PROJECTIVE DRAWINGS OF BLACK BEREAVED CHILDREN IN KWAZULU-NATAL, SOUTH AFRICA: A TEST IN SEARCH OF PSYCHOLOGICAL LIFE

BY

LINDIWE O. SHANGE

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LINDIWE O. SHANGE

A dissertation submitted in partial fulfillment of the requirements for the degree of Master of Arts (Clinical Psychology) in the Department of Psychology University of Zululand.

SUPERVISOR: PROF N.V. MAKUNGA

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DECLARATION

I hereby declare that this is my own work and all the sources I have used or quoted have been indicated and acknowledged by means of complete references.

LINDIWE O. SHANGE

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ABSTRACT

There has been a lot of concern as to whether children grieve or not when death strikes in their immediate environment. If the experience of bereavement can be reliably measured in children, insight into their painful experiences will be gained and appropriate treatment strategies will be established.

This study aims to explore whether projective drawings can provide a reliable method of exploring the world of a black bereaved child. The Human Figure Drawing (HFD), Self Portrait, Kinetic Family Drawing (KFD) and Own Choice/spontaneous Drawing was administered on a group of 20 bereaved children and a control group of 20 non bereaved children. In general, more Emotional Indicators were identified on HFDs and Self Portraits of the Bereaved Group. Results showed statistically significant differences between the two groups in four indicators on HFDs (big figure; teeth; monster/grotesque; hands cut off) and in two indicators on Self Portrait (slanting figure and hands cut off) KFDs and Own Choice Drawings could not statistically differentiate the two groups but were found to be of assistance in gaining insight into the family dynamics and for gaining respite from grief work respectively, in the bereaved group. Composite analysis of the four projective drawings provided more insight into the world of the bereaved child.
CHAPTER 1

1. INTRODUCTION

1.1 Statement of the problem

Although the word “death” is a source of strong emotional response, to many people children do not really understand about death (Mc Mahon, 1992; Hemmings, 1995). A general reaction to this idea is that, when death strikes in a family or in the child’s immediate environment, it is common that a child is ignored, assuming that the child is not aware of what is going on (Worden, 1986). Siegel, Mesagno and Christ (1990) agree that some parents see no reason why children should be involved in situations that are concerned with death. Forrest and Thomas (1991) documented that the emotional pain experienced by bereaved children may go unrecognized and thus unresolved. As a result, children may not get the necessary attention (social support), a response considered to be a protective factor (Anthony, 1986; Rossman, 1992).

According to Christ, Siegel, Masagno and Langosch (1991) psychosocial development and mental health of children may be endangered by the death in the child’s family or immediate environment. However, if the experience of bereavement is expressed by bereaved children and it is reliably measured, insight into the painful feelings will be gained and appropriate counselling strategies can be established for this group.

Helping children deal with emotional pain of bereavement is of utmost importance for healthy childhood and psychological well being in adulthood. Therefore, mental health professionals,
psychologists in particular, must ensure that they have a major contribution to make in respect of assisting bereaved children firstly by identifying those at risk and then by intervening relevantly.

1.2 Motivation and justification for the study

There has been a lot of concern as to whether children grieve or not when death strikes in their immediate environment. It is evident from literature (Worden, 1986; Case, 1987; Forrest & Thomas, 1991) that children do present with “grief-like” behaviours when relationship attachments are broken. In such children, psychological suffering expresses itself in intense feelings and emotions of anger, sadness, anxiety and guilt (Case, 1987). Grief may also be exhibited in conditions like enuresis and difficult behaviour, which adults may fail to interpret as grief (Mc Mahon, 1992).

Children find it very difficult to articulate this feeling verbally (Worden, 1986; Mc Mahon, 1992). Research (Siegel, 1960; Koppitz, 1968; Forrest & Thomas, 1991) has shown that for many children, expressing painful experiences through drawings can be much easier than verbal articulation. Indeed, many therapists introduce drawings as a possible channel of communication and expression and sometimes as a means of assessment. Besides helping children express their feelings of grief, drawings may help with the process of healing. For all these purposes it would be useful to know, if aspects of the experience of bereavement are reflected in drawings of black children in any way.
1.3 Scope and limitation of the study

Due to practical considerations the present study was conducted in Newcastle district – Northern KwaZulu-Natal.

1.4 Aim of the study

It is the aim of this study to report and to corroborate findings concerning the grieving of children when death strikes in their immediate environment. More specifically the relationship between projective drawings in terms of expressing an affective meaning in life, is to be ascertained. In this manner the inner world, individual feelings and personality structures of a black bereaved child are to be assessed more finely than it has been in the literature to date and in a manner that may not be possible through direct communication.

The present study therefore test the hypothesis that children’s drawings provide sufficient information about their emotional state to distinguish a group of children with a death in the immediate environment and a matched control group.

1.5 Definition of terms

Concepts that will be frequently used in this dissertation are defined below:
1.5.1 Grief

Freud defined grief as emotional pain that accompanies a sense of loss (Dershimer, 1990). Schneider in Deshimer (1990) defines it as a holistic process that affects people physically, emotionally and spiritually. In this study grief refers to the natural process following loss through death involving emotional, psychological, physical and behavioural reactions.

1.5.2 Bereavement

The American Psychiatric Association (1994) refers to it as the reaction to the death of a loved one. Deshimer (1990) defines it as the necessary recovery process from death of a significant person in one's life, which includes more than the pain of grief. The person experiences significant changes in behaviour, thoughts and attitudes amongst other things.

For the purpose of this study bereavement refers to the reaction process following death of a loved one, who might be the parent or sibling of the child. Bereavement encompasses more than just grief.

1.5.3 Mourning and grief work

Mourning is also referred to as grief work (Corr, Nabe & Corr, 1997). For the purpose of this study mourning and grief work will be used interchangeably.
Psychoanalytically mourning refers to mental work following the loss of a love object through death (Webb, 1993). Corr et al (1997) refer to mourning as the process of coping with the loss and grief and involves ways of how individuals try to learn to live with the loss and bereavement. Mourning/grief work in this study refers to the effort an individual put into dealing with the loss resulting from death of a loved one.

1.5.4 Child

This is a person between either birth and maturity, birth and puberty or infancy and puberty (Reber, 1985). For the purpose of this study a child will refer to a person from age 8 to 12 years.

1.5.5 Projective drawings

These are drawings that are used as an assessment method to reveal information about the person’s inner world, individual feelings and personality structures, in a manner that may not be possible through direct communication (Koppitz 1968). In this study the projective drawings will be used to reveal how the child is reacting and coping with the death of a loved one.
CHAPTER 2

This chapter deals with different aspects of bereavement in childhood. Even though emphasis is on children, some aspects of Adult Bereavement will be reviewed too, so as to clarify differences where they exist and the ensuing implications.

2.1 DO CHILDREN GRIEVE?

In this subsection literature that supports the assumption that children are capable of grieving or mourning is briefly reviewed.

Webb (1993) argues that in the very young, grief may only be reaction to a loss of attachment not necessarily mourning, which he believes is possible only in older children and adults.

Review of literature (Black, 1988; Fitzgerald, 1992; Hemmings, 1995; Lindsay, 1996; Tait & Depta, 1993) indicates that children grieve differently from adults. This difference may contribute to the misconception that children do not experience grief. According to McMahon (1992) children have learned that they are not expected (by adults) to talk about their feelings, thus they keep emotional pain to themselves. At the same time the very same adults assume children do not experience pain of mourning.
Differences in grief reaction could be the reason why adults think children are not capable of grief. According to Hemmings (1995) children certainly do grieve and it is unfair and wrong for adults to expect children to show same grief reactions as adults.

Cook (1996) mentions that even in children the pain of grief may take years to resolve. Children are capable of experiencing and expressing pain of bereavement, unfortunately their feelings tend to be underestimated (Wass, 1991). Research findings on long term effects of bereavement in childhood, like increased attempted suicide in adulthood further support the notion that children do experience pain of mourning (Black, 1998).

In the discussion following, signs and symptoms of grief further attesting to the fact that children do grieve will be explored.

2.2 CHILD’S UNDERSTANDING ABOUT DEATH: A DEVELOPMENTAL PROCESS

2.2.1 Concepts about death

Cook and Oltjenbruns (1989) have put forth concepts that are involved in understanding about death. These are:

a) non functionality

b) finality

c) universality and
Non-functionality refers to understanding that a dead person does not feel, breath etc.

Finality refers to recognition that death is final

Universality refers to realization that death happens to all individuals

Casuality refers to what a child thinks causes death.

According to Webb (1993), understanding these concepts is a developmental process which should have been fully acquired by age 9-10. Webb (1993) adds irreversibility and inevitability to the above concepts. Cultural as well as religious beliefs are also considered important for development of death awareness.

As noted by Fitzgerald (1992) with each stage of development the child perceives death differently. However (1993) further explains that even though cognitive development does occur in stages, the development is unique for each child and it is a gradual process.

2.2.2 Cognitive development

Piaget’s theory of cognitive development applies to the child’s understanding of death (Cook & Oltjenbruns, 1989; Web, 1992). Piaget’s cognitive developmental stages are:

a) Sensorimotor (birth-2 years)

b) Preoperational (2-7 years)
c) Concrete operational (7-11 years) and
d) Formal operational (11 through end of adolescence)

(Kaplan & Sadock, 1991; Webb, 1993). These stages and some of which are relevant to this study will be briefly reviewed below.

Preoperational (2-7 years)

Child’s thinking is concrete, magical and with tendency to distort reality. Egocentrism that is evident in early childhood diminishes as child develops, thus in a 6-year-old one would expect less than in a younger child. Due to failure to understand causality and because of magical thinking, the child may feel guilty thinking somehow he/she caused the death of the loved one. Black (1998) maintains that a five-year-old understands irreversibility and universality of death. In contrast Levine in Webb (1993) maintains a five-year-old is unable to understand irreversibility of death.

Concrete operational (7-11 years)

Death as irreversible and final will be understood during this stage. Although children by now have developed universality, still they do not see that death can happen to them too but they see it as only happening to old people (Webb, 1993). Thus, death of a sibling is very hard on children at this stage. According to Fitzgerald (1992) they think they could have prevented the death from happening.
Egocentric thought is now replaced by operational thought. The child now uses a lot of outside information, is capable of looking at issues from another person’s point of view and can reason and follow regulations (Kaplan & Sadock, 1991).

Since most of the subjects of the present study will be at this stage, its characteristics are further reviewed. Cook and Oltjenbruns (1989) mention the following:

- diminished egocentrism
- decentration, referring to considering multiple factors simultaneously
- transformation, that is capable of perceiving intermediate steps leading to an outcome.
- reversibility, referring to being able to reverse thought processes
- conservation, that is able to understand that certain characteristics of an object do not change
- related phenomena, although thought is now more logical, some magical beliefs still hold.

Transformation, for an example, will enable a child to understand that illness may lead to death.

**Formal operations (11 through end of adolescence)**

This is characterized by development of abstract thinking, reasoning and defining concepts, child’s thinking begins to be logical and systematic (Kaplan & Sadock, 1991).
By age 9 or 10 a child is expected to have insight to the fact that death is final, irreversible and universal. By age 12 the child is expected to have understanding of the abstract nature of death (Webb, 1993).

2.2.3 Psychosocial development and death awareness

Development is not only cognitive but has also a psychosocial aspect. In supporting this notion Smith and Pennells (1995) use Levine’s Developmental and Death Awareness Model which incorporates Erickson’s stages of psychosocial development from infancy to adolescence.

Kaplan and Sadock (1991) give Erikson’s stages of development as:

(a) Basic Trust vs. Mistrust (Birth -1 year)
(b) Autonomy vs. Shame and Doubt (1-3 years)
(c) Initiative vs. Guilt (3-5 years)
(d) Industry vs. Inferiority (6-11 years) and
(e) Identity vs. Role diffusion (11 years through end of adolescence).

Stages that will apply to the present study are further reviewed.
Industry vs. Inferiority (6-11 years)

This is the stage where the child is in a socially decisive age. The child can either be successful, mediocre or be a failure. The status the child has among peers is important. (Kaplan & Sadock, 1991; Smith & Pennells, 1995). Being bereaved may cause the child to feel different and the child may not like to discuss the bereaved state with peers. Smith and Pennells (1995) maintain that the level of death awareness according to Levin’s model mentioned above is as follows:

- realization that death is final
- neither denies nor accept death in his life
- still has some magical thinking
- personifies death
- greater level of death anxiety
- death may be seen as punishment for bad behaviour

The child will want information regarding details of the death and what happens to bodies afterwards (Smith & Pennells, 1995).

Identity vs. Role Diffusion (11 years through to adolescence)

During this stage the child engages in a lot of self-exploration or may remain confused. Also involves attachment to parents and avoiding dealing with identity issues (Kaplan & Sadock, 1991; Smith & Pennells, 1995).
Death Awareness

- Starts to develop adult concept about death
- May avoid funeral customs in order to avoid reality of death
- Worries about pain and suffering (Smith & Pennells, 1995)

All above issues will have an impact on how the child deals with grief work, involvement in rituals, grief symptoms and support needed at different stages.

2.3 SIGNS AND SYMPTOMS OF GRIEF

2.3.1 Grief in general

Grief, whether in adults or children can manifest itself in a variety of disturbances in feelings, physical sensations, cognitions, behaviours and social interaction (Corr et al., 1997). As mentioned by Fallaam and Vine (1996) such disturbances include:

- Feelings: Sadness, anger, guilt, self reproach, anxiety, loneliness, helplessness, yearning.
- Physical sensation: Tightness in the throat or chest, shortness of breath, lack of energy, sense of depersonalization, dry mouth, loss of coordination, muscle weakness.
- Cognitions: Disbelief, confusion, preoccupation, hallucinatory experiences, sense of presence of the deceased.
• Behaviours: Sleep or appetite disturbances, absent mindedness, social withdrawal, loss of interest in activities that previously were a source of satisfaction, crying, sighing, restless, overactivity.

• Social interaction: Difficulties in personal relationships, spiritual searching for a sense of meaning or hostility towards God.

• Immediate reaction include the following symptoms shock and disbelief, dismay, protest and apathy. Some individuals continue with their usual activities and show acceptance of loss with little reaction.

2.3.2 Childhood grief

Contrary to popular belief that children are not capable of experiencing deep feelings, Furman (1974) maintains that because children invest almost all their feelings on parents, when a parent dies they do experience intense feelings too.

Signs and symptoms of childhood grief mentioned by several authors (Baker, 1991; Cook, 1996; Cook & Oltjenbruns, 1989, Elsegood, 1996; Fitzgerald, 1992; Furman 1974; Grollman, 1991; Hallaam & Vine, 1996; Hemmings, 1995; McMahon, 1992; Smith & Pennells, 1995; Wass, 1991) include the following:
Feelings

- Extreme sadness or loneliness
- Denial, where a child acts as though nothing has happened
- Anger in the very young may be manifested in behaviours like smashing toys or tearing books on any other form of temper tantrums
- Guilt or self blame, the child may wrongfully believe he/she somehow caused the death
- Despair, depression or apathy
- Extreme insecurity, especially following death of a parent
- Anxiety or obsession about survival of remaining parent
- Withdrawal from surviving parent to protect self from another potential loss
- Jealousy, towards families that are still intact
- Repressed feelings.

Behavioural

- Searching and calling out for the deceased, depending on the child’s age. Even adults can exhibit such behavior. In support of this notion Parkes, (1985) states: “the fact that the intelligent human adult knows very well that it is useless to cry aloud and to search for a dead person does not remove the impulse to do just that” (p.11).
- Unusually withdrawn, quiet or excessive talking
- Sleep disturbance for an example, nightmares
- Negative feelings shown through violence and aggression towards other children or adults
- Regressive behaviour like bedwetting and thumb sucking
- Increased activity or acting out behaviour
- Unpredictable and demanding
- Clinging to adults
- May take extra responsibilities hoping to spare the parent from additional stress
- Pay less attention to previously liked activities
- Wondering aimlessly and staring into space
- Change of attitude towards food and meal times
- Search for immediate ways of regaining control over own life, which may be mistaken for inability to grieve
- Accident prone and self injury
- School based behavioural problems which include school truancy, poor performance, difficulty with concentration
- School over-achievement may result from the child channeling most of his/her energy on school work as a way of escaping pain.

**Somatic Reactions**

- Headaches and stomach aches are the most common
- Lethargy and lowered resistance to infection
- Identificatory symptoms where a child imitates symptoms of the deceased, occurs occasionally.
  
  Cain (1995) divided these identificatory symptoms into symptoms based on direct observation
of the deceased symptoms, those based on fantasy constructions and concealed identificatory symptoms.

Cognition

- Mental disorganization
- Forgetfulness

Just like in adults grief manifest itself differently in different children and different feelings may be felt within a day with some never being experienced through out the grieving period (Fitzgerald, 1992). It is not only death of a parent that can evoke grief in a child. Death of a sibling can have long term behavioural implications on the surviving sibling, 7-9 years later (Davies, 1991).

Symptoms which can still be observed up to three years post death include nervousness, withdrawal, unhappiness or being sad and depressive and somatic symptoms like headaches, stomach cramps and sleep disturbances.

2.3.3. Normal and abnormal or pathological grief

Though we talk about normal and abnormal grief, Cook and Oltjenbruns, (1989) maintain that it is not wise to consider the two as the only distinguishing factors in the case of grief. It seems it also is imperative to identify those at high risk of developing abnormal grief as it may lead to permanent mental health problems (Parkes, 1985).
Two further differentiating factors identified by Webb (1993) is to consider:

- the degree to which the bereaved child can carry out usual activities and continue in his/her development despite the grief.
- Untoward signs in the child’s socio-emotional or physical development are a sign of abnormal grief.

Grief which is delayed or postponed leads to abnormal grief. This occurs when the child feels that he/she is not supposed to show any emotions or when adults do not show emotions in front of the child or talk about the death (Cook, 1996). An incident later on may trigger the grief reaction which was earlier on postponed (Cook & Oltjenbruns, 1989). Other forms of abnormal grief are inhibited grief, where some symptoms will be manifested but in a limited fashion and chronic grief which lasts beyond 1-3 years, which is regarded as normal grief period. Furthermore pathological grief implies unresolved, self-destructive dysfunctional and prolonged grief. Behaviours include inability to talk about or remember the deceased, violence directed towards other, loss of contact with reality and being self destructive (Cook & Oltjenbruns, 1989). Not much guidance is given pertaining to duration of normal grief in children. Dowdney and Wilson (1999) suggest that childhood grief lasting more than three months will affect family relationship adversely.
2.3.4 **Difference between adulthood and childhood grief**

Even though grief is a universal experience, due to differences in cognitive development between adults and children and due to social norms which dictate how far children can be involved in death issues, differences do exist between adulthood and childhood grief (Parkes, 1985). Adults unlike children have a cognitive advantage of having a clear understanding of death's finality and feeling more intensely and concisely (Fitzgerald, 1992). In comparison children’s grief is more discrete (Hemmings, 1985). Fitzgerald, (1992) explains that:

- Children’s grief is sporadic, may run over many years but with less intensity than initial grief.
- Children have the capacity of putting grief aside and focussing on more pleasant activities, which may also be attributed to lack of experience in handling grief, unlike adults.
- Children do not have to deal with many deaths and funeral rituals to which adults are exposed to. These tend to serve as constant reminders of the loss.

Unfortunately the above mentioned factors make people think that children are not capable of grieving.

2.4 **GRIEF AND MENTAL DISORDERS**

Not all bereavement lead to mental disorders but Parkes (1985) contends that in some instances bereavement can endanger one's mental health.
A child who has experienced grief is more likely to develop disorders like depression and anxiety in later childhood, some even attempt suicide. Further losses often precipitate such disorders. Adults bereaved of a parent in childhood have been shown by research (Weller, Weller, Firstad & Bowes, 1991) that they tend to be more vulnerable than the general population to mental disorders.

Even though some bereaved individuals present with symptoms similar to those of a Major Depressive Episode, according to the Diagnostic and Statistical Manual. (DSM IV), this diagnosis is not given unless symptoms are still evident two months after the death of a loved one (American Psychiatric Association – APA, 1994).

Amongst anxiety disorders, Post Traumatic Stress Disorders (PTSD) is at times associated with bereavement both in adults and children (APA, 1994; Lindsay, 1996). Signs of PTSD like disturbing dreams, sleep disturbances and reminders of the death event are experienced by some bereaved individuals (Lindsay, 1996). In children PTSD is especially encountered in sudden and traumatic deaths (Webb, 1993). Grief symptoms in children are seen as being similar to reactions seen in PTSD (Smith & Pennells, 1991).

2.5 GRIEF WORK

Freud referred to grief as a process that is absorbing and involving work (Cook & Oltjenbruns 1989). This seem to imply that the bereaved individual, in this case the bereaved child, has to “work” on some issues, be actively engaged in order to resolve grief.
Although Hemmings (1995) mentions that bereavement is a unique experience, common psychological tasks, which will help in the resolution of grief have been identified in literature (Baker, Sedney & Gross, 1992; Cook & Oltjenbruns, 1989; Corr et al., 1997; Elsegood, 1996; Leick & Davidse-Nielsen, 1991; Tait & Depta, 1993). These tasks are regarded as cognitive, emotional, behavioural and social in nature (Corr et al., 1997). When a child is “working” on grief he/she moves through the following phases:

(a) Early
(b) Middle and
(c) Late Phase, with accompanying tasks (Baker et al., 1992; Corr et al., 1997).

Early Phase

This phase begins as the bereaved child learns about the death. It is mainly a cognitive phase involving seeking for information and seeking interpretation. At this point the child deals with:

- understanding the fact that someone has died
- making sense of what has happened and implications
- self protection through use of defense mechanisms such as denial to prevent feeling too much emotional pain.
Middle Phase

Mainly it involves acceptance and facing the loss. This is clearly an emotional phase involving release of emotions. Corr et al., (1992) maintain the individual realizes his loss is irretrievable and impossible to replace. Similarly Corr et al., (1992) agree with Cook and Oltjenbruns (1989) that acceptance and recognitions of the loss involve the following:

- accepting and emotionally acknowledging the reality of the loss and breaking away from the initial denial
- identification and validation of both positive and negative feelings towards the deceased
- appropriate tolerance and expression of painful and ambivalent feelings

Tait and Depta (1993) refer to this bearing of psychological pain as moving towards the pain of the loss. This implies the child will have to confront the loss.

Late Phase

This is the phase of identification and development of new skills. The child must simply learn to live a life without the deceased person. This does not however imply the child must forget the lost person, but should show appropriate remembrance. This is mostly a behavioural phase, when the child needs to do something concrete. Such as:

- Developing a new self identity based on a life without the deceased.
• Withdrawing emotional energy from the deceased and reinvest it in another relationship.
• Constructing a long standing internal relationship with the deceased in cooperating both absence and new kind of attachment. A new kind of relationship develops with the deceased.
• Returning to age appropriate developmental tasks and activities which were interrupted by emotional loss.
• Coping with periodical resurgence of pain which is likely to occur on important anniversaries like birthdays.

According to Leick and Davidse-Nielson (1991) the tasks related to each phase should be considered as intertwined and not exclusive entities, also they may need to be addressed repeatedly in a particular child (Corr et al., 1997).

2.6 MEDIATING FACTORS

Factors found to be influential on the intensity and duration of the process of grief work have been identified and documented in literature (Cook & Oltjenbruns, 1989; Corr et al., 1997; Webb, 1993). These are namely:

(a) Individual
(b) Death related and
(c) Family related
These factors will impact on the bereaved child in different ways depending on the child's unique circumstances.

**Individual Factors**

- Past coping skills e.g. at school.
- Past experiences with death and how the child coped.
- Age, sex, cognitive level of development. According to Dowdney and Wilson (1999) bereaved boys were found to show more acting out and aggressive behaviour.
- Deceased parent's age, sex and relationship with the child. Cook and Oltjenbruns (1989) allude to the fact that loss of a mother is expected to be different from that of a father due to differences in roles played by these parents.
- Personality of the child. According to Cook and Oltjenbruns (1989) children with a history of poor impulse control, tendency to withdrawal and having adjustment difficulties, tend to show more intense grief reactions.

**Family Factors**

- Family structure
- Pattern of adjustment
- Cultural background. According to DSM IV (1994) “duration and expression of normal grief vary considerably among different cultural groups” (p. 684)
- Religious affiliation
• Extent of child’s inclusion and preparation for the mourning process.

**Death Related Factors**

• Type of death e.g. was it sudden, anticipated as in prolonged illness or a suicide or homicide. Children tend to be better prepared when death follows a prolonged illness.

• Contact with deceased e.g. viewing the body.

With regard to mediating factors, Corr et al., (1997) maintain that the following are the most pivotal:

• Nature of prior attachment or perceived value the deceased had for the bereaved child

• The way the loss occurred and concurrent circumstances of the bereaved child

• Coping strategies tried with prior losses

• Developmental level of the bereaved child

• Social support received following the loss.

### 2.7 DEATH AND FUNERAL RITUALS

According to Cook and Oltjenbruns (1989) rituals serve the purpose of publicly acknowledging that a death has occurred. Furthermore these authors maintain that such a public acknowledgement somehow helps in the development of inner acceptance. Rituals, therefore are seen as part of the healing process.

The rituals help the bereaved family to, amongst other things:
• accept the reality of the loss
• express feelings related to the loss
• accomplish the tasks of grief work
• reach out for support

(Cook & Oltjenbruns, 1989).

As noted in literature, (Cook, 1996; Fitzgerald, 1992; Grollman, 1991) it is important for bereaved children to be involved in the rituals so that they also gain emotionally. Such participation is also emphasized by Bartman (1991) who judges it as more than just paying respect to the dead person, but as an integral part of the healing process. Some funeral rituals are described below.

2.7.1 Prefuneral rituals

Viewing the body and prefuneral prayer service are some of the prefuneral rituals that a child may participate in (Cook & Oltjenbruns, 1989). According to Fitzgerald (1992), involvement of the child should depend on the family’s culture, religion as well as the child’s willingness to the involvement. This serves the purpose of rather reducing fantasies like thinking that the deceased person will come back. The young child is singled out by Weller et al., (1991) as needing concrete experience of seeing the deceased in the company of an adult. This task can be carried out by a therapist or as Black (1998), contends by any adult less affected by the death. Furman (1974), however maintains that it is the surviving parent’s responsibility to support the child during the rituals.
2.7.2 Funeral and memorial services

Fitzgerald (1992), argues for the fact that young children should be allowed to attend funerals as long as they feel comfortable. This will assist in confirmation of the reality of death. Involvement may include participation in the family choir, singing alone or placing any meaningful article in the coffin such as a drawn picture (Excell, 1991). These activities provide a good avenue for the bereaved child to say “good bye.”

2.7.3 Post funeral rituals

Visiting the grave and reviewing photographs taken during the funeral facilitate resolution of grief (Cook & Oltjenbruns, 1989; Excell; 1991).

Bereaved children need to be involved in the rituals to help them through the pain of grief work. As explained by Fitzgerald (1992), children have the capacity to deal even with “sad truth, wrenching truth, even the most devastating truth and handle it in their own way” (p. 74). This implies the importance of being told the truth about the death of their loved ones and being involved in rituals like funerals. Tait and Depta (1993) and Grollman (1991) are in agreement that adults’ secrecy, withholding information or giving inaccurate information will impede the resolution of grief and even lead to serious problems later on.
2.8 MYTHS PERTAINING TO CHILDREN AND GRIEF

Some myths that have been identified pertaining to children's grief (Tait & Depta 1993; Wass, 1991) are:

- Children are uncurious, thoughtless and unfeeling
- Children recover quickly from the death of a loved one
- Children are emotionally fragile and need to be protected from dealing with death.

2.9 THE PSYCHOLOGY OF CHILDREN'S DRAWINGS

As early as 1935 (Harris, 1963) psychological evidence was abound showing that children's drawing reflect more than just their conceptual development, but also express emotions. As explained by Hammer (1960) children like to draw and it comes natural to them (Koppitz, 1968). Assessment utilizing drawings is less threatening to them (Cobia & Brazelton, 1994; Hammer, 1960).

Literature (Baker, 1991; Cobra & Brazelton, 1994; Davies, 1995; Goodman & Williams, 1998; Hackbarth & Murphy, 1991; Hanes, 1997; Kymissis & Khanna, 1992; Ndlovu, 2001; Tait & Depta, 1993; Thomas & Silk, 1991) to mention a few, indicate how drawings can be used to gain access to children's feelings. Goodman and Williams (1998) explain that because in children words do not suffice to express feelings, art is preferable to objectify passion and pain. Hence the present drawings used to objectify the pain of bereaved children. As pointed by Hammer (1960) what children draw is
what is important to them as well as what is troubling them. This implies that we can expect painful emotions to be expressed through the drawings.

According to Harris (1963), children's art include clay, paintings and drawings. These help in the expression of feelings like extreme anger and sadness which helps the process of accepting the irreversibility of death (Mc Mahon, 1992).

Davies (1995) gives objectives for art therapy use as:

- Awareness
- Expression of energy and feelings
- Working through a problem
- Spontaneity
- Creativity and joy

In this study the first four objectives apply. Although the focus of this study is on assessment aspects, while the child is drawing he/she is also confronting and working through present problems, in this case bereavement.

Some of the drawings that can be employed and which are also used in the present study are: Human Figure Drawings, Self Portrait, Family Drawings and Creative Drawing of own Choice (Davies, 1995; Thomas & Silk, 1991) with the exception of the simple family drawing which will be replaced by the Kinetic Family Drawing.
2.9.1 Human Figure Drawings (HFDs)

According to Koppitz (1968) HFDs assist to reveal the child’s attitude towards self as well as towards a significant other. Drawings are seen as a statement made by the child, which may be retelling what the child has experienced, or as mentioned before, be about how he/she feels. In this statement a child may be asking or demanding something, it is up to the Clinician/Therapist to find out what the child is communicating through the HFDs.

Webb (1993) points out that HFDs also allow for corrective emotional experience which is invaluable in grief assessment and therapy.

According to Koppitz (1968) when a child draws a particular member of the family this implies the person is important in the child’s life at that particular time. A child may then even draw the picture of the deceased person.

2.9.2 Kinetic Family Drawing (KFD)

This projective test which is an improvement on the Draw a Family Test, was developed by Burns and Kaufman (Marnat, 1984). KFD allows for insight into the family dynamics which was less possible in the static figures of the earlier test (Marnart, 1984; Cobra & Brazelton, 1994; Hackbath & Murphy, 1991). The child’s attitude towards other members of the family as well as own concept of one’s role in the family are revealed (Koppitz, 1968). The bereaved child may thus show isolation from, for an example a surviving parent.
As the child is drawing her family he/she will be simultaneously drawing and projecting into it (Hulse, in Kymissis & Khanna, 1992). Davies (1995) indicates that these projections are valuable indicators about the child’s life.

2.9.3 Spontaneous drawings

According to Baker (1991) these assist the Clinician to get insight into the bereaved child’s intuitive awareness.

Spontaneous drawings may be of a peaceful nature depicting flowers, heaven or angels or harsh, showing guns. (Tait & Depta, 1993). This will obviously depend on the cause of death, partly.

The different projective drawings provide a more composite picture of the bereaved child’s reaction to the death of the loved one.

2.9.4 Advantages of utilizing projective drawings

Machover in Anderson and Anderson (1951) mentions the following:

- interpretation is made directly from the figure drawn
- drawing may be preserved to be analyzed later
- drawing is often welcomed by those who are verbally shy or inhibited
According to Rabin (1960) projective drawings offer maximum freedom and spontaneity and they are least restrictive. This notion is ably expressed by Harris (1960) thus “the drawing page serve as a canvas upon which the subject may project a glimpse of his inner world, his traits and attitudes, his behavioural characteristics, his personal strength and weaknesses” (p. 258). This is exactly the type of information needed by a Clinician from the bereaved child so that a thorough assessment occurs leading to relevant interventions.

2.10 INTERVENTION PROGRAMMES FOR BEREAVED CHILDREN

Hallam and Vine (1996) indicate that all bereaved children need support from adults to help them validate their feelings and deal with the pain. This implies that it is not only those children with signs of pathological grief who will need help. As explained by Webb (1993) even those bereaved children who show under reaction warrant close observation and support to avoid delayed grief. According to Cook (1996) intervention should be instituted within few days following the death to minimize long term problems.

2.10.1. Role of health professionals

Literature (Fitzgerald, 1992, Lindsay, 1996) shows that health professional’s support is invaluable to bereaved children. Very often in times of death, adults are preoccupied with their own grief and thus are largely unavailable to help the bereaved child through the grief process, leaving a void which can be filled by health professionals, like Psychologists.
Needs of the bereaved child will guide the Clinician’s mode of therapy as well as the specific techniques to be used. Excell (1991) regards the following as some the needs of a bereaved child:

- information to correct any misperceptions
- understand feelings experienced and how to interpret them
- alternatives in rituals
- repeated explanation about death

Excell (1991) suggests that when a clinician is providing for the above needs, it is important to respect the child’s wishes, for an example if the child does not wish to view the remains of the deceased, that should be respected and an alternative way of saying “goodbye” be provided.

Black (1991) argues that the aims for interventions are to promote mourning and to improve communication between the child and adults. Therefore, environment for therapy should be a safe and caring one (Corr, 1991) and allow for honesty, openness and be non-judgemental (Excell, 1991). Such as a conducive-environment will allow the child freedom to ask questions.

2.10.2 Initial intervention

According to Fitzgerald (1992), the following simple measures are important during initial contact:

- telling the child precisely what has happened
- answering questions simply and honestly
• explaining about death
• involving child in rituals, including planning for funeral
• encourage expression of feelings
• offering love and support
• telling the truth even in suicide and murder deaths, before the child hears distorted information and warning the child about possibility of rumours.

Just giving information is not enough, the child must be prepared for grief work (Excell, 1991). This notion is supported by Black (1991), who refers to it as one of the aims of promoting mourning.

2.10.3 Modes of therapy

Therapy may be offered within an individual, family or group context, depending on age, nature of death and availability of resources (Webb, 1993).

Individual therapy is mostly indicated in suicide and other traumatic bereavement.

Group therapy is of help as a child is amongst children who are undergoing similar experiences.

Family therapy, according to Flemming and Balmer (1991) is important for helping the therapist understand the child’s bereavement in context. The family also gets an opportunity of supporting the child which they may not be capable of doing without the therapist’s support and encouragement. In
their study (Flemming & Balmer, 1991) found that family therapy can reduce post bereavement morbidity.

2.10.4 Specific techniques

Literature (Cook & Oltjenbruns, 1989; Hackbarth & Murphy, 1991; Kmietowicz, 2000; Webb, 1993; Wolfe, 1995) indicate how different techniques may be utilized when assisting a bereaved child. Such techniques include play therapy, art therapy for example drawings, role play, discussion, guided imagery with deep breathing exercises, empty chair technique, diaries, puppets and reading books. According to Webb (1993) even an 11-12 year old will benefit from play therapy.

Projective drawings, besides being useful tools for assessment, are also invaluable in helping children who are experiencing emotions like depression, fear, anger, denial or guilt (Kmietowicz, 2000; Fitzgerald, 1992).
CHAPTER 3

METHOD OF INVESTIGATION

In this chapter, the research sample, instrument and administration of the instrument and rationale for research technology are discussed.

3.1 THE PRESENT STUDY

This study intended to determine whether children’s drawings provide sufficient information about the child’s emotional state by distinguishing a group of children with a death in the immediate environment. For comparison purposes, data were also collected from non-bereaved children.

3.2 METHOD

3.2.1 Subjects

A total of 40 children attending primary school in the KwaZulu-Natal province participated in the present study. The subjects were Zulu speaking (one of the largest African language groups) comprising one group (experimental) of bereaved (n=20) and one group (control) of non-bereaved (n=20) children.

Sigel (1960) points out that research done using projective drawings is usually on small samples. None of the 40 subjects had any significant psychological disorder in the past. For the total sample, ages ranged from 8 to 12 years.
The researcher restricted the sample to black subjects since the target group was black South African children. Inclusion in the experimental group strictly meant that the bereaved child must have lost a parent or sibling in the past six months through death and not through any other loss.

The sample of the present study was largely a non-probability sample (Bailey, 1978; Reaves, 1992; Schweigert, 1998) which means that each member of the population is not equally likely to be selected. Bailey (1978) explains that small research projects often resort to non-probability samples because despite the drawbacks that arise from their non-representativeness, they are considerably less expensive, are far less complicated and can prove adequate in instances where the researcher has no intention of generalizing the findings of the study beyond the specific sample studied. The study also contained elements of purposive sampling as the researcher did not just pick the nearest people as in convenience sampling, but rather, picked only those subjects who best meet the purpose of the present study (Bailey, 1978).

### 3.2.2 Data collection

The data were collected in a series of individual interviews, during which the psychological assessments were also individually done. Literature (Harris, 1963; Koppitz 1968) emphasizes the importance of individual assessment with projective drawings and point out that individual assessment allows for thorough observation of the individual during drawing and avail an opportunity to pose clarifying questions about the drawn figures.
The environment was made as comfortable as possible and uncluttered, that is, with no pictures on the walls which could serve as models as suggested by Koppitz (1968).

All the psychological instruments used to collect data are well known, and have been used extensively with children. They are easy to administer and were well tolerated by all participants. The interviews and assessments took place over a period of six months. Informed consent was obtained from each participant's parent/guardian. Letter of informed consent from parents (Appendix A) was translated into Zulu (Appendix C) to accommodate the overwhelming majority of the parents who are Zulu speakers, mostly with primary school education. The accompanying questionnaire (Appendix B) was also translated into Zulu to allow for proper understanding by respondents (Appendix D).

All interviews with subjects were conducted in Zulu and instructions were also given in Zulu to avoid any misunderstanding. Observation by the researchers and interviews held with the principal revealed that mainly, medium of instruction was still in Zulu at the school where the sample was obtained. Mayekiso (1982) agrees that instructions to subjects should be given in the subjects' home language. The research design incorporated the use of both descriptive and inferential analyses.

3.2.3 Measuring instruments

A questionnaire and informal interviews with teachers were used as part of the research process which provided a case history and information relevant to the study.
The projective drawings used in this study were the Human Figure Drawing, Self-portrait, Kinetic Figure Drawing and Own Choice Drawing.

3.2.4 Procedure

In this study all subjects were asked to draw in the following sequence:

- Human Figure Drawing (HFD)
- Self-portrait
- Kinetic Family Drawing
- Own Choice Drawing

Subjects below age 9 were allowed a short rest period after drawing the self-portrait to avoid fatigue (Harris, 1963).

3.2.4.1 HFDs and self-portraits

For HFDs and self-portraits, Machover’s (cited in Anderson & Anderson, 1951) and Koppitz’s (1968) administration guidelines were used. Subjects were given a pencil, an erasure and an A4 size paper in the vertical position. Instructions for HFDs were:

"On this piece of paper, I would like you to draw a whole person. It can be any kind of person you want to draw, just make sure that it is a whole person and not a stick figure or a cartoon figure."
For younger children the above instructions were adjusted by adding:

“You may draw a man or a woman or a boy or a girl, which ever you want to draw” (Koppitz, 1968).

Instructions for the self-portrait were a modification of the first mentioned instruction.

3.2.4.2 Kinetic family drawing

Subjects were given an A4 size paper in the horizontal (landscape) position and the instruction was:

“I would like you to draw a picture of everyone in your family including you, doing something. Try to draw whole people, not cartoons or stick people. Remember, make everyone doing some kind of action” (Kaufman & Burns in Mamat, 1984).

Children who verbalized not being able to draw were encouraged by being told that the aim was not to assess quality but activity in the drawing.

3.2.4.3 Drawing of own choice

Subjects were given an A4 size paper in the horizontal position (to allow for enough drawing space) and asked to make a drawing of their own choice. According to Baker (1991) such projective drawings assist in gaining insight to the bereaved child’s intuitive awareness.
3.2.4.4 Informal interrogation

Literature (Harris, 1963; Machover cited in Anderson & Anderson, 1951; Koppitz, 1968) supports the idea of posing some questions following drawings. Such questions serve to clarify any ambiguous aspects of the drawing and thus assist in obtaining valuable information about the subject. Children with emotional difficulties can verbally express themselves following a drawing (Hammer, 1960.) The questions asked ranged from a simple “tell me about your picture” (Harris, 1963) to specific questions for example:

- What is this person thinking?
- When this person is alone what is he/she afraid of?
- What makes this person angry?

Only when the child was not forthcoming were the specific questions used.

According to Davies (1995), projective questions posed following self-portraits, may lead to self-descriptions.

Following a drawing of the KFD the subjects were asked to describe their drawings to help with accuracy of perception and interpretation.

Following a drawing of own choice, the subjects were also asked to tell a story about what has been drawn thus avoiding making assumptions about the drawn pictures.
3.2.4.5 Collateral information

A questionnaire (Appendix B) was attached to the letter of consent (Appendix A). Informal interviews were also held with the teachers. Information gained was compared with that obtained from the semi-structured interview with each subject.

3.2.5 Ethical consideration

According to Hammand & Gantt (1998), all form of art work (thus including projective drawings) produced by clients should be considered as confidential just like verbal communication. Thus the protocols were not identified by name and the parents were also assured of confidentiality (see Appendix A).

3.2.6 Scoring

Data collected was scored and coded by the researcher. All coding was rechecked by the researcher. Information on scoring is reported in Chapter 4.

3.2.7 Data Analysis

To make sense of the data collected frequencies of responses were tabulated for the total sample. The researcher also used the chi-square analysis for the testing of the hypothesis. Results of these findings are given in Chapter 4.
CHAPTER 4

PRESENTATION AND ANALYSIS OF DATA

This chapter deals with the presentation and analysis of data collected. A fuller description of subjects will also be given. Results which may be apparent even in this chapter, will however, be discussed in the next chapter.

4.1 SUBJECTS

As already mentioned in (Chapter 3) 20 pairs of children were matched for age, sex and grade. Subjects in the Bereaved/Experimental Group will hereafter be referred to as Group A and the Non-Bereaved/Control group will be referred to as Group B. Table 1 shows the distribution of subjects in the present study.
TABLE 1: Distribution of Group A by Age, Sex and Grade

<table>
<thead>
<tr>
<th>AGE</th>
<th>SEX</th>
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<th>3</th>
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<th>5</th>
<th>TOTAL</th>
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<td>3</td>
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<td>2</td>
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</tr>
<tr>
<td>TOTAL</td>
<td></td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>5</td>
<td>20</td>
</tr>
</tbody>
</table>

Distribution of Group B was similar to that of Group A. In each group, age ranged from 8 to 12 years. Grade ranged from Grade 1 to Grade 5. Each group of 20 subjects included 1 child in Grade 1, four in Grade 2, two in Grade 3, eight in Grade 4 and five in Grade 5. Table 2 shows distribution of Group A by age and sex. Group’s B distribution is similar to Group A’s.
**TABLE 2: Distribution of Group A by Age and Sex**

<table>
<thead>
<tr>
<th>AGE</th>
<th>FEMALES</th>
<th>MALES</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
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<td>2</td>
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<tr>
<td>10</td>
<td>2</td>
<td>1</td>
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<td>11</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>12</td>
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<td>0</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>13</td>
<td>7</td>
<td>20</td>
</tr>
</tbody>
</table>

In each group there were 13 females and 7 males. Out of these, 3 were eight years old, 5 were nine years old, 3 were ten years old, 7 were eleven years old and 2 were twelve years old.

**4.2 ANALYSIS OF PROTOCOLS**

All the protocols were analysed for presence of significant psychological signs as suggested by Harris (1963).
4.2.1 Scoring system

Since self portraits are a form of HFDs, they were all analysed using Koppitz’s (1968) scoring system for Emotional Indicators. The following is a list of the 30 Emotional Indicators identified by Koppitz (1968) as significant psychological sign on HFDs:

Quality signs

Poor integration of figure
Shading of face
Shading of body and/or limbs
Shading of hands and/or neck
Gross asymmetry of limbs
Slanting figure, axis of figure titled by 15° or more
Tiny figure, 2 inches or less in height
Big figure, 9 inches or more in height
Transparencies

Special features

Tiny head, 1/10th of total figure
Crossed eyes, both eyes turned in or out
Teeth
Short arms, not long enough to reach waist line
Long arms, long enough to reach knee line
Arms clinging to side of body
Big hands, as large as face of figure
Hands cut off, arms without hands or fingers
Legs pressed together
Genitals
Monster or grotesque figure
Three or more figures spontaneously drawn
Clouds, rain, snow

Omissions

No eyes
No nose
No mouth
No body
No arms
No legs
No feet
No neck
Quality signs are related to the quality of the projective drawing for example asymmetry or presence of transparencies. Special features are those signs not usually found on HFDs for example teeth. Omissions are those features that would be expected but are omitted on the particular child’s HFD, for example omission of the mouth is significant. See Appendix F for a complete description of the Emotional Indicators.

Some Emotional Indicators are valid for boys and girls at different ages, this was taken into consideration during analysis. Table 3 below shows the list of these Emotional Indicators and ages of validity (Koppitz, 1968).

**TABLE 3 : Emotional Indicators and Ages of Validity**

<table>
<thead>
<tr>
<th>EMOTIONAL INDICATOR ON HFD</th>
<th>VALID FOR BOYS</th>
<th>VALID FOR GIRLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor integration of parts</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>Shading of body and or limbs</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>Shading of hands and or neck</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Big figure</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Omission of nose</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Omission of arms</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Omission of feet</td>
<td>9</td>
<td>7</td>
</tr>
<tr>
<td>Omission of neck</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>
Each HFD and Self Portrait were individually assessed for presence of the 30 Emotional Indicators.

4.2.2 Analysis of HFDs

Table 4 shows Emotional Indicators for Group A and Group B on HFDs.

**TABLE 4** : Emotional Indicators on HFDs of the Bereaved Group (Group A) and Non-Bereaved (Group B).

<table>
<thead>
<tr>
<th>EMOTIONAL INDICATORS</th>
<th>GROUP A</th>
<th>GROUP B</th>
<th>X²</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor integration</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shading of face</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shading of body, limbs</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shading of hands, neck</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asymmetry of limbs</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slanting figure</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiny figure</td>
<td>3</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Big figure</td>
<td>4</td>
<td>0</td>
<td>4.444</td>
<td>.035</td>
</tr>
<tr>
<td>Transparencies</td>
<td>1</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiny head</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feature</td>
<td>Count 1</td>
<td>Count 2</td>
<td>Count 3</td>
<td>Count 4</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
<td>---------</td>
</tr>
<tr>
<td>Crossed eyes</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth</td>
<td>4</td>
<td>1</td>
<td>2.057</td>
<td>.151</td>
</tr>
<tr>
<td>Short arms</td>
<td>6</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long arms</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arms clinging to body</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Big hands</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hands cut off</td>
<td>4</td>
<td>1</td>
<td>2.057</td>
<td>.151</td>
</tr>
<tr>
<td>Legs together</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitals</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monster, grotesque</td>
<td>4</td>
<td>0</td>
<td>4.444</td>
<td>.035</td>
</tr>
<tr>
<td>Three figures</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clouds</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No eyes</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No nose</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Big mouth</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No body</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No arms</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No legs</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No feet</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No neck</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 4 shows that six of the items (poor integration, tiny figure, big figure, monster, teeth and no feet) were found exclusively in protocols of Group A. Five items (asymmetry, slanting, short arms, hands cut off and no neck) were found in both Groups' protocols but more often on Group A's protocols.

Three items (shading of face, no nose and no mouth) appeared equally often on both Groups’ protocols. Transparencies was the only item found more often on protocols of Group B than in Group A. The last four mentioned items thus failed to differentiate between the bereaved and the non bereaved children in this study. Fifteen items were not present in any of the Protocols. The implications of these results will be discussed in the next chapter.

Four items (Big figure, teeth, hands cut off & monster/grotesque) were found significantly more often on protocols of Group A than of Group B. Chi square values for two items (Big figure and monster) were significant at the .035 level. Two items (teeth and hands cut off) were significant at the .151 level. The mean of items for Group A was 1.9000 as compared to .8 for Group B.

According to Koppitz (1968), Emotional Indicators must be considered compositely for diagnostic significance. Thus the total number of Emotional Indicators for each subject’s HFD was considered important. Table 5 shows the number of Emotional Indicators on HFDs of the Bereaved children (Group A) in comparison to the Non-Bereaved children (Group B).
Table 5: Number of Emotional Indicators on HFDs of Bereaved Children (Group A) and non-Bereaved Children (Group B).

<table>
<thead>
<tr>
<th>NUMBER OF EMOTIONAL INDICATORS</th>
<th>GROUP A</th>
<th>GROUP B</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>1</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 5 shows that only one (5%) of the 20 subjects in Group A had no Emotional Indicators compared to nine (45%) in Group B. In Group A five subjects (25%) had more than two Emotional Indicators as opposed to none (0%) in Group B. Chi square value was 11.777 at .038 level of significance.

4.2.3 Analysis of self-portraits

Table 6 shows Emotional Indicators of Group A and Group B on Self Portraits. The table shows that nine of the items (poor integration, shading of face, asymmetry, tiny figure, big figure, crossed eyes, arms clinging to body, monster/grotesque and no feet) were found exclusively in protocols of Group A.
Four items (slanting figure, teeth, short arms and hands cut off) were present in both Groups’ protocols but more often on Group A’s protocols. There were no items found equally often on both Groups’ protocols. Transparencies and shading of hands, neck were the only items found exclusively on Group B’s protocols. Again with HFDs’ protocols, transparencies was the only item found more often on Group B’s protocols than on Group A’s. These last two items thus failed to differentiate on any level, between the bereaved and the non-bereaved children, in this study.

**TABLE 6: Emotional Indicators on Self Portraits of the Bereaved Children (Group A) and Non-Bereaved (Group B).**

<table>
<thead>
<tr>
<th>EMOTIONAL INDICATORS</th>
<th>GROUP A</th>
<th>GROUP B</th>
<th>X²</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor integration</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shading of face</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shading of body, limbs</td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shading of hands, neck</td>
<td>0</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Asymmetry of limbs</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Slanting figure</td>
<td>4</td>
<td>1</td>
<td>2.057</td>
<td>.151</td>
</tr>
<tr>
<td>Tiny figure</td>
<td>3</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Big figure</td>
<td>2</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Description</td>
<td>Count</td>
<td>Value</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------</td>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transparencies</td>
<td>0</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tiny head</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crossed eyes</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teeth</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Short arms</td>
<td>6</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long arms</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arms clinging to body</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Big hands</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hands cut off</td>
<td>5</td>
<td>1</td>
<td>3.137</td>
<td>.077</td>
</tr>
<tr>
<td>Legs together</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitals</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monster, grotesque</td>
<td>3</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Three figures</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clouds</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No eyes</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No nose</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No mouth</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No body</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No arms</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No legs</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No feet</td>
<td>1</td>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 6 shows that two Emotional Indicators (slanting figure and Hands cut off) were found significantly more often on protocols of Group A than on protocols of Group B, Chi square value for cut off hands was significant at the .077 level. Chi square value for slanting figure was significant at the .151 level.

Table 7 shows the number of Emotional Indicators on Self Portraits of the Bereaved Group (Group A) in comparison to the non-bereaved group (Group B). Eleven of the 20 subjects (55%) in Group B showed no Emotional Indicators on their protocols compared with only three (15%) in Group A. Twelve (60%) of Group A subjects showed two or more of the Emotional Indicators on their protocol as compared to only 4 (20%) in Group B. Chi square value was 9.495 at .05 level of significance.
TABLE 7: Number of Emotional Indicators on Self Portraits of Bereaved Children (Group A) and Non-Bereaved Children (Group B).

<table>
<thead>
<tr>
<th>NUMBER OF EMOTIONAL INDICATORS</th>
<th>GROUP A</th>
<th>GROUP B</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>20</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>

4.2.4 Combined analysis of HFDs and Self portraits protocols

In protocols for both HFDs and Self Portraits the number of protocols with two or more Emotional Indicators was always higher in Group A than in Group B. Total number of protocols from Group A with no Emotional Indicators was 4 (10%) as compared to 20 (50%) protocols in Group B. The total number of protocols with one Emotional Indicator was found to be 13 (33%) in Group A and 12 (30%) in Group B. According to Koppitz (1968) the presence of only one Emotional Indicator implies absence of serious emotional problems. For two or more emotional indicators, a difference between the
two groups was evident. The total number of protocols with two or more indicators was 23 (58%) for Group A and only 8 (20%) for Group B. Chi square value was 9.494, at 0.050 level of significance. According to Koppitz (1968) two or more Emotional Indicators are suggestive of emotional problems including interpersonal ones.

4.2.5 Analysis of Kinetic Familial Drawings (KFD)

4.2.5.1 Guidelines for assessment of protocols

Protocols were analyzed utilising guidelines adapted from Burns & Kaufman’s original analysis principles (Marnat, 1984). The scoring variables are divided into three categories viz. Styles, for example edge placement of figures; action and relations between KFD, for example physical proximity and characteristic of individual KFD Figures, for example omitted figures (See Appendix G for the full list of variables and definitions). Qualitative assessment of protocols was carried out. Generally the variables assisted the researcher to gain insight into the subject’s interpersonal relationships by interpreting the symbols for general atmosphere, attitude, nature of activities, key figures drawn and generally the content of the projective drawing.

In this study some of the variables warranted more attention due to their significance in a bereaved child's protocols. One of these variables is omission especially of self which according to Excell (1991) may be interpreted as the child having been an observer in the grief work rather than a participant.
4.2.5.2 Identified variables for both Group A & Group B

- **Compartmentalization**

  This variable was present only in protocols of two Group A subjects. All figures were separated by lines.

- **Underlining of Individual figures**

  Four subjects of Group A as opposed to only one subject of Group B had this variable in their protocols.

- **Physical Proximity**

  Subjects from Group A & B, 11 and 12 respectively, drew figures separately doing activities alone and not close together. Only 2 subjects from Group A drew figures close together, the rest were drawn in subgroups.

- **Interaction of self**

  Five protocols from Group A showed subjects interacting with siblings and one protocol showed the same from Group B.
• **Barriers Between figures**

Only one subject from Group A had this variable. He drew an HIV/AIDS symbols which was brought home by an aunt.

• **Field of force**

Five subjects from Group A drew figures playing with a ball and six protocols from Group B also showed the same. Fires were depicted in seven Group A protocols as opposed to six Group B protocols.

• **Encapsulation**

Equal number of subjects, one in each Group had this variable in their protocols.

• **Description of figure’s actions**

Only three subjects in Group A had unexpected activities viz. all figures drawn just crying, all holding hands and all drawings. The rest of subjects in Group A and Group B had expected activities depicted, for example mother cooking.
• *Relative height of self*

Only one subject from Group A placed self above rest of the family as opposed to two subjects from Group B.

• *Position of figures with respect to safety*

Only one subject from Group A drew self and twin sister on the edge of paper with feet almost cut off. None of the protocols of Group B showed this variable.

• *Bizarre*

Three protocols from Group A had bizarre figures as compared to only one in Group B.

• *Pencil erasures*

Ten protocols from Group A depicted erasures as opposed to two from Group B.

• *Arm extension*

Found in both Groups’ protocols but more often in Group A’s protocols, 8 and 7 respectively. Most figures were shown holding brooms and sweeping or garden tools.
• **Rotation of figures**

Four figures from Group A’s protocols were depicted sleeping as opposed to one from group B. The rest of the figures were drawn standing up.

• **Shading (except hair)**

Two protocols from Group A showed shading—several figures were shaded but not self. From Group B, four protocols showed shading which included one on self.

• **Line quality**

Two protocols from Group A showed heavy lines, whereas only one protocol from Group B showed overwork.

• **Evasions**

Three protocols showed some figures doing nothing from Group A and 4 protocols from Group B also showed some figures just standing and doing nothing or depicted as just sitting down.
• Omitted figures

From Group A, 3 protocols showed omission of self; 10 showed parents omitted (not the deceased); six just other members of the family were omitted. Those who omitted self would also omit other members of the family. Four protocols from Group A showed no omissions. Omission were also present in Group B's protocols, with fifteen showing omissions.

• No face

From Group A one protocol showed no face, none showed this variables in Group B.

Additional variables were also identified for example transparencies and omissions of other essential body parts like the nose, hands and mouth. According to Koppitz (1968) for example ordering of drawn figures is important – did child draw self first or last? If last that is significant.

All the variables identified per protocol were considered compositely and compared to data gained from questions and interviews conducted.

4.2.5.3 Summary of analysis of KFDs

Some variables were not present in protocols of both Group A and B viz: folding compartmentalization; lining at the bottom of the page; lining at the top of the page; figures on back of the page; bird’s eyevie perspective and edged placement of figures.
Variables which appeared exclusively on protocols of Group A subjects were: position of figure with respect to safety; compartmentalization; barriers and unexpected description of figure’s actions and no face.

Variables that appeared in both Groups’ protocols but more often in Group A were pencil erasures, rotation of figures, underlining of individual figure, arm extensions, omitted figures, line quality and bizarre figures.

In this study variables that showed to be of no clinical significance were shading, motionless figures and relative height of self as these appeared more often in Group B’s protocols than in Group A’s.

Encapsulation was found equally often in both Groups thus it is unable to differentiate a Group A from a Group B subject.

The clinical significance of these variables in this study will be discussed further in the next chapter.

4.2.6 Analysis of own choice projective drawings

The protocols were assessed for content as well as atmosphere projected, which was envisaged would provide additional insight into the inner and interpersonal world of each subject.
Following assessment by the researcher, two independent clinicians were presented with the protocols for independent assessment. The two independent raters were not aware which subjects belonged to the Bereaved or the Non-Bereaved Groups.

Instructions to raters:

"These drawings were produced by a sample of 40 children ages ranging from 8-12 years. Some of these children had lost a parent or sibling within the past six months. Please indicate those who have lost a family member. The raters were asked to do the assessment within a period of 10 minutes.

4.2.6.1 Contents of protocols

Commonly depicted figures were cars, houses, flowers and human figures, in both Group A and Group B. Less commonly drawn figures were animals, fruit multiple figures and school.

Four protocols from Group A showed cars compared to six in Group B. Houses were depicted in six protocols of Group A as compared to two of Group B. One protocol from Group B showed a school. Human figures appeared in four Group A protocols as opposed to two from Group B. Flowers were shown in four protocols from Group A and two from Group B.
4.2.6.2 Projective questions following drawing of own choice

Only the projective questions following completion of the own choice drawing helped to make sense of some of the contents of the drawings. For example a female subject would draw a car, on being questioned it would surface that the car belonged to the deceased parent.

4.2.6.3 Analysis by independent raters

Rater A was able to identify (12) 60% of protocols by Bereaved subjects (Group A) and (6) 30% of protocols by the Non-Bereaved subjects (Group B). Eighteen (45%) protocols in total were correctly identified.

Rater B identified 11 (55%) of protocols by Bereaved subjects (Group A) and 11 (55%) of protocols by the Non-Bereaved subjects (Group B). Twenty-two (55%) protocols in total were correctly identified.

The two raters concurred and correctly identified the same protocols of 11 subjects, but, erroneously identified the same protocols of 10 subjects.
4.2.7 Analysis of other materials

4.2.7.1 Analysis of data from questionnaires

Interviews were held with Group A subjects before starting on projective drawings. As already mentioned, the interviews were conducted in Zulu. The majority of the subjects reported the following symptoms:

- Tightness in the chest - 70%
- Pain in the heart area - 85%
- Palpitations - 70%
- Not sleeping well - 75%
- Dreams and nightmares - 80%
- Trembling - 65%

The least reported symptoms were dizziness (35%), sleeping too much (35%) and nausea (55%).

Crying was reported as an additional symptom experienced by 80% of subjects. Other reported symptoms were fainting (10%) and headache (15%).

Of the 20 subjects, 13 (65%) had lost parents and 7 (35%) siblings. Seven (35%) of the deaths were unexpected. The number of symptoms reported by subjects who experienced unexpected deaths ranged from 3-9 symptoms out of a total of 9 symptoms. This does not differ from range of subjects who experienced expected deaths.
4.2.7.2 Analysis of unstructured questions

In order to gain more insight about preparation for grief work by the child the following questions were posed in Zulu.

- Did you view the body?
- Did you attend the funeral or memorial service?
- Have you visited the grave since the funeral
- How did you say “good-bye” to the deceased?

Of the 20 subjects 16 (80%) reported having viewed the body or coffin. The rest who did not, said they would have liked to have viewed the body. Seventeen (85%) attended the funeral. Fifteen (75%) have not gone back to the cemetery. The memorial service and the funeral provided means of saying “good bye” to the deceased to 90% of the subjects. Most were engaged in family choirs and adults allowed them to engage in the funeral ritual of “ukuthela inhlabathi” saying “good-bye” being involved in the “dust to dust” process.

4.2.7.3 Data collected from parents/guardians compared to data given by children on information about death and symptoms.

With the very young subjects – age 8 and 9 years, discrepancies were noted between symptoms reported by children and those observed by parents. Parents tended to have observed less symptoms than those reported by the children.
As age increased there were less discrepancies noted.

Less discrepancy was noted generally on the sleeping patterns. Symptoms like pain around the heart area were less reported by parents.

4.2.8 Analysis of projective questions

Following each completion of a projective drawing, questions were posed to avoid uninformed interpretations.

Following HFDs a child would be asked to tell a story about the figure drawn.

All subjects failed to give a spontaneous story thus had to be guided by questions like “what makes this person sad?” Then they were able to answer such straight forward questions. They were also asked to label the figures drawn.

Following KFDs the subjects were asked to label the figures and write down the actions. The young were helped to do this. Where ordering was not clear the subjects was asked to number the figures in the order they were drawn.

Some subjects would fail to depict the action but would note down what the figure is supposedly doing.
The importance of this additional information will further be discussed in the next chapter.
CHAPTER 5
RESULTS AND DISCUSSION

The bulk of the discussion in this chapter is on projective drawings although other relevant issues as reviewed in the literature are also briefly discussed.

5.1 RESULTS AN DISCUSSION ON PROJECTIVE DRAWINGS

The present study’s aim was to determine whether projective drawings can provide an excellent method of exploring the world of a black bereaved child.

5.1.1 Human Figure Drawings (HFDs)

The results showed that four emotional indicators were significantly more on Group A and thus distinguish bereaved children from non-bereaved ones. These Emotional Indicators were: big figure, teeth, hands cut off and monster. The results thus suggest that these indicators can contribute in exploring the world of a bereaved child.

Koppitz (1968) stresses the importance of considering the total number of Emotional Indicators leading to a holistic picture of the subject’s attitudes and feelings. Thus no one to one relationship exist between a particular Emotional Indicator and a particular behaviour or emotional state. If a particular Emotional Indicator is present in one and not in the other bereaved child this does not mean the latter is
not having emotional problems from bereavement, what would be important would be to consider the total number of Emotional Indicators within that protocol.

Koppitz (1968) further explains that the presence of only one Emotional Indicator is considered inconclusive. When comparing Group A to Group B more Group A subjects (8) had one Emotional Indicator compared to (6) subjects of Group B. This implies that a bereaved child could have no emotional problems that warrant concern. Considering that two or more Emotional Indicators are suggestive of emotional problems (Koppitz, 1968) Group A subjects clearly showed a significant difference between themselves and Group B. No Group B subjects had three or more Emotional Indicators compared to five in Group A.

The statistically significant Emotional Indicators, those found more often in Group A’s protocols as well as those found exclusively in Group As’ – HFDs & Self Portraits – will be discussed below (see 5.1.3).

5.1.2 Self Portraits

The results showed two Emotional Indicators that were found significantly more often on Group A’s protocols. These Emotional Indicators are slanting figures and hands cut off. The results suggest that these Emotional Indicators can be contributory in distinguishing Group A from Group B and can be of significant value in exploring the inner world of the bereaved child. There are other Emotional Indicators which were found exclusively on Group As’ protocols or more often on Group As’ protocols that can also assist in distinguishing Group A from Group B.
Results considering total number of Emotional Indicators per protocol were significant. Twelve of Group A protocols had two or more Emotional Indicators as compared to only four in Group B. Self portraits can thus be utilized in assessing bereaved children's world.

5.1.3 Emotional Indicators identified in HFDs and Self Portraits and their relationship with other relevant data

Interpretations of results were mostly based on the work of Koppitz (1968) who also incorporated other research findings from for example Machover; Di Leo (Cox, 1993). Cox (1993) also, stresses the importance of assessing for Emotional Indicators together with other valuable data. The discussion following outlines HFDs and Self Portrait results.

• Big Figure

The emotional Indicator is associated with immaturity and expansiveness. Six protocols in Group A as opposed to none in Group B made this indicator significant. Two of the subjects presented with a lot of grief symptoms, having reported presence of seven grief symptoms out of nine. These subjects could be communicating their wish to be noticed by adults at home. They might be feeling insignificant and ignored by parents who are still dealing with their own grief and having no time for the bereaved child. One of the subjects had crossed eyes (a rare Emotional Indicator). This child had threatened the guardian with suicide and wanted to go and stay with her father. She was literally asking for recognition in her drawing.
• Crossed eyes

This rare Emotional Indicator was present in the last above mentioned Group A subject on the self portrait. Crossed eyes seem to be associated with rebellion and anger which was apparent in this case. Frequency of reported grief symptoms was also high, seven out of nine.

• Teeth

Aggression is associated with this sign and in total it was identified in seven protocols of Group A and only one of Group B. It significantly distinguished Group A subjects from Group B. One of the Group A subjects had a total of four Emotional Indicators and had presented with eight out of nine grief symptoms. Clearly this child had emotional problems emanating from bereavement.

• Tiny figure

A total of six protocols from Group A and none from Group B showed this Emotional Indicator. This could significantly differentiate the bereaved children from the non bereaved. It is considered a symbol of extreme insecurity, inadequacy, withdrawal and depression. These form part of grief symptoms. According to Koppitz (1968) it can be assumed with confidence that a child who has shown this symbol is having depressive symptoms. In this study this was also apparent as one subject had a total of 5 Emotional Indicators and serious emotional problems were present.
• **Monster/Grotesque**

Seven protocols of Group A and none of Group B showed this Emotional Indicator. It was thus able to significantly differentiate Group A from Group B. It is reflective of feelings of extreme inadequacy and poor self concept. The child could be perceiving self as different from others. All protocols which included this symbol had a total of 2 or 3 Emotional Indicators, which on its own signifies emotional problems.

• **Hands cut off**

Nine protocols of Group A as compared to two of Group B showed this symbol. This is associated with being troubled and feeling inadequate. Such feelings are likely to be present in a bereaved child, who could be wrongfully thinking he could have some how stopped the death of a sibling or parent. According to Fitzgerald (1992) a child who is within the concrete operational stage of cognitive development (7-11 years) may wrongfully assume he/she could have prevented the death from happening.

• **Slanting figure**

This was shown in seven protocols of Group A and only two of Group B. It was able to significantly distinguish Group A from Group B. It is associated with a child who is either mildly or seriously emotionally disturbed. In this study this was confirmed as it was shown in protocols of subjects with
total Emotional Indicators ranging from 2 to 5, from Group A. The two subjects from Group B had only this one Emotional Indicator in their respective protocols.

A couple of Emotional Indicators which were found in both Groups though more often in Group A, will be briefly discussed.

- **Short arms**

A total of 12 protocols in Group A and 7 from Group B had this symbol, which is associated with withdrawal, introversion and having difficulties with reaching out to others. Most subjects from Group A with this symbol had a total of Emotional Indicators ranging from 1 to 4 as opposed to only two from Group B. Thus even though it was identified in both Groups intensity of emotional problems was different, with more problems identified in Group A subjects.

- **Shading of face**

Shows manifestation of anxiety and is always significant in a projective drawing. It was present in two Group A protocols and in one Group B protocol. Serious emotional problems were detected in one of the Group A subjects who was also tearful during the procedure and interview. Again he took too long to finish the first drawing. This subject also experienced a lot of grief symptoms including headache. Anxiety state was apparent in this bereaved child.
The HFDs and self portrait were thus capable of distinguishing the bereaved group from the non bereaved group.

The Emotional Indicators which were found exclusively on or more often on Group A protocols but not necessarily statistically significant, were found to be clinically significant as they contributed in distinguishing the bereaved from the non bereaved group.

5.1.4 Kenetic Family Drawings

Analysis of results showed that some variables were able to differentiate the two groups as they were found exclusively on protocols of Group A's subjects. These variables included compartmentalization, barriers, unexpected description of figures actions, no face and position of figure with respect to safety. Even though some of these would not be considered statistically significant, however, by virtue of their presence in this study, they are of importance in screening for psychopathological family dynamics, which may be expected in a bereaved family. Their contribution in the screening process was made salient when data from other projective drawings and interviews were combined. A few examples will be given below.

- **Compartmentalization**

In Marnat (1984) it is interpreted as a symbol of failure to share feelings and a beginning of social isolation. One subject who had this symbol had only one Emotional Indicator each of HFD and Self Portrait. On the basis of considering one Emotional Indicator this child would be considered as not
having emotional problems but by combining the two, one realizes that there might be some problems. The KFD in this instance was able to make it clear that problems were present.

The second subject had three Emotional Indicators on the Self Portrait, pointing to serious Emotional Problems (Koppitz, 1968). In this case the KFD served to substantiate the self portrait’s results. The two protocols communicated an atmosphere of constraint.

- **Unexpected description of figure’s actions**

Strange activities were depicted in three protocols of Group A, viz. all figures drawn holding hands, all crying and lastly all figures, in one protocol, were drawn also drawing. The first two are clearly related to bereavement and the last one may be interpreted as an evasion. According to Marnat (1984) protocols commonly show parents in stereotyped roles like a mother cooking, which was shown by majority of protocols from both Groups. Incidentally the subject who drew all figures drawing was the one who showed a lot of anxiety even during the drawing and interview sessions. The three protocols exuded an atmosphere of pain and need for support. Generally the rest of protocols depicted the social life of the subjects for example most had drawn self playing or fetching water from the local commune tap. The three protocols clearly differentiated the bereaved subjects from the non bereaved.

- **No face**

Burns and Kaufman (1972) interpretes this as a symbol of poor communication. The subject who produced this protocol, had other figure’s faces shaded, a sign of anxiety or inhibition towards that
particular figure (Burns & Kaufman 1972). In total 6 variables were present in the KFD including omitted figures. The subject’s HFD and Self Portrait had 2 Emotional Indicators each, including no mouth, asymmetry and slanting figure. Clearly according to Koppitz (1968) the child had emotional problems.

The fact that there was only one protocol with this variable in this study does not however diminish its diagnostic value in the particular subject.

• Position of figure with respect to safety

The subject drew self and twin sister almost falling out of the bottom of the paper, which reflects insecurity (Marnat, 1984). The very subject had reported dreaming that the mother was also going to die too. The protocol showed a need for reassurance. Other variables in same protocol were subgroups (family proximity) balls as field of fire and omissions of other family members. In this particular protocol, this one variable was important as more insight was gained about how subject felt within the family.

Since a decision was taken to focus on the global and qualitative aspects of the KFDs rather than quantitative, some of the variables which were found in both Group A and Group B but more often or even just slightly more on Group A, will be briefly discussed below.
• **Underlining individual figures**

An unstable relationship between subject and the underlined figure is assumed (Burns & Kaufman, 1972). The majority were Group A (4) as opposed to 1 in Group B. Even quantitatively there seem to be a difference between Group A and Group B. The one subject from Group B had no recent death in the family, but tension between the subject and the particular family member might be assumed. One of the four Group A subjects had 5 Emotional Indicators on HFD and 5 again on Self Portrait, pointing to serious Emotional problems. Group B subject had only 1 Emotional Indicator on the HFD. Projective questions following completion of drawing revealed that one of Group A subjects, a 10 year old girl, was only staying with two older siblings (maternal grandfather visits them occasionally). She was able to relate through her KFD, the tension that was present at times between the three orphans. The combination of different projective drawings, projective questions and unstructured interview assisted in creating a composite picture of the subject’s world.

• **Erasures**

Shows conflict with figure and insecurity (Burns & Kaufman, 1992; Anderson & Anderson, 1951). Majority (10) was from Group A as opposed to two from Group B. Clearly the Bereaved subjects depicted more conflict at home than non-bereaved subjects. Conflicts assumed to be with the constantly erased figure.
• **Omitted figures**

Not much difference was noted between the two Groups. According to Koppitz (1968) omission of parents and sibling is diagnostically significant. Self omission is also significant, according to Marnat (1984) self omission implies feeling of separateness from the family. It is stressed that this should never be considered accidental. Omissions were thus treated with concern and projective questions were posed. Subjects from both Groups gave answers like, “I forgot her or there was no longer any space.” According to Burns and Kaufman (1972) omitted figures are associated with rejection and conflict with that figure. Group B subjects omitted parents more often than siblings. Only three had omitted self. The omitted parents may be portrayed as not being supportive to the bereaved child. Self omission could imply lack of empathy from other family members about how the death has affected that particular bereaved child. The child might feel rejected and not part of the family.

• **Rotation of figures**

Drawing a figure at a different angle from the rest of other figures implies that person is judged as different, or is being rejected (Burns & Kaufman, 1972). The four figures that were depicted sleeping while others were all standing in Group As’ 4 protocols were characteristically perceived as different from rest of family members. Where self was drawn sleeping, the subject could be feeling rejected by other family members. More Group A protocols than Group B protocols had this variable, thus it may serve to differentiate the two groups.
Some variables were identified more on Group B's protocols than Group A's, thus nullifying their capability to differentiate between the two Groups as expected. One of these variables, proximity, will be briefly discussed. Cox (1993) maintains that distance between figures as well as between self and other figures are a symbol of presence or lack of emotional affinity, in real life. Results showed that majority of both Group A & B protocols had disparate individuals and subgroups. When a subject had drawn self with another person, it would be with a sibling. This may be reflective of culture, children not mixing with adults. On the basis of disparate individuals and subgroups, it would be difficult to differentiate the two groups.

In the above discussion some of the variables for assessment of KFDs were discussed. The aim was to show the importance of each variable irrespective of its frequency in the total of each Group’s protocols. Some variables on top of their qualitative value as a form of diagnostic tool, were also more often found in the Group As’ protocols.

Qualitative assessment allowed for insight to be gained into how the subject views family relationships, how she/he feels towards each member and how she views self in the family. Thus the rationale (Marnat, 1984) for utilizing the KFD as a projective test was achieved. Perceptions from projective drawings were also validated by additional information obtained from the subjects.

On its own though KFDs would not be able to differentiate the two groups as only a few variables were exclusively found on Group A protocols. As an additional tool they are invaluable though in understanding a subject's psychological life. They enhanced information obtained from HFDs and self portraits. For example self omission clearly shows a sense of being not part of the family. From the
protocols the general atmosphere at home was communicated, it was out there for the clinician to perceive and interpret, using also other available data.

5.1.5 Own choice/spontaneous drawings

According to Tait and Depta (1993) spontaneous drawings will contain peaceful items like flowers or harsh ones like guns. Only one protocol depicted a gun amongst several items including a cellular phone, the deceased relative had died violently. The flowers were found in both Group A and Group B protocols. One would not then conclude that flowers might have reminded the bereaved subjects about the funeral. Other commonly depicted items were cars, houses and human figures, again both in Group A and B. The two independent raters, who were reputable clinical psychologists with five and seven years clinical experience respectively, on the basis of global qualitative assessment could not significantly predict group membership.

Even with the researcher the meaning of the drawing was made relevant by the projective questions posed following completion of drawing. For example one subject who had drawn a car, said she had seen such a car in town when she had gone shopping with her deceased mother, only then did it have a meaning. This stresses the importance of projective questions following drawing.

In this study the spontaneous or own choice drawing served the purpose of relieving tension or relaying wishes rather than differentiating the two groups. Davies’s (1995) view is thus validated, that such drawings can serve as a mechanism of distraction from grief work. Children were free to draw any thing and an overwhelming majority chose to draw pleasant pictures.
Advantages of projective drawings as cited by Anderson and Anderson (1951) were realized in this study. It was possible to analyze repeatedly the protocols thus checking and rechecking one's assessment and scoring system. Interpretations could also be made directly from the protocols and the subjects had a chance of "saying" what they could not freely say about themselves or their families verbally. Rabin's (1960) statement that the projective drawings serve as canvases for projecting one's inner and interpersonal world, was thus realized. Subjects from both groups willingly made their drawings not realizing how much they were communicating about themselves. This is what was aimed for, to gain insight into their functioning, without using a lot of verbal assessment.

5.2 DISCUSSION ON OTHER MATERIALS

5.2.1 Questionnaires

The results obtained demonstrated that the majority of the bereaved children experienced the physical and sleeping patterns symptoms cited in the questionnaire. This validates literature (Baker, 1991; Cook, 1996; Cook & Oltjenbruns, 1989; Elsegood 1996; Fitzgerald, 1992; Furman, 1974; Grollman, 1991; Hallaam & Vine, 1996) to mention a few, that children are capable of experiencing grief symptoms. Sleep disturbances in the form of dreams and nightmares and not sleeping well was mostly reported. Dreams reported revolved around the deceased person, attesting to the fact that the child has been psychologically affected by the death and is unconsciously working through the pain of the loss. Some subjects showed emotional pain even during the interview, as they cried.
Some subjects reported having experienced as few as three symptoms, supporting Fitzgerald (1992) in that grief is manifested differently in individuals. Some symptoms will not be experienced throughout the grief period.

From analyzing symptoms experienced and other relevant data, for example a projective drawing, it is not easy to conclude whether a child is experiencing normal grief or pathological grief unless intensity is considered, thus supporting Cook and Oltjenbruns (1989) contention that there is no clear line of demarcation between the two, only intensity makes differentiation clear.

Intensity of feelings and the accompanying body sensations could have been toned down by timeliness as in the majority of subjects the death had occurred about a month or two ago. Fitzgerald (1992) maintain that children again are capable of putting grief aside and focus on pleasant activities which might also have been a contributing factor.

The majority of the subjects seemed to be experiencing normal grief as they were capable of continuing with their normal developmental activities, which Webb (1993) cites as a sign of normal grief. What would have been pathological is if teachers had reported serious problems like school truancy or self-destructive behavior. The bereaved subjects with serious emotional problems were identified, for example the child who threatened suicide, and brief therapy was conducted, even though intervention was not part of this study. This was considered an ethical and humane gesture by the researcher. Hallam and Vine (1996) maintained that all bereaved children need support from adults, this child warranted such support.
The above mentioned example highlighted the relationship between grief and mental disorders like depression. Parkes (1985) contends that some bereavement endangers ones mental health. Early detection, prompt and relevant intervention thus cannot be overemphasized.

Post Traumatic Stress (PTSD) was evident in the child who was literally trembling during the interview and sweating profusely. He also related having constant dreams about his deceased father. He clearly had experienced intense sleep disturbances. The death of the parent had also been traumatic and unexpected as he was stabbed. Webb’s (1993) view of relationship between PTSD in children and traumatic sudden deaths was supported, in this instance.

The interview on how the child felt following the death gave also the child a chance to verbalize some issues, that had troubled them for example if the child was not told that a parent or sibling had died but would just see people crying or not being allowed to visit the deceased while still in hospital. According to Cook and Oltjenbruns (1989) it is important for the child to be actually engaged in some exercise to help resolve grief. Thus producing the four projective drawings and being interviewed assisted the child to move forth in the grief work.

By the time the study was undertaken the majority of the children were in the Middle Phase (Corr et al., 1992) of the grief work. No child was still in denial, which would have meant that child was still in the Early Phase. The children were thus ready for the task of confronting their loss, which in time, it is envisaged, helped them move forward in the grief process. Some children had reached the late phase, where they had learned to move on, without the deceased.
The seven children who had experienced unexpected death, however, showed a frequency of symptoms similar to children who had expected death, like following long illnesses. What may account for these unexpected results is that no child actually witnessed a traumatic death. Though unexpected death is considered a mediating factor with capacity to increase intensity of feelings (Cook & Oltjenbruns 1989; Corr et. al., 1997; Webb 1993) in this study these children behaved not as expected attesting to resilience of some children. As also pointed out by Wass (1991) children can show hardiness and resilience too.

Results showed that parents/guardians tended to have observed and thus reported less symptoms as having been experienced by the bereaved children. Self report by the children showed more symptoms were experienced. As age of the child increased less discrepancies between reported symptoms was noted. This supports the view that children's feelings tend to be underestimated (Wass, 1991). McMahon (1992) contends that adults tend to assume that children do not experience pain of mourning, which to a certain degree was shown by the parents responses on the questionnaires. It is important than to talk to the child about his loss as a professional and not to depend on history given by adults. On the other hand the children might have kept such emotional pain to themselves, wrongfully thinking they are not expected to talk about their pain. According to McMahon (1992) this is what is done by most children.

The above discussion thus aptly answers the question of whether children are capable of grieving, they are capable of experiencing pain from loss of a loved one. Projective drawings can help demonstrate such as well as with help of limited interviews.
5.2.2. Unstructured interviews

Death and Funeral Rituals, which are considered part of the healing process (Cook & Oltjenbruns 1989) are also in the researchers experience, practised widely in the African Culture. The majority of the children viewed the deceased body or just coffin and this assisted them to accept the reality of death and to move on in the healing process. Engagements in these rituals is emphasized by Cook (1996); Fitzgerald, (1992) and Grollman, (1991) and it was evident in this study that the rituals are widely practised. The majority of them again attended the funerals and took part in memorial services, for example, by being part of the family choir. Excell (1991) advocates for such involvement of children in memorial services. Those who did not attend the funerals cited for example lack of transport which was a tragedy, when considering importance of a final “good-bye” in the grief work. Fitzgerald (1992) maintains that children should be allowed to attend funerals al long as they feel comfortable. The “dust to dust” process – “ukuthela inhlabathi” is a powerful ritual of finally saying good bye. And all those who attended funerals were given by adults chance to engage in this ritual. The Post Funeral Ritual of visiting the grave following burial was not undertaken by the majority of the bereaved children. Cook and Oltjenbruns (1989) and Excell, (1991) maintains such a visit facilitates resolution of grief. Seeing that the children had participated in the majority of the rituals, this had contributed a lot towards their healing process. By the time the study was undertaken, initial intervention, which includes these rituals had already taken place. This may again account for attenuated symptoms and feelings portrayed in the projective drawings.
The discussion showed how the different variables in this study were intertwined in order to understand the experiences and the resultant emotional and interpersonal functioning of the bereaved child.
CHAPTER 6
CONCLUSION AND RECOMMENDATIONS

This chapter will explore whether the aim of the study was achieved, limitations of the study, subsidiary but relevant findings will be discussed and recommendations be offered.

6.1 DO CHILDREN GRIEVE WHEN DEATH STRIKES IN THE IMMEDIATE ENVIRONMENT?

The findings of this study showed that indeed children do grieve. Grief symptoms reported by the bereaved children were confirmed by parental reports, even though it was to a lesser extent. Again the Emotional Indicators on Human Figure Drawings and other variables on Kinetic Family Drawings, reflected symptoms that are generally known as characterizing bereaved individuals. Findings also supported the contention that grief is a unique process (Hemmings, 1995) because grief symptoms were not similar in all the bereaved children and grief process was not similar too.

6.2 CAN THE USE OF PROJECTIVE DRAWINGS AS AN ASSESSMENT METHOD REVEAL INFORMATION ABOUT THE BEREAVED CHILD’S INNER WORLD, INDIVIDUAL FEELINGS AND PERSONALITY STRUCTURE?

This study was able to support the hypothesis that childrens’ drawings provide sufficient information about their emotional state to distinguish a bereaved group and a matched control group.
According to Cobia and Brazelton (1994) projective drawings are amongst the most commonly used assessment tools for socio-emotional assessment, this was validated by the findings of this study. Human Figure Drawings (HFDs) and self portraits were able to significantly distinguish the bereaved group from the non-bereaved group. Big figure, teeth, monster/grotesque figure, hands cut off and slanting figure were the emotional indicators where a significant difference was found (when HFDs and Self Portraits were separately considered). Those Emotional Indicators found exclusively on Group A’s protocols were found to be diagnostically important as they could assist in understanding the inner world of the bereaved child.

The Kinetic Family Drawings which were qualitatively analyzed could not significantly differentiate Group A from Group B but were found to be invaluable in providing insight into the family dynamics. Variables identified, for example, omissions were consistent with psychopathological interpersonal relationships within bereaved families.

Own choice/spontaneous drawings which were also qualitatively analyzed could not significantly distinguish Group A from Group B but served as a much needed distraction from grief work.

Conclusion was reached that the HFD, Self Portrait and KFD provide a more composite picture and would suffice for primarily gaining insight into the inner world of the bereaved child as well as into the bereaved family’s dynamics.
Own choice could thus be administered to find out how the child feels about the bereavement once this has been identified. Excell (1993) suggests asking the child to for example draw what she/he thinks death is.

Projective questions following completion of drawing any projective drawing was invaluable, thus supporting Robin and William (1991) when they maintained that when in doubt, check information out, ask the subject.

6.3 LIMITATIONS

The sample was small due to the limited scope of the study. It was also confined to a limited geographic area. Both factors thus affected generalization of the results.

6.4 SUBSIDIARY RELEVANT FINDINGS AND IMPLICATIONS

Even though the focus was on exploring whether projective drawings can provide an excellent method of exploring the world of a black bereaved child, other factors became salient, which warrant mentioning.

- There were no available bereavement support programmes in the area for any age population and a need for such programme was identified.
• The bereaved population amongst children could be easily accessible at schools, which is important for future intervention plans.

• Adults tend to underestimate effects of bereavement in a child which implies a need of relevant Mental Health Education.

• High rate of bereavement amongst school children is especially associated with prolonged illnesses of parents.

• Black children are generally involved in death and funeral related rituals which assist with healing process. This should thus be promoted in the communities.

• Besides above mentioned factors it is anticipated that conducting the study at this school increased the awareness of teachers about possible problems that such children might be facing. The researcher also got the opportunity of explaining the role of a Clinical Psychologist within Mental Health and health generally. Community psychology was further implemented as some bereaved subjects received very brief therapy due to intensity of their emotional problems identified during the study.
6.5 RECOMMENDATIONS

- Future study exploring similar concept should have a bigger sample to allow for generalization of results.

- Have independent raters for HFDs, self portraits and KFDs to increase reliability.

- Quantitative analysis of KFDs to increase objectivity.

- There is a dire need for implementation of bereavement support groups, especially for children in all communities.

- A close working relationship between Social Welfare Officers, School Health Nurses, Teachers and Psychologists as is imperative for intervention programmes to be implemented.

To conclude, the study showed that projective drawings still have an important role in psychology. Usually projective drawings studies are criticized for selective reporting, where only significant results are shown or utilized (Garb, Wood & Nezworski, 2000) also for distortion in analysis, where indicators are not clearly defined (Abraham in Lev-Wiesel, 1999). In this study all results were shown, even those not highly significant or not significant at all, again guidelines to scoring were used, and lastly in all the four techniques indicators were clearly defined.
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Dear Parent/Guardian

A study is being conducted on bereaved children. It is hoped that the results will improve our understanding of how children react to a death in the family and how they can be helped to cope with bereavement. The study will involve children from age 8 to 12 years.

It will be greatly appreciated if you may allow your child to participate in this study. Confidentiality will be maintained.

Kindly complete the following consent form as well as the accompanying questionnaire.

Thanking you in anticipation

Yours faithfully,

INTERN CLINICAL PSYCHOLOGIST (STUDENT NO. 000010)

CONSENT FORM

I/We .................................................. being the parent(s)/guardians(s) give permission/do not give permission for ............................................ to be involved in this study.

SIGNATURE ............................................

DATE ............................................

PLEASE RETURN SIGNED CONSENT FORM WITH COMPLETED QUESTIONNAIRE.
CHILD'S PERSONAL INFORMATION

DATE OF BIRTH:  
AGE:  
GRADE:  

INFORMATION ABOUT DEATH

RELATION TO THE CHILD

WAS THE DEATH EXPECTED (e.g. through illness)?  YES  NO

WAS THE DEATH UNEXPECTED (e.g. through accident)?  YES  NO

WERE THE FOLLOWING PHYSICAL SENSATIONS EXPERIENCED ...

Tightness in the chest  YES  NO
Pain in the heart area  YES  NO
Palpitations  YES  NO
Dizziness  YES  NO
Nausea  YES  NO
Trembling  YES  NO
Any other physical sensations experienced

WERE THE FOLLOWING SLEEP PATTERNS EXPERIENCED:

Not sleeping well  YES  NO
Sleeping too much  YES  NO
Dreams and nightmares  YES  NO

Thank you for filling in this questionnaire.
APPENDIX C

2002-01-24

Ngiyakubingelela Mzali/Mphathi womntwana

Lolu cwaningo luqondene nabantwana abashonelwe. Kunethemba lokuthi imiphumela yalo iyokwenza ngecono ukuqonda isimo abantwana ababhakana naso ngokwedlula emhlabeni kwelinye lamalungu omndeni, nanokuthi bangasizwa kanjani ukubhekana nesimo esinjalo. Ucwaningo luzobandakanya abantwana abeneminyaka esukela kweyisishiyagalombili kuya kweyishumi nambili.

Kungathokozisa kakhulu ukuvumela umntwana wakho ukuba abambe iqhaza kulolu cwaningo. Konke okuyovunjululwa ucwaningo kuyogcinwa kuyimfihlo.

Uyanxuswa ukuba ugcwalise leli formu lokuvuma kanye nephepha lemibuzo elihambisana nalo.

Ngibonga kakhulu ukwethembeka kwakho.

Yimina ozithobayo

LINDIWE SHANGE
INTERN CLINICAL PSYCHOLOGIST (UMFUNDI WEZEMPILO)
(INOMBOLO YOKUBHALISA 000010)

IFOMU YOKUVUMA

Mina/Thina .................................................. njengomzali/abazali/umphathi/abaphathi
ngiyavuma/siyavuma/angivumi/asivumi ukuthi umntwana wami/wethu u
.................................................. abambe iqhaza kulolu cwaningo.

Isiginesha ........................................
Usuku ........................................

NGICELA UBUYISE LELE IFOMU LOKUVUMA NEPHEPHA LEMIBUZO ELIGCWALISIWE.
IMINININGWANE YOMNTWANA

Usuku lokuzalwa: .............................................

Iminyaka yobudala: ............................................

Ubulili: umfana □ intombazane □

Isigaba semfundo: .............................................

Imininingwane ngesifo: ........................................

Ubuyhlobo nengane: ............................................

Ingabe isifo sasilindelwe (njengokuthi nje wayegula)? YEBO □ CHA □

Ingabe isifo sasingalindelekile (njengokuthi nje savela ngenxa yengozi yemoto)? YEBO □ CHA □

Ingabe lezi zimpawu ezilandelayo zaphawuleka enganeni:

- Ukucinana kwenhliziyo YEBO □ CHA □
- Ukushaya kwenhliziyo YEBO □ CHA □
- Ukuphefumulela phezulu YEBO □ CHA □
- Isiyezi YEBO □ CHA □
- Ukucanuzela kwenhliziyo YEBO □ CHA □
- Ukuqhaqhaqha YEBO □ CHA □

Okunye nje owakuphawula enganeni ongakusho.

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Ingabe lezi zimpawu ezilandelayo ezikhathazayo uma ulele zaphawuleka:

Wayengalali kahle YEBO □ CHA □
Wayelala kuze kweqe YEBO □ CHA □
Wayenamaphupho asabisayo YEBO □ CHA □

Ngbonga kakulu usizo lwakho ukugcwalisa leli phepha tembuzo.
APPENDIX E

2001-04-09

Chief Education Specialist
Newcastle District

Dear Sir/Madam

Re: PERMISSION TO CONDUCT A STUDY

I hereby request permission to conduct a study in one of the schools in your district. This will involve children from age 8 to 12 years.

The topic is “Projective drawings of Black bereaved children in KwaZulu-Natal, South Africa: test in search of psychological life.”

It is envisaged that the results of this study will not only be beneficial to the practice of psychology but to education as a whole.

Thanking you in anticipation

Yours faithfully,

INTERN P cảnhHOLOGIST
STUDENT NO: 00010

LINDIWE SANCHE
APPENDIX F

QUALITY SIGNS

1. Poor integration of parts (Boys 7, Girls 6): one or more parts not joined to rest of figure, part only connected by a single line, or barely touching.

2. Shading of face: Deliberate shading of whole face or part of it, including "freckles," "measles," etc. : an even, light shading of face and hands to represent skin colour is not scored.

3. Shading of body and/or limbs (Boys 9, Girls 8).

4. Shading of hands and/or neck (Boys 8, Girls 7).

5. Gross asymmetry of limbs: One arm or leg differs markedly in shape from the other arm or leg. This item is not scored if arms or legs are similar in shape but just a bit uneven in size.

6. Slanting figures: Vertical axis of figure tilted by 15° or more from the perpendicular.

7. Tiny figure: Figure two inches or less in height.
8. Big Figure (Boys and Girls 8): Figure nine inches or more in height.

9. Transparencies: Transparencies involving major portions of body or limbs single line or lines of arms crossing body.

SPECIAL FEATURES

10. Tiny heads: Height of head less than one-tenth of total figure.

11. Crossed eyes: Both eyes turned in or turned out sideway glance of eyes not scored.

12. Teeth: Any representation of one or more teeth.

13. Short arms: short stubs for arms, arms not long enough to reach waistline.

14. Long arms: Arms excessively long, arms long enough to reach below knee or where knee should be.

15. Arms clinging to body: No space between body and arms.

16. Big hands: Hands as big or bigger than face or figure.
17. Hands cut off: Arms with neither hands nor fingers; hands hidden behind back of figure or in pocket not scored.

18. Legs pressed together: Both legs touch with no space in between, in profile drawings only one leg is shown.

19. Genitals: Realistic or unmistakably symbolic representation of genitals.

20. Monster or grotesque figure: Figure representing nonhuman, degraded or ridiculous person; the grotesqueness of figure must be deliberate on part of the child and not the result of his immaturity or lack of drawing skill.

21. Three or more figures spontaneously drawn: Several figures shown who are not interrelated or engaged in meaningful activity; repeated drawing of figures when only "a" figure was requested' drawing of a boy and a girl or the child's family is not scored.

22. Clouds: Any presentation of clouds, rain, snow or flying birds.

OMISSIONS

23. No eyes: Complete absence of eyes; closed eyes or vacant circles for eyes are not scored.
24. No nose: (Boys 6, Girls 5)

25. No mouth

26. No body

27. No arms: (Boys 6, Girls 5)

28. No legs

29. No feet (Boys 9, Girls 7)

30. No neck: (Boys 10, Girls 9)
DEFINITIONS OF SCORING VARIABLES – KFDs

A. STYLES

1. Compartmentalization

One or more straight lines or page divided into boxes and separate figures in each section. Indicates inhibition of strong emotions; isolation; inability to communicate.

2. Folding Compartmentalization

Folding the paper into sections and drawing a figure in each section. Indicates severe anxieties; presence of very disruptive relations within family; highly significant.

3. Underlining of Individual Figures

Heavy lines, skipping rope, shaded chair, etc. Indicates unstable relationship and tension between self and underlined figure; possible needs for structure.
4. **Lining at the bottom of the page**

Strong ground line. Provides strong foundation for child who feels stress and instability permeate the family, typical of family undergoing divorce.

5. **Lining at the top of the page**

Acute anxiety, generally diffuse worry, fear.

6. **Encapsulation**

Complete enclosure of one or more figures, but not all, by lines that do not stretch the full length of the paper. Often isolates a threatening figure; fear/anger/jealousy felt towards that figure.

7. **Edged placement of figures**

The drawing of all figures on two or more edges of the paper. Indicates resistance; highly defensive child.
8. Bird's Eye view perspective

Figures drawn as though viewed from above. Indicates detachment, isolation, not feeling part of the family.

B. ACTIONS AND RELATIONS BETWEEN KFD FIGURES

1. Physical Proximity

United family or subsystems. Indicates isolation, rejection versus support and acceptance.

2. Interaction of self

Isolated, with parents or siblings. Indicates poor inter-personal skills, rejection, lack of acceptance of self, depression.

3. Barriers between figures

Trees, house, fences, etc., between figures. Indicates guardedness, defensiveness, conflict with figure.
4. **Parental orientation**

Towards or away from child. Away from indicates possible lack of interest, rejection; associated with poor self-concept (especially father).

5. **Field of force**

Movements of energy between people.

(a) **Balls:** two figures playing with indicates competition, jealousy. Self or figure bouncing a ball indicates inability to direct force of competition.

(b) **Electrical appliances** (light bulbs, lamps, vacuum cleaners). Indicate emotional deprivation, need for love, warmth and affection.

(c) **Fires:** anger, hostility towards person closest to fire.

**Intense** feelings

(d) **Dangerous objects being pushed or thrown:** anger and aggression.

6. **Description of Figures Actions**

Indication of basic psychological integrity

(a) are actions expected, strange or unreal?

(b) Is self figure very distorted unrecognizable without verbal description?
(c) Action of father – activity level associated with self-concept. (Stronger father activity is, lower the child’s self-concept and higher the anxiety).

C. CHARACTERISTICS OF INDIVIDUAL KFD FIGURES

1. Relative height of self

Placing self above rest of family, standing on box, stool etc. Indicates striving for dominance/power versus inadequacy (very small figure), self concept within family group.

2. Position of figures with respect to safety

Figures in precarious positions, on edge of roof, ladder, falling. Indicates turmoil, tension or anxiety connected to figure.

3. Bizarre figures

Robots, animalistic features, visible internal organs. Indicate distortions of reality, thought pattern disturbances. Severe emotional disturbance.
4. **Pencil erasures**

Ambivalence/conflict with figure; insecurity; resistance to task.

5. **Arm extensions**

Figure holding rake, broom, or with very long arms. Indicates need to control environment, figures perceived as controlling.

6. **Rotation of figure (45°)**

Associated with feeling different, rejected, off balance.

7. **Shading (Except Hair)**

Preoccupation with, anxiety towards shaded figure, fixation or inhibition associated with shaded object,

8. **Line quality**

(a) Light, broken, uneven: insecurity, inadequacy, fear

(b) Heavy, overworked: anxiety, impulsivity, aggression
9. **Evasions**

One or more, but not all, family members drawn as stick figures or no action. Indicates defensiveness, passive resistance to task, poor relationship with figure.

10. **Omitted figures**

People associated with rejection; denial; conflict with figure.

11. **Figure/s on the back of the page**

Interpersonal, usually direct conflict with the figure, desire to remove person from family (e.g. new baby sibling.)

12. **No face**

Very poor communication with that figure. If on self, suggestive of withdrawal.