Intervention Measures that are Used to Support Children with Complicated Grief. A Case of Selected Public Primary Schools in Nairobi County, Kenya

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ABSTRACT

Children who do not have a parent or other caregiver who can help them both emotionally and physically during their grieving process are more likely to develop Complicated Grief. This study aimed to find out intervention measures that are used to support children with complicated grief in selected Public Primary Schools in Nairobi County, Kenya. This study was guided by Piaget's Cognitive Development Theory. Multistage sampling, purposive sampling, inclusion, and exclusion criteria were used to select 259 pupils aged 10-13 years who had lost a loved one to participate in the study. Purposive sampling was also used to select 22 class teachers of the bereaved pupils who participated in the study. The study employed a convergent mixed-method design. Data was collected through self-administered questionnaires (SDQ, ICG, and STAB) and interviews. Quantitative data was analyzed through descriptive and inferential statistics using SPSS Version 25.0. Qualitative data was gathered via interviews and analyzed through thematic analysis. The findings indicated that the most used intervention measure was counseling at 79.16%. However, the study found that only 3 out of 22 teachers were trained counselors. The study recommends the Ministry of Education introduces a school-based counseling program incorporating grief intervention techniques and recommends trained counselors who do not double up as teachers to be school counselors to negate dual relationships.

Keywords: Complicated grief, intervention, children, loved one

INTRODUCTION

Children's grief process is influences by developmental, relational, and systemic factors. A child's chronological age and cognitive developmental level dictate their capacity to comprehend the permanence of death (Bui, 2018). Importantly, the child's attachment style with the deceased significantly influences their grieving patterns. While children with secure attachments are generally equipped to process loss and eventually form healthy, continuing bonds with the deceased, those with insecure attachments often struggle, raising their susceptibility to complicated grief (Schenck et al., 2016). Other factors are the relationship between a child with the decease. Children who lose their parents may experience more intense grief than children who lose their uncles or grandparents. This is because children are more reliant on primary care givers for their safety, shelter, and love. Additionally, the nature of death (was it sudden or prolonged illness), individual personality traits, and prior exposure to loss; a child with previous experiences of death may navigate subsequent bereavement more effectively than a child experiencing death for the first time.

Family and environmental systems further influence how children process grief. Consistent with Social Learning Theory, children mirror familial mourning behaviors, which are heavily mediated by cultural and spiritual backgrounds (Ferow, 2019). Children will find it difficult to articulate their thoughts about death and loss in families where death is not discussed honestly, making it difficult for them to process grief (Walsh, 2011). Left unattended, factors mentioned above can make grieving children encounter behavioural and

emotional disruption that prevents the normal grieving processing leaving children "stuck" in a state of Complicated Greif (CG) (Ener & Ray, 2018; Shear, 2012).

Complicated grief is postulated into three different types by the American Psychological Association (APA) Dictionary of Psychology (2013): absent grief, delayed grief; chronic grief, which is intense and prolonged grief. It is characterized by masked, delayed, exaggerated, or chronic emotional pain. CG is heavily linked to severe trauma, multiple losses, sudden or violent deaths, ongoing concurrent stressors, and a lack of adequate support networks (Worden, 2018).

Nakajima (2018) and Shear (2015) point out the symptoms of CG as intense longing that lasts for a long time, emotional pain or longing for the deceased, thoughts and memories of the deceased that preoccupy you frequently, a sense of disbelief or inability to accept the loss, and difficulty envisioning a meaningful future without the deceased. Along with avoiding events that serve as a reminder of the loss, there is often grief, resentment, and guilt about the circumstances of the death. Shear (2015) purported that, maladaptive behaviours, dysfunctional thinking, and emotion dysregulation can result from these symptoms of CG. This study focused on complicated grief among children concentrating on intense yearning and longing for the deceased person, preoccupation with thoughts and memories of the deceased, anger and sadness, feelings of self -blame and a feeling of disbelief or inability to accept the loss.

Children are vulnerable to CG for several structural and social reasons. To begin with, children are not given attention during mourning as most families assume that children do not grieve (Akerman & Statham, 2014). Also, children are not given enough information about the death, are not allowed to participate in funeral ceremonies and rites and do not having a safe haven to express feelings and act out stress (Martell et al., 2013),

Additionally, environmental factors like living arrangements within the family, poverty and inadequate grieving support can lead to complicated grief (Mwona & Pillay, 2015 as cited in Ngesa et al., 2020b). Families with low socioeconomic status and limited resources may not access medical care or therapy (Jacob, 2017; Roulston et al., 2017) and will then not seek intervention for their children when grief starts to get complicated. In some families where they cannot afford service care, children especially girls are turned into caregivers giving them no room to mourn their loved one which can hinder them from grieving (Roulston et al., 2017). CG can have devastating consequences in children like the development of somatic symptoms, aggression, developmental regression, detachment from their peers or family members, academic decline, drug or alcohol use, withdrawal, anxiety or depression (Ferow, 2019; Ener & Ray, 2018).

Globally, the United Nations Children's Fund **(**UNICEF) (2017) recorded that there are roughly 140 million orphans worldwide as of 2017, with 61 million in Asia, 52 million in Africa, 10 million in Latin America and the Caribbean, and 7.3 million in Eastern Europe and Central Asia. In the United States of America, 4% of children and teenagers under the age of 18 suffer the loss of one of their parents (Revet et al., 2018). Harrison and Harrington (2001) carried out a study in Northern England in the United Kingdom (UK) among adolescents aged between 11-16 years to estimate the prevalence of bereavement experiences in adolescents. According to their findings, 77.6% of the teens had experienced the loss of at least one close friend or relative (Revet et al., 2018).

In Sub-Saharan Africa, UNICEF (2017 as cited in Huynh et al., 2019) recorded that there are more than 52 million orphans. A study conducted by Thurman et al. (2017) in South Africa indicated that 88% of bereaved adolescents experience complicated grief. In Tanzania, a study on treating unresolved grief and posttraumatic stress symptoms in orphaned children indicated that 92% of the participants had symptoms of unresolved grief (O'Donnell et al., 2014). In Kenya, Making Well-Informed Efforts to Nurture Disadvantaged Orphans and Vulnerable Children (MWENDO), a USAID-funded program projected that there are around 2.6 million orphaned children under the age of 18 (MWENDO, 2021). The death of a parent has been considered one of the most distressing experiences for children that may have both short and long-term effects on their health and well-being in the short and long term (Bylund-Grenklo et al., 2021). Bylund-Grenklo et al. (2021) further indicated that grief in children has been associated with the risk of self-injury, suicide attempts, and complicated grief. Consequently, the 2.6 million orphans in Kenya are vulnerable to complicated grief which might lead to antisocial behaviours if not helped to process grief.

The breakout of the Corona Virus Disease (COVID-19) Pandemic led to a sudden upsurge in death in the globe which caused many people to mourn (especially children) the loss of a loved one. It was projected that two children and four grandchildren experienced grief for each COVID-19 death (Birkner & Soffer 2020). The global and national protection measures (limitations on funerals and hospital visits, quarantine policies, social separation laws, cemeteries closure, ban on religious festivities and other worship activities, social-economic stressors, and national lockdowns) had a negative effect on people's grief for their loved ones (Santos et al., 2021). traditional communal mourning rituals and physical support systems (Santos et al., 2021). This disruption severely obstructed natural grief processing, dramatically increasing the prevalence of CG during and after the pandemic, particularly among children and adolescents (Gesi et al., 2020; Weinstock et al., 2021).

Studies are abundant on normal grief, but there is little study on complicated grief in adults (Glass, 2005 as cited in Newson et al., 2011). Despite the prevalence of complicated grief being unclear and debatable, it is estimated that 10 to 40 % of grievers experience CG (Newson et al., 2011). This estimation seemed to agree with (Enez, 2018; Kersting et al., 2011) who stated that between 10% and 20% of those who lose a loved one may have difficult grieving causing complicated grief. Just like in adults, there is also a gap in the area of complicated grief in children since the epidemiological studies centered on this subject are sparse (Revet et al., 2018). This is echoed by Ngesa et al. (2020a) who noted that there are inadequate studies in Africa and Kenya on complicated grief in children. Accordingly, there is a shortage of literature on complicated grief among children, its prevalence, and its impacts. This study therefore sought to fill this knowledge gap by finding out the intervention measures that are used to support children with complicated grief in selected public primary schools in Nairobi County, Kenya.

Problem statement

McCoyd and Walter (2016) referred to children as the forgotten mourners. Family members tend to think that children are not aware of the loss in their lives unless others draw their attention to them. As a result, children are left out during the grieving process by being excluded from death-related events (Akerman & Statham, 2014). They are not given room or space to share their feelings, thoughts, and questions they have. In the words of Huynh et al. (2019), this hinders children from processing grief which may lead to complicated grief. Complicated Grief can manifest in antisocial behaviours like physical and social aggression, rule breaking which might affect the child's social, cognitive, academic, and relational functioning. Additionally, Burns et al. (2020) noted that regardless of grief's consequences on well-being and lifetime health, the frequency of bereavement in childhood is not fully comprehended. Furthermore, there is a gap in the area of CG among children as it has not been amply researched especially in Africa (Ngesa et al., 2020a). This study therefore sought to address this knowledge gap by finding out finding out the intervention measures that are used to support children with complicated grief in selected public primary schools in Nairobi County, Kenya.

Research objective

The research sought to find out the intervention measures that are used to support children with complicated grief in selected public primary schools in Nairobi County, Kenya.

LITERATURE REVIEW

Theoretical Review

Piaget's Cognitive Development Theory was developed in the 1920s by Jean Piaget. Jean Piaget was born on August 9, 1896, in Neuchatel, Switzerland, and died on September 17, 1980 (Miller, 2016). Piaget documented and examined children of various ages. Piaget's theory includes concepts of schema or schemes, adaptation, assimilation and accommodation, and four stages of development (Sanghvi, 2020). The development of mental structures, or schemes, is the process by which cognition develops (Flavell, 2011). Through their strategies, children learn about their world. Children arrange and interpret their experiences through schemes. Piaget postulated that organization and adaptation, two inborn cognitive processes, are the building blocks of all schemes and knowledge forms. Children mix preexisting schemes into new and more sophisticated intellectual

schemes through the organization. As per Piaget's theory, children are always arranging their schemes into increasingly intricate and useful structures (Miller, 2016).

Assimilation and accommodation are two complementary processes that allow for adaptation. While accommodation is the act of changing preexisting structures to allow for new experiences, assimilation is the process by which children attempt to understand new experiences in terms of their preexisting conceptions of the world. Piaget thought that for cognitive development to occur, assimilation and accommodation must cooperate (Gillibrand & O'Donnell, 2016). Rabindran and Madanagopal (2020) highlighted four major stages of cognitive development identified by Piaget: sensorimotor stage (birth to 2 years), preoperational stage (2 to 7 years), concrete operational stage (7 to 11 years) and formal operational stage (11 years and beyond).

In the sensorimotor stage (birth to age 2), infants understand the world by coordinating sensory experiences with motor actions. They also develop object permanence. The second stage is the preoperational stage (ages 2 to 7) where children start utilizing words and symbols and their thoughts are self-centered. Children become imaginative in their play activities. The concrete-operational stage (ages 7 to 11) is characterized by the appropriate use of language. Children acquire and use cognitive operations. They gain an understanding of the fundamental characteristics of and relationships between common items and occurrences by relying on cognitive processes. By examining the actions of people and the situations in which they take place, they can conclude intentions.

The last one is the formal-operational stage (ages 11–12 and beyond). The cognitive processes of adolescents are restructured to enable them to perform tasks. Their logical thinking is no longer restricted to the tangible or observable; instead, it is methodical and abstract (Slater & Bremner, 2017). In this study, the cognitive developmental stages will be considered in determining if the respondents comprehend death and how well they are able or not able to process grief. Of interest in this theory is stage three; concrete-operational stage (ages 7 to 11) and stage four; the formal-operational stage (ages 12 and above) of cognitive development. Children under both categories can appropriately use language as well as cognitive operations to understand death and process grief.

Other scholars like Rachamim (2017) noted children between the ages of 6 and 9 have a strong curiosity about dying and may have queries about what happens to them after they pass away. They start to realize that death is inevitable and that it only affects other people, not themselves. They too feel deeply bereaved, but they find it hard to express it, thus they require permission to grieve. Shaffer and Kipp (2014) referred to this stage as the concrete operational stage where children have appropriate use of language and can use cognitive operations. They can understand everyday events and make conclusions by observing others' behaviours and the circumstances in which they occur.

Therefore, as they experience death, they try to make sense of the event and might blame themselves or others for the death. As they strive to master the event, they would want to be part of the mourning process since at this stage they want to be involved in decision-making. This suggests that children this age are aware of death and are capable of feeling grief. At age 9 years and above, a child can view death as final and happens to everyone. They have a clear understanding that death is unavoidable and not a punishment. They have an inquisitiveness about the bodily viewpoint of death. They can articulate their emotions verbally, but they tend to show their feelings through their behaviour instead of their words (Shaffer & Kipp, 2014)

The respondents in this study were children aged between 10-13 years. They were categorized under the last two cognitive development stages which indicated that children aged 10 years and above can comprehend and process death due to their cognitive abilities as well as the appropriate use of language. For that reason, if children are not helped to understand the event (death) and to be part of the grieving process, they might not grieve their loved ones. This can cause CG which in turn can lead to maladaptive behaviour like antisocial behaviours. This study applied Piaget's principles of cognitive development to identify children with the ability to comprehend and process death and grief. The theory was also used to identify children who could express their thoughts and feelings in writing.

Empirical review

Intervention Measures to Support Children with Complicated Grief

The word intervention has been defined as the act of purposefully getting engaged in a challenging situation to make it better or stop it from growing (Cambridge University Press, 2008). Intervention describes the planned social work tactics and methods that a social worker uses to help a client achieve their goals and objectives (Levine, 2002 as cited in Drenth et al., 2012). Intervention measures on the other hand are different methods that can be used to help patients in a counseling session. These methods can be personalized to each patient's needs and treatment goals (Johnson, 2019). In this study intervention measures were defined as the different counseling approaches that teachers and school counselors use or feel can be used to help children with CG to process it. Therefore, the study sought to find out from class teachers intervention measures used to help children with CG.

The ways that children deal with loss, grief, and trauma differ greatly from those of teenagers and are not always the same as those of adults (Palmer et al., 2016). Because of this, methods for assessing and treating children who are experiencing loss and grief must be different from those used with adults and adolescents. Surprisingly, children's reactions to stress, loss, and mourning can include recurrent grief, and the process might take a long time (Hogan & DeSantis, 1996 as cited in Malone, 2016).

Children grieving and response to loss is ironically continuous and irregular which can be a source of confusion for the child's friends, family, and other caregivers. A child may withdraw and seem depressed, then revert to their former, more outgoing self, and finally experience intense grief once more. Even the child may find this puzzling and challenging (Palmer et al., 2016). It is essential to remember, too, that certain children are inherently resilient and have family, spiritual or religious networks, and other loving adults as support systems to help them deal with trauma, loss, and sadness (Malone, 2016).

In normal grief, children may not need the intervention of a professional to process grief. However, children that have difficulty facing and coping with loss, will have an increase in behaviour problems. Consistent with (Ayyash-Abdo, 2001; Luecken, 2000 as cited in Martell et al, 2013), children who have experienced a loss are more likely to experience social issues, behavioural and psychological disorders, and other challenges during and soon after the grieving process, as well as in later adulthood. Consequently, child development professionals, parents, and extended family have chances to mediate these effects. Usually, unwarranted behaviours that persist over time and are challenging for caregivers and educators to recognize and deal with in a healthy way are targeted for intervention (Heath et al., 2008).

Children who do not have a parent or other caregiver who can help them both emotionally and physically during their grieving process are more likely to develop CG (Therivel & McLuckey, 2018). With CG, children are not capable of finishing the tasks involved in reconciliation which ends up impairing their normal functioning (Dyregrov, 2013). Bergman et al. (2017) stated that, when children lose a parent or loved one, they may need assistance from a healthcare provider during their bereavement process so that their mental health needs are satisfied and they can keep moving forward with their positive growth. Thus, it is important to help children who have developed CG to process it and be able to assimilate the death and move on.

Consequently, when helping children with CG, it is important to have an intervention plan cutting across the family, the therapist, and the school. This intervention should consist of a collaborative team including Healthcare specialists from diverse fields who collaborate regularly with families, schools, and other organizations to guarantee that patients receive continuous care (Verdery et al., 2020). Intervention can be offered by adult family members who are with the child to establish a secure atmosphere for the child to understand and process the loss.

If the child is unable for whatever reason to process grief with the help of the adult family member(s), a therapist can be involved who in return can work with the school to put up measures to support the grieving child (Malone, 2016). These are measures like; having a section in the school library containing a section with materials on bereavement and loss such as videos and books. Offering a needed routine to a child whose home

and family became emotionally charged and chaotic after losing a loved one. Formulate a counseling team among the teachers that can act as a listening ear and confidant to children who have lost loved ones.

An intervention for CG can be put in place before a loved one dies by adults around the child (Kinzbrunner & Policzer, 2011). This is meant to get the child ready for any eventuality. For example, a child can be made to understand the health condition of the loved one, be allowed to ask any question he or she might have, and if not traumatizing can be permitted to visit the ill person if the child wishes to. Also, allowing the child to care for the sick person in whatever way they see fit, such as sending a card, is important (Bergman et al., 2017; Carter, 2016; Kinzbrunner & Policzer, 2011). Vising or caring for a dying person might help a child understand the reality of death which might help in processing grief.

Following the passing of a loved one, adult caregivers must discuss the death with the child. The child should be told the truth about the death in a gentle and caring way. However, this does not mean using euphemisms like “went away” or “went to sleep” to explain death. Such synonyms tend to make the child think the individual will return or awaken one day (Bergman et al., 2017; Kinzbrunner, & Policzer, 2011). However, talking with young children is difficult since their attention span is limited and when the news stimulates their emotions, they will shift from one thing to another, in and out of grief. A child can only handle limited information at any one time. Caregivers and therapists should give information a bit at a time and the child will put together the information when needed (Carter, 2016). Kinzbrunner and Policzer (2011) pointed out that it is important to inform a child about a loved one’s passing and allow him/her a lot of time to express reactions, and feelings and raise questions and concerns. Additionally, it is critical to acknowledge and respect the child's feelings by making him or her understand that feeling sad, angry, and fearful is normal when a loved one dies.

Another intervention to limit CG is to involve children in funeral arrangements or rituals to know what to expect. In certain situations, parents and other caregivers forbid children from attending wakes and funerals out of concern that it may be upsetting for them or because they are themselves grieving and unsure of their ability to offer suitable assistance (Schonfeld & Demaria 2016). This is very common in African communities where children are not involved in the planning or attending the funeral since they are assumed not to understand what is happening. It is of essence, however, to prepare children psychologically for what is going to happen to them and reassure them about the attention they will receive during the funeral.

Through proper preparation, Dyregrov (2016) stated that children need to be part of the ceremony of viewing the body and attending the burial service. This will guarantee that they receive the same opportunities for grieving as adults, so as not to strengthen children’s denial of the death. However, when including children, it must be ensured that this will not unnecessarily stress the children. In addition, Kinzbrunner and Policzer (2011) observed that children should be included in the planning of the burial service and should be allowed to attend a funeral or burial if necessary. Children get the opportunity to grieve and say goodbye to the departed on their own terms when they participate in these ceremonies with family members.

Correspondingly, Søfting et al. (2016) suggested that attending wakes, funerals, and other memorial events following the death of a close family member is beneficial for kids just as it is for adults. It gives them the chance to grieve in front of friends and family, with their support and if the family feels it suitable, solace from their spiritual beliefs. Schonfeld and Demaria (2016) further alluded that children who are not involved or are excluded from funeral and memorial services will mostly feel aggrieved for being denied the opportunity to engage in a meaningful activity with a person they truly care about. Children could also be curious about what their loved ones are going through which is inappropriate for them to see. It is conceivable that children's imaginations are much worse than reality. All the same, Kinzbrunner and Policzer (2011) declared that children should not be made to attend a funeral or memorial ceremony against their will, but it is key to find out why they are refusing to go so that any worries or concerns may be cleared up. All of this is intended to support the child in processing the loss of a loved one and provide them the freedom to express their grief at their own pace and in their own way.

Children with CG can likewise be supported by going to the deceased's last resting place or cemetery. The child may use this as a way to express their desire to say farewell or to satisfy their natural interest. However, before visiting, children need to be prepared psychologically for what they might witness and experience at the

graveyard and should be allowed to pose inquiries for clarification. Flowers, photos, small gifts, and notes to be placed on the grave can be brought with them. As a way of encouraging children to share their feelings, adults can share their feelings while visiting the grave first. It is critical to analyze any sentiments and ideas they may have following the visit (Bergman et al., 2017).

Counseling is another intervention that can be used. Counselors are invaluable in supporting a child throughout bereavement. Counseling can foster an environment of empathy and openness while giving the bereaved child constructive ways to communicate their negative feelings. Through counseling, bereaved children can better manage their feelings of loss, remember the deceased, and seize the opportunities that lie ahead (Ferow, 2019). Children can convey things that are hard to speak by using many counseling approaches like writing, music, and painting. Recognizing how life has changed and finding closure can be achieved by writing a letter to the departed loved one. These methods also assist in establishing a connection between the grieving child's thoughts, feelings, and actions (Fineran, 2012).

An additional intervention is group therapy. Group therapy confirms to children that they are not alone and allows them to feel the support of others who mourn similar losses. It helps children to get in touch with their feelings of loss which allows them to hear about coping strategies with loss from others at their developmental level (McCoyd & Walter, 2016). Individual and family therapy can also be used to form a safe space for the children to express their thoughts and feelings as well as educate children's caretakers on ways to establish a secure environment to listen to the child's thoughts and feelings (Goldman, 2014). Family therapy prioritizes the natural context in which loss is expressed and processed. This enables the recognition of the child's emotional needs giving him or her an opportunity to process grief.

As proposed by (Ngesa et al., 2020b), interventions can also be done using a school-based program where counselors are trained and equipped with the right techniques to handle children with CG. Intervention is meant to help the child understand the loss, and grief, remember the deceased, and move on with life. Goldman (2014) detailed that intervention should help a grieving child recognize the reality of the loss, experience the pain, learn to go on without the departed and channel the grief's emotional energy into a new life. It is in this regard that this study sought to find out the intervention measures that are used to support children aged 10-13 years with CG in selected public primary schools in Nairobi County, Kenya.

METHODOLOGY

The study adopted a mixed methods approach. Multistage sampling, purposive sampling, inclusion, and exclusion criteria were used to select 259 pupils aged 10-13 years who had lost a loved one in the last year. Purposive sampling was also used to select 22 class teachers of the bereaved pupils who participated in the study. The study employed a convergent mixed-method design where quantitative and qualitative data was gathered, examined, and combined independently. Data was collected through self-administered questionnaires (SDQ, ICG, and STAB) and interviews. To test the reliability of the tools (STAB and ICG), a Cronbach Alpha measure was used and both had a value of Cronbach's Alpha of 0.8. Content validity was tested during the pilot study to ensure the phrasings of the items were correct and written in a language the respondents could understand. Quantitative data was analyzed through descriptive and inferential statistics using SPSS Version 25.0. The findings were presented as tables, pie charts, and graphs.

Ethical Considerations

The researcher adhered to the American Psychological Association (APA) principles of ethics in human research, as outlined by the American Psychological Association Code of Conduct and Ethical Principles namely; institutional approval, informed consent, beneficence and nonmaleficence, fidelity, and Responsibility.

RESULT AND DISCUSSION

Intervention Measures That Are Used to Support Children with Complicated Grief

The fourth objective of the study sought to find out intervention measures that are used to support children

with complicated grief in selected public primary schools in Nairobi County, Kenya. Children who have experienced a loss are more likely to experience social difficulties, behavioural and psychological disorders during and soon after the grieving process, as well as in later adulthood. Thus, child development professionals, parents, and extended family have chances to intervene in these effects (Ayyash-Abdo, 2001; Luecken, 2000 as cited in Martell et al, 2013). As said by Bergman et al. (2017), when children lose a parent or a loved one, to meet their mental health needs and continue their positive growth, they might require assistance from a healthcare expert during their grieving process. Consequently, it is important to have intervention measures that can help children who have developed CG to process it and be able to assimilate the death and move on. Hence, these intervention measures should help a grieving child recognize that the loss is genuine, experience the pain, learn to go on without the departed, and channel the grief's emotional energy into a new life (Goldman, 2014).

Intervention Measures Used to Help Children Cope with Loss in Different Schools

Qualitative Data

To achieve this, the researcher interviewed class teachers to grades 4 to 7 respondents. The interview schedule consisted of nine open-ended items that generated qualitative data. The data was analyzed using themes. The study sought to find out the distribution of class teachers involved in the survey according to their grades which was as follows; 5(23.81%) were grade four teachers, 7(33.33%) were grade five, and 9 (42.86%) were in grade six. Class teachers to grade seven pupils did not participate in the study since most of them reported having been the class teacher for less than six months. The study found that the methods that were employed in different schools to help the children cope with the loss were as follows.

Table 1. Intervention Measures Used to Help Children Cope with Loss in Different Schools

	Method Used to Cope with Loss in Different Schools	**Frequency (f)**	**Percent (%)**
1.	Counselling	16	76.19%
2.	Prayers	3	14.29%
3.	Empathy	1	4.76%
4.	Financial Support	1	4.76%
	Total	**21**	**100.00%**

Table 1 shows the different methods used in the sampled public primary schools in Makadara and Embakasi East Sub Counties in Nairobi County, Kenya. From the findings, counseling was the most preferred method of intervention to help children cope with grief in 76.19% of the schools. Counseling was done by the guidance and counseling teachers or class teachers for schools that did not have a guidance and counseling teacher. However, the class teachers reported that the counseling offered was inadequate since there were no structured ways on how to offer support. The bereaved child would only receive a one-off counseling session if they exhibited unwanted behaviours. Most of the class teachers shared that when asked to have a session with the bereaved child, they did not know how to go about it or what to say.

Secondly, they expressed concern that there were no designated trained school counselors in most schools but teachers who doubled as class teachers and counselors. Out of the 11 public schools that participated in this study, only three had teachers who had counseling training but still, they doubled as teachers and counselors. This can be a challenge for the child in the area of confidentiality if the same teacher who is teaching the bereaved child will also wear the hat of a counselor. Also, this is an ethical issue of dual relationships in the counseling session. They also raised the concern of not having a counseling room. Most of them were forced to talk to the grieving child from the staff room or in the classrooms where there was no confidentiality. The class teachers felt that if there was a functional guidance and counseling department, with trained counselors and counseling rooms, it would be easier for them to refer the bereaved children for counseling. They also shared that if equipped with basic grief counseling, it would help them debrief with the bereaved children which might curb antisocial behaviours.

The second method of intervention was the use of prayers by 14.29% of the schools. In some schools, the class teacher would request one pupil in class to pray for the child who has lost a loved one, or the teacher would offer the prayer. In addition, special prayers were conducted during the Programme for Pastoral Instruction (PPI) where the bereaved child would be mentioned by name and if time allowed would be called in front of the assembly or the hall and would be prayed for. Reactions to death and bereavement are significantly influenced by spirituality and religious commitment. Consistent with Sifers et al. (2012), children use spirituality to shape their perceptions of life. Bryant-Davis et al. (2012) added that children use religious and spiritual coping strategies when they are facing stress, trauma, or illness.

It has been suggested that religious participation is a coping mechanism and that it is frequently beneficial when it encompasses elements like a common story about death and the afterlife, spiritual connectedness, and a purpose to life (Bui, 2018). Children raised in a Christian environment think about life after death and the likelihood of heaven. Christians hold that while grieving during funerals is appropriate, death is not the end because there is still life to come. Children are given hope by this that their loved ones are "safe" and that they will eventually get to see them. When it comes to providing for people's needs as part of a continuous pastoral ministry, the priest typically takes the lead (Kim et al., 2012 as cited in Ilunga, 2021).

Accordingly, during bereavement, a priest gets the opportunity to talk to children and for them to ask questions like; ‘Why did it happen? Is there a God? Will they meet their loved ones in heaven? (Carter, 2016). Asking questions, as stated by Schonfeld and Demaria (2016), is considered therapeutic as children ask to gain an understanding of what happened to the deceased which can help in processing grief. However, this study questioned the effectiveness of the one-off spiritual support offered through prayers during PPI and in class. Prayers were made with no interaction with the grieving child/ren. The teachers indicated that it was not necessarily a pastor who prayed for the grieving child but whoever was sharing the Word during the PPI that day. This showed concern if the children’s spiritual questions like “Why did God allow it to happen” were answered.

The least methods used were empathy and financial support at 4.76% of the schools. Children were asked by the head teachers to contribute any amount that was collected and given to the family of the bereaved child. Having the right support in place for bereaved children and young people is essential for promoting flexibility and mitigating the risks of future problems. In this study, children who came from poor families and those who lost their breadwinners (in some schools) were enrolled in the school bursary program where their school fees were paid. In other schools, some teachers would identify the struggling child after the loss of a loved one who was a breadwinner and offer to support them financially by buying personal effects and once in a while providing food for the child. However, this was not sustainable for the teachers would do it when in a position to. This puts such children at risk of going without food or dropping out of school.

From these findings, it was clear that there are no structured ways to support bereaved children financially especially those who lose their caregivers/ breadwinners in public primary schools. This study resonates with Ferow (2019) who stated that teachers are responsible for attending to and fostering the well-being of their students to the best of their ability once they are aware of a grief/loss incident. This includes paying attention to the signs and symptoms of grief and loss, making the necessary accommodations to their learning, meeting with the child’s caregivers, and helping to ensure that the child’s experience in the classroom is as normal as possible and a safe place for him. In conclusion, counseling though wanting, was the most preferred form of intervention in most schools.

CONCLUSION

The findings showed that the most used intervention to help children during grief was counseling. The findings also showed that there were very few counselors and those available doubled up as counselors and class teachers. This would reduce the effectiveness of counseling due to dual relationships worsening the situation and increasing the risk of developing CG among grieving children. The schools also did not have suitable counseling programs with intervention measures to help children process grief.

Limitation

One limitation of the study is that the study was done in selected public primary schools in Nairobi County, Kenya hence the findings may not be generalized in all the 47 counties in Kenya. Also, the study was limited to children aged 10-13, leaving out those below nine. Secondly, CG is common in the general population but this study focused on public primary school children. The findings may not be generalized to the general population. An additional delimitation is that complicated grief can contribute to other disorders but this study focused on antisocial behaviours only.

RECOMMENDATIONS

The study recommends that:

The Ministry of Education introduces a school-based counseling program incorporating grief intervention techniques and recommends trained counselors who do not double up as teachers to be school counselors to negate dual relationships. With rudimentary age-appropriate resources and guidance, teachers and caregivers should be prepared to address grieving children's emotional needs in addition to guiding them through the challenging feelings related to grief. Public primary schools are encouraged to provide counseling rooms that are well-equipped for the task and develop several training programs to help teachers understand how to intervene and foster resilience in their students who have experienced grief.

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