

# *How Later Adolescents With Adult Responsibilities Experience HIV Bereavement in Nigeria: Application of a Bereavement Model*

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*Conceptual models assist in the better understanding of phenomena and also in the planning of effective responses. We applied the Dual Process Model (DPM) to examine how six later adolescents (ages 18-24 years) experienced the multiple stressors of bereavement, maturational tasks, and caregiving roles. Using a semi-structured interviewing approach, participants who were purposively recruited narrated how parental loss to HIV impacted their lives. In relation to the proposition of the DPM model, the study revealed that participants (a) anticipated grief before the death of their parents, (b) engaged in activities to return to normalcy after parental loss, and (c) neglected grief emotions in order to cope with the demands of caregiving. The application of a model to examine responses to bereavement can assist health care practitioners to appreciate and have a deeper understanding of how best to approach caring interventions for late adolescents with multiple stressors.*

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Parental death, irrespective of its cause, has been observed as the most stressful and traumatic event that a child can experience (Brent, Melham, Masten, Porta, & Payne, 2012; Lopez, 2011). Evidence abounds to support that childhood orphanhood

carries significant risk factors for poverty and reduced height in adulthood (Beegle, De Weerd, & Dercon, 2006; Evans, 2012), psychosocial distress such as depression and anxiety (Cluver, Orkin, Gardner, & Boyes, 2012), poor educational achievement (Guo, Li, & Sherr, 2012), and increased vulnerability for HIV infection (Gregson et al., 2005), among others. The likelihood of experiencing parental death varies by locality and social circumstances (Shaw, Gordon, Dorling, Mitchell, & Smith, 2000). In regions such as Sub-Saharan Africa, the HIV pandemic is a major contributor to the massive number of orphans (Evans, 2010). In more than three decades of the HIV epidemic, the U.S. President's Emergency Plan for AIDS Relief (2012) documented that 17 million children had lost one or both parents to HIV infection; 90% of these children lived in Sub-Saharan Africa. Due to the challenges of scaling up the availability of life-saving antiretroviral therapy, HIV orphans have been projected to increase to about 40 million worldwide in 2020 (United Nations International Children Emergency Funds [UNICEF], 2004).

The impact of the HIV pandemic goes beyond those who are infected with HIV, and HIV orphans

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are a burgeoning population of those affected by the world's leading infectious killer. As stated earlier, parental loss in any form comes with grave consequences for children in all life domains; however, carefully designed studies have demonstrated that parental loss to HIV carries more risk factors than any other type of bereavement (Cluver et al., 2012; Gregson et al., 2005; Kumar, Dandona, Kumar, Ramgopal, & Dandona, 2014). The peculiarities of parental loss to HIV (stigma, exclusion, and coping with the disease) made UNICEF (2010) recognize that HIV orphans have particular needs that require sensitivity if better outcomes are to be achieved. The pervasive influence of stigma and discrimination attached to HIV-related mortality has led scholars (Kain, 1996; Sikkema et al., 2000) to conclude that HIV bereavement complicates coping and adjustment and that it challenges historical models of bereavement. The care of HIV orphans thus constitutes a dilemma for health professionals whose core aim is to ensure healthy childhood and optimum youth development.

Literature is replete with research conducted on various dimensions of HIV orphans, and this has given rise to interventions such as cash transfers (Adato & Bassett, 2009), education support (Lewin & Sabates, 2012), home visiting/mentoring support (Mikton & Butchart, 2009), and various forms of counseling and psychotherapy (Rotheram-Borus, Weiss, Alber, & Lester, 2005). Sadly, however, despite the millions of dollars invested in Orphans and Vulnerable Children (OVC) programs, the needs of HIV orphans continue to outstrip resources, with UNICEF (2010) noting that only 11% of households caring for OVC receive some form of external care and support. There is, therefore, no better time to devote greater attention to the coping strategies of HIV orphans, especially for late adolescents, whom society regards as young adults.

Adolescence is a life phase in which opportunities for health are great and future patterns of adult health are established (Sawyer et al., 2012). However, the developmental phase of adolescence also comes with a heightened threat of chronic illnesses, poor academic performance, drug and alcohol abuse, and other risk-taking behaviors (Barnes, Hoffman, Welte, Farrell, & Dintcheff, 2006). Bereaved adolescents face not only the ambiguity and confusion of

their grief (Balk, 2011), but also "ambivalence engendered by maturational phase conflicts" (Fleming & Adolph, 1986, p. 104). This suggests that bereavement is an additional stressor for adolescents, a stressor that can mar healthy youth development. In order to understand how grieving adolescents respond to the loss of a loved one, it is useful to adopt the idea that adolescent development occurs in three phases (Balk, 2011; Kurz, 2012): early adolescence (10-14 years of age), middle adolescence (15-17 years of age), and later adolescence (18-24 years of age). It is important to categorize adolescents according to their age groups because of differences in how early, middle, and later adolescents respond to bereavement because of the maturational tasks of each phase. For instance, bereaved early adolescents are likely to think that only their peers will understand them, while later adolescents see belonging in another person's life as giving a purpose to life and providing meaning that will be missed after the death of the loved one (Balk, 1996).

The international development discourse and interventions for HIV orphans (see the OVC policies of the U.S. President's Emergency Plan for AIDS Relief, UNICEF, and the United States Agency for International Development) do not regard later adolescents as dependent orphans in need of support, and therefore, exclude them from assistance when they reach the threshold of 18 years (Evans, 2012). Also, the contemporary literature on HIV orphanhood largely concentrates on children and early and middle adolescents, despite the fact that the prevalence of HIV orphans increases by age (Ruland et al., 2005). The experiences and needs of later adolescents have, therefore, been neglected and subsumed in the OVC literature. Having been stripped of eligibility for the interventions discussed above, one can predict that later adolescents face more damning challenges than their younger counterparts. Emerging but limited evidence substantiates this prediction, as it has been demonstrated that negative mental health outcomes amongst orphans are maintained and worsen beyond middle adolescence into later adolescence (Brent et al., 2012; Cluver et al., 2012). Gilbert and Charles (2012) stated that older orphans were more adversely affected, presumably because they took on parental responsibilities, which came at a

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