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Support for the Dying and Bereaved in Zimbabwe: Traditional and New Approaches

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ABSTRACT

Since dying and bereavement are basic to the human condition, all societies have developed ways of providing support for those undergoing these experiences of loss. However, the emergence of the hospice movement marks the beginning of the provision of organisational support beyond that traditionally supplied within the family and friendship network. Zimbabwe presents an interesting situation whereby traditional support systems function side by side with newer voluntary organisations providing services for the dying and bereaved, mainly within the white community but also, increasingly, to those black Zimbabweans in a state of transition between rural and urban life.

Both traditional and organisational support systems are analysed with particular emphasis on the 'holistic' approach being practised by two voluntary organisations in Zimbabwe. Holistic care manifests several new features, which distinguish it from that provided in more orthodox western medical settings, and which, actually, converge with traditional African approaches. A brief review of problems being experienced by bereaved and dying people receiving assistance reveals that in the changing social conditions in present day Zimbabwe there is potential for useful cross-cultural fertilisation in approaches to the care of those experiencing loss and some suggestions are made to this end.

Introduction

Dying and bereavement are basic and unavoidable aspects of the human condition. None of us escape death and few of us go through life without losing a close friend or relative. Yet, despite the universal nature of death and bereavement many people are ill-prepared for the experience and this results in a level of trauma and suffering beyond that which is inevitable, given that loss is always to some extent a painful experience.

However, bereavement counselling and support for the dying are

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becoming increasingly available and acknowledged as important areas of social work practice owing to two developments – one positive and one negative. Firstly on the positive side, the advent of the hospice movement has put death on the social service map, as it were. The word 'hospice' originally meant a house of rest for travellers but is now used world-wide in referring to all aspects of skillful care for persons suffering from life-threatening illnesses. Such care would include pain control, psychological counselling and social support as well as normal medical treatment. The hospice movement has led to the provision of such care in many parts of the globe, including Zimbabwe.

Secondly, the AIDS epidemic in Africa has challenged the public to consider the needs of the dying and bereaved in a way that has never been called for before. In Zimbabwe plans are afoot to increase counselling support for AIDS patients whom it is recognised have special needs for understanding and caring attention given the social stigma that is often attached to the disease. Furthermore, recent research indicates that victims of the HIV virus are responding well to 'holistic' therapies applied in conjunction with conventional medical care. These holistic therapies, which incidentally have also been shown to have beneficial results with ordinary non-AIDS related cancer sufferers, very much emphasise the alleviation of stress, and a key factor in this is counselling. Consequently, there is a growing interest in new approaches to counselling persons with life-threatening illnesses.

The seminal work of Elizabeth Kubler-Ross (1969) and others has shown that there are common features in the human response to loss, whether it be impending loss of one's own life or the loss of a loved one. These common features, identified as the stages of working through loss, can be approached in a variety of ways. In addition different cultures have developed means of dealing with loss in their own style, depending on the traditional beliefs surrounding death and bereavement.

A few decades ago in Europe and North America death tended to be a 'taboo' subject and the bereaved were encouraged to resume normal activities as soon as possible after their loss. In Africa, however, more emphasis is given to rituals surrounding death, and the bereaved are expected to give attention to their departed loved ones, through various traditional practices undertaken by the extended family, for a prolonged period.

In both cultural contexts therefore, the process of dying and bereavement are no longer simply a matter of private familial concern. External social support is required and a number of different professionals are becoming involved. Furthermore a new body of literature on appropriate intervention is evolving. This paper aims to contribute in a small way by outlining the traditional support for dying and bereaved people which is typically

provided in the Shona extended family, usually straddling the urban and rural areas. Trends in formal organisational support, which is more geared to urban dwellers, will also be identified. Problems arising out of changing social and cultural conditions will be highlighted, and some possibilities for new directions and suggestions for therapeutic responses will be considered.

As a prelude to the discussion of support, a brief résumé of the psychological needs and experiences of those undergoing loss will be provided, followed by an outline of the Shona traditional beliefs which underpin support to the dying and bereaved. The main focus is on Shona culture since the Shona peoples comprise the majority ethnic group in Zimbabwe, and the group with which the author is most familiar, outside her own. While there are variations in the particularities of customary practice relating to death and bereavement, even among Shona clans, the overall belief systems of the African peoples of Zimbabwe hold much in common.

Psychological stages of loss

The important work of Elizabeth Kubler-Ross (1969) on dying and bereavement now supported by John Hinton (1972), Stephen Levine (1982) and many others, has revealed that there are common feelings which arise in response to loss, whether the impending loss be of one's own life or that of a loved one. The underlying feeling is usually one of grief, but in addition denial, anger, bargaining, depression and finally acceptance commonly surface. Although these responses do not always follow a set pattern there is a tendency for the first response to be denial when one hears of a loss that has occurred or is about to occur. This means that when people with a life-threatening illness are informed about their condition they are likely, at first, to be unable to accept the news. They might say, "It can't be true. I feel so well. There must be a mistake in the diagnosis". Equally in a situation of bereavement, particularly when the news comes unexpectedly, as in the case of an accident, a close relative such as a mother may deny the news by saying, "It can't be my child. I saw her a few hours ago and she was quite alright".

This denial response functions as a kind of buffer to the psyche, allowing it time to mobilise its resources while the body gets over the shock reaction. It could be overwhelming to accept all at once that one is likely to die or that a close relative or friend has died, so denial provides the space to ease into the news.

However, denial cannot be maintained for long in the face of reality and very often, as the difficult news is accepted as true, the subsequent response can be of anger. The anger may be directed at God, "Why Me?" "What have I done to deserve this?' Or the anger may be directed at doctors, "You should have seen this coming earlier and been able to prevent it." Or the

anger may be directed at others who could be blamed for the death. Or, in the case of bereavement, the anger might even be directed at the departed person, "Why did you die when I wasn't there. I needed to say good bye".

The anger may also surface again later, and from time to time, as, in the experience of the author, it is one of the most difficult emotional responses to resolve. Everybody can understand a shock reaction resulting in denial and there is a lot of sympathy for sorrow and depression. However, friends, relatives and others find anger difficult to handle, especially as it may at times be displaced. The patient with a life threatening illness may be angry with his doctor, but find it difficult to express this in his vulnerable position, so instead he takes it out on his wife who has been a pillar of support throughout his illness. It may be hard for his wife to recognise that anger is a normal response and that her husband's anger is being displaced from the doctor onto her. In such situations counselling, which helps to identify the true target of anger and then facilitate its release in constructive ways, can be of great assistance.

Once anger has been experienced the ensuing response may be one of bargaining, in other words trying to 'buy time' in some way. Some patients make promises to God, or ancestral spirits, or to their doctor, that they will reform their lives or perform certain acts if they are spared from death altogether or even for a few more months. Some mothers who have children with terminal illnesses may even say to God, "Take me rather than my child". Such bargaining arises out of a sense of desperation and reluctance to face the inevitable.

When it becomes clear that the bargaining has failed depression may set in. Part of the depression is a sense of sorrow and grief which is fully experienced when there seems to be no escape from the loss. A more harmful aspect of depression may be anger turned inwards, resulting in guilt. Patients may blame themselves for not having stopped smoking when instructed by the doctor, or the bereaved adult child may regret not having given an elderly parent more care and attention. Guilt and anger turned inward require especially skillful handling because, if left to fester, they may further impair the health of the patient and prevent the psychological healing of the bereaved person. There is an old saying "Sorrow which has no vent in tears makes other organs weep". However, if sorrow can be fully allowed, and if guilt is worked through, then very often calm acceptance of loss will occur. This acceptance is not the same as resignation or defeatism, for example "there is nothing I can do about it, so I have to accept it". Real acceptance involves coming to terms with loss in a creative and peaceful way. Such acceptance is based on an inward opening to whatever feelings have arisen – anger, guilt, frustration or fear. When these are faced in a compassionate, allowing way, then peaceful accommodation to loss can occur.

The above overview of the stages of coping with loss has been presented in a sequence which, as mentioned previously, is not always true to life. These responses appear and disappear in any order or may even occur concurrently. However, the essential qualities of the feelings have been described as a basis for consideration of how the needs of the dying and bereaved are, or should be, met, both in terms of traditional social practices and also through the type of professional assistance which is provided by the relevant voluntary organisations.

Shona traditional practices

Even in towns, where tradition is being eroded, Shona practices in respect of dying and bereavement cannot be viewed separately from religious beliefs and spirituality. It is almost impossible to conceive of an entirely secular funeral in Shona society. It is therefore necessary to provide a very brief outline of Shona religious thinking which pervades the whole of life. As Hannan has put it (in Gelfand, 1977: foreword):

> "The foreigner so it seems to the Shona tends to regard religion as a separate compartment of life, but for the Shona themselves religion is an integral, all-pervading element of their way of living and thinking and acting".

The core of Shona religion is the belief in a creator God known as Mwari and in an after-life in which those who die are seen as having a different and continuing existence within the spirit world, but are still members of the extended family. Such spirit members known as *vadzimu*, or *mudzimu* in the singular, are greatly respected and are seen as overseers of the moral behaviour and welfare of the living family members.

The relationship of ordinary people to Mwari is both distant and intimate. It is distant in that requests to Mwari are usually mediated by the vadzimu, who are seen as intermediaries between the living and Mwari. Yet, there is also an intimacy and trust, which is well described by Hannan (Gelfand, 1977: 8):

> "The difference between a Shona adult's feelings towards his *mudzimu* and his feelings towards his God is much the same as the difference between his feelings towards his father and his feelings towards his grandfather. He fears his father, but while he respects his grandfather he can also be familiar with him. This attitude to God finds expression on those occasions, for example at a bereavement, when a shona might scold the almighty with words he would never dare address to his *mudzimu*".

From the above emerges a picture of a religious viewpoint in which there is a community of the living and the dead in the care of God, but with the spirit elders very much monitoring and guiding the lives of the living. Where requests are made to the *vadzimu* for assistance, mediation or in

reparation for wrong doings, these requests are always accompanied by gifts, in the same way that a living messenger, if asked to mediate between living families, as in the case of marriage arrangements, would always carry gifts with the request. Similarly, when requests are made to the *vadzimu* the seriousness is conveyed by an accompanying gift of beer or the killing of a beast. Such gifts should not be mistaken for ancestor worship as they are signs of respect and have the same meaning as gifts accompanying requests to the living (Hannan, in Gelfand: 1977).

The process of burial and its aftermath then become the means of ensuring a smooth transition from living membership of the family to membership as a spirit elder or *mudzimu*. In describing this process, however, detailed attention will not be given to the whole range of rites and rituals but rather the focus will be on how feelings related to death and bereavement are handled. One further aspect, though, of attitudes to *vadzimu* needs to be highlighted and that is that respect for *vadzimu* is extremely important because it is believed that if serious neglect of duty takes place, and this may be duty to the living or the dead, then the *vadzimu* may lift their protection from the offender who could then fall victim to witchcraft and the witchcraft could even result in death. Death, however, could also be caused directly by an avenging spirit, *ngozi*, which is the spirit of a person who has been murdered or even suffered an accidental killing. Such an *ngozi* could take revenge on the family of his murderer by causing the death of another family member. Thus it can be seen that, as Bourdillon (1987: 206) puts it, "death is always considered to be unnatural and in most areas every death is considered to demand divination", except in the case of an elderly person where people "might say that an old man died because he was 'tired' or that the death was caused by the high god alone".

Therefore, the time of death is not only marked by grieving and loss but also by concerns about the cause of the death on a spiritual level. If death is preceded by an illness it is incumbent upon relatives to consult a diviner about the cause of the malady, in case they could make reparation for any wrong doing, which could then result in recovery. An illness is therefore not a matter to be dealt with exclusively by the patient and his doctor, but is very much the concern and even responsibility of the whole family. Furthermore, the illness is not seen as a purely somatic condition but is rather viewed as a reflection of some spiritual disease on the part of the patient or even another family member.

Support for the dying

This viewpoint on illness means that any seriously sick person is given a great deal of support from the family who, in practical terms, see the illness as their illness. Family members also consider it to be important for the sick

person never to feel deserted, and will therefore visit frequently. If a patient is cared for at home then a relative must be present with the patient at all times. Most ill people express a preference for returning home as soon as possible, and most prefer to die at home in a familiar environment in the company of those to whom they feel close. There is also a practical consideration here, that is transporting a corpse from hospital to a rural home may be difficult and costly to arrange.

Elderly people quite often wish to talk about their impending departure and may summon the family to give instructions about the distribution of their possessions, which is usually done by the family according to customary guidelines rather than in accordance with a written will. However, more and more of the younger generation are writing wills or specifying beneficiaries in insurance policies. The customary guidelines are also being superceded in certain instances by the new Law of Inheritance in Zimbabwe which leads to a rather complicated situation, about which more will be said later in the paper.

Younger people who are dying do not as often talk about death, and family members will not raise the subject if the dying person does not refer to it themselves. Patients who are told by doctors that they have terminal illnesses may lose heart and this in turn can lead to a quicker decline, particularly in the case of persons with AIDS. On the other hand, some patients who are worried about certain aspects of their departure or its aftermath may actually really need to talk to someone but find it difficult to open up the subject with their relatives. This is where a trained counsellor may be very helpful in facilitating communication, as the author's own experience has revealed.

Bereavement

At the time of death of a member of a Shona family all close relatives will have gathered to pay their last respects to the dying person. If the death is unexpected then relatives will gather as soon as possible, Relatives, friends, neighbours and acquaintances will come to visit the bereaved, *kubata maoko,* literally to hold the hand of the mourning person, but in fact to express condolences and give support to the bereaved for a prolonged period, sometimes including an overnight stay or even longer. Relatives and friends who are women will remain in the house with the bereaved women at times crying, wailing, singing and dancing, while men gather outside around a fire. Grief is expressed in a very open way, both in respect of emotions and verbal sentiments felt by the bereaved. As each person arrives, especially close relatives, fresh weeping and wailing occurs and thus sharing of the grief occurs throughout the day or night. Sometimes a widow will call out, "What will become of me and the children?" "How will we survive?" On occasion, men will also be seen to weep but not as loudly as women.

The repeated fresh weeping of a bereaved woman is psychologically healthy in that the sorrow is not at all repressed. However, it has been suggested by Mutandwa (Sunday Mail, 25 September 1988) that women are sometimes under pressure to wail when they are actually exhausted and would really appreciate a little quiet time by themselves. Unfortunately, solitary quiet time for a newly bereaved widow would not be favoured as it could be construed as unhealthy brooding, or else as a lack of deep mourning for the lost husband. In this case the widow might even be accused of being implicated in his death.

The crowd of people who come to the home of the bereaved to express their sympathy need to be fed and given periodic refreshments. This burden too is shared and, particularly in high density, lower socio-economic areas, people from as many as four or five groups may come to help with contributions in cash and kind. Such groups as burial societies, the local church of the bereaved, a political group, neighbours, a women's club or a group of colleagues from work would normally gather contributions for the bereaved and even come and help in practical ways. Only social isolates in a high density community would suffer from lack of support at the time of bereavement.

The situation of middle class Shona people in low density suburbs could at times be more difficult, particularly if the person who died was not well known and did not have a large extended family. In this case the bereaved could feel alone and need more support. Even in the case where many friends and relatives come to the house a problem in catering could occur when many people would require bought drinks and food but would be less likely to provide contributions in kind. This situation could result in financial embarrassment for the bereaved family. In fact, all in all, death in a Shona family can be a very expensive event.

A further expense usually occurs in the form of transport if the death occurs in town, since most families prefer to bury their dead relatives in the vicinity of their rural village – *kumusha*. Most individuals, too, in thinking ahead to their own death, would express the wish to be buried at their rural home. This of course is not possible for expatriate families who have to utilise city cemetries.

The preference for a home burial is related to the need to ensure the smooth transition from the community of the living to a peaceful existence among the spirit elders who are part of the extended community of the living and the dead, as mentioned earlier. There is a sense that a person buried in a rural home is not forsaken. There will be continued caring and respect articulated through a series of ritual events. Such rituals are not as easily carried out in a distant city cemetry, although many families do still observe them and expatriate families from Malawi, Zambia and

Mozambique have made adaptations to cater for urban life in a foreign country.

When a burial does take place in a rural village there are a number of ritual practices which allow the mourners to express their feelings and the departed to feel calm and peaceful. The details of customary practices surrounding burial and its aftermath vary from area to area and from clan to clan and are too numerous to describe in this paper. However, key features noted by the author while attending Shona burials will be highlighted, particularly those relating to expression of feelings.

Firstly, in most areas after the corpse has been washed and prepared for burial, kinsmen and friends will file past to bid farewell and pay their last respects to the deceased, sometime leaving a small gift and saying a few words. This bidding of farewell is particularly important for those who had not seen the deceased immediately prior to his death. Viewing of the corpse brings home the reality of death which at times is hard to face, and yet must be fully apprehended in order to move through the denial stage mentioned earlier. Furthermore, it is easier to let go after saying goodbye and expressing thoughts and feelings which could otherwise be a form of unfinished business, resulting in preoccupation with the deceased.

When the paying of respects is completed then it will be time to carry the body to the grave. During this period and earlier there is a particular person who helps to facilitate proceedings and who has the special function of lightening the atmosphere and reducing tension. This person is the *sahwira,* or ritual friend, usually a person well known to the family from a neighbouring village. The *sahwira* will engage in various antics which make the family laugh, sometimes imitating the deceased in a clever and witty way. This laughter is a great antidote to the kind of heavy depressing atmosphere which can develop at funerals and which is very tiring and debilitating. The release of tension through laughter balances the atmosphere and gives the mourners renewed energy to complete the task of burial.

As the family nears the graveside, and the tension and sorrow increases in anticipation of the final parting with the body, the *sahwira* may have to think of particular antics to lift the atmosphere. For instance, one *sàhwira* told all the daughters-in-law, the *varoora,* when they were kneeling after they had put the pots of water they were carrying down near to the grave, to place their cloths over their heads. He then took a light branch and surprised them with quite a sharp beating. At first the *varoora* were cross but then succumbed to the laughter of everybody else.

Although the burial marks the physical separation from the deceased it is by no means seen as a final parting. Those relatives who were unable to attend the funeral will gather a few weeks later to mourn the death again, *kuchemwa.* Six months to a year or more later the *kurova guva* will take place. Literally, *kurova guva* means to beat the grave, but the ritual is actually

performed to welcome the spirit of the deceased back into the home village. As Bourdillon (1987: 209) describes the ceremony:

"A large number of relatives and friends of the deceased gather to sing and dance in honour of the spirit through most of one night; there follows in the morning a procession to the grave or some other spot outside the homestead where various rituals are performed including generous libations of millet beer, and the spirit is requested to come home; this is followed by further music and feasting in the homestead to welcome the spirit home."

The ceremony allows relatives and friends to vividly remember the deceased and to give vent to a variety of emotions surrounding the death. At this time, mourners will speak to the deceased and may express anger about the circumstances of the death. If there is a suspicion that the death was caused by the machinations of another, the deceased might be encouraged "to fight back against whoever killed you".

The combination of an abundance of beer, dancing and staying awake through the night allows for much reminiscing and contacting of feelings related to the deceased, and facilitates the expression of the range of feelings which arise. Furthermore, there is emotional satisfaction in the sense that the deceased is back home in his new form.

At the time of the *kurova guva*, or sometimes earlier or later, an inheritance ceremony takes place at which the possessions of the deceased are distributed among the relatives. According to Shona customary law, if the deceased was a married man, his widow(s) will be given the opportunity of being inherited by one of the brothers of their late husband. The inheritance ceremony seems to be a time when disputes inevitably arise. These disputes are obviously connected to the acquisitiveness from which most people suffer. However, the disputes also give an opportunity for the expression of anger, which is one of the natural responses to loss that is most difficult to work through as emphasised earlier in this paper. Anger is bound to arise at the time of loss, but it is not easily expressed in a socially acceptable manner. When it is repressed, if it does not cause the disputes, it at least makes them all the more acrimonious. It should be mentioned that disputes do not only occur about possessions, but also develop sometimes in connection with ritual procedures. Various family members may hold strong views about the proper conduct of burials and this again is an occasion for anger to be expressed.

Generally there are ample opportunities for the venting of the various feelings arising from loss in Shona society. Anger still presents the most problems, but nevertheless is not commonly repressed totally. Widows, if anything are under too much pressure to express emotion and before the funeral do not get enough rest and peace, which are also necessary for the healing process to take place after loss. When the funeral is over widows,

and all family members for that matter, do get and need time to relax and recover.

This account of the handling of the common responses to loss in Shona society serves as a basis for considering what kind of additional professional assistance is needed and what is actually being provided in Zimbabwe. Beginning with the latter, a review of what are considered to be the important aspects of organisational support currently being offered by three organisations in Zimbabwe will follow.

Aspects of organisational support

The two main voluntary organisations providing care for the dying and bereaved in Zimbabwe are the Island Hospice Service and the Cancer Association of Zimbabwe. These will shortly be joined by ACT (Aids Counselling Trust) which has just begun functioning and is in the process of registration. Within the Cancer Association the Cancer Centre Help Service, recently launched in Harare, will be the focus here, as this holistic support programme incorporates pioneering approaches to cancer care and is in the forefront of those being explored currently in Britain and Europe.

In fact, both Island and the Cancer Centre Help Service are employing highly innovative policies with respect to the dying. Island, the older organisation, was founded in 1979, and has a well-developed, progressive bereavement service. Full details of the programme in operation under the auspices of these two organisations cannot be provided in an article of this nature. However, certain key features will be highlighted, which distinguish the approach of these organisations from that which is generally adopted in orthodox, western medical settings caring for the terminally ill.

Perhaps most importantly, these two organisations propound a different attitude to death. This is exemplified in the viewpoint of Mary Aikenhead who established the first hospice in Europe. "She considered death to be the beginning of a journey, a thoroughfare and not a terminus" (Lamerton, 1979). Such an attitude can diminish the sense of dread which taunts the life of those suffering from 'life-threatening' illnesses. Even the latter term, employed in preference to 'terminally ill' more common in conventional medicine, implies a sense of hope. The Cancer Centre Help Service approach does not view death as inevitable even in the advanced stages of cancer. Countless miraculous remissions and recoveries have lead to a view of cancer as 'life-threatening' but not necessarily fatal. Kubler-Ross (1969) warns, too, about "contradicting patient's day-dreams". They may come true! Thus the emphasis is on living as rich a life as possible in the present, not anticipating death and yet opening to death when the time is ripe, and to the possibilities of life thereafter.

This latter spiritual dimension links into a second important feature of

hospice and the new approaches to cancer care. They both maintain a holistic vision of the patient. To quote the first Cancer Centre Help Service newsletter (1987):

> "The concept of an holistic approach of Cancer patients and their problems is directed towards the whole person in body, mind and spirit and not just the disease itself. In no way does this approach seek to replace orthodox medical treatment, but rather to complement it and enhance its effectiveness by stimulating a positive attitude promoting self-healing and self-help."

The spiritual and psychological life of a patient thus become equal foci of concern with the patient's physical well-being.

While the role of conventional medicine is in no way discounted, the holistic cancer care team would include, in addition to doctors and nurses, counsellors, nutritionists, art and dance therapists, spiritual healers and trained teachers of relaxation, meditation and visualisation. Island Hospice, rather than having such a range of personnel, opts for a generic para-professional 'care-giver' to supplement the work of nurses, social workers and clergy in catering for the needs of the whole person.

Recently, in Europe and America, the holistic approach has been gaining credence in the treatment of AIDS patients. Williams (Sunday Telegraph Magazine, 23rd August 1987) reported that

> "It is to the mental attitudes of the PWA (person with AIDS) that practitioners who offer complementary therapies first address themselves. Increasingly it is accepted that the way our immune system functions is profoundly affected by our 'core' feelings. Dr Lawrence Leshan, who over thirty years has pioneered an approach to cancer patients based on this principal said in London recently that there was now so much material available on the subject that the contention that emotional factors play a profound part in recovery – certainly in his speciality, cancer – now has to be accepted as fact. . . . Put simply, misery makes us illness-prone and slow to recover. Its reverse, hope and joy, love and attention, can help sometimes miraculously, to heal".

Concommitant with the hostilistic approach is the movement away from an hierarchical staff structure and the inclusion of the patient in determining treatment directions. The first hospice in England, St Christopher's, was actually conceived of and planned jointly by a patient with a life-threatening illness, David Tasma, and his social worker, Cicely Saunders, who later studied medicine for the express purpose of implementing their shared vision. The patient's family are also deeply involved, and Island Hospice provides nursing care at home so that the patient is able to remain with his family rather than in hospital, and the family are given guidance and support in carrying out their responsibilities.

Island Hospice administration and meeting rooms have been decorated

in such a way as to create a non-clinical, homely atmosphere and Cancer Centre Help Service is in the process of doing the same. Patients and bereaved people are encouraged to 'drop-in' when they feel the need. They do not always have to wait for appointments, and both organisations promote not only self-help but also mutual help among clients. The therapeutic support that dying and bereaved people can give each other is fully recognised and tapped through therapeutic and social groups. It is acknowledged, further, that staff require group support at times. The regular groups for staff at both organisations, help the members of the care teams to share the burdens arising out of their work and to reach beyond the professional façade to the caring human being beneath, who is so much more healing to the patient than the distant and detached professional operating in a strictly clinical environment. Lastly, both organisations accept the challenge to educate the public about the holistic aproach, and the need to be open and allowing to one's own and other people's grief and the range of feelings arising out of loss.

In identifying the above features of hospice and the holistic approach to cancer care it can be seen that there is a convergence taking place with Shona traditional care which never separated spiritual and psychological life from physical health and where the family always played a key role in treatment. In general, the Shona viewed major bodily ailments as having spiritual causes and it was also commonly accepted that stress would have a negative impact on health. People were discouraged from 'thinking too much', ie brooding over problems in an unhealthy way. Furthermore, the traditional healer, like the members of the holistic team, related to the patient and his family in a non-hierarchical way and in an intimate, sharing manner. There is potential, therefore, for a creative dialogue to occur, since the gap between the western holistic approach and Shona traditional healing is much narrower than that between western orthodox medicine and traditional healing practices.

Problems in experiences of loss

Nevertheless before enthusiasm outsteps realism it may be as well to consider some of the kinds of problems that are being confronted in the work of the above organisations. Social workers and medical staff were interviewed in order to form a picture of the main problems that clients were experiencing. It was found, in the bereavement work of Island Hospice, that socio-economic and cultural factors played a role in determining the kinds of difficulties being faced. Thus a differential pattern emerges among different racial groups. There is also a great deal of overlap. For purposes of comparison a brief account will be provided of some of the problems commonly experienced by white bereaved people, followed by a commentary on the situation of black widows in Harare. Widows tend to be

the main client group from the black community utilising Island Hospice Services. The white client group is wider and was reported as having the following problems (Martin, 1988):

(a) Elderly white widows sometimes experience anger with their grief because they have been left so helpless. They usually have sufficient funds to live, but have no experience running the family finance or getting cars serviced and licenced, etc. Younger couples usually share financial management more democratically.

(b) Younger widows are often not as well provided for and so have to cope with financial stress as well as the additional stress of decision-making on their own. Having sole responsibility for major decisions which were previously shared, such as schooling, housing, holidays, etc, feels particularly burdensome.

(c) Widows in general experience the most 'aloneness' and loneliness. They miss sharing the little things of life and sometimes find that they are socially isolated in a couples oriented social circle. Sometimes they are not invited out as they are seen as threats to existing marriages, and this exacerbates the feelings of rejection that arise when a spouse dies.

(d) Bereaved people sometimes find that their friends and family resist the kind of changes that are inevitable during a time of loss. They encourage the bereaved to 'be their old selves' and to 'let go of the past' which of course takes time and needs periods of sorrow, anger, etc.

(e) Many bereaved people feel ill-prepared themselves for what they are experiencing. They do not realise how devastating loss of a loved one can be and they cannot believe that others feel the same way, which is why groups are so helpful.

(f) In the case of the death of a child, which is probably the most devastating bereavement experience, often accompanied by guilt and helplessness, there is the problem of fathers not wishing mothers to talk about their child's death. Fathers often want the mother to forget and she is then faced with the double burden of bearing her grief and hiding it. Fathers also tend not to come to the groups for bereaved parents unless they are divorced or widowed.

(g) Lastly, young bereaved children are often not helped to express their grief. They are frequently left out of the funeral and are not shown the body, although many who see the body are helped both because the deceased usually looks very peaceful and also because it assists them to recognise that the person is no longer there.

The above problems indicate tendencies for older and younger widows

to experience practical difficulties, but otherwise the focus is on loneliness and problems in opening up to feelings. A contrasting picture emerges of the situation of black widows:

(a) Black widows seldom suffer from isolation as their mother or another close relative will remain with them in the house for a prolonged period. Their problems usually stem from practical matters which sometimes lead to family disputes.

(b) When the death of the breadwinner occurs many widows find themselves without accommodation in towns because access to home ownership for Shona people was severely curtailed during the time of the previous white minority government. If a widow is unemployed, she usually is unable to maintain rent payments and thus has to return to the rural areas where schooling for her children is not as readily available and is of a lower standard.

(c) There is still no universal widow's or old age pension scheme and those widows who are entitled to a private pension or insurance benefit have difficulties working their way through the bureaucratic procedures and paper work that this involves. As in the case of older white widows, many black widows, across the age range, did not have full involvement in their husbands' financial affairs and this leaves them very vulnerable at the time of his death.

(d) Widows frequently find themselves caught in a bind between new state laws and customary practices. For instance, often they are not the sole claimants on their husband's estate. In the past, under customary law, the husband's brother would inherit most of the estate and would inherit the widow and children as well. The wife would belong to her husband's family. Many widows nowadays do not wish to be inherited and would rather survive alone. They then have recourse to new inheritance laws which generally favour the children but allow the parent with custody some usufruct until the children reach the age of majority. Sometimes the husband's family are offended when the widow does not want to be inherited and pressure is put on her to choose one of the brothers, who also compete with eath other since they want access to the deceased brother's estate. If the husband was very poor these problems are less acute. Emotional blackmail of the wife is, however, possible because of the belief that death is unnatural. If the widow wants to live alone and to keep her husband's property she may be accused of causing her husband's death through witchcraft. It is also very difficult for a widow to re-marry, as Mutandwa (1988) states:

"However, Lord have mercy on a woman who remarries even as long as five years after the death of her husband. She will be accused of having

'burnt her husband's grave' (*kupisa guva*). She will also be suspected of having expedited the departure of her husband from mother earth so she could take on a new spouse."

Widows are therefore caught between customary practices and the new state laws which better fit their urban life in a more nuclear centred family. Although the new law offers better protection for widows the extended family has by no means lost its power. Jabangwe (1988) related the situation of one widow where, even before the husband's death, his relatives said they were worried that the neighbours were bewitching the husband. Then, they removed the ailing husband to his sister's house without even consulting the wife who was very offended. She did not see her husband before he died, which was subsequently a cause of deep grief for her. The wife refused to be inherited and the husband's family then cut her off completely and said she should return to the home of her parents.

Thus we see a picture of a widow not only coping with her own loss but faced with family disputes and severe financial worries about the future. It is ironic that the Shona widow who is given so much support in expressing her grief is then subjected to all sorts of practical difficulties.

The above constitute some of the problems being experienced by bereaved persons seeking help from Island Hospice. The Cancer Association, working more with persons with life-threatening illnesses, identified several problems specific to those faced with future loss of their own lives rather than bereavement. One of the main problems experienced by white cancer patients is that of guilt – blaming themselves for their illness. This tendency to take individual responsibility is very different from the Shona family-oriented perspective. Guilt is a major problem in the western context and is a clear impediment to healing in that it causes a great deal of distress and negative energy turned inwards.

Not unexpectedly, another common problem is anger which is less damaging to overall health if it is expressed. However, anger at others is not so easy to express as anger directed at ourselves – and patients, therefore, need to be encouraged to contact and work through their anger. This would apply equally to white and black patients, as does the next problem which is the difficulty cancer-sufferers experience in coming to terms with the fact that they have a life-threatening condition. On account of this, they may neglect their symptoms for a long time before seeking medical attention. Shona patients in particular tend to delay contact with the western medical system for as long as possible. This is partly due to the expectation that a western doctor will recommend surgery, and since many black patients only agree to surgery when the condition is advanced quite frequently death does follow shortly afterwards, thus resulting in further reluctance in others to undergo surgery (Weinman, 1988).

Hopefully, the growth of the holistic approach will attract more Shona people to seek help earlier, especially if the Cancer Help Service could incorporate Shona traditional healers who already employ an holistic analysis in diagnosing illness and prescribing treatment.

To summarise the problems arising out of loss in different cultural settings, it would seem that Zimbabwean whites suffer from loneliness and lack of social support at the time of loss where materially the problems are not so severe. On the other hand, black Zimbabweans suffer from many financial worries and other practical difficulties, such as housing, but the social support system at the time of bereavement is very extensive and if anything overbearing rather than lacking. It would seem therefore that whites could spend more time with bereaved and dying people, unless they indicate a preference to be left alone. Whereas black families perhaps need to give a little more space for self-determination among widows who have lived in town for a long period and have become used to functioning in a more nuclear family setting.

The positive aspect of the way Shona people deal with stress and physical ailments is that any problem is not an individual problem, but a family problem and this may even involve departed members in the spirit world. Thus, no person need feel alone and there is recognition that a problem experienced by one member of the family system may be the expression of a wider problem within the whole system and the whole family will take responsibility for dealing with it. In many western families it is hard for them to recognise that the problems of one individual can be symptomatic if a general malaise within the family system. The negative aspect of the Shona approach is the sometimes oppressive nature of family demands which can place a heavy burden on certain members, especially those who function as head of the family. These burdens can be very stressful and themselves lead to stress related illnesses such as cancer. The other negative feature is the inclusion of witchcraft in the Shona belief structure. When people believe that their illness is caused by witchcraft they may lose hope and thus enter a negative spiral, ie in becoming despairing they feel worse physically and then conclude that the spell is working and thus become more despairing until they have no will left to live. Thus, it would seem that although the spirituality in Shona society is an extremely valuable feature the belief in witchcraft is not. Cultural beliefs need to catch up with the law which prohibits any behaviour arising out of the belief in witches.

On the basis of this brief overview of the difficulties experienced at the time of loss, and some of the lessons which could be gained from cross-cultural fertilisation, the concluding section will make a few suggestions for additional therapeutic techniques which could meet the needs of individuals and families.

New directions in therapy

One approach to therapy, which has been utilised in a limited fashion in Zimbabwe but could have wider applicability, is gestalt therapy. The author has used gestalt therapy with groups of bereaved persons and individuals and has found that it has a useful role in helping individuals contact buried feelings which are difficult to express, such as anger, and that it also offers a means of resolving anger and resentment. Very briefly, the approach begins by asking the client to focus on the body and scan it for any tension or disturbance. The client is then asked to be that part of the body which is tense and speak for it. This technique by-passes the rationalising and censoring qualities of the thinking process. Very often if a person with repressed anger is asked to think about how they are feeling they will say they are fine. Whereas, speaking for tense shoulders the person might say "We are tired of this burden we are carrying". To give an example of a client situation: A young woman who was having difficulties with concentrating on her studies on account of stomach pain sought therapy and the following extract of the session is provided (using a pseudonym):

Client: (after being asked to scan the body)
"My stomach is painful."
Therapist: "Be your painful stomach. What does it say?"
Client: "I am in pain."
Therapist: "What do you want to say to your painful stomach?"
Client: "Stop being painful. You are preventing me from working."
Therapist: "What does the stomach reply?"
Client: (as stomach) "I can't stop being painful because I am still feeling pain about the death of Tsitsi's father."
(as Tsitsi) "What is causing you pain?"
(as stomach) "I feel angry because he died when the mother was out of the room. He sent her out of the room on an errand and then died. She was very hurt."

The therapy session contined with the client being asked to imagine her father sitting in front of her. She was then told to express her feelings of anger to him and then to reply as him. She thought for some time and then replied as the father.

Client: (as father) "You know I was very close to your mother but I thought she would panic and be very upset at the actual time that I passed away, so I sent her out of the room on an errand. I am sorry she was hurt for I only wanted to protect her."

Through this continuing dialogue with the client genuinely trying to speak for her father and then listening to him, she finally felt resolved and had got her feelings 'off her chest', or rather her stomach!

This approach is useful in that it does not entail a lengthy case history but

rather focuses on immediate feelings identified through scanning the body. The technique of encouraging the client to speak out feelings to the person to whom they are directed facilitates emotional discharge and release. However, the approach is geared to individual work and even when it does take place within a group setting it does not focus on the interactive process among family members, other than from the perspective of the individual. Consequently, there is need for approaches which heal the wounds arising out of family tensions.

Family therapy has been available for some time in Zimbabwe and its value is being increasingly recognised. Among whites, there is need to see the individual more as part of a family system and to tap the creative potential in that system. Within the Shona context, although the extended family is being eroded in urban areas it is still powerful and the power of that system may be channelled in negative and positive ways in the current changing cultural conditions in Zimbabwe. Since the norm for Shona families is to deal with problems through the extended family, therapy approaches may be adapted so as to utilise already operational traditional structures. For instance, link therapy has been developed for families in transition and could be applied in a bereavement situation. In this approach one key member of the family, such as the *tete* (father's sister), who traditionally has a counselling role, is coached to do family therapy with the extended family. It is easier for members of a Shona family to be open with an already established figure within the family than with a stranger. Furthermore, the family could find it simpler to gather at a venue in a rural area where most of the extended family were resident rather than going to a family therapy office. This link therapy approach is described by Landau (in McGoldrick et al, 1982).

However, in some areas even the family has been found to be too narrow a grouping for therapy purposes and thus *network therapy* has been developed. Attweave (1979: 192) suggests that:

> "Network therapy seems to be based upon the concept of mobilising the family, relatives, and friends into a social force that counteracts the depersonalising trend in contemporary life patterns. The concept appears to be particularly attractive to those attempting to counteract the isolation experienced by urban residents."

Attweave, herself of North American Indian extraction, has suggested a further adaptation of network therapy for groups of people who have an existing clan system such as American Indians. She calls this 'network-clan therapy'. The focus here is not so much on combating isolation, as on tapping the resources of core clan members and significant others such as close neighbours, or in the Shona context, the *sahwiras* referred to earlier. Attweave (1979: 192) recognises that: "Natural clans and networks, like

other human institutions, can focus energies in healthy or pathological directions."

However, the constellation of a large number of people, who are closely involved in a bereavement situation and may have tensions among them, can be a powerful force for healing. Attweave contends that: "the dramatic results from the mobilised resources of the simulated clan seem to follow without the process involved being seen clearly". She also recognises that "networks and clans are made up of individuals some of whom from time to time need to be seen and treated as individuals".

Thus, it can be seen that there is a place for therapy at a variety of levels, from the individual level right through the extended family to even the neighbourhood level where deep rifts have occurred.

Conclusion

This paper has sought to identify support structures for those coping with loss in Zimbabwe. The traditional Shona support system was briefly describe followed by an account of the important features of the work undertaken by relevant voluntary organisations. Some of the problems experienced by the clients from these organisations revealed the strengths and weaknesses of traditional support practices in Shona culture and also in western culture. It is interesting to note that certain trends in western approaches to working with the dying and bereavement, particularly those summarised under the heading of 'holistic care', are actually moving towards Shona traditional patterns and away from some aspects of orthodox western medical care. The holistic approach treats the whole person with a body, mind and spirit just as the Shona traditional healer always has done, and in a non-hierarchical more intimate way, again in line with practice in Shona traditional settings.

In order to develop the positive aspects of this cross-fertilisation it is recommended that the potential role of the Shona traditional healer in holistic care be further explored and also that western therapies, that can be adapted to the Shona context, be investigated and further utilised.

References

Attweave C L (1979) "Therapy in tribal settings and urban network intervention," in **Family Processes**, Vol 8.

Bourdillon M (1987) **The Shona Peoples**, Mambo Press, Gweru.

Brohn P (1987) **The Bristol Programme**, Century Books, London.

Cancer Centre Help Service Newsletter (1987) Cancer Association of Zimbabwe, Harare, November.

Dengu K (1986) "The Impact of Short-term Hospice Care on Patients' Relatives: A comparative Study," unpublished dissertation submitted to Edinburgh University, UK.

Gelfand M (1977) **The Genuine Shona: Survival Values of an African Culture**, Mambo Press, Gweru.
Gelfand M (1977) **The Spiritual Beliefs of the Shona**, Mambo Press, Gweru.
Hinton J (1972) **Dying**, Penguin Books, Harmondsworth.
Jabangwe P (1988) Personal communication.
Kubler-Ross E (1969) **On Death and Dying**, McMillan Press, New York.
Lamerton R (1973) **Care of the Dying**, Priority Press, UK.
Levine S (1982) **Who dies?** Anchor Books, New York.
McGoldrick M et al (1982) **Ethnicity and Family Therapy**, the Guilford Press, New York.
Martin R (1988) Personal communication.
Mutandwa A (1988) "Give Widows same rights as Widowers" in **The Sunday Mail**, Septembr 25.
Perls F et al (1973) **Gestalt Therapy**, Penguin Books, Harmondsworth.
Wienman M (1988) Personal communication.
Williams P (1987) "AIDS: At Last the Good News" in **The Telegraph Sunday Magazine**, 23 August, 1987.