form.

If loss is regarded as a crisis situation, it initially requires Crisis Intervention. It is in this regard that the work of Pynoos and Eth (1986:306-319), Webb (1991:23) and Rando (1996:67-70) are such useful intervention strategies.

There are however, other techniques available to therapists, as they attempt to create a safe therapeutic environment in which children grapple with their loss. Options may include Crisis Intervention which has already been alluded to, Play Therapy in any of its forms, Family Therapy or Bereavement Group Counselling. The actual technique selected may range from the directive "Witness to Violence Questionnaire" format, through direct verbal communication for older children, to more indirective story telling, bibliotherapy, puppets or board games, through to non directive art, clay and sand play as examples. The alternatives are endless. Some are detailed in Dyregrov (1991); Webb (1991; 1993); Lendrum and Symms (1992) and Figley (1985). Although not designed specifically for bereaved children, ideas and techniques may be gleaned from Oaklander (1988), Janet West (1992), and a myriad of books and sources on the subject of therapy with children.

What is clear, is that in the same way as the mourning adult needs to review over and over the details surrounding the death of a loved one, so too does a child. "Whatever the loss the child has suffered her self esteem will have been damaged and one of the most important healing processes is the repair of self esteem. They may need to be helped to learn self control and responsibilities more appropriate to their age. Children also need to be helped to say good-bye" (Lendrum & Symms, 1992 :121).

In grief-work with children, the **person of the therapist** may be affected by specific grief symptoms and emotional reactions including shock, disbelief, denial, helplessness, anger, guilt, fear, anxiety, disorganization, intellectualization, depression, existential insecurity, self reproach, changes in value and various somatic complaints (Dyregrov & Mitchell, 1992:5). There may be unresolved personal issues associated with a personal loss, transference or countertransference, also referred to as "ghosting" (Webb, 1993:182), and situations such as those recognized as vicarious traumatization, in which the therapist is no longer congruent and thereby unable to render effective help. (McCann and Pearlman, 1990:131-154; Webb, 1993:56) This is primarily the focus of this research and will now be discussed in further detail.

2.5 THE EFFECTS OF BEREAVEMENT COUNSELLING WITH CHILDREN, ON ADULT THERAPISTS

Although much has been written on the topic of death in general, and on bereavement counselling or therapy in particular, there is a paucity of literature which focuses on bereavement therapists, with special reference to counselling bereaved children. " It is hypothesized that work with seriously ill children or injured children potentiates motivating factors in the helper's personality, breaks down natural defenses and leads to strong identification with the victims. . . The potential for intense emotional reactions as a consequence of the professional relationship with injured children, is considerable" (Dyregrov & Mitchell, 1992:5). This extract refers to work with injured or physically traumatized children. The effects on therapists who deals with emotionally traumatized children (paediatric trauma), is felt to be similar (Dyregrov & Mitchell, 1992:5; Webb, 1993:56; McCann & Pearlmann, 1990:131).

For many therapists it may be possible that they are not always adversely affected by this therapeutic relationship. This is achieved, inter alia, through their ability to be congruent and to understand the limits of their intervention (Webb, 1993:57). Therapists also need to acknowledge their pain and vulnerability, and to continuously work on these (Dyregrov, 1991:121).

There appears to be a growing interest in the literature on the manifestations of stress, burnout, post-traumatic stress signs, post-traumatic decline and Posttraumatic stress disorders of victims, as well as the associated compassion and emotional fatigue, or vicarious traumatization, which impinge on the occupational, physical, emotional, psychological and social well-being of those associated with working with difficult populations (Worden, 1991:138; Wass & Corr, 1984:172f.; McCann & Pearlman, 1990:133f.; Webb, 1993:55f.; Figley, 1985:5f.; 1986:xviii f.).

McCann and Pearlman (1990:131f.) suggest that exposure to the traumatic experiences of the victim, may be hazardous to the mental health of people close to the victim, including therapists who are involved in the victim's healing process.

The following section refers to the manifestation of burnout in its various forms, and then refers to the necessary coping strategies that need to be employed by bereavement therapists as they attempt to deal with vicarious traumatization.

2.6 MANIFESTATIONS OF STRESS; PREVENTION AND COPING MECHANISMS

2.6.1 Introduction

Lattanzi-Lich (as quoted by Papadatou & Papadatos, 1991:298f.), refers to stress and burnout as a **loss of balance.** This loss of balance is described in terms of the efforts of therapists, in their relationships with clients, exceeding their resources or ability to cope. This loss of balance is manifested in one, or a combination of the following:

* A general dissatisfaction or unhappiness or sense of discomfort with situations and people at home and at work.

* Distortion, where small concerns become obstacles. Caregivers may overemphasize their role in the caring process.

* Drama or a heightened sense of emotionality surrounding people and events.

* Decreased tolerance or an increased level of irritability, criticism, and complaining, plus a decreased productivity and an inability to manage work effectively.

* Distancing, whereby the care-worker seems distanced, and withdraws.

* Depersonalization or a decreased lack of concern or involvement may also be manifested.

* Depression may be apparent via a significant lack of energy and difficulty with decision making.

* Diminished sense of self, which is manifested in disturbances in sleep and eating patterns, as well an increased use of alcohol or other substances.

* Without professional intervention, increased distress can lead to an erosion of self worth and self esteem.

These manifestations of stress and associated coping mechanisms, can also be classified in terms of their effects on the physical, psychological, interpersonal and occupational systems, each of which will now be examined in more detail.

2.6.2 Physical Manifestations of Stress

According to Vachon and Pakes (as quoted by Wass and Corr, 1984:172), **physical manifestations** of stress exhibited by caregivers may or may not be related to psychological problems. These may include chronic fatigue, headaches, stomach aches, frequent colds and flu, somatic complaints, weight gain or loss - poor eating, including under eating and overeating, increased use of off days, lack of physical exercise, and sleep disturbances, including dreams and nightmares, all of which may be disturbing and debilitating.

A lack of exercise is often an indication of a lack of personal interest. Taking care of others whilst avoiding to care for oneself, is viewed as self destructive. Walking, running or other forms of aerobic exercise are important in a grief-worker's schedule. Proper sleep habits need to be established, maintained and monitored. A balanced diet and controlled use of nicotine, caffeine, carbohydrates and abusive substances, is recommended.

It is only via a knowledge of their own body and an understanding of the warning signs of stress overload, that physical manifestations of stress exhibited by grief-workers, can be prevented or coped with.

2.6.3 Psychological Manifestations of Stress

The **psychological manifestations** of stress strike at the very core of therapists as grief-workers. Psychological manifestations is an umbrella term, which includes overt emotions such as sadness, rage and anger which could be parallel emotions to those exhibited by the client. Included is also depression and symptoms of depression characterized by low self esteem, apathy, and withdrawal.

Within the same category are **defense mechanisms**, which may be unconscious or covert manifestations of stress, developed to protect therapists from facing the heinous reality of their work. Defense mechanisms such as denial, anxiety, conflict laden dreams, overidentification with the clients' anger, projection, displacement, intellectualization, dissociation, transference and countertransference are included.

The explanations offered for the manifestation of various defense mechanisms are complex. Wass and Corr (1984:175) describe the defense mechanisms used by physicians and others who deal with death on a daily basis, as possibly being a manifestation of an inability to resolve the issue of death, or existential uncertainty, within themselves. They thus ignore death and by so doing may become angry, withdrawn, or minimally involved with their clients or patients. Those who are able to resolve the issue of death and the inevitability of death, are better able to deal with their clients and provide support.

Withdrawal has been described as a defense mechanism, or a reaction formation, following an intense involvement or overidentification with clients. Overinvolvement with clients or their families may be as a result of unconscious transference or countertransference reactions. This could be an attempt on the part of therapists, to reverse that which has happened, or to stem the flow of the inevitable. Role definition is essential in this regard. Therapists who enters a therapeutic relationship with bereaved children are not their parents and cannot act as surrogate parents.

This "need to be needed" may be as a result of **transference** on the part of the children, or may be an unconscious **countertransference manifestation** on the part of the therapists. Identification with the victim is especially strong, according to Dyregrov and Mitchell (1992:10), when the helping relationship involves children. This strong identification could also be described in terms of a reawakening of therapists' own childhood anxieties and fears, and their own **attachment history**, which brings the "self-as-therapist" and the "self-as-child" into conflict.

"All caregivers will occasionally suffer from at least some degree of job related stress. It is naive to attempt to prevent this entirely as that would imply that the caregivers are automatons" (Wass & Corr, 1984:173). It however becomes a serious state of chronic grief and emotional drain, conceptualized as burnout, when the individual feels generally depressed, numb or unable to respond appropriately to the emotional needs of others.

Chronic grief may also occur when caregivers are not helped and supported to face their own unresolved loss issues. These may be unresolved experiences with death, or may be any other form of loss including divorce, miscarriage or loss of a job which creates a state of chronic grief or emotional drain for therapists.

There may thus be chronic unresolved grief issues for clients, as well as for therapists, which could cloud the therapeutic interaction. This is especially true when the personal death experiences of therapists have either not been worked through fully, or are denied. Lendrum and Syme (1992:165) caution "that if a counsellor realizes that she is unexpectedly angry, puzzled, disbelieving, judgmental or distracted from the counselling relationship, then this should lead her to reflect on whether she is picking up the client's difficulties with anger or guilt, or whether the client's material is exposing hidden feelings associated with unresolved losses of her own, which need attention".

There is a particular concern with grief counsellors who choose to work in grief counselling situations, because of their own loss experiences. This is more than likely to be lay counsellors, who, because of their own bereavement experiences, become voluntary counsellors. The professional therapists should however, not be excluded from this category. When a loss has not been adequately resolved in the therapists' life, it can be an impediment to meaningful or helpful

intervention and those who are recently bereaved, should not undertake this type of work. "However if the counsellor has moved through his or her own bereavement and found resolution on the other side of the loss, this can be useful and helpful in the counselling intervention" (Worden, 1991:139).

The strategies of **disclosure, congruence and immediacy** as used by therapists in therapeutic interactions need to be referred to specifically as they apply to working with bereaved children. Opinion as regards the use of these therapeutic strategies in this sensitive area, vary. There are those who believe that disclosure as a tool in therapy in general is useful (Joubert, 1995:15 f.). In grief therapy specifically, it is felt that disclosure and immediacy, may in fact help therapists tolerate the tears and pain of their clients so that they do not become engulfed by them. As such disclosure, for example, would be used to the therapists' advantage, by reducing "the pressure cooker effect" that the therapeutic relationship may create. It may, at some point in the relationship, also assist clients in understanding that therapists are ordinary people with ordinary emotions and feelings. At the same time the question of what constitutes disclosure, and at which point, if ever, in the therapeutic relationship with bereaved children does disclosure become appropriate, needs to be investigated further.

The therapist who counsels the child, as well as the surviving or ill parent, may create a **conflict of interest** within the system. Family therapy in this case may be an alternative or complementary form of therapy. The support of co-therapists is essential in this regard.

Therapists with their own children are especially vulnerable to feelings of sadness, insecurity, and countertransference when dealing with bereaved children. This vulnerability may stem from an irrational, but very real fear, that something similar could happen to their loved ones. This **existential type of anxiety** is felt by therapists and grief-workers who work with traumatized and bereaved children, primarily because the sequence of life is distorted. Young children are not supposed to lose their caregivers.

There is little doubt that therapists who face depressed clients may find themselves feeling **helpless.** They may be drawn into a wild goose chase of doing all the work in the sessions which does nothing more than exhaust them. Therapists need to identify, face, and deal with feelings of hopelessness and helplessness in themselves, in order to stay with, and truly empathize with the client. It is in this regard that congruence and immediacy as therapeutic skills need to be addressed.

There are other difficult issues which may also have to be dealt with in grief-work with children. The death that the child experienced may have been years before counselling begins. The memory of a loved one may be coloured by the passing of time. The death event, or person, may have been romanticized or even forgotten. Yet the work was never done i.e. the "working

through" never occurred. There may thus be layers of defenses that have been built up over time. Therapists need to be congruent, and have knowledge and an inner strength, to deal with their clients' raw emotions.

It may occur in therapy that the therapists are confronted with a situation that they know are **idealization of the deceased.** It becomes especially difficult with children to confront them on these issues for fear of ostracizing the child. . Yet, it is necessary for therapists to lead the children to a realization that the anger, for which idealization is a cover, is a normal response.

The therapist does not want to collude with the idealization. Lendrum and Syme (1992:166), suggest that discussion and planning with the help of supervision, should help the therapist steer a path between collusion and too rapid confrontation. It is necessary, in this regard, that the therapist works at the client's pace. If the client leads and the therapist follows, a balance between collusion and confrontation will be maintained.

McCann and Pearlman (1990:131f.); Webb (1993:57); and Rando (1993:660), all describe **vicarious traumatization** as a parallel process of traumatization, whereby the grief-worker is affected or traumatized by the victim's traumatic material i.e. he displays the same symptoms of stress as those experienced by the client. The grief-worker may thus become hypervigilant, experience intrusive thoughts and images, become anxious and have disturbed sleep. This is especially the case when caregivers have insufficient opportunity to talk about, and process their experiences of the traumatic event of the victim, in **supervision or therapy** situations. The following extract from a personal journal entry demonstrates the power of **vicarious traumatization.** "I know I felt some trepidation about the circumstances of Carl's death and about the nature of his head injury. Even now in this chapter I have avoided giving details. As I think about it now it suggests the concept vicarious traumatization. . . . It is possible that I am protecting myself" (Webb, 1993: 57).

McCann and Pearlman (1990:137) go as far as to suggest that all therapists who work with trauma survivors will experience lasting alterations to their cognitive schemas, which will have a significant impact on the therapist's feelings, relationships and life. It is possible that the therapist's reaction replicates a Posttraumatic stress disorder or post-traumatic signs, evidenced by intrusive thoughts and painful emotional reactions. Webb (1993:58) is of the opinion that these strong emotional reactions are most evident when the victim is a child. She refers to the adult therapist's **existential insecurity** which trigger thoughts of life's meaninglessness and unfairness.

Webb (1993:56); McCann and Pearlman (1990:143); and Rando (1996:71), all suggest that therapists have to engage in a parallel process of integrating and transforming their personalized feelings of the client's trauma, as a way of preventing and coping with psychological

manifestations of stress. Further suggestions for the prevention of psychological manifestations of stress include the need of therapists to identify their emotions, to acknowledge their existence rather than deny them, to understand their cause, and then to work on normalizing them in personal therapy, supervision or debriefing, or any environment where therapists feel safe enough to share and work through these painful and debilitating reactions.

Supervision is an essential and integral aid for all therapists. Supervision refers to a relationship between a therapist and a more experienced therapist, who acts as supervisor for a "case". During supervision, therapists talk through, and reflect on their cases, and on the progress of their sessions. The supervision environment is both collaborative and supportive.

Supervision is however, not only to reflect on counselling sessions. It is also a place where therapists are free to feel their feelings. "Such a place for feelings is very necessary, for in choosing to enter the world of other people's losses, counsellors are entering something different from the normal and everyday. There are times when it may not seem barely worthwhile to the counsellor. Counsellors can think they have lost their way and feel useless, helpless and drained. It is this very reflecting and sharing, in the context of a secure and professional supervisory relationship, which can offer comfort and care for the counsellor's struggle with the client" (Lendrum & Syme, 1992:166).

The supervisor, who is personally secure, offers a "secure base" where the therapist can return for comfort, healing and "on the job training". It is also a place for ensuring the maintenance of effective standards.

Personal therapy is an effective medium in which therapists are able to review their countertransference reactions, their histories of loss, and to work on their own personal growth, within the containment and safety of their own therapeutic relationship.

Peer group supervision is also a useful tool for more experienced counsellors but should never be regarded as the only supervision necessary (Lendrum & Syme, 1992:167). In these sessions co-workers may focus on feelings, both positive and negative, associated with their work. It is amongst colleagues that the therapist reaffirms the purpose and value of being involved in such work (Poss, 1993:113).

In order to work effectively it sometimes becomes imperative that therapists themselves are able to discharge tension, to tell their story, and to discuss their reactions to an event, in such a way, as to normalize their experiences and at the same time, discharge tension. Stories may be retold time and again. This can be achieved within a **debriefing group**, where the role of the facilitator is to acknowledge each person and to actively listen. No interpretations or formal interventions are necessary. If therapists are part of a disaster relief team, it is vital to have staff support.

Without this support, staff may experience loss of focus and impaired concentration. In these situations it is best that the person who does the debriefing is not part of the disaster situation (Webb, 1993:223).

An **acknowledgment of personal grief** on the part of the facilitator is essential in this type of work. Unless grief and feelings of sadness are acknowledged and worked through, they may interfere with the counselling process. This process does not necessarily require a great deal of time or effort. It requires rather, only a recognition of emotions and thoughtfulness on the part of the facilitator.

In certain cases it may become necessary for therapists to refer their clients elsewhere. If therapists feel that the therapeutic relationship is not working, or has become stuck for some reason, then they are duty bound to refer. Mature counsellors know their own limitations and knows at which point, or with which type of client, it becomes necessary to refer.

Papadatou, (as quoted by Papadatou & Papadatos, 1991:287) suggests that therapists attempt to **connect with their own inner core** in an attempt to cope with grief-work. Isolating and connecting with one's own spiritual core, involves making use of one's own balances and resources in whatever form these may take. There is a suggestion, for example, for personal creativity via writing and painting and other creative pursuits. The use of personal journals or diaries is shared by both Webb (1993:56) and Papadatou (1991:286). Both authors make use of their diaries or journals as cathartic exercises, to record their feelings and observations, and to resolve certain problems that arise in the course of their grief-work with children. Personal journal entries are also used as the basis for observations in their writings.

2.6.4 The Interpersonal Manifestation of Stress

Among the manifestations of burnout as experienced by grief-workers, are those that occur within their own home, or in social interaction with family and friends. These manifestations may result in constantly bringing home job tensions, in decreased sexual energy, or its converse, an increase in libido. There may be a fear of pregnancy associated with a projected fear of loss, and a constant awareness of their own, and their families' vulnerabilities. Therapists who do not maintain boundaries are apt to have little time for friends, and a non existent social life.

Prevention and coping with manifestations of stress that could impinge on the therapists' personal and social life may be found in debriefing, in support groups, in supervision, in therapy and also by creating a physical space or a break between work and home (Wass and Corr, 1984:177).

Therapists, with children of their own, are constantly under pressure to separate their personal and professional lives. They need to understand that their children and family are healthy and normal and should not bear the load of their profession, or their projected fears. The development of a good outside support system of friends and family, who have nothing to do with the traumas of bereavement counselling and the pain of this type of work, is viewed as both refreshing and enriching.

2.6.5 Occupational Manifestations of Stress

It becomes difficult to separate occupational manifestations of stress from that which has already been discussed. As has been alluded to, grief-workers may have unrealistic expectations of their capabilities and role in the healing process. There is thus a tendency towards work overload with increasing amounts of time being spent at work, or on work related activities. This may lead to feelings of being overwhelmed by the responsibilities of the job, an inability to become detached, or to adequately define boundaries. There may also be a tendency amongst some therapists to withdraw from their clients. This appears to be a way of preventing personal pain.

Role ambiguity, role conflict and role strain are significant in terms of the inability to maintain boundaries. The tendency towards a role reversal with the surviving parent is also evident in this regard.

In response to **work overload**, Wass and Corr (1984:79) write the following: "This is often a reflection of an inordinate need-to-be-needed guilt over the failures of a desire to show that one is the most competent person in the group". There is a need, in the case of work overload and frustration on the part of the therapist, to assess their goals and priorities, to take time off for outside interests and family, to take time away and to seek the help of professional supervision. The provision of mutual help, offered by therapists who work together, makes the work load more tolerable for all.

There is no doubt that feelings of inadequacy on the part of therapists, may stem from a **lack of training**. Although perhaps not directly included in university training courses for educational psychologists, there are bereavement counselling seminars and training programmes within the community, aimed at imparting knowledge and skills. Poss (1993:44) states that the caregiver needs to invest in acquiring knowledge and skills. This acquisition of facts does not, however, constitute adequate preparation for the task of bereavement therapy. This needs to be combined with a willingness on the part of therapists, to look at themselves in relation to their work. An understanding of the self, as well as insight and knowledge, are important in this type of work (Poss, 1993:45).

Worden (1990:140) cautions that people should not undertake grief therapy, unless they have the necessary education and training. His reference here is directed particularly at lay counsellors. It is equally applicable, however, to trained and qualified therapists who have not worked at acquiring new skills and knowledge, and thereby integrating their personal and professional selves.

2.6.6 Manifestations of Stress Associated with Work in South Africa, as an Example of a Violent Community

The South African community has been beset by violence in different forms for the last decade. The current state of hijackings and murder, including family murders, has resulted in many children as trauma victims in bereavement therapy situations. The vicarious traumatization discussed is apparent amongst therapists who counsel, or offer debriefing therapy, to hijacking victims and survivors. The therapists report a hypervigilance, sleep disorders, and a **psychic numbing** as they attempt to normalize an abnormal situation for their young clients. The ramifications of the fear of danger to their own children, family and friends is real. The necessity of coping strategies, in the form of maintaining boundaries, supervision and debriefing, is critical (Moosa, 1992:126).

2.7 CONCLUSION

This literature review has attempted to examine the concepts of bereavement, grief and mourning and to apply these to children who are bereaved. The bereavement counselling relationship has been examined with special reference to children. The professional and personal effects of this relationship on the grief-worker, has been discussed. The physical, psychological, interpersonal and occupational manifestations of stress, have been elucidated. The manifestations of stress associated with working with the victims of violence in South Africa, has also been alluded to. This research study will now attempt to apply this to educational psychologists in their work with bereaved children.

CHAPTER THREE

THE DESIGN AND PROCESS OF THE INQUIRY

3.1 INTRODUCTION

This chapter focuses on the research design selected for this particular investigation and presents an overview of the format of the study and the processing thereof. The motivation for the study as part of the contextual background will be mentioned. The research method, methods of data collection and data processing techniques will be described. The issues of validity and reliability will briefly be addressed, as will the credibility and ethical considerations of the research inquiry.

3.2 THE RESEARCH DESIGN

Yin (1994:19) describes the research design as the "logic" that links the data to be collected, and the conclusions that are drawn, to the initial questions that motivated the study. "Colloquially a research design is an action plan for *getting from here to there*, where *here* may be defined as the initial set of questions to be answered and *there* is some set of (conclusions) answers" (Yin, 1994:19). Getting from *here* to *there* involves an idea, certain fundamental questions, the selection and design of a particular method of data collection, deciding on a target group of participants, and thereafter the execution of the project.

3.2.1 Context of Research

The "idea" behind a research design becomes a specific statement or question, as opposed to a vague curiosity, a general interest, or a personal "gut" feeling when it is identified and conceptualized by the researcher as the particular problem to be investigated. Schein (1987:13), Merriam (1988:ix) and Leedy (1997:45) are of the opinion that clinicians tend to research what they trust and believe in, and find personally meaningful, from their own practical experiences in the field. Thus in this specific case, my curiosity and interest in the deep and profoundly personal reactions of therapists, especially educational psychologists, when confronted with bereaved children, the history behind these reactions, there possible effects on the counselling process and on the therapists, was the idea behind the research design and is part of the contextual background of this investigation.

3.2.2 Problem and Purpose

What began as an observation in a lecture room (refer to section 1.8), was transcribed in time into the following research problem: **What are the professional and personal ramifications of the therapeutic relationship with bereaved children on psychologists, and specifically, educational psychologists?**

The purpose of the research inquiry is seen to be three fold. Firstly, it is advantageous for the general population of educational psychologists to arrive at a "comprehensive understanding of the groups under study" (Merriam, 1988:11). Secondly, it can be used "to develop general theoretical statements about regularities in social structure and process" (Merriam, 1988:11). Finally, it is also expected to contribute to the scholarly literature of the field.

3.2.3 A Qualitative Inquiry

The nature of this question, with the focus on the therapist's real life experiences, perceptions, thoughts and feelings within a particular context, lends itself best to a method of investigation that is both **descriptive and contextual**. This is best served via a **qualitative** design. The focus of the study being "a naturally occurring, ordinary event, in a natural surrounding (that will give one) a strong handle on what real life is like" (Miles & Huberman, 1994:10).

One of the main criteria of qualitative research is that it provides the researcher with what Miles and Huberman (1994:10) refer to as "thick descriptions that are vivid, nested in real context, and have a ring of truth that has a strong impact on the reader". The term "thick description" is one that has been borrowed from anthropology and suggests a complete and literal description of that which is being examined. Words and pictures, rather than numbers or figures, are used to convey what the researcher has learned about a particular phenomenon.

3.2.4 The Research Method

This particular qualitative research is **phenomenological** in that it describes in detail the personal experiences of the therapist within the bereavement counselling relationship and emphasizes the "meanings people place on the events, processes and structures of their lives: their perceptions, assumptions, prejudgements, presuppositions" (Van Maanen in Miles & Huberman, 1994:10). Phenomenological research attempts to describe human experiences at their deepest level. For the researcher investigating the **phenomenon** of bereavement counselling as an interactional experience between therapist and (child) client, the personal feelings, emotional manifestations and effects on the therapist can be captured, examined and explored. This is in accordance with the description of phenomenological research as suggested by Leedy (1997:166), namely, that phenomenological research is concerned primarily with *the meaning of an experience for people.*

It is suggested (Merriam, 1988:5-16; Rudestam & Newton, 1992:37) that there are certain preconditions for this type of qualitative research:

* The research design is **exploratory**, in that the researcher identifies recurring themes and patterns.

* It is **inductive** in nature, in that the researcher hopes to gain new insights that could be applied to the field under investigation.

* It is **deductive**, in that the literature in the field provides the framework to study and verify existing research.

* It is **bounded** to a particular context, situation or system in which the researcher attempts to understand as an insider and then convey this understanding to outsiders.

* It is **holistic**, in that the phenomenon is understood in its totality.

* It is a **naturalistic** inquiry, in that the researcher attempts to understand the phenomenon in its natural surroundings.

3.2.4.1 Sampling

According to Burgess (1982; as quoted by Merriam, 1988:47), "sampling in field research involves the selection of a research site, time, people and events." In qualitative research the choice is **nonprobability sampling**. This is aimed at gaining an understanding or insight of a particular phenomenon under investigation, by using a represented sample, rather than quantifying results by using a large number of samples. Nonprobability sampling is also referred to as criterion based sampling, in which, according to Goetz and LeCompte (1984; as quoted by Merriam, 1988:48), the researcher establishes the criterion to be investigated and then purposefully sets out to select the sample of the study that matches the criteria to be measured.

According to Patton (1980; as quoted by Leedy, 1997:162), phenomenological researchers choose participants "purposefully in order that they may increase the utility of the information derived from their sample" (Leedy, 1997:162). In the case of this study, the Masters' students who were asked to participate, were chosen because they were likely to be knowledgeable and informative about the phenomenon that the researcher was studying. In this regard the researcher and participants "work together to arrive at the heart of the matter" (Tesch, 1994; as quoted by Leedy, 1997:162).

The clinical psychologist chosen as participant may be referred to as a **reputational-case selection** as she was "chosen on the recommendation of experienced experts in the area" (Merriam, 1988:50).

3.3 METHODS OF DATA COLLECTION

In using qualitative research as a format of investigation, the researcher is not bound to any one particular method of collecting data. Researchers can make use of a number of different sources including observation, interviews, audio and visual recordings and questionnaires. Data collection is aimed at **describing** a particular phenomenon or event and discovering meaning, with the intention of interpreting, theorizing or applying to the field that which has been discovered or described (Merriam, 1988:27f.). It is not about quantifying results.

By using this format I, as researcher participant, became the filter through which the content was interpreted. I had to suspend judgements and preconceptions, and concentrate on the descriptions of the relationship between therapists and bereaved children, and on the ramifications and effects of this relationship, as described by the therapists. By so doing I hoped to be able to gain an " holistic integrated overview of the context under study; its logic, its arrangements, its explicit and implicit rules" (Miles & Huberman,1994:6). I had to be sensitive to both non-verbal as well as verbal clues. In order to assist the process, a number of methods of data collection were used:

* The **literature review** preceded the data collection in this investigation. It served to anchor the investigation in scientific truth and provided both the foundation and framework within which to work.

* **Observations** of that which was seen and heard were enhanced by the use of video recordings, notations and field notes. The field notes for example reflect my personal feelings on a metacognitive level of the particular interview situations. I made use of field notes throughout the project but these were not interpreted.

* Video and audio recordings of the **individual in-depth interview** and the **focus group interview** were made. These were then transcribed and later analyzed. The emphasis throughout being on both the verbal and non-verbal cues of the respondents.

* Data gathered from the **structured, open-ended questionnaire** was a valuable source of data, in that it assisted in gathering background information, which contributed to an holistic understanding of the participants in the investigation.

The use of multiple sources of data collection in qualitative research is referred to as **triangulation** (Miles & Huberman,1994; Yin, 1988) It is a way of ensuring validity, in that independent measures agree, or at least do not contradict each other. This will be discussed in more detail in the section dealing with validity.

3.3.1 The Literature Review

According to Merriam (1988:61), "A literature review interprets and synthesizes what has (already) been researched and published in the area of interest". It helps to provide the researcher with a foundation as well as a framework of previously published information and opinion on the problem under investigation. Findings of a study can then be interpreted in the light of that which has already been written and researched in the field or area of interest. The literature review is also, according to Rudestam and Newton (1992:47), the presentation of a coherent argument of empirical support that presents both sides of the coin for the reader.

The literature review in this study is both inductive and deductive in nature. It is inductive in that the research builds on theories, concepts and hypotheses presented in the literature, and deductive in that it tests theory by applying it to the research field.

The literature review of this study is presented in Chapter Two. It was conducted at the beginning of the study. It began with a broad investigation of the concept of bereavement in general, " its vocabulary, concepts and theories" (Goetz & Le Compte, 1984; as quoted by Merriam, 1988:54). It then moved on to deal specifically with bereavement work with children, shedding "light" on the effects on the adult therapist; a road less travelled in the literature. The literature review of Chapter Two is "a narrative essay that integrates, synthesizes and critiques the important thinking and research of (this) particular topic" (Merriam & Simpson; as quoted by Merriam, 1988:64).

3.3.2 Observation and Secondary Sources of Data

Observation, as a planned research strategy, involves the systematic observation of the subjects in the study under investigation, and is a fundamental tool in qualitative research. It is the researcher's way of gathering data first hand, as it exists in the field, in its natural phenomenological context, by watching, listening and exploring. The researcher is able to learn via observation about specific behaviours, as well as the meanings attributed to these. Observation provides the researcher with "*detailed descriptions* of situations, events, people, interactions, and observed behaviours" (Merriam, 1988:67). It allows the researcher to an *"in situ"* look at what is fundamental, or central, to that which is under observation (Merriam, 1988:69).

For observation to qualify as a data gathering technique, as opposed to simple social observation, requires that certain criteria be met. These include:

* Writing descriptively.
* The disciplined recording of field notes.
* Separating important from trivial recording of data.
* Using rigorous methods of validating one's observation.
* Maintaining a degree of objectivity, and
* being conscious of personal metacognitive processes and subjective interpretation of data (Merriam, 1988).

It is in this regard that observations by the researcher are aided by the use of video or audio recordings. Observation includes commenting on the setting, on the body language, facial expressions and frequency or sequences of particular activities. In recording observations the more complete the recording of raw data is, the easier it becomes for the researcher to analyze the data.

There are secondary sources of data which are used to validate the primary data sources as already described. It is necessary, for example, that non-verbal cues and subtle nuances are recorded as **field notes** to add to the information that may be obtained in interviewing. Throughout the investigation, observations of what I saw, heard, experienced, thought of, and reflected on at a metacognitive level, were recorded in the form of detailed field notes. It was these reflections, for example, after the initial interview with the psychologist, that led to the formulation of the focus group questions which will be discussed in section 3.3.3. According to Merriam (1988:98), the content of field notes include verbal descriptions of the setting, the activities, and the people. They may include direct quotes and observer comments which are the researchers feelings, hunches, reactions or working hypothesis. I view the comments on the process of analyzing my data, as well as the personal grapplings and reflections in my professional journal, as field notes in that they refer directly to the project. The field notes, in the case of this study, were a supportive source of data and were not analyzed in detail, although they may be useful for later data interpretation.

3.3.3 Interviews

In the same way that observation needs to be more than social comment, so too does the interview have to be more than social conversation. "An interview is a conversation but a conversation with a purpose" (Merriam, 1988:74). In qualitative research the interview is viewed as an important method of gathering data in the form of person-to-person, individual, or group encounters. In these interviews, the researcher attempts to understand another person's thoughts, feelings, perceptions and ideas by entering his world and thereby gaining an

understanding of his personal perspective and paradigm. In order to do this two formats were used. The first, was a semi-structured long interview with an expert in the field of trauma and bereavement therapy. The second, was a focus group interview with a group of educational psychology students. Both of these will be described.

The semi-structured long interview was conducted with a psychologist in practice on Thursday 10 July 1997, at her home. The interview was audio taped. Detailed biographical information is presented in Chapter Four section 4.4.2.

The interview was semi-structured in that it was to be neither a conversation nor a response to a closed questionnaire. I had designed a number of questions aimed at eliciting the psychologist's responses, opinions and feelings on her experiences as bereavement counsellor, and the effects of this on her, in both her professional and personal life-worlds.

I was also interested in her own history of loss, her skills training, and her specialized knowledge of the process of death, and the subsequent recovery of survivors. Her particular therapeutic approach was also of significance. By using a semi-structured in-depth technique, I was able to use the questions that I had designed, but to change the particular order, and to "ad lib" questions if necessary. Although reflective listening was used, the interview was not a therapy session. It was an attempt, on my behalf, to probe and prompt for information. I attempted to be conscious of, and to reflect on, my own countertransference reactions and vicarious traumatization as they occurred, and to use these in the analysis of the data.

The content of the interview was transcribed verbatim and became a starting point for the analysis of the data for this research. Examples of the types of questions used in the semi-structured interview are the following:

1. What are your qualifications?
2. What do you call yourself?
3. Can you describe the process of becoming a bereavement counsellor in terms of:
   -skills training;
   -knowledge of the process of death, mourning etc.;
   -attitude or emotional effect of this type of work?
4. Can you describe your current experiences and responses as a bereavement counsellor in terms of your own history of losses?
5. Can you describe your personal experiences in dealing with clients in therapy, in terms of: . . . disclosure; vicarious traumatization; the importance of skills training; feelings of helplessness; and anger?
6. How much of you as "a person" enters the therapeutic situation?

7. Can you describe the effects of this type of work on you, as a person and how you deal with it, in terms of the physical effects; emotional effects; cognitive effects; social effects; effects on your family; and effects at the work place?
8. Is there anything you would add to a training programme for psychologists in the area of bereavement counselling, if you could design such a programme?
9. Anything not covered?

Kvale (1983:174) describes the twelve main aspects of the qualitative research interview as the following:

* It is centred on the interviewee's life-world.
* It seeks to understand the meaning of phenomena in this life-world.
* It is qualitative, descriptive and specific.
* It is presuppositionless.
* It focuses on certain themes.
* It is open to ambiguities.
* It changes.
* It depends on the sensitivity of the interviewer.
* It takes place as an interpersonal interaction.
* It may be a positive experience.

I believe that all of the above 12 aspects were fulfilled, to a degree, in the semi-structured interview, and the focus group interview which will be described further forward in this section.

Interview questions of this study for both the in-depth individual interview, as well as for the questionnaire, which is described in section 3.3.5, were structured according to Patton's list of six kinds of questions that can be used to elicit different types of information (Merriam, 1988:79):

* Experience or behaviour questions, aimed at eliciting a description of a particular experience.

* Opinion or value questions, aimed at eliciting a personal opinion or thoughts on a particular topic.

* Feeling questions, aimed at eliciting an emotional response.

* Knowledge questions, aimed at ascertaining factual information on a particular topic in which the respondent is considered knowledgeable.

- Sensory questions, determining the respondent's sensory reaction to a particular stimulus.

- Background or demographic questions which locate the respondent in relation to other people as regards age, education, and background.

The focus group interview or "focus group session, can be simply defined as a discussion in which a small number (usually 6 to 12) of respondents, under the guidance of a moderator, talk about topics that are believed to be of special importance to the investigation. Participants are chosen from a specific target group, whose opinions and ideas are particularly germane to the investigation" (Folch-Lyon & Trost, 1991:443).

The participants in the focus group are designated "experts" in the area under investigation, thus the format is usually that of an open conversation where the comments, responses and interaction amongst members of the group and the facilitator are encouraged. The role of the leader is seen to be that of facilitator, or moderator, who introduces the topic in the form of a question and encourages the participation and opinion of all the members.

The attitudes, personal disclosure and opinions of all members of the focus group are deemed important and group interaction becomes an important variable if the members of the group are known to each other. Focus group sessions are well suited for eliciting responses that are of a sensitive nature (Folch-Lyon & Trost, 1991:442), and was thus thought to be a useful data collecting technique in this instance.

The focus group session for this research project was conducted with a group of ten Educational Psychology Masters' students on Wednesday 23 July 1997, at the Institute of Child and Adult Guidance at the Rand Afrikaans University at 2pm. A description of the participants is presented in Chapter Four, section 4.2.3.

The focus group session was conducted around two particular questions which were introduced to the group as follows:

"You have all attended a workshop on trauma therapy and have, or will soon be dealing with, the topic of Bereavement in your course. Some of you may already have seen clients who are bereaved or have experienced loss. You have also completed the bereavement questionnaire for which I thank you. What I'd like you to think about as your first question is, **what happens to you, or could happen to you, as therapist in a therapeutic relationship with a bereaved child, in terms of the cognitive, emotional, physical, spiritual, social and occupational effects of this type of work?"**

The second question was introduced to the group thirty minutes after the first as follows: **"Bearing in mind what we have been talking about for the last thirty minutes, if you, as experts, were to design a training programme aimed specifically at your needs in bereavement or trauma work with children, what variables would need to be addressed?"** A thirty minute discussion on this question ensued.

The focus group session in this case was meant to serve a number of purposes. In the first place the group forum provided an opportunity for the respondents to examine and reflect upon their training in skills and knowledge in the area of bereavement and trauma. It provided the opportunity to reflect on their own history of losses and to establish, in some way, if there was any relationship between their losses and their current status as therapists. It also provided the opportunity to reflect upon the question of boundaries and limits between therapist and client. Finally it provided the opportunity for the interviewer to establish what this group believed they needed in terms of knowledge, therapeutic skills and aids to self preservation in order for them to be integrated and competent grief therapists of children.

There was also time for unstructured person-to-person interaction between me and the respondents so as to facilitate "fresh insights and new information" (Merriam, 1988:74). This interaction, as well as the person of the interviewer, including dress and mannerisms, are all important in qualitative research.

The types of responses that I aimed at eliciting in both the interviews, as well as in the questionnaire, (refer to section 3.3.4), were those that elicited feelings and emotional responses on the one hand, and a description of background, experiences, knowledge and behaviour on the other. Interviews were transcribed for analysis and processed in detail to arrive at an understanding of the phenomenon of bereavement counselling. Examples of this can be seen in Chapter Four (refer to section 4.3.1.1 & 4.3.1.2).

3.3.4 The Questionnaire

A structured, open-ended questionnaire was handed to the trainee educational psychologists on 26 June 1997. An example of the actual questionnaire, with an invitation for the respondents to attend the focus group session, appears in Appendix A.

In total 20 questionnaires were distributed, thirteen of which, were returned. The questions were aimed at eliciting the same kinds of responses as Patton's (1980; as quoted by Merriam, 1988) typology of questions, and referred to above (refer to section 3.3.3).

The analysis of these responses was an important source of data and can be seen in Chapter Four (refer to section 4.3.1.3). What follows is an example of the type of questions that were

asked. The questionnaire presupposed that the respondents had attended a three day Trauma Workshop in June 1997.

How did you benefit (or not) from the course and any previous courses or lectures on the subject, in terms of:

1. Your knowledge on the subject?
2. The skills necessary for this type of therapy?
3. Your attitudes or feeling towards this type of work with a young client?
4. What specifically do you think would affect you as therapist in this situation?
5. What do you think would assist you to cope as therapist in this situation?
6. How do you think that you, as therapist, would have coped before the course and will now cope in this particular type of therapeutic encounter?
7. What role do you think your own history of loss plays, and how will it affect the counselling situation?

3.4 METHODS OF DATA ANALYSIS

The collection and analysis of data are activities that occur simultaneously. These activities begin with the first idea and refinement thereof, and proceed through the literature review, the selection of one's sample, the formulation of the research question and the decision of which data collection methods to use. Data analysis can be viewed as a form of channeling and focusing from the general, to the particular, within the parameters of a particular subject. It is an interactive process that occurs throughout a project and is concerned with selecting, focusing, simplifying, abstracting and integrating one's data. Merriam (1988:126) refers to this ongoing process as being recursive and dynamic. The methods of data analysis in a qualitative research project are aimed at validating the results in such a way so that the researcher stands accountable for results, that are credible and can be trusted, an important criterion of validity.

In this study the approach to data analysis that was used is based on the suggestions of Miles and Huberman (1994). They define qualitative data analysis as a process consisting of three phases, namely data reduction, data display and conclusion drawing or verification. As already alluded to, these three processes are interwoven and are in constant interaction before, during and after data collection. In this view then, qualitative data analysis is ". . .a continuous iterative enterprise" (Miles & Huberman, 1994:12).

3.4.1 Data Reduction

The identification of themes is part of the process of data reduction which occurs throughout a project and is conceptualized as the ongoing process of extracting, selecting, transcribing, simplifying, interpreting and transforming data from its transcribed raw form, through to

information that can be applied in the field (Miles & Huberman, 1994:10). Data reduction is part of the analysis of data, whereby the researcher "sharpens, sorts, focuses, discards, and organizes data in such a way that final conclusions can be drawn and verified" (Miles & Huberman, 1994:11). Most analysis is done with words. The words can be assembled, subclustered and/or broken into semiotic segments. They can be organized to permit the researcher to contrast, compare, analyze, and bestow patterns (themes) upon them (Miles & Huberman, 1994:11). In this study the data reduction process was achieved by clustering, conceptualizing and dendrograming. This process is referred to as narrative discourse and will now be described.

Firstly the interviews were transcribed. This means that the tapes of the interview, as well as of the focus group, were transcribed verbatim, from the oral into the written form. Then the raw data obtained from the interviews, as well as the raw data from the questionnaires, were coded and clustered topically and contextually using the technique described by Merriam (1988) as dendrograming (refer to sections 4.3.1 & 4.3.2).

3.4.2 Clustering and Conceptualization

Miles and Huberman (1994:249) describe clustering as a tactic employed to try and "understand a phenomenon better by grouping and then conceptualizing objects that have similar patterns and characteristics". This reduction method of "clumping" aims at assessing which things are like each other and need to be grouped, and which need to be left out.

Clustering is the inductive formation of categories and may be viewed as a method of moving to higher levels of abstraction (Miles & Huberman, 1994:249). Clustering and coding and patterning are closely linked. Coding is the "key process" since it involves the organization of the copious notes, transcripts and documents that have been collected, into more manageable units of information (Miles & Huberman, 1994:249).

The elements in the study were organized or clustered around particular topics and left in their natural context. By reducing data in this way one is left with a high level of coherent thought. The content-analytical technique of dendrograming was used in this study as a way of facilitating the consolidation and interpretation of information. To facilitate this process the following steps were employed:

* The audio and video recorded data that was obtained from the interviews was transcribed verbatim. These transcripts were written with many paragraphs and wide margins so as to facilitate the analysis of the data.
* Transcripts in the form of the questionnaires were read several times in order to gain an holistic understanding.

* The main ideas and themes were recorded.
* Semantic units were identified and indicated on the particular data source.
* Semantic units were then grouped together in categories. Recurring units were grouped together until a finite number of loose standing ideas, with no relation to each other, were disseminated. Developing these categories involves looking for recurrent regularity in data. It is, according to Merriam (1988:132), a process that is both intuitive and systematic.
* Operational definitions were then written for these categories. Definitions were formed through the researcher's orientation and knowledge, as well as from information derived from the literature.
* Dendrograms of the main categories and semantic units were then drawn to arrive at a deeper analysis of meanings and themes.

The processing of all the above is the main focus of Chapter Four. The same process was followed individually with each data source. Once all the possible themes had been described outliers were recorded.

Much of the work involved in the construction of categories involves the analysis of content. As such categories according to Merriam (1988:132) need to:

* Reflect the purpose of the research.
* Be exhaustive.
* Be mutually exclusive.
* Be independent.
* Be derived from a single classification principle.

3.5 VALIDITY AND RELIABILITY

I have already mentioned that in qualitative research, researchers are "accountable" for their results. Accountability is established via validity and reliability. Research findings need to be grounded in supporting detail in order to be credible and trustworthy to those who read the report, or who use the findings of the study to generate further scientific knowledge. "All research is concerned with producing valid and reliable knowledge in an ethical manner" (Merriam, 1988:164). Validity and reliability are achieved via careful attention to a study's conceptualization and the way in which data is collected, analyzed and interpreted (Merriam, 1988:166). The scientific ethos and spirit of the study needs to be maintained at all times.

3.5.1 Internal and External Validity

"Validity, in qualitative research, deals with the question of how the researcher's findings match reality" (Merriam 1988:166). Given that reality is multi-dimensional, ever-changing and in a sense

subjective, Eisenhart and Howe (1992; as quoted by Le Compte, Millroy & Priessl, 1992:657f.) present five standards of validity that need to be invoked in a valid research project. These are:

* That there be a fit between one's research questions, data collecting procedures and analysis techniques.
* That there are credible reasons for selecting a specific group of subjects, specific data gathering procedures and specific analysis techniques.
* That there is an alertness to, and a coherence with, prior knowledge derived from a comprehensive literary review.
* That there are value constraints in terms of the usefulness of the study and the risks involved. This addresses the issue of both the usefulness of the particular research, as well as ethical considerations towards the participants.
* That the project is comprehensive in terms of clarity, coherence and competence.
* That there is an application of all five of these standards and that attention to them is borne in mind throughout the project.

In order to achieve standards of validity and hence construct truth as honestly as possible, Leedy (1997:168) proposes a number of strategies, employed by Gall et al. (1996), to achieve trustworthiness and thereby achieve validity in a qualitative study. These are "triangulation, member checking, chain of evidence, outlier analysis, pattern matching, and representativeness checking". For the purposes of this study the following was done to implement, as far as possible, the abovementioned checks to validity:

* **Triangulation** refers to using multiple data collection methods, data sources and analysts to check the validity of the findings. If similar themes are noted in the data collected, then the credibility of one's interpretation is enhanced. I used multiple sources of data collection in the form of an in-depth interview, a focus group interview and a semi-structured questionnaire. The data of the project was also decoded by an independent person and the results of her decoding and mine were compared and correlated.

* **Member checking** refers to having the participants review the research for accuracy and completeness. As such a number of the participants of the focus group were asked to view the chapter on the dissemination of the data and to comment on my findings and themes. I also asked colleagues to comment on the findings as they emerged. This peer examination serves both a critical and a supportive function.

* **Establishing a chain of evidence** between the research questions, the methodology employed, the raw data, and the findings of a study, implies that those who read a research paper can see a coherent thread running through. A chain of evidence in this

research will be evident if the reader is able to determine whether the conclusions that I have offered are logical or not. I also continuously attempted to clarify and crystallize my own assumptions, aims and terminology throughout the process of researching and writing this study in order to maintain this chain of evidence.

* **Outlier analysis** refers to the researcher examining those cases that differ markedly from the majority of individuals or situations examined. These extreme cases can actually be used to strengthen the findings of a study by determining what is present or absent in them, as compared to more common examples. The description of the process of outlier analysis, together with examples, is presented in section 4.3.2.

* **A representativeness check** is used to determine whether a finding is typical of the site from which it was obtained, or whether it is an artefact of the persons who were interviewed, or the presence of the researcher. In this study the findings appear to be typical of the site, in that they relate to the feelings and opinions of a particular group of students and a particular psychologist. It is hoped that the presence of the researcher did not in any way jeopardize the process.

3.5.2 Reliability

Reliability, according to Merriam (1988:170), refers to the extent that one's findings can be replicated. Leedy (1997:169) refers to "long term involvement" and "coding checks" to address reliability.

* **Long term involvement** refers to the length of time that is spent on collecting data. If data is collected over a long period of time the researcher is in a better position to distinguish between perceptions and trends. In terms of this study, events over more than a year from the initial idea to the collection of data have been described. Furthermore, in terms of the syllabus as it exists for the training of educational psychologists, bereavement counselling per se is not addressed. In terms of this criteria for reliability, what this research paper deals with is not a perception, but a trend. If this study were to be replicated given the same set of circumstances, the same results, I believe, would be achieved. In other words there would be consistency of results if circumstances were not altered.

* **Coding checks** according to Leedy (1997:169) "involves having more than one researcher code the data obtained form field notes, interviews and documents to calculate interrater reliability coefficients. A high level of agreement between raters suggests that the coding process was highly reliable". In order to achieve this criterion for reliability, an independent person was asked to decode the data, and to see if similar

themes or outliers could be found. The results of this independent data analysis were integrated with my own and can be seen in Chapter Four.

3.6 ETHICAL CONSIDERATIONS

Ethical considerations in qualitative research emerge at two points, according to Merriam (1988:184). During the collection of data and during the dissemination of results. Problems that could arise include a lack of objectivity on the part of the researcher, and an over-involvement with issues under investigation. Problems associated with a lack of confidentiality, as well as problems that result from an inability on the part of the reader, to differentiate between the findings and the interpretation of the findings, are also possible. This becomes an issue of vested interest, in that researchers need their project to work for their sake, rather than for science's sake.

In the case of this study it is hoped that the effects of participation in the project have not adversely affected the participants. It is clear however that there are many issues, and much pain associated with bereavement counselling, that the participants have to face, and deal with. This needs to occur either in supervisory situations, or in private with their own therapists.

Finally there is the ethical consideration of being privy to the private reflections and personal thoughts of the participants. There is however, an ethical code associated with being a psychologist and this study was conducted bearing this code of ethics and confidentiality in mind The identity and confidentiality of participants has been respected and maintained, and the permission for using the information gleaned from the questionnaires, interview and focus group was given by the participants.

3.7 CONCLUSION

"Choosing a qualitative research design presupposes a certain view of the world that in turn defines how one selects, samples, collects data, analyzes them and approaches issues such as validity, reliability and ethics" (Merriam, 1988:119). This chapter has attempted to be an overview of this process. It has described my "world view" and the contextualization of the project from the original idea, through to a description of the research question, a motivation for a qualitative inquiry format, a description of the sample and an overview of the methods of data collection, reduction and analysis. The questions of validity, reliability as well as the ethical considerations in a project of this nature, have been discussed. Chapter Four will present a detailed description of the analysis of the data and a discussion of the themes. An integration of these themes with existing theory will be presented. Suggestions for the training of integrated educational psychologists as grief counsellors will be made.

CHAPTER FOUR

THE PRESENTATION AND INTERPRETATION OF THE DATA, CONCLUSIONS AND SUGGESTIONS

4.1 INTRODUCTION

Given the current interest that exists in the field of thanatology, it is surprising how little attention has been focused on the experiences of the professional caregivers, specifically psychologists and educational psychologists, within the therapeutic bereavement counselling relationship of children.

This chapter aims at providing the reader with a detailed description of the personal and professional consequences of bereavement counselling on psychologists, with special reference to educational psychologists. It begins by briefly clarifying the research problem. It then continues with a description of the study in terms of its context and characteristics. This is followed by an example of the data from each data source, which is presented in its transcribed raw state. The process of analysis into semantic units and categories for each data source is demonstrated, and the extrapolation of themes is described. These themes are then compared to, and integrated with, existing theory as has been presented in Chapter Two. Suggestions for the training of integrated educational psychologists as bereavement therapists or counsellors (refer to section 1.6), are presented. This chapter concludes with suggestions for further research and comments on the limitations of this inquiry.

4.1.1 The Research Problem

Briefly stated, the research problem as has already been described in Chapter One, is aimed at examining the ramifications of the bereavement counselling relationship with children, on adult therapists, specifically educational psychologists, in both their professional and personal worlds. Given the reality of the broader context of the therapists' own life-world experiences and the narrower context of the therapeutic relationship between therapists and children, what are the effects of this relationship on therapists, in both the professional and personal contexts?

The fact is that therapists are expected to create a safe and uncontaminated, contained therapeutic environment in which children are able to heal and grow. The questions are, what strategies do therapists have and what strategies can they develop, so that both they and the children are safe and contained? It would appear that bereavement counselling as it applies to children may not be the same as all other forms of counselling and may be governed by its own unique and specific set of 'rules' which are described as the themes of this study.

4.2 THE CONTEXT OF THE STUDY

As has already been described in Chapter Three, (refer to section 3.2.1), the data for this project was derived by the researcher from three main sources, namely an interview with a psychologist, an open-ended semi-structured background questionnaire completed by Educational Psychology Masters' students at the Rand Afrikaans University, and a focus group interview session with a group of the aforementioned students. The completion of the questionnaire and the attendance at the focus group interview were both voluntary and in both cases the fact that the data was to be used for research purposes was stressed. The following paragraphs provide a detailed discussion of the above-mentioned context.

4.2.1 The Researcher

Michael White, the Australian narrative therapist, refers to the act of telling and retelling stories as a way of gaining a rich and thick description of a person's story (White & Epston, 1990:216). By so doing, and via a process of questioning, both the teller and the listener makes sense of the material and arrive at an understanding of the former's life world. Both are enriched by the experience. It is with this in mind that I, as researcher, observer and listener, describe myself as part of the context. A description of the observer status of the interviewer as researcher-participant has been given in Chapter Three, and the researcher's effects on the process have already been described (refer to section 3.3). It is however the personal gain and professional growth derived from this project that I also refer to.

4.2.2 The Psychologist

The psychologist who is described in the study is a clinical psychologist, who, for the past two years has been primarily involved in trauma counselling of children who are victims of violence. These included children who were victims of political and social violence including rape, murder, incest and abuse. Many of the children with whom she worked were bereaved as a result of the sudden and traumatic death of a parent. The interview with Mrs. X is described in Chapter Three, (refer to section 3.3.4).

Mrs. X had been employed by the Centre for Violence and Reconciliation in Johannesburg for two years prior to this interview. She describes herself as a "traumatologist" who has worked with almost four hundred victims of violence in two years. A week before the interview she left the Centre to begin work in an environment where the primary focus was no longer trauma work. She continues to run a small private practice at her home where the focus remains trauma work. Mrs. X is a married woman with three daughters.

4.2.3 The Educational Psychology Masters' Students

The group of Educational Psychology Masters' students represented in this study, are all registered post graduate students of the Education Faculty of the Rand Afrikaans University in Johannesburg. This group of students are receiving their theoretical and practical education and training at the Institute of Child and Adult Guidance, which is situated on the campus of the aforementioned university.

Work with bereaved children is not the primary focus of educational psychologists. They are involved in the psychological assessment and counselling of children of all ages, who are experiencing problems in their life-worlds, and who are referred for assessment and therapy. One possible area of work is the traumatized and bereaved child.

The educational psychology students at RAU are a diverse group of people. They range in age from mid 20's to mid 40's. They are both English and Afrikaans speaking people from various religious and cultural orientations. These full time and part time adult students are in the process of qualifying as psychologists, who will be registered with the Interim Medical and Dental Council of South Africa, under the registration category of educational psychologist. The academic course has both a practical and a theoretical component. It fulfils the requirements that are stipulated by the Senate of the University/Professional Board of Psychology, in accordance with the basic requirements of the Interim South African Medical and Dental Council.

4.3 METHODS OF DATA ANALYSIS

The methods of data analysis have already been described in detail in Chapter Three, section 3.4. Broadly speaking the data from the interview, the focus group and the semi-structured background questionnaire was analyzed and reduced via the process of coding, and clustering data topically and contextually by means of a technique that is referred to as dendrograming. What follows is an examination of the process.

4.3.1 The Process of Data Analysis and Reduction

An example of the transcript of data from each of the data sources is presented. The process of clustering and categorizing as it was applied to the transcribed data is illustrated.

The raw data from both the interview and focus group was transcribed from the taped form to a verbatim transcription of the data. These transcripts included some comments relating to the non-verbal behaviour of the participants. The questionnaires were analyzed directly from their raw state.

Transcription Codes

Code	Meaning
r	researcher
m	psychologist
j,l,g,v,i	students

4.3.1.1 An Example of Data Analysis from the Individual Interview

What follows is an example of the transcribed raw data from the **individual in-depth interview** with the **psychologist**.

r. How much of you as a person enters the therapy room?
m. Not much. The kids pick up nervousness.
m. You need to be in supervision regularly and you need to be in therapy regularly just looking and watching and seeing what happens to you as a person.
r. Like what kinds of things?
m. Oh physical things
r. What kinds of physical things?
m. Oh lots of little things that my GP and I know are stress signs. I get tired. Last year I had chest pains and odd little things. Stomach problems, headaches, anxiety things but I use breathing techniques and thought stops. Rescue remedy and Milo. . . . Ya and obsessive thoughts not about me and my family but about my work. I think they are more depressive thoughts, cognitive walking around, but there are sometimes when I'm really tired that I haven't managed to stop the thoughts. They just stay there like aspects of a case. I think its more cognitive than obsessive.

r. So there is vicarious traumatization?
m. Oh yes it's real, very real, it's exposure therapy. They talk about emotional fatigue but I think its more.

m. Then there are anxieties about, although I don't know how to explain this, but they're about working where I work, like in Soweto... where I had to drive right through the area and I was mugged once. This work is stressful. But there is just something about doing it. . . . What I don't do is, for example, when my girls drive around Joburg, I don't stay awake at night. . .worrying about them. . . .I haven't transferred that onto my children. . . . You see I believe in this type of work. I believe that it has to be done in South Africa at the moment and it's umm...something that has to be done. . . It's very hard but it has to be done.

r. What do you do about the emotional effects.?
m. You watch the signs and you learn when 'enough is enough' and then there has to be supervision and personal therapy. Although an hour of supervision a week is not that much.

The above raw data in its transcribed format was then analyzed into **semantic units and categories** as is illustrated below in Table 4.1.

The presentation of these tables is my chosen method of data display. Data displays, according to Miles and Huberman (1994:11), are used by researchers to "assemble organized information into an immediately accessible, compact form so that the analyst can see what is happening". Analysts are instructed to "hand craft" appropriate data displays for their own study (Miles & Huberman,1994:93).

Table 4.1 An Example of Data Analysis from the Interview

Semantic Unit	Category
The kids pick up nervousness	Therapist and client affect each other
You need to be in supervision regularly and you need to be in therapy regularly	Supervision and therapy
r. What kinds of physical things m. Oh lots of little things that my GP and I know are stress signs	Physical manifestations of stress
I use breathing techniques and thought stops	Coping strategies
Ya... and obsessive thoughts.... cognitive walking around	Emotional manifestations of stress
I think its more cognitive than obsessive	Cognitively one is affected
They just stay there	Cognitive schemas are affected
And then there are anxieties ...about working where I work ... like in Soweto...I was mugged once, This work is stressful	Occupational manifestations of stress
Vicarious traumatization is real... emotional fatigue	Vicarious traumatization
What I don't do is ...I don't stay awake at night ...I haven't transferred that onto my children	Transference

The same procedure was followed step by step for the complete interview as well as for the focus group interview (refer to section 4.3.1.2).

4.3.1.2 An Example of Data Analysis from the Focus Group Interview

What follows is an example of the transcribed raw data from the **focus group interview** with the **students**, as well as an example of the analysis of the raw data into semantic units and categories.

j) I think to add to what L just said about being good to yourself once you have dealt with a lot of such cases I think you'll have to go on leave more often.
a) I was thinking about changing jobs, or the specific focus of your work, like not just doing trauma like for a month break away into something else and then come back and that would also help.
c) Something else that I just thought of and it may seem strange coming from me but if you're busy with something like this then I think you should watch your diet very carefully (J agrees)

I think you should go to a dietician so that you get a balanced way of eating, so you get all the energy you need and you look after yourself as well in that way.

r) Do you think it affects your thinking if you keep on doing this type of work? (nod consent)
l) You get skewed vision which is what we have said before.
g) And I know for myself I would get hypervigilent (group agrees)
r) G, you mentioned physical things?
g) Sleeplessness would be one of them to come to the fore straight away.
l) I would sleep too much.
a) Also the fragility of life. I think that the fragility of life is something after you experience a loss. Whatever it is you become very fragile and you kind of extend this to your immediate family and its a process that you suddenly realize that people just come and go and it can happen to others That's something that I experienced.
v) What about the opposite, desensitization (group agrees) where you become so hard that you don't empathize properly where in order to protect yourself you say I just can't bear this anymore.
l) And also from a physical side I think that you experience a whole lot of stress and tension in your body just from listening to all this and you automatically tighten your neck and your back and I mean that's jolly painful after a while.

Table 4.2 An Example of Data Analysis from the Focus Group Interview

Semantic Unit	Category
To be good to yourself... you have to go on leave more often...changing jobs or the focus	Self knowledge and strategies to prevent occupational manifestations of stress
Watch your diet carefully	Self knowledge and strategies to prevent physical manifestations of stress
You get skewed vision	Bereavement work may affect the life view
I would get hypervigilent...	Emotional /physical manifestations of stress - vicarious traumatization
Sleeplessness...I would sleep too much	Emotional/physical manifestations of stress - vicarious traumatization
Fragility of life...after you experience a loss you become fragile	The therapist's own history of loss
Desensitization	Emotional manifestation of stress - vicarious traumatization
A whole lot of stress and tension in your body . . . just from listening	Physical manifestations

4.3.1.3 An example of Data Analysis from the Questionnaires

Two responses to examples from the **questionnaire** completed by **the students**, are given. These are then divided into semantic units and an indication **of clustering** is given.

What do you think would assist you to cope with the therapy situation?

1. "A strong supportive background, either from colleagues or family and friends that one works with a stable personality or life and constant supervision with colleagues (debriefing sessions)".
2. "Support of peers, supervision, short breaks and holidays and a combination of this type of counselling with other forms of therapy and assessments."

Table 4.3 An Example of Data Analysis from the Questionnaires

Semantic Unit	Clustering/Possible Categories
Supportive background	Support/containment
Peer support	Support/containment
Supervision	Support/containment
Personality of the therapist	Person of the therapist
The therapist needs breaks and holidays	Support/containment
The importance of other types of work	Balance necessary

4.3.2 Dendrograming of the Main Categories

In order to arrive at a deeper analysis of meanings and themes, dendrograming of the main categories was undertaken. The categories from each data source are presented, and examples of the process of clustering as well as outlier analysis is given.

The categories that were identified in the individual interview with the psychologist are the following, which with the aid of dendrograming, are reduced to the final themes.

1.	Children who are bereaved are victims.	5
2.	The person of the therapist is important.	1
3.	One's history of loss is important in this type of work.	1
4.	Bereaved children need uncontaminated space to work through their losses.	2
5.	Bereavement work requires specialized knowledge, skills and training.	4
6.	Trauma work requires an understanding of the processes.	4
7.	grief-work is contagious.	3
8.	You have to understand your signs and act on them.	3
9.	Trauma work is difficult, it needs to be balanced with other work.	3
10.	To do this kind of work requires professional support.	4
11.	An outside support system is essential.	4
12.	Death work is isolating.	5
13.	There is a deep rooted sadness in this type of work.	5

14.	The therapist requires a specific structure in which to work.	2
15.	Trauma events need to be worked through before therapy can begin.	2
16.	It's a privilege to do this type of work.	1
17.	The number of trauma victims in South Africa is staggering.	6

An example of the process of **clustering** from the semantic units of the raw data is given for **Category One**, "children who are bereaved are victims". This was obtained from the following semantic units:

* Children are helpless to change their circumstances.
* There is often guilt which needs to be dealt with.
* There will always be posttraumatic symptoms which come and go.
* There are irreversible changes that the therapist needs to be aware of in the circumstances of their lives.
* Children are amazingly resilient.
* There is an ever present deep-rooted sadness in death that remains.
* The therapist shares with the child at a deep level of sadness that is often indescribable.

Outlier analysis has been described in Chapter Three (refer to section 3.5), as an instance which differs markedly from the majority of situations that were presented or examined. The category "it's a privilege to do this type of work" as described by the psychologist, is an example of an outlier. The category emerges from the psychologist's understanding and experience with this type of work. Although the students indicated that they may be attracted to this type of work they did not make reference to the fact that it would be a privilege (refer to table 4.3.3).

The categories that emerged in the focus group interview are the following which, with the aid of dendrograming, are reduced to the final themes:

1.	The severity of loss cannot be undermined.	5
2.	The family suffer, they cannot be undermined or forgotten.	5
3.	The bereavement therapist is a particular type of person.	1
4.	The therapist's history of loss is very important.	1
5.	The therapist creates a contained space for the client to experience pain.	2
7.	The therapist's visible sadness affects the therapeutic relationship.	3
8.	There is a difference between short term trauma work and bereavement therapy.	4
9.	Specialized knowledge and skills cannot be overemphasized.	4
10.	The bereavement therapist needs to be contained personally.	4
11.	Grief-work is contagious.	3
12.	Transference/countertransference allow the therapist to feel the client's sadness.	3
13.	A balance needs to be achieved between trauma work and other types of work.	3

14. Hijacking and trauma are specific issues in the current South African climate. 6

Outliers identified in this instance, centre around the issue of disclosure and whether there is a place for the display of therapists' visible sadness in the therapeutic relationship with bereaved children. The following semantic units were identified in the raw data:

* "For me to show tears would be negative".
* "The moment I saw tears in the therapist's eyes I felt he was there for me".
* "Maybe for children it is important that therapists don't cry".
* "Tears need to be shown somewhere else but not in the therapy room".

This outlier strengthens the argument that novice therapists feel inadequate and that specific training is essential (refer to section 4.4.2 and Table 4.4.3).

The categories that emerged from the background questionnaire are the following, which with the aid of dendrograming, are reduced to the final themes.

1. The person of the therapist is essential in this type of work. 1
2. The therapist's own history of loss is important 1
3. The therapist has choices as regards the type of work he does. 1
4. The therapeutic relationship between therapist and child is a mutual one. 2
4. Trauma work with children requires specialized intervention, knowledge and skills. 4
5. The therapist as person is affected by this relationship. 3
6. The trauma therapist needs to be contained. 4
7. Bereavement work is isolating. 5
8. South African therapists have to deal with particular issues. 6
9. Trainee therapists have specific needs. 5

An example of the process of **clustering** for **category nine**, "trainee therapists have specific needs" was derived as follows:

* Trainee therapists have very little experience in specific areas of counselling.
* Trainee therapists need preparation, practice and experience.
* Inexperience and a lack of knowledge means that certain situations may be ignored.
* The trainee therapist is scared and vulnerable and may panic.
* Training teaches you about the needs of the clients.
* Specific skills training is empowering for the therapist in training.

4.3.3 Division of Categories into Themes

The following table presents the division of categories that emerged into the main themes:

Table 4.4 The Division of Categories into the Themes of the Research

	Interview	Focus Group	Questionnaire	
Person of the therapist	*	*	*	1
History of loss	*	*	*	
Choices	*	*	*	
Privilege	*	X	X	
Uncontaminated space	*	?	?	2
Mutual relationship	*	*	*	
Balance	*	*	*	3
Contagious/affected	*	*	*	
Know one's signs	*	*	*	
Sadness	*	*	*	
Skills and structure	*	**	**	4
Personally contained	*	*	*	
Training for trauma	*	*	*	
Knowledge of death	*	*	*	
Professional support	*	*	*	
Outside support	*	*	*	
Isolating	*	*	*	5
Victims	*	*	*	
Sorrow	*	*	*	
Family	*	*	*	
Severe	*	*	*	
South Africa	*	*	*	6

4.4 MAIN THEMES THAT EMERGED

The following table presents the main themes that emerged from the data sources when the categories were reduced. Each theme will be discussed individually.

Table 4.5 Main Themes that Emerged

Interview	Focus Group	Questionnaire	
The person of the therapist	The person of the therapist	The person of the therapist	1
The bereavement therapist creates a contained space for the child	The bereavement therapist creates a contained space for the child	The bereavement therapist creates a contained space for the child	2
The therapist is affected by this relationship	The therapist is affected by this relationship	The therapist is affected by this relationship	3
The therapist needs to be contained	The therapist needs to be contained **trainee therapists**	The therapist needs to be contained **trainee therapists** *	4
Death and death work is isolating **children are victims**	Death and death work is isolating **children are victims** **	Death and death work is isolating	5
South African community	South African community	South African community	6

* "Trainee therapists have their own needs" emerged as a sub-theme for the specific group of trainee therapists and is thus significant. It is seen as a sub-theme of the main theme "The Therapist Needs to be Contained" and will be discussed under that theme (refer to section 4.4.4).

** "Children are victims" is seen as a sub-theme of the main theme that "Death and Death Work is Isolating" and will be discussed under that theme (refer to section 4.4.5).

4.4.1 The Person of the Therapist

In Chapter Two, the literature refers to the importance of an integrated and mature therapist as being central to the therapeutic relationship between therapist and client in bereavement therapy. The person of the therapist emerges as a central theme in this investigation. The personality, will to heal, knowledge, skills, relationships, life view, spirituality and history of loss are inextricably bound into a weave that is the person of the therapist who meets the child in a therapeutic relationship. The integrated therapist has an understanding of self in terms of strengths and weaknesses, reactions to the client's material, likes and dislikes, personal strengths and vulnerabilities. The integrated therapist is also "able to visit old wounds", according to the respondents of this study.

The therapist's **history of loss** is viewed as central to the person of the therapist. Loss is viewed as any loss and not necessarily only the loss of a person by death. This is what makes the therapist sensitive to the needs of the client in therapy and may direct the unconscious processes of transference and countertransference. It was confirmed by the students and psychologist that it is necessary to have dealt with one's history of losses, to have confronted unfinished business, and to have achieved closure, before entering into a therapeutic relationship with bereaved children. This history allows therapists to put themselves into the client's shoes - a common description of empathy - and feel what the client feels at a deep level of sharing and sadness.

The closure and resolution of issues associated with loss is part of the matrix of an integrated therapist. This confirms the views held by both Lendrum and Syme (1990:165) and Worden (1991:139), who caution that only if the therapist has adequately dealt with and integrated past losses, do these have any positive value in a therapeutic encounter. The therapist's own grief should not however under any circumstances be allowed to contaminate the process. This will be referred to in 4.4.2.

It would appear as if therapists exercise choice in this type of work. This choice relates to whether the therapist wishes to be involved in grief-work per se, as well as the choice of how to manage the stress that is inevitably associated with this type of work which, according to Rando (1993:664), "is one of the most difficult positions to be in as caregiver".

Some of the students indicated that out of choice they would prefer not to do grief-work. For some therapists rejection of this work may be part of an existential anxiety that centres around life and death and the fear of death and dying. Schoenberg (1980:63) is of the opinion that admission of, or exposure to thanatophobia is felt by some therapists to mark them ". . . as immature, weak or morbid. It is childish, it is unmanly. . .Helpers in the death milieu who are afraid to disclose their own fears of death show little authenticity or congruence". For others

however, the rejection of this type of work may be based on self preservation and a conscious decision that they would prefer not to be involved in bereavement work, as far as possible.

Then too, the study confirms that there are those therapists who find enormous fulfilment and a sense of achievement in this type of work. In reviewing work with victims, McCann and Pearlman (1990:147) believe that there are positive side effects to this type of work which include a deep sense of hopefulness that the human being is able to endure, overcome and transform even the most traumatic experiences. The psychologist in this study indicated that she actively chose to do this type of work at the beginning of her career and that, because of the rewards attached, she would ultimately return. Some of the students indicated that if properly prepared they too would engage in this type of work, although perhaps, not exclusively.

4.4.2 The Bereavement Therapist Creates a Safe Space for the Child

The creation of a safe space by therapists for children to experience their sadness and pain is viewed as being an important theme. The bereavement therapist cannot take away the child's pain. In the words of Rabbi Grollman, an eminent expert in the fields of bereavement and bereavement counselling, "no one can determine how each individual child and his parents will react to the fact of death. . . It is good to remember that courage is not the absence of fear, but the affirmation of life despite the fear" (Grollman, 1967:242).

It is with this in mind that the direct format and steps of the Witness to Violence Questionnaire as developed by Pynoos and Eth (1986:306-319), as well as the phases as suggested by Rando (1996:67-70), are viewed as such useful tools in allowing children to confront their losses directly within the safety of the therapeutic relationship. Over time, when the actual trauma has been dealt with, various other techniques, as mentioned in Chapter Two, are confirmed as useful for therapists to assist children to achieve some measure of closure.

It is only after children have experienced their pain that they can, in time, be in a position to move forward and mourn. According to Freud (as quoted by Deitrich and Shabad, 1989:6), when the work of mourning is completed, only then does the ego becomes free and uninhibited again. Mourning is viewed as the psychological process of leave taking, achieved via remembering and working through the loss and it is in this regard that therapists contain the process.

The safe space created by therapists cannot be contaminated by personal issues. The psychologist in the study is of the opinion that trauma work with children excludes "disclosure" on the part of therapists. Personal disclosure is deemed to be inappropriate especially in the initial stages of trauma work (refer to section 2.6.3). Two of the conditions, as stated by the psychologist, as being important for the creation of this safe space is that it is uncontaminated by the therapist's own issues, and that the therapist is seen by the client to be in control. It is for this

reason that therapists make use of all their resources, both external and internal, available to them (refer to section 4.4.4).

This may seem to be in conflict with the opinion expressed by Joubert (1995:15), who states that "the therapists' own reactions, including his own turmoil and uncertainties, actively encourage the process of psychotherapy if shared in an appropriate way". It would appear that within the confines of the bereavement therapeutic relationship, therapists have to work out for themselves when, if ever within this particular situation, disclosure is appropriate.

For both the students and the psychologist, countertransference and transference reactions, if understood for what they are, assist the process in that they enable therapists to recognize, be aware of, and act upon the unconscious processes that are evoked by clients' material.

4.4.3 The Bereavement Therapist is Affected by this Relationship

Implicit in the concept of a reciprocal therapeutic relationship, is that the therapist is affected by the relationship. This is a central theme of this study. The literature review of Chapter Two notes the adult helper's personal vulnerability and deep, personal reactions to the material of the child. Reactions of sadness, anger, helplessness, fear, anxiety and responses that are parallel to post-traumatic stress signs have been described.

It is in this regard that the concept of vicarious traumatization and the manifestation of stress or burnout, in all its forms, as a ramification of this type of work, on therapists, becomes a dominant theme. This, according to the participants, ranges from an inability to sleep as a result of obsessive thoughts, to personal distancing, to being unable to continue with this type of work and to seeking alternative employment.

The term "vicarious traumatization" is used to describe the effects that therapists may experience in response to this type of work. Webb (1993:56) quotes McCann and Pearlman who state that "exposure to the traumatic experiences of the victim may be hazardous to the mental health of the people close to the victim, including therapists involved in the victim's healing process." Vicarious traumatization, secondary traumatization, compassion fatigue or emotional fatigue, may bring with it manifestations or symptoms of stress or burnout that may be physical, psychological or occupational, and may impinge on psychologists' personal relationships with family or friends.

Therapists with their own children may personalize the losses of their clients and become overprotective of their own children. Apprehension, or feared loss, may interfere in the counselling process. So too, may identification with a specific child or a specific parent, cause therapists to loose both their perspective and the boundaries of the therapeutic relationship. This was confirmed especially by the students of the study.

The psychologist in this study referred specifically to the problem of **psychic numbing** or distancing of herself from the traumatic material of her clients. One possible way of distancing is "intellectualization" or moving from an emotional involvement with clients, to working at a more cognitive level, confirming the view expressed by Hartman (1995:128). In a discussion of the role of dissociation as a response to trauma, Hartman proposes that although the language and the concepts may vary, there is agreement amongst the experts that a traumatic experience overwhelms the individual's ability to cope psychologically. "Typically such responses are seen as occurring in intrusive or/and denial or avoidance clusters of symptoms".

The students in the study make reference to their rose-coloured view of the world changing forever. The various other effects of vicarious traumatization that were borne out by this research are documented in Chapter Two.

In discussing the need of therapists to **detach** themselves from their clients Papadatou, distinguishes between "mature concern" and "detached concern". With mature concern she believes "the therapist is able to identify with the pain of her client, but not with her client. She is able to understand their feelings, participate in their experiences, and share their journey, knowing she will be affected by them. But never can she live their journey, their life or their death as her own" (Papadatou, as quoted by Papadatou & Papadatos 1991:290). This, according to the psychologist, implies a clear role definition and a distinct realization of personal boundaries and limitations. The child's loss and grief, although tragic, is not the therapist's. The allocation of personal energy should include work, play, relating to family and friends and relating to and respecting one's self. All of these are essential for a balanced life and assist therapists to deal with their personal vulnerabilities and fragility.

Bereavement counselling is, according to both the students and the psychologist, by and large trauma work and as such, the participants believe that they need strategies to counter the negative side effects of this type of work. Grief counselling of children presents a special challenge for therapists. They have to establish and maintain an effective therapeutic relationship under the most adverse circumstances, as well as maintain their own physical, social, spiritual and occupational well-being. It is with this in mind that integrated therapists need to understand their stress signs and act on them. "This process is essential if therapists are to prevent or ameliorate some of the potential damaging effects of their work" (McCann & Pearlman 1990:145).

In terms of this research project, the psychologist, after having worked in the most extreme conditions of trauma work for two years, changed jobs temporarily in order to reduce the negative side effects of this work, as described in Chapter Two. For her, one of the side effects of her

work was that it had deepened her level of seriousness to such an extent, that she needed to distance herself from her work temporarily in order to regain personal balance.

4.4.4 The Bereavement Therapist Needs to be Contained

The containment of the therapist as a theme, is referred to in the literature as "good self care, a sin qua non or necessity for being able to provide good help and support" (Dyregrov, 1991:112). Broadly speaking containment refers to the resources that therapists have at their disposal to support them in their task as bereavement counsellors. These are both inner resources, as well as an outside support system, which act simultaneously to buffer therapists.

Inner resources refer to an understanding of the self in terms of personal stressors and strengths (refer to section 4.4.1). They refer in essence to the integrated person of the therapist. This, for the participants, is aided by their spiritual beliefs, keeping personal journals, art, meditation, physical exercise, correct eating, frequent breaks and holidays and the importance of integrating skills and knowledge.

An outside support system, was described by the participants, as the importance of skills training and knowledge acquired via specific training programmes, as well as the importance of supervision, personal therapy, benign peer support of colleagues, consultation groups and the importance of a personal support system of family and friends. These have also been described in detail in the literature review of Chapter Two.

Empowerment through knowledge is described as an immediate need of therapists, and specifically in this study, therapists-in-training. This includes:

* A thorough knowledge of basic counselling skills.
* Knowledge of the course of an illness as well as knowledge of the processes of death, of dying and of recovery.
* Knowledge of complicated and uncomplicated mourning.
* Knowledge of children in terms of phases of development and life tasks as has been described in Chapter Two.
* Knowledge of specific therapeutic techniques and theoretical models and approaches of value with bereaved children, as well as referral sources within the community, as discussed in Chapter Two.
* Specialized training and experiential workshops also afford therapists the opportunity of visiting personal wounds and reflecting on issues that they may not have been dealt with for a long time, within the confines of a structured situation.

Trainee therapists appear to have their own insecurities which are closely linked with a competence/confidence struggle. This was clearly borne out by the students who participated in this study. The paradox is, according to Papadatou and Papadatos (1991:290), "that our power as 'experts' lies in our willingness to remain 'students' and to learn from every child and every family". Generally however, the more prepared therapists are in terms of knowledge, skills and self understanding, the better equipped they are to provide containment for the child.

It is in this regard that the "what if . . ." questions associated with the therapist's behaviour in the therapy room, are so important for novice therapists to think about, practice and deal with. It would appear as if "the moral is for adults to help our children mature and grow in meeting the sadness of bereavement and in so doing to grow with them ourselves" (Wass & Corr, 1984:184).

The importance of therapy and supervision as far as the participants were concerned, cannot be undermined. This confirms what has been discussed in detail in Chapter Two. The former, to deal with personal issues related to the therapist as person, and the latter to deal with thoughts, feelings and professional progress as related to specific cases. Debriefing groups and benign support of colleagues was also viewed as essential for therapists to be able to "feel their feelings" without fear of censure or criticism.

In summary, this theme supports the view of Rando (1994:270), who believes that a number of specialized qualities are important in undertaking work with complicated mourning. These include professional knowledge and skills, a personality that is able to withstand the demands of the work, an awareness of, and success in, continuously confronting one's own prior losses and an ability to care for oneself as a caregiver.

4.4.5 Death and Death Work is Isolating

This theme is central to the field of thanatology and centres around the impact of death in the life-world of the child. This impact of the death in the life-world of the child is the reason for the therapeutic encounter in the first place. It also serves to describe the isolation and helplessness that this type of work brings to therapists.

This was clearly illustrated by the psychologist who participated in the study. The psychologist in the study made reference to how personally and professionally isolating grief-work is. Although her family and friends knew in general what she did professionally, she could not share with them at any level of intimacy. Even co-workers had little time to share. "Emotional distancing and other self protective strategies seem important" (Dyregrov & Mitchell 1992:5). It would appear as if grief-work deepens the therapists' level of seriousness. This too is isolating especially on an interpersonal, social level. It is in this regard that therapists need to work at balancing their professional and personal lives.

The severity of loss in the life world of children cannot be undermined. Children become the victims. They are helpless in changing the circumstances of their lives and therapists are in reality powerless, at least initially, to do anything other than meet the children where they are in their sadness. In terms of their status out of the therapy room, children face the conflict of being forever marked as different to their peers.

Rando (1996:60) describes the myriad of secondary losses that follows the death of a loved one. "It is not uncommon that in one fell swoop entire segments of the mourner's psychosocial world are shattered, with his or her physical world often being adversely impacted as well".

Loss, according to the participants in this study creates a fragility, a vulnerability and a sense of insecurity that affects children, their families, and therapists. The death of a loved one changes everything in the life-world of children. The family, and the surviving parent or caretaker, may also need support and therapy to deal with the reactions of children to their changed status and to the loss of significant others.

4.4.6 The South African Community

"Professional and lay counsellors alike in South Africa acknowledge the impact that working with traumatized individuals has on them" (Moosa 1992:127). The current state of violence in the South African community and the need for therapists to be well prepared in meeting the demands of trauma work in this country emerged as a theme.

The psychologist stated that in her two years working with victims of violence she had seen almost four hundred children, many of whom had lost parents (exact statistics unavailable). The implication of this is staggering for educational psychologists who work almost exclusively with children. The need for specific skills and training for educational psychologists who work in the community is seen to be paramount in the current climate in this country, and needs to be addressed as a matter of urgency. "The stark reality of the society in which we live deems it necessary to accept that trauma will be part of our work" stated one of the student participants. "Within the context of South Africa, therapists also need to be sensitive to the cultural background of each individual child" stated another. This confirms the view held by Rando (1993:664) who states that "having enhanced awareness of the social and political conditions that lead to violence, can lead caregivers to greater social activism".

4.5 POSSIBLE SUGGESTIONS FOR THE SELECTION, TRAINING AND MAINTENANCE OF THE SELF OF EDUCATIONAL PSYCHOLOGISTS AS BEREAVEMENT THERAPISTS

One of the sub-aims of this project, as stated in Chapter One, was the formulation of possible suggestions for the self management and care of educational psychologists-in-training, to prepare them to deal with the demands of grief counselling/bereavement therapy. It appears from the research and themes, as presented above, that selection and training are integral to the maintenance of the self of therapists and therapists-in-training.

The following suggestions are offered in an attempt to reduce the negative effects on educational psychologists, as bereavement therapists, specifically within the South African context.

4.5.1 Suggestions for the Selection of Educational Psychologists

The following needs to be taken into account in respect of the selection of educational psychology students:

* age, life experience and life view, personality, resolution of unfinished business, history of loss and support system.

4.5.2 Suggestions for the Training of Educational Psychologists as Bereavement Therapists

The following needs to be taken into account in respect of the training of educational psychologists as bereavement therapists:

* Specific knowledge and skills are empowering.
* Therapists need to have integrated general therapeutic skills and models, for example those of Egan (1996).
* Training and experiential learning of general models of childhood development, counselling/therapeutic models and theory is essential.
* Specific techniques for crisis intervention, such as the Witness to Violence Questionnaire as designed by Pynoos and Eth (1986), as well as the phases of counselling as suggested by Rando (1996) and those of Webb (1991) (refer to section 2.4), should be taught as part of the programme.
* If specific techniques for crisis intervention are not taught as part of the programme, and therapists intend to work within this field, then they are duty-bound to seek training within the community.

* An understanding of the processes of death, bereavement and recovery as well as complicated and uncomplicated mourning, is necessary.
* An understanding of the concept, vicarious traumatization, and the knowledge of the possible effects on therapists in both their personal and professional lives, should be addressed.
* The physical, psychological, spiritual, social and emotional needs of individuals and the possible symptoms of stress or burnout should be monitored on an ongoing basis.

4.5.3 Suggestions for the Personal Integration of Educational Psychologists as Bereavement Therapists

The following needs to be taken into account when considering the preservation of the self of educational psychologists as bereavement therapists:

* The importance of ongoing, regular supervision sessions.
* The importance of regular debriefing sessions.
* Benign support of colleagues.
* A decision as regards "self preservation" on the part of students should be encouraged. This could embrace a discussion on the importance of keeping a journal as an example:
  1. For self growth and awareness.
  2. As a means of exploring the student's own personal history.
  3. In an attempt to depersonalize the effects of therapeutic situations.
  4. As a method of personal dialogue with oneself as therapist.
* A policy as regards personal therapy of students. This would relate to the policy of the particular university as regards their responsibility on the personal integration of their students.
* If trainee therapists intend to engage in this form of therapy they need to be aware of their responsibility as far as personal therapy and supervision are concerned and to seek these within the community.

4.6 IMPLICATIONS FOR FURTHER RESEARCH

This study has focused on therapists, specifically educational psychologists, in therapeutic relationships with bereaved children. The aim of the research was to examine the ramifications of the therapeutic bereavement counselling relationship on adult therapists, specifically educational psychologists. The sub-aims of the research were directed at a review of the literature focusing on the bereavement counselling relationship and isolating and identifying those factors that make psychologists vulnerable when dealing with children who have experienced loss. The identification of strategies that therapists have at their disposal to lessen the negative effects of this therapeutic interaction was also stated as a sub-aim. A further sub-aim as discussed above,

was to offer suggestions for the self management and care of educational psychologists and educational psychologists-in-training, as bereavement therapists.

Attempts were made via the context of the participants and the research procedure to acquire as detailed an account of the situation as possible. The researcher therefore invites a similar study within a similar context of therapists and clients, where clients may be bereaved. If this study was to be replicated, given the same set of circumstances the same results, I believe, would be achieved.

In terms of the implications for further research I am of the opinion that because of the nature of their work, educational psychologists need specific training and preparation for other instances of therapy where loss is a factor, and where, if not adequately prepared, they could be adversely affected. A similar study could therefore also be undertaken with therapists who work with children who are affected by other types of loss e.g. parental divorce, or emigration to mention but two examples relevant to the current situation in South Africa.

It is evident from this that there is a broad area of possible study which could provide many opportunities for further research. This research could then result in the design or implementation of specific courses, workshops or modules to be introduced into the academic programme for Educational Psychology Masters' students.

4.7 LIMITATIONS OF THE INQUIRY

The ultimate goal of research is to provide the academic world with credible findings. This is difficult for the novice researcher who is often hampered by limitations. By describing the data collection procedure and methods of analysis and interpretation in detail, however, the novice researcher attempts to ensure objectivity and reliability. This process refers to the gathering of data, its analysis and interpretation, but it also, in part, refers to an honest discussion of the limitations of the study.

This study was conducted with one psychologist and representatives of one class of educational psychology students at a particular university in South Africa. Given a different set of circumstances the results could indeed be different.

A second very important limitation of the study, is that it was conducted by a novice researcher with no previous research experience, as a result many unintentional errors were made. Through continuous reflection and correction of these errors both the study as well as the researcher were enriched. Errors are however still possible.

4.8 FINAL COMMENTS

In this chapter the findings of the analyzed data were interpreted and discussed, within the framework of existing theory, as presented in Chapter Two. The themes were discussed and recommendations and suggestions were made. Possible areas of further research were suggested and the limitations of the inquiry were stated.

In the area of bereavement therapy, the educational psychologist as person has been stressed, as has the role of the therapist in containing the client. The reciprocal nature of the therapeutic relationship has been emphasized. The impact of this relationship on the therapist has been discussed, as has the therapist's need for containment. The isolating effects of death and death work on both therapists and children have been presented and the specific effects of bereavement counselling, within the South African scenario, have been alluded to. Within each theme, general findings have been discussed and examples from the raw data presented. The literature review has, by and large, supported the findings of this study.

Finally, when I reflect on this study in its totality, what has become clear is stated in Papadatou and Papadatos (1991:xvii) namely "the conviction that exploring the issues of death may help each of us identify our values, priorities and goals in life and (thereby) enhance the quality of our everyday living by giving it deeper meaning".

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APPENDIX A

Semi-Structured Questionnaire and Invitation to Attend Focus Group Interview

Melanie Frankel

26 June 1997

Dear friend,

I am currently compiling the data for my dissertation on the subject of **The Educational Psychologist's personal and professional experiences as Bereavement Counsellor in the therapeutic relationship with children,** and would value your contribution to my research.

I know that you took part in a very valuable workshop between 23 - 25 June run by the Centre of the Study of Violence and Reconciliation, on the subject of Trauma Counselling and as there is an overlap between the two subjects please could you you take a few moments to reflect on the following:

How did you benefit (or not) from the course and any previous courses or lectures on the subject, in terms of:

1. **Knowledge on the subject:**

2. **Skills necessary for this type of therapy:**

12 Nicolaine Road, Sunningdale, 2192. Tel: 882-8476

3. Your attitudes or feeling towards this type of work with a young client:

4. What specifically do you think would affect you as therapist in this situation:

5. What do you think would assist you to cope as therapist in this situation:

6. How do you think that you as therapist would have coped before the course and will now cope in this unique type of therapeutic encounter:

7. What role do you think your own history of loss plays and will it affects the counselling situation.

Please take a few minutes today to complete these questions. (It may be a good idea for you to keep a copy of your answers for your own journal and for continual reflection).

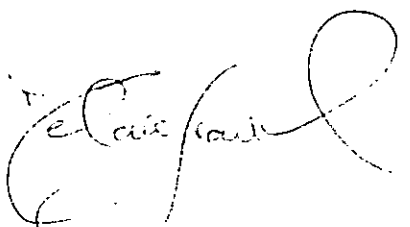
Please leave the completed questionnaire - in either English or Afrikaans - in my box or on my desk. Your thoughts and feelings will be respected and kept in confidence.

I would value your participation in a **focus group interview** that will be held on Wednesday 22 July (the day your lectures start) at 2.00 pm in the video room. **Please diarise.**

Name:----------Will be there/ can't make it(circle)

Thanks very much for participating, and for your thoughts and reflections on the subject. If you think of anything as time passes that you think could be relevant please phone me.

With best wishes,



Melanie Frankel