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AIDS in South Africa: Therapeutic interventions to strengthen resilience among orphans and vulnerable children

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Abstract

Worldwide, approximately 10% of the 34.2 million individuals infected by human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) are under the age of 18. Additionally, 17.8 million children have experienced one or both parents dying of HIV/AIDS. In comparison to other countries, South Africa has the highest per capita of recorded HIV/AIDS cases. These deaths have altered the social landscape by compromising the security and stability of communities and families. In order to address these challenges, research-based and practitioner-recommended interventions are offered to strengthen South African children's resilience and to facilitate their emotional well-being. In particular, orphans and vulnerable children (OVC) affected by HIV/AIDS must be supported in continuing their education and staying connected with immediate family, extended family, peers, and teachers. Acknowledging the shortage of mental health professionals, school psychologists are encouraged to prepare teachers and caregivers to share responsibility in implementing interventions to support OVC.

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In 1981, the US Centers for Disease Control and Prevention (CDC) publicly announced a rapidly emerging disease which severely compromised the human immune system: Acquired immunodeficiency syndrome, or AIDS (Gallo, 2006). Shortly thereafter, four high-risk groups were identified, the '4 Hs'—'hemophiliacs, heroin addicts, homosexuals, and Haitians' (Gallo, 2006). Individuals from these groups were contracting AIDS at a much higher rate than the general public. However, AIDS rapidly expanded beyond the initial high-risk groups and became an international epidemic across all sectors of society. Based on worldwide data reported by the Joint United Nations Programme on HIV/AIDS (UNAIDS, 2013), 35.3 million individuals are currently infected with HIV/AIDS.

According to Richter and Desmond (2008), children (ages 0–18 years of age) are an especially vulnerable group affected by the HIV/AIDS epidemic. Globally, almost 10% of individuals infected with HIV/AIDS are children and youth under the age of 18 (UNAIDS, 2011) and almost 17.8 million children have been orphaned by AIDS (UNAIDS, 2013). Furthermore, as an indication of future risk for passing the disease on to newborn infants, almost two-thirds of adolescents (15–18 years of age) who are infected with HIV/AIDS are females. Another indication of children's vulnerability to the HIV/AIDS epidemic, based on data from 2012 reports, is that only 34% of children infected with HIV/AIDS received the life-saving antiretroviral medication compared to 64% of infected adults who received treatment (United Nations Children's Fund [UNICEF], 2013a).

Although AIDS is considered a global epidemic, the disease disproportionately afflicts specific regions, particularly in Africa. In fact, 90% of all AIDS infected and directly affected children live in sub-Saharan Africa (AVERT International HIV & AIDS Charity, 2011a). Our article focuses on one country in sub-Saharan Africa—South Africa. This country was selected because it is particularly affected by HIV/AIDS and because two of this manuscript's authors (Donald and Theron) reside in South Africa and are familiar with this country's educational system, culture, history, and challenges associated with HIV/AIDS.

More specifically, this article's content is geared toward strengthening resilience processes among children and adolescents (hereafter denoted as children) whose parents and caregivers are either infected with HIV/AIDS or have died as a result of the disease. Throughout this article, we refer to these children as OVC (orphans and vulnerable children). Prior to offering recommendations to strengthen resilience processes among OVC, we review the following topics: Children's grief, particularly in the context of South African families, schools, and communities; practical aspects of offering social-emotional support; and ethical considerations

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related to offering interventions and conducting research with OVC and communities impacted by HIV/AIDS. To assist school psychologists (referred to as educational psychologists in many countries outside of the United States) and teachers in applying information provided in this article, a large section of the article is dedicated to interventions. Additionally, recommendations and resources are succinctly summarized in user-friendly tables. This type of information is easily accessed for training teachers and caregivers, preparing them for their role in offering emotional support to OVC.

AIDS in South Africa: Impact on communities and children

In South Africa, the country with the highest per capita of recorded HIV/AIDS cases, approximately 18% of 15- to 49-year-old individuals are infected with HIV/AIDS (AVERT International HIV & AIDS Charity, 2011a). Sadly these numbers do not fully describe the tragic situation: Based on 2012 statistics, currently almost 2.1 million of South Africa's children are identified as orphans who have lost one or both parents to AIDS (UNICEF, 2013b).

Additionally, prior to their being orphaned, it is common for these children (especially girls) to care for their dying parents and, following their parents' death, to continue caring for younger siblings (Ramphele, 2012). Betancourt, Meyers-Ohki, Charrow, and Hansen (2013) drew attention to the numerous risks threatening children who are caregivers for their dying parents. These risks include feeling pressured to withdraw from school, witnessing caregiver suffering and decline, and forfeiting community support because of stigma associated with HIV/AIDS.

Unfortunately, until recently, children were largely ignored by AIDS medical and educational prevention and intervention efforts (The Global Partners Forum, 2006). Although not universally heeded, initial call-to-action efforts were noted in 1994—the same year that Nelson Mandela's government came to power in South Africa. That year Swart-Kruger and Donald released a ground-breaking book chapter specifically addressing South African OVC. Uncovering the harsh reality of AIDS in South Africa, Swart-Kruger and Donald (1994) pointed out the severe risks of children becoming infected with HIV/AIDS, an almost certain death sentence prior to antiretroviral medication (HRV). Additionally, in order to survive, many children fell victim to widespread prostitution and other social ills (Ramphele, 2012; Salaam, 2005; Swart-Kruger & Donald, 1994). These children were commonly referred to as 'street children', now considered a pejorative term. Ramphele (2012) also noted that these children were sorely neglected under the Apartheid regime. She further lamented that vulnerable children's quality of life had regressed, despite South Africa's leadership and population having known almost two decades of democracy.

In the midst of communities ravaged by AIDS, children and families continue to live in extreme poverty (Cluver, Gardner, & Operario, 2009; Marais et al., 2014; Ramphele, 2012). Although South Africa's constitution stipulates the right of every

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child under the age of 18 to receive basic health care services, in 2010 only 40% of all HIV infected children in South Africa received HRV medication (Children's Institute, 2011). Additionally, almost one-third of pregnant women in South Africa are carriers of HIV/AIDS, with a 15% to 45% chance of their infants being infected with AIDS through mother-to-unborn-child transmission (AVERT International HIV & AIDS Charity, 2011b; World Health Organization [WHO], 2010).

After investing resources and gaining experience intervening with families impacted by AIDS, national and international organizations concede that successful intervention strategies must focus on people's 'stomachs, spirits and bank accounts' (Joint Learning Initiative on Children and HIV/AIDS, 2009, p. 49). Emphasizing the importance of expanding intervention goals beyond mere physical survival, The Global Partners Forum (2006, p.1) recommends relief efforts include counseling and psychological support to OVC traumatized by AIDS. In regard to how these services should be offered to OVC in South Africa, Lochner et al. (2013) specify the need for community-based mental health support. Identifying the focus for services, Li et al. (2008) emphasize the importance of addressing children's psychosocial needs, including interventions that acknowledge and are sensitive to children's grief.

Children's grief

Noting the challenges facing children who experience the death of a parent, Haine, Ayers, Sandler, and Wolchik (2008) encouraged adults—such as the surviving parent, teachers, and school-based mental health providers—to preemptively provide grief education. Geared to a child's understanding and developmental level, this education is proposed to initiate and facilitate conversations about death; provide opportunities to address common misperceptions; and explain and normalize emotional responses, fears, and concerns.

Based on research findings and input from practitioners who have extensive experience working with bereaved children, this section initially considers foundational concepts regarding children's grief, then takes into account the specific social and cultural context of South African families and communities directly affected by HIV/AIDS. Comprehending children's grief within this context lays the groundwork for better understanding OVC's bereavement. Ultimately this understanding will assist caregivers, teachers, and mental health professionals in encouraging and offering adaptive and culturally sensitive coping strategies in order to better support OVC's emotional needs.

Foundational concepts

Turning away from the traditional linear stages of grief (Kubler-Ross, 1969), Wolfelt (2002, p. 657) described six general *tasks of grief*. Although each child's grief is unique, the following tasks encompass universal challenges children face

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when coping with the death of a loved one: (a) understanding that death is a reality; (b) managing the emotional pain associated with the death and separation from the deceased loved one—not in isolation, but with others' emotional support; (c) remembering the deceased loved one and assimilating these memories with current and future thinking; (d) reconfiguring perceptions of oneself and relationships with others; (e) finding new purpose and meaning in one's life by coming to terms with death and loss; and (f) in addition to maintaining existing relationships, branching out socially to develop new relationships.

Wolfelt (2002) acknowledged that tasks of grief are not sequenced in a step-by-step process, but rather certain tasks may arise as situations elicit memories and emotions associated with the deceased person. For example, one young woman who gave birth to her first child mourned the absence of her deceased mother. The new mother temporarily had an especially difficult time managing the emotional pain associated with her mother's death. Emotions associated with this loss were particularly poignant at this time when the deceased mother's presence was sorely missed.

The following example further demonstrates the re-emerging tasks of grief across the life span. During a school graduation ceremony an adolescent mourned the death of his father and had intense feelings of resentment that his father was not present to share this important event. The adolescent son had difficulty remembering the deceased loved one and assimilating past memories with current and future thinking. He experienced difficulty coming to terms with his feelings of resentment and the fact that his graduation and other important occasions would not include a living father.

Wolfelt (2002) also indicated that children do not fully resolve each task of grief. The goal of adaptive coping is not to move beyond grief, but to live with grief (Heath & Cole, 2012). Across the life span, individuals will re-experience grief in a variety of ways and from a variety of perspectives, depending on the individual's level of maturity and specific life experiences. Furthermore, adults should not expect children to grieve within a limited time frame. As children celebrate important events and as they face life's challenges, the loss of a loved one will be felt. In particular, a parent's death creates intense feelings of loss which are felt across the surviving child's lifetime (Webb, 2010; Webb, 2011; Worden, 2009).

Haine et al. (2008) identified common reactions children experience following the death of a parent:

a) Children may become angry, sad, anxious, and fearful. At times, these emotions may be strong and overwhelming.
b) Children may experience feelings of guilt and believe that they are somehow responsible for their parent's death.
c) Even though adults may be uncomfortable talking about death, children may want to talk about the deceased parent. At the other extreme, as parents and supportive adults encourage conversations about death, children may resist such involvement.

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d) Children may have recurring dreams about the deceased parent or may claim to have seen the parent or to have heard their voice.
e) Children may have an intense desire to remember and stay connected to the deceased parent.

These common reactions contribute to children's emotional vulnerability and should be considered as family members, teachers, and school psychologists offer support and guidance.

Social and cultural context

The context in which loss is experienced should also be considered. The following excerpt from a single case study of a child orphaned by AIDS provides an interesting perspective on children's grief within a traditional South African context. This excerpt describes how children and their caregivers (commonly grandmothers) typically cope with the death of family members. These insights, offered by a South African school principal, describe the challenges of supporting children during these difficult situations:

> You will find there is this child bullying or very withdrawn and you bring them in and ask what is wrong and they just pour out the tears. Then you go and look at the family profile and there have been so many deaths. Most of the people around here are taking things as usual so they follow the tradition of not talking to children about death and once the mourning period is over they go back to normal life. From long ago we did not talk too much about how we were feeling. We were also categorising the information we shared with young ones—all the issues that were too delicate we did not talk about. But these are unusual times—we have learned that you need to get children to talk about what has happened in their families—to tell their story if they are going to get over it. (Clacherty, Donald, & Dlamini, 2010, p. 165)

This quote elucidates several points. First, it describes potential psychological symptoms exhibited by bereaved children who struggle to resolve their grief and loss issues. In particular, two major categories of behaviors are noted: (a) crying and withdrawing from others (internalizing symptoms; Little, Sandler, Wolchik, Tein, & Ayers, 2009) and (b) aggressive outbursts (externalizing symptoms; Cohen & Mannarino, 2011). Cohen, Mannarino, and Deblinger (2006, 2012) stress the importance of gradually helping children to face and to feel their intense emotions associated with grief, a critical part of the healing process. This recommendation aligns with a commonly used phrase among therapists: 'You have to *feel* the feelings in order to *heal* the feelings'.

Second, the principal's comments reveal an important cultural set of beliefs and practices related to death in traditional South African communities. There is guardedness, a resistance to exposing sensitive feelings. Additionally, this guardedness is reflected in adults' tendency to avoid talking with children about sensitive,

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private issues associated with intense feelings (Van Dijk & Van Driel, 2012). This desire to protect children from the harsh realities of death actually delays opportunities to learn about death and to become familiar and comforted by customs and traditions unique to one's family and community (Heath & Cole, 2012).

Third, the principal's quote demonstrates the belief that what is most important following a family member's death is to observe a respectful period of mourning, then to quickly *get on with normal life*. Ironically in South Africa's cultural context, getting on with normal life and submerging feelings in the process may be interpreted as a form of *hidden resilience* (Ungar, 2004).

Typically, resilience denotes adaptive processes that support positive adjustment, with adjustment being bolstered by the socio-cultural ecology in which children develop (Masten & Wright, 2010). However, the exact connotation for positive and adaptive adjustment depends on the way in which resilience is conceptualized within a given sociocultural ecology and at a given point in time (Bottrell, 2009). Hidden resilience refers to those processes which might not be considered constructive by mainstream society but which support purported adaptation within a specific context.

For example, in communities adhering to Western values, grief is scripted across an extended timeframe (Worden, 2009). In contrast, the South African expectation for individuals, including children, is to quickly rebound and resume daily activities. Rather than indicate resilience, this quick return to daily activities and the expedited time frame for mourning might be considered in a Western context as insensitive and unrealistic (Theron, 2012). However, in the previously quoted school principal's community, the obligatory priority to *get on* and cope with the tasks of daily living temporarily protects impacted individuals from the emotional distractions associated with grief. This is particularly true in conditions of poverty where the primary focus is on daily physical survival. In such conditions, the immediate social environment does not afford the time and means for an extended period of mourning (Ungar, 2011). Rather, the cultural script is one of getting on with life.

More recently, Theron and Theron (2013) explained that familial expectations form the bedrock of cultural scripts that support resilience processes among African youth from risk-saturated contexts. Likewise, familial expectations foster and perpetuate the driving force influencing children to submerge grief. Specifically, families in South Africa *expect* their children to quickly adjust to loss and tragedy, to resume the status quo of day-to-day living, to avoid burdening others, and to make their family proud. However, experts are careful to point out that such behaviorally and culturally aligned indicators of resilience might merely mask psychological distress (Easterbrooks, Chaudhuri, Bartlett, & Copeman, 2010; Theron, 2012).

Theron (2012) suggested that children's grief is likely complicated by the context in which perceptions of death and grief are defined. This is particularly relevant in African contexts where HIV/AIDS continues to be stigmatized, where children commonly experience family members' deaths from HIV/AIDS, and where

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surviving kin urge stoicism (Van Dijk & Van Driel, 2012). However, as evidenced by the previous comments of the school principal, Viviers, Clacherty, and Maker (2010/2011) acknowledge that South Africans are beginning to demonstrate some regard for the importance of listening to children and permitting children to express emotions.

Outside of the family, the stigma surrounding HIV/AIDS often becomes a barrier to children receiving social support. Embarrassment, shame, and avoidance overpower the natural tendencies of individuals to nurture and console those who grieve. Balk, Zaengle, and Corr (2011) refer to this type of grief as *disenfranchised grief*. In regard to disenfranchised grief, the challenge of addressing social stigma associated with illness and death is not unique to South Africa. In general the public fears what it does not understand.

Although there are many examples of disenfranchised grief and social stigma surrounding AIDS, the following example captures the pain of one young man's experience. In 1988, 16-year-old Ryan White, diagnosed with AIDS, spoke to a convention of approximately 8,000 educators attending US's annual meeting of the National Education Association. He openly discussed his personal battle with AIDS and described the emotional pain and isolation he suffered.

> Because of the lack of education on AIDS, discrimination, fear, panic and lies surrounded me. I became the target of Ryan White jokes, lies about me biting people, spitting on vegetables and cookies, urinating on bathroom walls. Some restaurants threw away my dishes. My school locker was vandalized inside and folders were marked 'Fag' and other obscenities. I was labelled a troublemaker, my mom an unfit mother, and I was not welcome anywhere. People would get up and leave so they would not have to sit anywhere near me. Even at church, people would not shake my hand . . . I stand before you to ask for your help . . . Teachers can play an important role in helping an AIDS student be accepted and treated as normal as possible by teaching the facts, not the myths . . . Help me beat the odds and together let's educate and save the children of the world. By proper education, AIDS can be a disease, not a dirty word. (Associated Press News Archive, 1988)

Social-emotional support

The role of social-emotional support in addressing children's grief—in addition to addressing the stigma and challenges of living with HIV/AIDS—cannot be underestimated. However, for many communities, mental health professionals are simply not available to provide social-emotional support. In fact, WHO (2013) noted that half of the world's population lives in communities where one to two mental health professionals serve 200,000 individuals. According to Richter et al. (2009), strategic efforts must include families' and local community's support for OVC. Likewise, in their systemic review, Betancourt et al. (2013) foregrounded the resilience-promoting value of supportive parents and parent-figures.

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Contrary to the media's stereotyped portrayal of AIDS orphans as homeless or living in orphanages, more than 90% of children infected with AIDS or children whose parents are infected live with immediate or extended family (Irwin, Adams, & Winter, 2009; Richter et al., 2009). However, a growing problem exists: Grandmothers are becoming progressively overloaded with the burden of caring not only for grandchildren, whose young parents are dying of AIDS, but also for other relatives' children in their extended family (Clacherty et al., 2010). The school principal, previously quoted in this manuscript, describes his concern for the heavy burden placed on grandmothers.

> I feel pity for the grannies. Some of the grannies have so many children dead and they cannot get away from it here in the rural areas because they are buried in the yard. They get up and see this pile of soil—this is my daughter, this is my son ... They feel that there is no hope of support, no hope of any help .... (Clacherty et al., 2010, p. 165)

Although child-rearing by grandmothers (and other extended kin) is often flagged as supportive of resilience processes among South African OVC (Theron, 2012) and African American OVC (Winston, 2006), there are increasing reports of child-headed families—families in which children take on adult/parent roles and responsibilities (e.g. taking care of younger siblings and earning income to support surviving family members). Despite the fact that kin typically support child-headed systems in varying ways, Van Dijk and Van Driel (2012) witnessed multiple child-headed families that were forced to function independently of extended family systems. A variety of reasons underpin such independence, including unsupportive kin, overburdened kin, and absent kin, either because of geographical distance or death, often related to HIV/AIDS (Daniel & Mathias, 2012; Pillay, 2012; Van Dijk & Van Driel, 2012).

Not all OVC have the option of depending on kin to buffer cruelties associated with growing up in HIV/AIDS afflicted communities (Cluver et al., 2009; Meinck, Cluver, Boyes, & Ndhlovu, 2013). Skovdal and Ogutu (2012) reported that in families where parents are dying or dead, Kenyan youth adjust constructively to coterminous demands associated with parental decline/death by mobilizing *peer social capital*, drawing on protective resources embedded in friendships and supportive peer groups. Children's reliance on peer support speaks to youth agency and also to Afrocentric socialization processes which heighten awareness of socially valued interdependence.

In the US President's Emergency Plan for AIDS Relief (PEPFAR; 2012), program guidelines are offered to support OVC. In addition to meeting physical and economic needs, PEPFAR's prioritized activities include strengthening children's education and psychosocial care and support (2012, p. 7). However, in prioritizing supportive activities and interventions, PEPFAR urges building on existing community strengths and structure and ensuring that, when necessary, OVC are placed and supported in 'stable and affectionate environments' (PEPFAR, 2012, p. 37).

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Ethical and therapeutic considerations

A general caveat when offering therapeutic intervention or when conducting research with OVC—approach sensitive issues with great care. Invest adequate time in developing trust prior to broaching sensitive topics, such as personal experiences with family members' HIV/AIDS illness and death. Initially, those who work with OVC should engage the children in non-threatening activities, such as drawing and conversing about favorite activities, friends, and sports. Only after developing trust should the discussion begin to focus on specific and sensitive questions (Clacherty & Donald, 2007).

Another factor related to children's hesitancy to develop trust is that those who provide intervention services must be cognizant of adult-child power disparities, a common cultural expectation in South Africa (Clacherty & Donald, 2007). When conducting their evaluation research projects related to HIV/AIDS, Clacherty and Donald (2007) reported their heightened sensitivity to this disparity. They noted the following observations:

> The usual pattern applied in our work is for the entire first day of the workshops to be spent in building trust through games and activities that focus on the children's everyday lives without touching on sensitive topics. The activities purposefully create opportunities for every child, even the most reticent, to speak: Usually about something related to their own life that they have drawn. Activities such as, 'draw all the things you do in your day' or 'draw all the places you go to in your week' are particularly useful here as they are non-threatening and easy to talk about. Once trust is won (usually only on the second or even the third day), the initial activities are revisited with discussion about problems that children may encounter in their everyday lives. Only at this stage may the discussion begin to focus on specific and sensitive research questions related, for example, to their experiences of HIV/AIDS in their families and community or to difficulties that AIDS orphans experience. However, in traditional communities, where children are seldom if ever asked their opinions, it can take up to three days of trust-building workshops for children to begin to overcome their hesitancy to talk to researchers openly about their lives. (Clacherty & Donald, 2007, p. 149)

Finally, the following excerpt from the evaluation of the *Soul Buddyz Club* (Clacherty et al., 2010) demonstrates the importance of practitioners respecting children's resilience and fostering intergenerational transmitted pro-social values in all the children's proximal systems. Soul Buddyz was created for youth ages 8- to 12-years-old, encouraging participation in multimedia entertainment (e.g. television, radio drama, and printed materials). This program operates in schools throughout South Africa and promotes educational information about AIDS and other important topics. Clacherty et al. (2010) noted the importance of respecting culture, social cohesion, and social values:

> Culture also emerged as an important thematic factor in terms of the balance between developmental risks and the protective assets and resources available to individual

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> children. It is a highly complex factor. Yet, at the risk of oversimplifying, it was noted in the ecosystemic analyses of the respective social contexts that the degree of social cohesion and pro-social values that did, or did not, appear to apply in the individual case studies could, in broadly general terms, be related to the relative consistency and intergenerational strength of such values in the different social contexts concerned. Importantly, it should be noted that 'social context' includes any one child's proximal systems—family, peer and adult support networks, school, etc.—and the degree to which such values are mediated to the child through these systems. (Clacherty et al., 2010, p. 213)

When adapting interventions to fit specific children and specific schools in which interventions are implemented, Donald, Lazarus, and Lolwana (2010) stressed the importance of using an ecosystemic approach. This approach is based on the amalgamation of ecological and systemic principles. In this approach, as practitioners consider and implement interventions, they expand their consideration beyond the individual. Donald et al. (2010) encouraged practitioners to integrate principles of systems theory and to carefully consider all levels of the proximal ecologies in which children interact (e.g. family, peer–group, school, local community, etc.).

In their extensive literature review of research on mental health and resilience in children infected and affected by HIV/AIDS, Betancourt et al. (2013), Cluver and Gardner (2007a), and Wild (2001) noted the scarcity of rigorous research investigating interventions to improve OVC's mental health. In fact, after identifying only four intervention studies, Betancourt et al. concluded that future HIV/AIDS research agendas must place a high priority on investigating social-emotional interventions. Summarizing their findings, Betancourt et al. noted that past intervention studies focused more on adjustment to and management of HIV status (physical health) than on children's emotional needs and their coping with AIDS-related illness and deaths of parents and caregivers.

When selecting interventions, practitioners must proceed with caution given that few interventions have been rigorously implemented, monitored with quantitative data, and proclaimed effective with OVC in general and more specifically with OVC from South Africa (Murray et al., 2013). Although the research basis for therapeutic and health benefits of creative activities is generally considered weak, some evidence supports the use of creative activities for teaching information about HIV/AIDS (Tukhareli, 2011), for positively impacting children's behavior (Bungay & Vella-Burrows, 2013), and for improving health and psychological outlook (Murray, 2002; Smyth, 1998).

Prior to Betancourt et al.'s (2013) review, the *African Journal of AIDS Research* published a special issue focusing on trajectories of resilience and well-being among OVC. This special issue included two articles that reported on interventions supporting OVC's resilience in South Africa (Thamuku & Daniel, 2012; Wood, Theron, & Mayaba, 2012). Although the results from these two research studies were promising, the paucity of research documenting effective grief counseling to

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promote resilience in grieving OVC signposts the need to carefully investigate, document, and share findings regarding what works (Murray et al., 2013). This need is especially pressing in contexts such as South Africa where mental health services in community and school settings are seldom available for needy children (Pillay, 2012; Verrijdt, 2012). Such research endeavours must, however, proceed from the premise that efforts to support resilience must be tailored to align with the sociocultural context, developmental stage, and unique background of each child (Theron & Donald, 2013). Furthermore, caution must be taken when rolling out Eurocentric interventions or applying Western-focused counseling techniques to support South African children's resilience. Although data may support these interventions in other settings, the effectiveness of interventions specifically implemented with South African OVC will most likely vary, given the unique setting and situation (Amzel et al., 2013; Murray et al., 2013; Theron & Donald, 2013).

Therapeutic interventions

Taking into account the ethical and therapeutic considerations of intervening with South African OVC, this section details a variety of therapeutic interventions, including activities aligned with cognitive behavioral therapy (CBT; Beck, 2005; Kazak et al., 2010; Murray et al., 2013); bibliotherapy (Tukhareli, 2011; Wood et al., 2012); culturally aligned rites of passage (Clacherty & Donald, 2008; Thamuku & Daniel, 2012); coaching and guiding children's thoughts (Haine et al., 2008); and activities to assist youth in expressing feelings and telling their story. These activities include Clacherty's *Suitcase Project* (2004, 2008); creating a memory box (Ebersöhn, Eloff, & Swanepoel-Opper, 2010); encouraging children to share their dreams (Bettelheim, 1976, Ekstein, 1981, Healy-Romanello, 1993); offering opportunities for creative expression and writing (Thupayagale-Tshweneagae, Wright, & Hoffman, 2010); and organizing participatory projects and youth activities (Ssewamala, Alicia, Bannon, & Ismayilova, 2008; Van der Heijden & Swartz, 2010). The overarching common goal across all of these interventions is to specifically address the social-emotional needs of OVC. These interventions and activities are more fully described in the following sections.

In order to best address OVC's emotional needs, psychosocial interventions must be adapted to the context of the country and local community. In particular, intervention strategies must focus on including surviving caregivers and affected family members (Amzel et al., 2013; PEPFAR, 2012, p. 37). Moving beyond one-on-one service delivery, psychosocial interventions must rely on community-based support for caregivers (Amzel et al., 2013); group interventions for youth focused on activities that build on social capital and strengthen peer-to-peer relationships within social groups (Skovda & Ogutu, 2012); and mentorship programs, pairing OVC with individuals who will serve as strong role models (Donald, 2013a; PEPFAR, 2012, p. 37).

PEPFAR (2012) recommends intervention services be offered within natural settings, such as schools, and within existing community organizations which are

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central in day-to-day interactions, such as religious or spiritual centers. Interventions must also be sensitive to the social ecology in which OVC live. ‘Interventions must be culturally and developmentally appropriate and should avoid causing secondary trauma thorough lack of sensitivity or skill . . . [Those who plan and implement interventions must consider] familial, communal, cultural, spiritual, and socioeconomic factors that surround and influence individuals’ (PEPFAR, 2012, p. 34).

To assist those who are considering interventions to address the social-emotional needs of OVC, the following tables are provided: Table 1 lists school-based strategies to address common challenges; Table 2 offers therapeutic activities to encourage OVC’s emotional expression; and Table 3 lists additional resources to support South African OVC (refer to Supplemental Material for all tables). Additionally, information provided in the following sections more fully describes potential interventions to address the social-emotional needs of OVC.

Cognitive behavioral therapy (CBT)

In general, CBT is considered the most empirically-based foundation for mental health interventions (Beck, 2005; Kazak et al., 2010). Treatments based on principles of CBT effectively address a wide range of children’s behavioral and emotional needs (Butler, Chapman, Forman, & Beck, 2006; Kazak et al., 2010). In particular, CBT has been effective in trauma-focused therapy with children (Cohen et al., 2006, 2012), both in individual and group settings (Jaycox, 2004; Jaycox, Langley, & Dean, 2009), and with children from a variety of backgrounds and ethnicities (Jaycox et al., 2009).

CBT is based on the premise that thoughts, emotions, and behaviors are all interconnected. Hence, when an intervention has the leverage to change an individual’s thoughts/cognitions and emotions, behaviors will also shift to align with those newly formed thoughts and emotions. Rather than working solely on controlling behaviors, CBT seeks to change cognitions which underlie behaviors. Therefore, the identified person’s behaviour is not being controlled by a therapist, but the identified person is the individual in charge of controlling their own thoughts, feelings, and behaviors (Butler et al., 2006).

Many of the recommended interventions listed in the following sections are based on principles of CBT. However, even though CBT has the strongest foundation of empirical support for intervening with children exposed to traumatic events, minimal research has investigated its application to OVC’s needs and, more specifically, its application with OVC living in South Africa (Betancourt et al., 2013; Murray et al., 2013). Therefore, those working with OVC from South Africa will need to adapt interventions to align with cultural, religious, and societal preferences and constraints, and then carefully monitor OVC’s response to intervention.

In general, interventions based on CBT have proven effective in building children’s adaptive coping and proactive problem-solving skills; teaching relaxation skills and reducing anxiety/depression; and strengthening parent-child

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relationships (Cohen et al., 2006, 2012; Jaycox et al., 2009). Acknowledging the shortage of mental health professionals to serve children exposed to trauma, Jaycox et al. (2009) developed a parallel program to *Cognitive Behavioral Intervention for Trauma in Schools* (CBITS; Jaycox, 2004). This newer version of CBITS is titled *Support for Students Exposed to Trauma* (SSET; Jaycox et al., 2009) and is intended to be implemented by adults who are not mental health professionals (e.g. teachers, volunteers, paraprofessionals, and staff). The SSET manual outlines ten group meetings in a teacher-friendly lesson plan format. The sessions are intended for groups of six to ten students, ages 10- to 14-years-old. Similar to developing a personal *trauma narrative* (Cohen et al., 2006; Jaycox et al., 2004), over time, children who participate in SSET groups gradually approach and face their traumatic experiences by telling their personal story through drawings and/or writing activities. The SSET manual, listed in Table 3 (see Supplemental Material), is available as a free PDF download from the Rand Internet website [rand.org].

Bibliotherapy

A popular marketing book, *Made to Stick* (Heath & Heath, 2008) emphasizes the power of a good story to stick with individuals and create leverage to shift attitude and change behavior. In line with Heath and Heath (2008), proponents of bibliotherapy propose that carefully selected stories hold the power to persuade individuals to consider another point of view (change in thinking); which in turn leads to a change in heart (change in feeling); and ultimately, a change in behavior. More specifically, carefully selected stories encourage children's adaptive coping and prosocial behaviors (Heath & Cole, 2012; Tukhareli, 2011; Wood et al., 2012).

Based on Forgan's (2002) definition of bibliotherapy, reading books/stories helps individuals to heal their emotional wounds. Although bibliotherapy is commonly used by mental health professionals (Heath, Sheen, Leavy, Young, & Money, 2005), teachers and parents are also invited to read books with children, encouraging adaptive coping skills (Heath, Dyches, & Prater, 2013; Pardeck & Pardeck, 1993; Prater, Johnstun, Dyches, & Johnstun, 2006). Forgan offered several purposes for bibliotherapy in classroom settings. He indicated that shared stories decreased children's feelings of isolation and helped them know that they were not alone; relieved tension and stress; offered options for problem-solving strategies; and empowered students to follow through with newly acquired insights.

As children participate in bibliotherapy, initially the story peaks their interest and they are drawn into the story. As they become engaged, they begin to identify with the story's major character. Engagement increases as the story's plot parallels certain aspects of real life. As the story builds, children place themselves in the character's role and experience the character's feelings. Upon conclusion of the story, children internalize the core message (a cognitive shift in thinking and a change in attitude) and apply these new insights into daily living (change in behavior). Subsequent discussions about the story and related activities provide children with opportunities

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to apply their newfound knowledge. These extensions of the story further strengthen the link between the story's core message and its personal relevance.

Two interventions based on the principles of bibliotherapy are described by Tukhareli (2011) and Wood et al. (2012). Their interventions are reviewed in the following paragraphs. Additionally resources from their publications are listed in Table 3 (see Supplemental Material). Also in Table 3, Donald's (2012a, 2012b, 2013b) children's books are recommended. These engaging chapter books detail struggles of OVC and touch on South African traditions, customs, and religious beliefs, making the stories highly relevant to South Africa's OVC. At each story's conclusion, Donald provides a list of 'questions to think about'. He also suggests activities and offers information to parents, caregivers, and teachers. Adults can either read these books with children (ages 7- to 9-years-old) or offer these books to older children (ages 9- to 19-years-old) for individual reading. These books are also appropriate for teachers to read in classroom settings and to follow up with related activities and discussions. Because Donald worked in South Africa's educational system for over 30 years, his many experiences with OVC lend credibility to these stories. Details in his stories 'ring true' to OVC who are experiencing similar challenging circumstances.

Bibliotherapy in a library setting (Tukhareli, 2011). During the spring and summer of 2010, Tukhareli (a librarian) conducted a library project in Nkosi's Haven Library in Johannesburg, South Africa. Nkosi's Haven provides services for indigent HIV/AIDS infected mothers, their children, and orphans. Although Tukhareli's reading program, which was based on principles of bibliotherapy, was intended for all community members in Nkosi's Haven, her report (2011) focused primarily on bibliotherapy with 59 children and young adults (ages 6- to 19-years-old).

Tukhareli (2011) specified that her bibliotherapy program's major objective was to reduce the stigmatization of HIV/AIDS, which she identified as a major barrier to accessing much needed social-emotional support. She also wanted to educate children about the disease, increase children's self-awareness, and strengthen their adaptive coping skills. She read stories aloud to small groups of children (four or five children, same age and same gender). Following the read-aloud story she held activities and guided discussions. Across a three-month period, her library reading program conducted 45-minute sessions for each participating group of children. Each group attended one session per week. Based on Tukhareli's assessment of the program, 92% the majority of children learned factual information about HIV/AIDS, and 78% reported less fear about the disease and an increased comfort when thinking and talking about AIDS. Table 3 lists an Internet link to Tukhareli's recommended books for bibliotherapy with OVC. She noted that her bibliotherapy sessions increased children's openness and willingness to talk about HIV/AIDS and challenges associated with the disease.

Read-me-to-resilience (Wood et al., 2012). Stories, including fables and parables, have been used for centuries as a way of passing established teachings from one

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generation to the next (Friedberg & Wilt, 2010). Also relying on children's stories, Wood et al. (2012) reported their initial findings based on a piloted bibliotherapeutic intervention, *Read-me-to-Resilience* (RM2R). This research, conducted with 32 orphans, supported the value of using traditional, resilience-themed, African stories to bolster OVC's resilience. Theron reports that RM2R includes 22 stories, each of which is approximately ten minutes in length. These stories are collectively printed into a 60-page booklet and are available electronically on the Internet [http://readmetoresilience.co.za]. In addition to children self-reporting strengthened resilience and positive outcomes, participating teachers who read these stories to their students also reported perceptions of strengthening students' resilience. Currently the stories are available in English, isiXhosa, and isiZulu. In the future, further translation will include additional African mother tongues.

Culturally aligned rites of passage

In the same journal issue that shared RM2R (Wood et al., 2012), Thamuku and Daniel (2012) reported implementing a culturally aligned rites of passage intervention with 44 orphans in Botswana. During a therapeutic retreat, these children publically expressed and affirmed their grief experiences. Additionally, related to personal loss and ongoing adjustment, participating children proactively identified and confirmed strengths upon which they could draw personal support. Because communities sent orphaned children to participate in the retreat and because participating children publicly witnessed both affirmation and confirmation of grief, there was a strong communal sense of strengthening resilience. Generalizing these effects to school settings, adults need to consider the importance of all children feeling included and having opportunities to share life experiences.

Additionally, Siyabakhumbula is another example of a program offering opportunities for OVC to communally share their experiences. Clacherty and Donald (2008) evaluated this program which offered a defined structure and processes to facilitate supportive grieving related to HIV/AIDS. They noted that this intervention drew on culturally meaningful practices such as song, group sharing, and ritualistic fire offerings to the departed ones (now ancestors). In their report they further defined this program:

> Siyabakhumbula is a programme that helps people to grieve, to access feelings and memories for which there is otherwise no time or space, to develop rituals of remembering that contain the unbearable and sustain hope, to uncover the inner and collective resources needed to turn the struggle for survival into an affirmation of life ... There is a particular overlap between the Siybakhumbula and Khululeka programmes, and the bereavement work has been integrated into the work with adults living with HIV and AIDS, orphaned teenage caregivers as well as children infected with HIV and their caregivers. (Clacherty & Donald, 2008, p. 2)

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Coaching and guiding children's thoughts

Haine et al. (2008) identified the benefits of coaching children's negative and destructive thinking and self-talk. Serving as models, caring adults are instrumental in helping children reframe maladaptive thoughts and feelings. By offering examples of positive self-talk, adults help children turn from negative self-talk. For example, children often blame themselves for contributing to their parent's death. Feelings of guilt and blaming oneself for their parent's death are counterproductive in the healing process (Sandler et al., 2010). When a child expresses feelings of guilt, it is important to acknowledge these feelings, reassuring the child that feelings of guilt are commonly experienced. However, adults must also reiterate that the death was not the child's fault. Addressing children's misperceptions and positively reframing negative thoughts elevates positive thinking and reduces anxiety and depression often associated with grief and guilt (Cohen et al., 2006, 2012; Sandler et al., 2010).

Countering *hidden resilience*, resilience literature does not advocate for children to hide their emotion. Greenberg (2003) encouraged therapists to utilize emotion-focused therapy. This approach supports children in facing strong emotions. Rather than avoiding challenging thoughts and feelings that are associated with trauma and grief, Greenberg noted the importance of guiding children to their emotions (*arriving*) and then guiding them through their emotions and toward healthy adaptation (*leaving*). He also addressed three underlying evidence-based principles to guide supportive intervention which assists children in expressing and coping with their emotions: (a) awareness of emotions; (b) regulation of emotions; and (c) transformation of emotions. Offering various opportunities and modes of emotional expression, those who work closely with children should invite, but never force participation (Haine et al., 2008; Heath & Cole, 2012; Webb, 2010, 2011). Offering a variety of modes to express feelings opens the opportunity for children to have control in selecting what is most comfortable and appropriate to their particular needs.

Suitcase project

Another intervention implemented in South Africa, Clacherty's (2004, 2008) *Suitcase Project* describes a therapeutic process that offers refugee children an opportunity to express their feelings in the process of telling their stories. Based on this project, she wrote a book detailing 11 children's individual stories (*The Suitcase Stories: Refugee Children Reclaim Their Identities*; Clacherty, 2008). In summary, the book contains stories (recorded verbatim) of refugee children (orphans included), whose traumatic journeys led them to Johannesburg, South Africa. Clacherty explains the therapeutic value of encouraging children to work through their traumatic grief by creating symbolic artwork (painting and drawing pictures on the outside and inside of small suitcases) representative of life experiences.

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Clacherty initiated the Suitcase Project in 2001 and then joined with art teacher Diane Welvering in 2002 to formalize this lay counseling program offered to South African refugee children. Clacherty noted that as children decorated their suitcases they also gradually shared their harrowing life stories. Across several weeks and months, the Suitcase Project's artwork served as a focus for each child's story, allowing details to unfold bit by bit. Over time, children added journal entries and included transitional objects and mementos to the contents of their suitcases. Some children chose different drawings/paintings on the outside of their suitcase (public and visible to all) than they chose for the inside of their suitcase (private and not visible to outsiders). The symbolic nature of their drawings created a way to gradually reveal their story at a comfortable pace.

Creating the artwork, combined with telling personal stories associated with the artwork, helped create a safe emotional distance from the real life experience. Although the trauma of real life experiences was overwhelming, telling the story with artwork made the trauma more approachable. One child commented, '[W]hen a problem is in your heart there is no solution and it makes you angry. But when you talk it makes you better' (Clacherty, 2004, p. 5).

Memory box

When working with families affected by HIV/AIDS, Ebersöhn et al. (2010) described the need to equip community volunteers with activities that offer therapeutic value and focus on children's resilience, in spite of challenging situations. Based on narrative therapy—which encourages children to gradually share their story—and positive psychology (Seligman & Csikszentmihalyi, 2000), Ebersöhn et al. (2010) offered the option of making a memory box. This activity encourages participants to tell their story (narrative) and draws upon positive memories about the deceased loved one. This activity is based on principles of positive psychology, which encourages adults and children to focus on 'assets, resources, and capacities' of survivors (Eloff, Ebersöhn, & Viljoen, 2007, p. 79; Seligman & Csikszentmihalyi, 2000). As the memory box is decorated, individuals talk about memories and tell stories related to the objects they select to include in their memory box. Special mementos, official documents (e.g. birth certificates, parents' marriage certificates, etc.), pictures, small trinkets, special letters, poems, and other prized and sentimental objects are placed in the box.

As a class-wide activity in a school setting, teachers could encourage each student to decorate a box (such as a shoe box). Each box is unique to its creator and may hold a wide range of emotional attachments, depending on the individual child's experiences and losses. Each child's memory box becomes a container to store meaningful keepsakes, drawings, notes, poems, etc. For OVC, selected objects linked to memories of their deceased loved one would help in expressing grief and/or celebrating memories of good times. Teachers could also encourage children to share their stories about the selected contents. Over time, and as trust is

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established, OVC will elaborate on their life stories, increasingly sharing more details (developing a personal narrative).

Dream work

Historically, cultures such as the Native Americans in the United States, the Chinese, and Latino—in particular those from Mexico—perceived their dreams as a meeting place to visit with their deceased loved ones and relatives. Dreams involving the deceased may be drawn upon to help survivors face challenging problems, gain insights into how to address problems, clarify life's meaning, and experience enlightenment—a sense of direction and purpose (Bulkeley, 1997).

Dream work is a potential strategy to stimulate grief work in South African children impacted by HIV/AIDS. Cluver and Gardner (2006) noted that children orphaned by AIDS were more likely than their peers to have *constant nightmares*. Research shows that children's dreams are impacted by their daily experiences (Ablon & Mack, 1980; Dollinger, Molina, & Campo Monteiro, 1996; Englehart, 1990; Foulkes, 1982). For instance, Ablon and Mack (1980) noted that some of the most common developmental stressors for children can be clearly represented in the content of their dreams—such as 'toilet training . . . birth of siblings, deaths, marked alterations in a parent's emotional state, changes in home or school situation, illnesses, operations, injuries, frightening events of the day, and similar stresses or traumas' (p. 185). Similarly, Cooper (1999) showed that children who are grieving recall their dreams more frequently and seem more conscious of their dream worlds than non-grieving children. Focusing on dreams, then, may help grieving children make sense of what is happening around them.

Healy-Romanello (1993) suggested that in a group counseling setting, children be given time to share their nightmares and dreams by talking about the dreams, by drawing pictures to represent their dreams, or by depicting and modelling their dreams with clay. Thus, encouraging children to talk about and share their dreams may be a powerful way to help grieving children identify and express painful feelings. Allowing children to explore their dreams may also lead to increased problem-solving. Reminiscent of Bettelheim (1976), Ekstein (1981) stated:

> I often use the dreams of children as if they were fairy tales. Behind every tale there is a bit of psychological truth. The fairy tale is not only magic wish fulfilment, the happy ending, but it is also the representation of inner conflict, of developmental tasks and developmental dilemmas. The fairy tale is more than a cautionary tale. It is not only a warning but also an attempt at solution. Behind the happy ending there is hidden, it seems to me, an adaptive solution. (p. 122)

Children's dreams have the potential to reveal specific problems as well as the essential tools for addressing and solving them. Additionally, discussing dreams offers opportunities for caring adults and peers to discuss a child's worries and concerns in a less direct fashion. This distance offers a safe atmosphere often

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associated with storytelling. Parents and teachers might encourage OVC to discuss their dreams by showing interest when children talk about their dreams. Furthermore, adults can encourage discussion by simply saying, ‘Tell me more about your dream’.

Creative expression and writing

Writing journal entries, poetry, creative writing, and participating in narrative theatre/drama(Nyawasha & Chipunza, 2012) may be beneficial to some children and serve as an outlet for strong and painful emotions. When offering a menu of activities, OVC’s preferences for certain activities over others should be honoured. For example, some children may prefer drawing pictures in their journal rather than directly writing about their experiences with HIV/AIDS and family deaths (Thupayagale-Tshweneagae et al., 2010). In their research focused on OVC’s journal writing, Thupayagale-Tshweneagae et al. (2010) noted that some OVC avoided using direct terms related to AIDS and death. For example, one student’s diary entry obliquely referred to her mother’s situation of dying with AIDS as a ‘heavy situation’, without mentioning AIDS (Thupayagale-Tshweneagae et al., 2010, p. 12).

Participatory projects and organized youth activities

Ssewamala et al. (2008) evaluated an intervention with AIDS orphans attending school in rural Uganda. Of the participating adolescents ($n = 96$), 50 participated in the intervention (experimental condition) and 46 participated in a comparison condition (control condition), 70% were female, and the mean age was 13.8 years. All youth received peer group counseling, health education, and school materials. In addition to the routine services, the experimental group received an economic intervention, consisting of six two-hour classes on career development and financial planning which focused on helping youth save a small amount of money. Additionally, for each adolescent in the experimental group, a savings account was set up, in which family and friend donations were matched (2:1) by the research project’s contributions. Savings accounts could only be spent on the participating youths’ education or family income-generating activities. On average, adolescents saved approximately $8.85 each month; in 2008, this amounted to $318.60 per year in US dollars. In context, this yearly amount would pay for two years of a student’s post-primary education. Those in the experimental group also held more positive aspirations for the future and held more positive attitudes about using AIDS prevention methods.

A project similar to the Ugandan project was conducted in Tanzania under the auspices of Humuliza, the funding organization for both projects. In line with the outcomes of these two projects, in 2005 Clacherty’s and Donald’s evaluations of Humuliza projects produced similar outcomes (Clacherty & Associates & Donald, 2005). The importance of this observation is that a replication producing similar outcomes endorses both the reliability and validity of the implemented practice.

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In turn, this type of research encourages practitioners and researchers to attempt similar interventions with OVC in other sites.

Another participatory project involved peer-to-peer intervention. Van der Heijden and Swartz (2010) countered the lack of mental health professionals and the culture of silence associated with HIV/AIDS related deaths in South Africa. They offered peer-led interventions for youth ages 10- to 13-years-old. These gatherings gave students the opportunity to openly talk about death and to reminisce about deceased loved ones, topics which were typically discouraged in their homes.

Concluding thoughts

Given the medical and psychosocial demands created by HIV/AIDS, Ebersöhn (2004) and Ebersöhn et al. (2010) bemoaned the severe lack of mental health professionals in South Africa and other developing countries in Africa. To address this need they proposed strengthening the roles of volunteers. However, even though volunteers reported confidence in their ability to offer physical care to AIDS inflicted individuals, they reported feeling particularly 'ill equipped' in providing psychosocial care to those individuals (Ebersöhn et al., 2010, p. 74).

Addressing this need, Ebersöhn et al. (2010) reported that when volunteers were given an activity such as helping HIV/AIDS survivors in making a memory box, volunteers were able to follow the activity's directions and to competently provide therapeutic intervention. Therefore, in providing lay counselors, volunteers, teachers, and caregivers with directions to implement evidence-based therapeutic activities, psychosocial support can be offered to OVC in familiar settings (e.g. classrooms, homes, libraries, and community activity centers).

Although this article focused on South Africa's OVC, this information should be carefully considered for OVC in other countries faced with similar issues and challenges. Schools and communities must support OVC in continuing their education and staying connected with immediate family, extended family, peers, and teachers (Cluver & Gardner, 2007b). Additionally, as new interventions are tested and proven effective, teachers, volunteers, and others who work closely with OVC must be kept informed to ensure their services are up-to-date.

This manuscript provided a list of evidence-based and practitioner-recommended interventions to strengthen South African children's resilience and to facilitate their emotional well-being. Although these interventions may be utilized by school psychologists and other mental health professionals, these interventions can also be implemented by caregivers, parents, teachers, and volunteers. The information and resources listed in this manuscript's tables offer all adults a framework to better support the social-emotional needs of OVC.

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