COMPLICATED GRIEF IN THE SOUTH AFRICAN CONTEXT – A THERAPEUTIC INTERVENTION PROGRAMME

CORNELIA MARIA (NELIA) DRENTH

MA (SW) Medical Social Work (UP)

Thesis submitted for the degree

Philosophiae Doctor

In Social Work

At the North-West University (Potchefstroom Campus)

Promotor:	Prof. H. Strydom
Co-promotor:	Dr. A.G. Herbst
Assistant-promotor:	Prof. K.F.H. Botha

November 2008

Potchefstroom

COMPLICATED GRIEF IN THE SOUTH AFRICAN CONTEXT – A THERAPEUTIC INTERVENTION PROGRAMME

by

CORNELIA MARIA (NELIA) DRENTH

North-West University (Potchefstroom Campus)

November 2008

ACKNOWLEDGEMENTS

This research is dedicated to all the people who trusted me with their intense emotional pain and taught me about grief.

I express special thanks to:

- Rendert, my husband and best friend, who quietly supported me and never hesitated to prepare dinner when I was too engaged in my studies.
- My children Rendert, Johan, and Ané and my daughter-in-law Adèle, for their constant support.
- My father Johan, and my sisters, Gerda, Annelie and Susan for always being there when I needed them.
- Prof. Herman Strydom for sharing his knowledge on research and for always being available with sound explanations and guidance throughout the process.
- Dr. Alida Herbst for her excellent understanding of my research attempts as well as her sound advice and positive criticism.
- Prof. Karel Botha for his support on Article 2.
- The Ferdinand Postma Library (Potchefstroom Campus) for an excellent service and specifically Louise Vos for her professional and friendly help at all times.
- Colleagues and friends who did not allow me to lose focus and specifically Sue Cameron who found time in her busy schedule to assist me with the English language.
- Cecilia van der Walt and Marthie Potgieter for professional editing of the language.
- The respondents who trusted me and who willingly shared their deepest emotions during the implementation of the CGIP.
- And above all, God, my Creator, who dealt me with a talent and gave me the strength to complete this study.

TABLE OF CONTENTS

Acknowledgements

Opsomming iv

Summary v

Preface vii

SECTION A : ORIENTATION TO THE RESEARCH

1. *CONTEXTUALIZATION AND PROBLEM STATEMENT* 1
2. *AIM AND OBJECTIVES OF THE STUDY* 4
3. *SCIENTIFIC PARADIGM* 4
   - *3.1. Theoretical frameworks* 5
4. *DESCRIPTION OF CONCEPTS* 5
5. *METHOD OF INVESTIGATION* 6
   - *5.1. Literature study* 7
   - *5.2. Empirical investigation* 7
     - *5.2.1. The design* 7
     - *5.2.2. Sample* 10
     - *5.2.3. Measuring/assessment instruments* 11
     - *5.2.4. Data gathering methods* 11
     - *5.2.5. Data analysis* 12
     - *5.2.6. Ethical aspects* 12
6. *RESEARCH LIMITATIONS* 13
7. *REPORT LAYOUT* 13
   - *7.1. Journals* 14

REFERENCES 14

SECTION B : ARTICLES

ARTICLE 1 : COMPLICATED GRIEF IN THE SOUTH AFRICAN CONTEXT

ABSTRACT 23

1. *INTRODUCTION* 24
2. *PROBLEM STATEMENT* 24
3. *AIM* 25
4. *NORMAL GRIEF* 25
5. *COMPLICATED GRIEF* 26
6. *RISK FACTORS FOR THE DEVELOPMENT OF COMPLICATED GRIEF: THE SOUTH AFRICAN SCENARIO* 31
   - *6.1. Cultural beliefs on death and bereavement* 31
   - *6.2. AIDS- and cancer-related deaths* 34
   - *6.3. Crime and socio-political deaths* 36
7. *COMPLICATED GRIEF AS CONCERN FOR SOCIAL WORKERS IN SOUTH AFRICA* 37
8. *CONCLUSION* 40

REFERENCES 40

ARTICLE 2 : SCREENING SOUTH AFRICAN CLIENTS FOR INCLUSION IN A THERAPEUTIC COMPLICATED GRIEF INTERVENTION PROGRAMME
ABSTRACT 46
1. *INTRODUCTION* 47
2. *PROBLEM STATEMENT* 48
3. *AIM* 49
4. *ASSESSING COMPLICATED GRIEF* 49
   4.1. The Inventory of Traumatic Grief (ITG) 53
   4.2. Grief Assessment Guide (GASsG) 55
5. *SCREENING CLIENTS FOR INCLUSION IN A THERAPEUTIC COMPLICATED GRIEF INTERVENTION PROGRAMME* 57
   5.1. Ethics 57
   5.2. Recruitment 58
   5.3. Criteria for inclusion as a participant in the study 59
6. *CONCLUSION* 61
REFERENCES 66

ARTICLE 3 : A COMPLICATED GRIEF INTERVENTION MODEL (CGIM)
ABSTRACT 70
1. *INTRODUCTION* 71
2. *PROBLEM STATEMENT* 72
3. *AIM* 73
4. *LITERATURE REVIEW* 73
5. *THE DUAL PROCESS MODEL OF COPING WITH BEREAVEMENT* 76
6. *A TASK-CENTRED APPROACH TO COMPLICATED GRIEF INTERVENTION* 79
7. *THE COMPLICATED GRIEF INTERVENTION MODEL (CGIM)* 82
8. *LAYOUT OF THE COMPLICATED GRIEF INTERVENTION MODEL (CGIM)* 84
   8.1. Step 1 : Assessment 85
   8.2. Step 2 : Intervention 86
   8.3. Step 3 : Evaluation and termination 86
9. *CONCLUSION* 87
REFERENCES 87

ARTICLE 4 : A COMPLICATED GRIEF INTERVENTION PROGRAMME (CGIP)
ABSTRACT 92
1. *INTRODUCTION* 94
2. *PROBLEM STATEMENT* 94
3. *AIM* 95
4. *COMPLICATED GRIEF INTERVENTION MODEL (CGIM)* 95
5. *COMPLICATED GRIEF INTERVENTION PROGRAMME (CGIP)* 96
   5.1. Outline of the Complicated Grief Intervention Programme 98
      5.1.1. Step 1 : Assessment 98
      5.1.2. Step 2 : Intervention 102
      5.1.3. Step 3 : Evaluation/termination 104
6. *INTERVENTION TECHNIQUES* 107
   6.1. Desensitization 107
   6.2. Visualization 107
   6.3. Client-log 107
   6.4. Miracle question 108

6.5. Metaphors 108
6.6. Rituals 108
6.7. Memory work 109
6.8. Humour 109
7. CONCLUSION 109
REFERENCES 110

ARTICLE 5 : IMPLEMENTATION AND EVALUATION OF THE COMPLICATED GRIEF INTERVENTION PROGRAMME (CGIP)

ABSTRACT 113
1. INTRODUCTION 114
2. PROBLEM STATEMENT 115
3. AIM 115
4. RESEARCH METHODOLOGY 116
4.1. Participants 116
4.2. Measuring instrument 117
5. RESEARCH FINDINGS 119
5.1. Relationship to the deceased and time since death 119
5.2. Inventory of Traumatic Grief 119
5.3. Implementing the complicated Grief Intervention Programme (CGIP) 123
5.4. Themes 125
5.4.1. Theme 1 : Life is empty 125
5.4.2. Theme 2 : I've been robbed 125
5.4.3. Theme 3 : You get used to death, not over it 126
5.4.4. Theme 4 : The need for information (Please inform me) 127
5.4.5. Theme 5 : Please listen to me 127
5.4.6. Theme 6 : Don't use that word 128
5.4.7. Theme 7 : Challenge the future 129
5.4.8. Theme 8 : There is life after death 129
5.5. Case example 130
6. EVALUATION OF THE COMPLICATED GRIEF INTERVENTION PROGRAMME 135
6.1. Advantages of the CGIP 136
6.2. Limitations of the CGIP 137
7. CONCLUSION 137
REFERENCES 138

SECTION C : SUMMARY, EVALUATION, CONCLUSION, IMPLICATIONS AND RECOMMENDATIONS

1. INTRODUCTION 142
2. SUMMARY OF THE RESEARCH 142
3. EVALUATION OF THE RESEARCH 143
4. CONCLUSIONS 144
4.1. Conclusions on complicated grief in the South African context (Article 1) 144
4.2. Conclusions on screening South African clients for inclusion in a therapeutic complicated grief intervention programme (Article 2) 145
4.3. Conclusions on the Complicated Grief Intervention Model (CGIM) (Article 3) 147

4.4. Conclusions on the Complicated Grief Intervention Programme (CGIP) for social workers (Article 4) 148
4.5. Conclusions on the implimentation and evaluation of the Complicated Grief Intervention Programme (CGIP) for social workers (Article 5) 149
4.6. Conclusions regarding the objectives 151
4.7. Conclusion regarding the research aim 151
5. RECOMMENDATIONS FOR RESEARCH 151
6. SUMMARY STATEMENT 153
REFERENCE 154

SECTION D : APPENDICES
APPENDIX 1 : Informed consent 155
APPENDIX 2 : Inventory of Traumatic Grief (ITG) 156
APPENDIX 3 : Request for use of the ITG 160
APPENDIX 4: Holly Prigerson- approval to use ITG 161
APPENDIX 5 : Health and Social work 162
APPENDIX 6 : The Social Work Practitioner/Researcher 164
APPENDIX 7 : Health SA Gesondheid 166
APPENDIX 8 : Social Work/Maatskaplike Werk 169
APPENDIX 9 : Journal of Social Work Practice 171

SECTION E : CONSOLIDATED LIST OF REFERENCES
REFERENCES 173

LIST OF TABLES, ILLUSTRATIONS, DIAGRAMS AND GRAPHICAL PRESENTATIONS

ARTICLE 2
Table 1 : Inventory of Traumatic Grief (ITG) 63
Table 2 : Grief Assessment Guide (GASsG) 64

ARTICLE 3
Table 1 : Models of bereavement and applicability to complicated grief 74
Table 2 : Comparison of tasks in complicated grief 78

Diagram 1 : Complicated Grief Intervention Model (CGIM) 85

ARTICLE 4
Table 1 : CGIP-Intervention worksheet (step 1) (Illustrating the intervention objectives) 101
Table 2 : CGIP-Intervention worksheet (step) (Example of a completed source document) 103
Table 3 : CGIP-Task worksheet (step 2) (Example of a completed task worksheet) 104
Table 4 : CGIP-Evaluation of service (step 3) 106

ARTICLE 5
Table 1 : Complicated Grief Intervention Programme format 118
Table 2 : Relationship to deceased and date of death 119

Table 3 : Implementation of the CGIP-sessions needed 120
Table 4 : Objectives 124
Table 5 : CGIP-Intervention worksheet for Mrs. X 133

Graph 1: Separation distress (ITG) before implementationof the CGIP 122
Graph 2: Separation distress (ITG) after implementation of the CGIP 122
Graph 3: Traumatic distress (ITG) prior to implementation of the CGIP 123
Graph 4 : Traumatic distress(ITG)after implementation of the CGIP 123

Illustration 1 :Genogram of case example 131

OPSOMMING

GEKOMPLISEERDE ROU BINNE DIE SUID-AFRIKAANSE KONTEKS – 'N TERAPEUTIESE INTERVENSIE PROGRAM

Sleutelterminologie: *Gekompliseerde rou, risiko faktore, Vraelys van Getraumatiseerde Rou, Gids tot Rou-assessering, Intervensiemodel vir Gekompliseerde Rou, Intervensieprogram vir Gekompliseerde Rou.*

Gekompliseerde rou is 'n relatief nuwe konsep waaroor psigiaters en sielkundiges wêreldwyd debatteer. Die tyd het aangebreek dat maatskaplike werkers by hierdie debat aansluit en programme ontwikkel en implementeer om die gevolge van gekompliseerde rou aan te spreek, veral dit wat lei tot belemmerde sosiale funksionering.

Gekompliseerde rou, verlengde rou en getraumatiseerde rou is almal sinonieme. Die term *gekompliseerde rou* is die voorkeurterm in hierdie navorsing.

Artikel 1 is 'n literatuurstudie oor faktore wat tot gekompliseerde rou lei en 'n poging om dit terselfdertyd met die Suid-Afrikaanse situasie te verbind. Suid-Afrikaanse burgers is nie vrygestel van die ervaring van gekompliseerde rou nie. Kulturele gelowe oor dood en die sterwensproses, VIGS- en kankerverwante dood, en misdaad en sosiopolitieke sterftes is enkele van die risikofaktore. Die navorser lê verder klem op gekompliseerde rou as 'n saak wat deur maatskaplike werkers geassesseer behoort te word.

Die normale verloop van rousmart word bevraagteken wanneer die rouproses die individu verhinder om na 'n pre-verlies vlak van maatskaplike funksionering, of so na as moontlik daaraan, terug te keer. Gekompliseerde rou word deur baie navorsers as 'n spesifieke toestand beskou wat spesifieke intervensie vereis. Die doeltreffendheid van rousmart intervensie in die geval van normale rou word

bevraagteken en dit blyk dat individue wat gekompliseerde rou ervaar meer baat vind by rousmart intervensie.

Artikel 2 poog om duidelikheid te verkry oor die noodsaaklikheid van die sifting van kliënte voor hul insluiting in 'n gekompliseerde rou intervensieprogram, deur die bespreking van die Intervensieprogram van Getraumatiseerde Rou deur Prigerson en kollegas. Die navorsers stel verder die Gids tot Rou-evaluering *(Grief Assessment Guide-GASsG)* voor as 'n assesserings hulpmiddel tot die siftingsproses.

In artikel 3 stel die navorsers 'n tabel van 'n paar van die belangrikste modelle/benaderings vir rousmart op en bespreek die toepasbaarheid op gekompliseerde rou. Spesifieke aandag word aan die Tweeledige Prosesmodel *(Dual Process Model)* (Stroebe & Schut,1999) verleen, asook die taakgesentreerde benadering ('n maatskaplike werkbenadering tot terapie) in 'n poging om 'n model te ontwikkel vir gekompliseerde rou intervensie. Die artikel beveel aan dat die Gekompliseerde Rou Intervensie Model (GRIM) deur middel van die integrasie van die tweeledige prosesmodel en die taakgeoriënteerde benadering aangebied word, terwyl intervensie tegnieke van ander terapeutiese benaderings benut word.

Artikel 4 verklaar hoe die implimentering van die Gekompliseerde Rou Intervensieprogram (GRIP) saam met die Gekompliseerde Intervensie Model (GRIM) as raamwerk tot intervensie dien. Die navorsers bespreek kortliks sommige van die intervensie tegnieke, soos desensitisasie, visualisering, kliënt-staat *(client-log)*, wonderwerk-vraag *(miracle question)*, metafore, rituele en humor. Hierdie tegnieke ondersteun die maatskaplike werker en die kliënt om hul doel te bereik. Die GRIP is 'n tydsbeperkende intervensieprogram. Dit bestaan uit, en is gebaseer op, die drie stappe van die GRIM: assessering, implementering en evaluering/terminering. Alhoewel die GRIP nog nie wetenskaplik getoets is nie, het dit die potensiaal om 'n begeleidende program vir maatskaplike werkers in die gebied van rousmart te wees.

Artikel 5 is 'n bespreking van die empiriese bevindings van die navorsing. Hierdie artikel beskryf die implementering van die voorgestelde GRIP in die Suid-Afrikaanse

konteks. Die artikel het verder ten doel om die uitvoerbaarheid van die GRIP te evalueer, eerder as om die effektiwiteit van die program te toets.

Afdeling C som die navorsing op, evalueer dit, en maak aanbevelings ten opsigte van die waarde van die navorsing en op moontlike toekomstige navorsing oor gekompliseerde rou in die Suid-Afrikaanse konteks.

SUMMARY

COMPLICATED GRIEF IN THE SOUTH AFRICAN CONTEXT – A THERAPEUTIC INTERVENTION PROGRAMME

Key Terms: *Complicated Grief, Risk Factors, Inventory of Traumatic Grief, Grief Assessment Guide, Complicated Grief Intervention Model, Complicated Grief Intervention Programme.*

Complicated Grief is a relatively new concept that is globally debated by psychiatrists and psychologists. The time has come for social workers to join this debate and to develop and implement programmes to address the consequences following complicated grief, specifically which results in impaired social functioning.

Complicated Grief, prolonged grief and traumatic grief are all synonyms. The term 'complicated grief' is the preferred concept used in this research.

Article 1 is a literature overview on factors leading to complicated grief and at the same time attempts to link these factors to the South African circumstances. South African citizens are not exempted from experiencing complicated grief. Cultural beliefs on death and dying, AIDS and cancer-related deaths, crime and socio-political deaths are but some of the risk factors. She furthermore highlights complicated grief as a matter to be assessed by social workers.

The normality of grief is questioned when the grief experience prohibits the individual to regain a state of social functioning as close as possible to the pre-loss state. Complicated grief is regarded by many researchers as a specific condition in need of specific intervention. The efficacy of bereavement intervention in the case of normal grief is questioned, and it seems that individuals who experience complicated grief benefit more from bereavement intervention.

Article 2 attempts to clarify the necessity to screen clients prior to including them in a complicated grief intervention programme by discussing the Inventory of Traumatic Grief as developed by Prigerson and colleagues. The researcher furthermore introduces the Grief Assessment Guide (GASsG) as an assessment tool during the screening process.

In article 3 the researchers tabulate some of the most important models/approaches to bereavement and discuss its applicability to Complicated Grief. Specific attention is given to the Dual Process Model (Stroebe & Schut, 1999) and the task-centred approach (a social work approach to therapy) in an attempt to develop a model for Complicated Grief Intervention. This article furthermore proposes the Complicated Grief Intervention Model (CGIM) through the integration of the dual process model and the task-centred approach, while drawing on intervention techniques from other therapeutic approaches.

Article 4 explains the implementation of the Complicated Grief Intervention Programme (CGIP) with the CGIM as framework for intervention. The researchers briefly discuss some of the intervention techniques, such as desensitization, visualization, client-log, miracle question, metaphors, rituals and humour. These techniques assist the social worker and the client towards achieving the goal. The CGIP is a time-limited interventions programme. It consists of, and is based on, the three steps of the CGIM: assessment, implementation and evaluation/termination. Although the CGIP has not been scientifically tested, it holds the potential to serve as a guided programme for social workers in the field of grief and bereavement.

Article 5 is a discussion of the empirical findings of the research. This article describes the implementation of the proposed CGIP in the South African context. This article furthermore aims at evaluating the feasibility of implementing the CGIP rather than testing the effectiveness of the programme.

Section C summarizes and evaluates the research and makes recommendations regarding its value and the value of possible future research on complicated grief in the South African context.

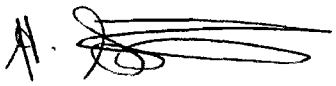
PREFACE

This manuscript is presented in an article format in accordance with Rules A.11.5.3 and A.11.5.4 that are set out in the *calendar* of the North-West University: Potchefstroom Campus. The context and technical requirements of the accredited professional journals *Health and Social Work, Social Work Practitioner-Researcher/Maatskaplike Werk Navorser/Praktisyn, Social Work/Maatskaplike Werk, Journal of Social Work Practice* and *Health SA Gesondheid* were used as basis to formulate the articles.

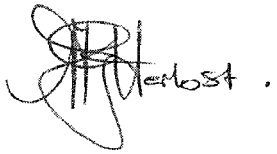
DECLARATION

It is herewith declared that the research was conducted by the candidate, C.M. Drenth. The authors of the articles agreed that the candidate be indicated as the first author, while the promoter, Prof. H. Strydom is indicated as the second author. The co-promotor, Dr. A.G. Herbst is indicated as the third author while the assistant-promotor, Prof K.F.H. Botha is indicated as the fourth author in article 2.

C.M.DRENTH



H. STRYDOM



A.G.HERBST

K.F.H.BOTHA

SECTION A

ORIENTATION TO THE RESEARCH

ORIENTATION TO THE RESEARCH

1. CONTEXTUALIZATION AND PROBLEM STATEMENT

Grief is a natural reaction after the death of a loved one. A statement made by James and Friedman (1998:3) that grief following death is normal and natural, but that it is also the most neglected and misunderstood experience by grievers and those supporting them, is fully supported by the researcher. Incomplete recovery from grief can have a lifelong negative effect on the social well-being of an individual. The researcher has an in-depth interest in factors leading to complicated grief after the death of a loved one and the consequences of complicated grief. It was observed in practice that incomplete grief recovery leads amongst others, to relationship problems, depression, isolation and substance abuse. Kelly (1997:5) is of opinion that awareness of the change brought about by death results in the potential to affect all aspects of a person's life, including the emotional, social, cognitive, physical, behavioural and spiritual aspects.

The term *complicated grief* has only recently become the subject of discussion and research. The *Inventory of Complicated Grief (ITG)* identifies symptoms distinct from bereavement-related depression (Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka, Frank, Doman & Miller, 1995). This is the first indication of a measurement tool to distinguish between *normal* and *complicated* grief. Horowitz, Siegel, Holen, Bonanno, Milbrath and Stinson (1997) developed a seven-item diagnostic criterion for complicated grief.

There is an increased interest from psychiatrists to include complicated grief as a pathological form of grief in the Diagnostic and Statistical Manual of mental disorders (Shear & Smith-Caroff, 2002:1). The DSM-IV-TR only includes a diagnosis of bereavement-related Major Depression if symptoms

still exist two months after the loss (American Psychiatric Association, 2000:684).

Socio-demographic variables, the manner in which a person died, personality traits of the bereaved and socio-cultural factors all influence the outcome of grief. Opperman (2004:222) added the effect of the larger environment to the afore-mentioned aspects. Opperman's study indicates the influence of both close (proximal) and distant (distal) relationships on grief and subsequently complicated grief. Complicated grief can thus be the result of the socio-environment, the family context and the personal context (relationship of the bereaved with the deceased) simultaneously. Opperman (2004:254) is also of opinion that the risk for grief to become complicated grief increases when the bereaved person's sense of material well-being, emotional security and self-identity are threatened by the death of a loved one. This was also the experience of the researcher, although one has to be careful to marginalize and categorize the bereaved. Vessier-Batchen and Douglas (2006:25-32) quote Redmond and confirm the statement that the stigma attached to certain modes of death, such as suicide, homicide and crime adds to complicated grief.

The researcher is of opinion that grief counselling in South Africa is mainly done from the foundation laid by Elizabeth Kübler-Ross's Five Stages of Loss, Worden's tasks of grief and John Schneider's Model of Transformative Grief (Watson, Lucas, Hoy & Back, 2005:750-751). Different other models emerged in recent years such as the Cognitive Equilibrium Model as described by Kelly (1997). This model concentrates on the important role of cognitive development and self-talks, in striving towards returning to a balanced life. South Africa, with its cultural diversity, high crime rates and an increase in AIDS-related deaths, poses a great challenge to all grief counsellors. The above-mentioned models were all developed from a European or Western perspective, while South Africa has to accommodate the traditions embedded in each cultural, language and religious group, mostly from an African perspective. Social work intervention on complicated grief in South Africa is

not a simple task and the development of an intervention programme has long been the interest of the researcher. One person's normal grief experience might be another's complicated grief experience. Who then decides when normal grief turns into complicated grief? (Casarett, Kutner & Abrahm, 2001:212). When is intervention indicated and who should be included?

Worden (1991:53) mentions that people fail to grieve due to the following: relational, circumstantial, historical, personality and social factors. Traditional prescripts on the way in which a person should mourn, is not included in his list of factors. The researcher has found, although not very often, that these prescripts can lead to the complication of grief. One example is that in some of the cultures in South Africa women are not allowed to be part of the community and social life unless a year has elapsed after the death of a spouse. Informal conversations with women from these traditional groupings revealed that they see this as a hampering factor in the healing process. Robben (2004:7) is also of opinion that the mourning process is dictated by cultural rites and thus supports the researcher's opinion that this dictation of cultural rites in the South African context can lead to the manifestation of complicated grief. The researcher agrees with Rosenblatt (1993:18) when he says that we should not "assume that somebody who speaks our language and comes from the same part of the world has the same beliefs and understandings and will express feelings in a similar way." People must be understood on their own terms, within their own traditional environment.

This study therefore attempts to answer the following research questions:

- Are there any complicated grief risk factors amongst South African citizens?
- Is it necessary to screen clients for complicated grief before including them in such a programme?
- How can the social worker assist the client with complicated grief?

- How does the social worker enable the bereaved client who presents with elements of complicated grief, to integrate the loss into the client's life?
- What is the feasibility of the proposed complicated grief intervention programme?

2. AIM AND OBJECTIVES OF THE STUDY

This research is aimed at the development, implementation and evaluation of a therapeutic Complicated Grief Intervention Programme (CGIP) within the South African context.

The specific objectives of this study are formulated as follows:

- To review the literature on complicated grief as relevant to the South African context.
- To screen clients in the South African context for inclusion in a therapeutic complicated grief intervention programme.
- To develop a complicated grief intervention model for social workers.
- To develop a complicated grief intervention programme for social workers in the South African context.
- To implement and evaluate the proposed therapeutic complicated grief intervention programme in the South African context.

3. SCIENTIFIC PARADIGM

The researcher enters the research from a micro-theoretical level and holds the view that people are continually making sense of the life they experience by creating social structure through their actions and interactions, thus supporting the ethno-methodological paradigm (Babbie, 2005:34). Ethno-methodology is a challenge to violate people's expectations, or to break the rules in order to create new structure.

3.1. Theoretical frameworks

The following theoretical frameworks shaped the development of the Complicated Grief Intervention Model (CGIM) and the Complicated Grief Intervention Programme (CGIP) and were utilized during the literature study as well as during the implementation of the intervention programme.

- Models of bereavement (Fleming & Robinson, 2001; Kristjanson, Lobb, Aoun, & Monterosso, 2006; Lightbody, 2005; Martin & Doka, 2000; Parkes, 2001; Silvermann & Klass, 1996; Stroebe & Schut, 1999; Stroebe, 2002; Worden, 1991).
- Dual Process Model (Matthews & Marwit, 2004; Shaver & Tancredy, 2001; Stroebe & Schut, 1999; Stroebe & Schut, 2001; Zhang, El-Jawari & Prigerson, 2006).
- Task-centered approach (Doel, 2006; Eaton & Roberts, 2002; Ligon, 2002; Milner & O'Byrne, 1998; Reid & Fortune, 2002; Watson & West, 2006).
- Cognitive-behavioral therapy (Brown, 2006; Cigno, 2006; Matthews & Marwit, 2004; Vonk & Early, 2002; Watson & West, 2006).
- Narrative therapy (Bowman, 1999; Kelley, 2002; Reyneke, 2004; Thomas, 2000).
- Solution-focused therapy (Cooper & Lesser, 2002; De Jong, 2002; Watson & West, 2006).

References to these theoretical frameworks are found throughout this study in the development of the Complicated Grief Intervention Model (CGIM) and the implementation and evaluation of the Complicated Grief Intervention Programme (CGIP).

4. DESCRIPTION OF CONCEPTS

The following definitions of terms directed this study:

Grief is a normal process that occurs after the death of a loved one and refers to the emotional distress associated with that loss. Grief is an individual process influenced by the relationship and the person's perception of the loss through death (Keene Reder, 2003; Rosenblatt, 1993; Zhang *et al.*, 2006). Grief thus refers to the physical, emotional, cognitive, spiritual and social experience of the loss.

Bereavement is the state of having suffered a loss through death and the accompanying emotional and physical state for an unidentified period of time after the loss (Keene Reder, 2003; Kristjanson *et al.*, 2006; Zhang *et al.*, 2006). Bereavement then refers to the period of time it takes a person to overcome the death of a loved one.

Complicated grief, traumatic grief, pathological grief, and prolonged grief are used interchangeably in the literature. In this study the concept of complicated grief is used. Complicated grief refers to a prolonged state of grief and indicates an inability of the client to integrate the death into his/her life. Complicated grief is characterized by a constant yearning and searching for the deceased, consistent thoughts of the deceased and intense and painful emotions. The intensity of the grief is prohibiting the client to regain the pre-loss state (or as close as possible to the pre-loss state) of social functioning (Keene Reder, 2003; Kristjanson *et al.*, 2006; Prigerson *et al.*, 1995; Schut, Stroebe, Van Den Bout, & Terheggen, 2001).

Intervention refers to the social work methods and strategies used by the social worker in a structured manner to enable the client to achieve the identified goals and objectives (Levine, 2002:829).

5. METHOD OF INVESTIGATION

This research attempted to clarify whether a complicated grief intervention programme can assist the individual in integrating the death of a loved one

into his/her life. The strategy to obtain the answer will subsequently be dealt with next.

5.1. Literature study

Literature on the topic of complicated grief in social work is limited and it was necessary to access literature from other disciplines such as psychology, theology, nursing and anthropology. The books which were utilized included theses on the identified topic. Complicated grief as subject is usually included in books written on grief, and these were also included in the literature study. The main focus was, however on accessing recent journal articles and research publications. A systematic library search was conducted during this study by utilizing the following databases: NRF Nexus database system and research networking, Social Sciences Citation Index, Social Sciences Index, Institute for scientific information and EBSCO host. The literature study was conducted throughout the research study.

In addition to database searches for published articles, websites were searched for additional resources. However, complicated grief was very briefly discussed in only a few of these websites. It was found that complicated grief intervention programmes are even less discussed in all forms of literature. Kristjanson *et al.* (2006:14) refer to the fact that they could not find resource kits specifically aimed at complicated grief thus supporting the researcher's inability to find reliable complicated grief intervention programmes.

5.2. Empirical Investigation

5.2.1. The Design

A great deal is known about the normal grief reactions of a person after the death of a loved one, while it has only recently become the concern of psychologists, psychiatrists and social workers to learn more about complicated grief. The increased interest in the phenomenon of

complicated grief gives rise to the need for the development of intervention models, strategies and programmes.

This study intended to develop, implement and evaluate a complicated grief intervention programme for social workers within the South African context. Intervention research was conceptualised by Thomas and Rothman (1994) and divided into three focus areas: intervention knowledge development, knowledge utilization and design and development. Intervention research (Creswell, 2003: 157-159; 179-183; De Vos, 2005a:396; Fouché, 2005:109) within a mixed methodologies framework that employed qualitative and quantitative strategies (Neuman, 2003:16), was found to be the most effective in achieving the objectives of the study. The major phases of the design and development model of intervention research were adapted to suit the needs of this research:

- *Problem analysis and information gathering*

  Problem analysis was conducted through a thorough literature study on bereavement, grief, mourning, models of grief and bereavement, complicated grief and intervention programmes. Through observation and experience, it is clear that death impacts on everyone in South Africa. It changes the lives of at least 10%–20% of the population who will experience complicated grief, (Prigerson, 2005:10) be it as a result of crime, AIDS, motor-vehicle accidents, chronic illness, cancer or suicide. The number of adult deaths in South Africa, increased by 62% over a period of five years; from 272 221 in 1997 to 441 029 in 2002. (Statistics South Africa, 2005:9). This means that, from the findings of Prigerson (2005:10), that at least 52 923 individuals (conservatively estimated at one bereaved individual per deceased) might have experienced complicated grief in South Africa since 2002.

The unit of analysis of this study was aimed at individuals who lost a loved one through death 14 months and longer prior to the study and who had the experience that they could not resume their pre-death level of social functioning. Informal personal contact methods such as word of mouth and discussions with interested people lead to the identifying of clients.

The researcher's observation of bereaved clients over a period of years in practice lead to the gathering of more information by studying client notes. No examples of complicated grief intervention programmes in the South African context could be found

- *Design*

  The findings in the problem analysis and information gathering phase lead to the development of Cornplicated Grief Intervention Programme (CGIP).The CGIP followed from the Complicated Grief Intervention Model (CGIM)and was developed from a strength perspective (DuBois & Miley, 2002:199; Saleebey,2006:1). The design of the CGIP relied on the flexibility to suit individual needs, therefore allowing the social worker to adapt and change the programme. De Vos (2005b:408) discusses the necessity of an observational system during the design phase The utilization of a standardized measurement instrument (Inventory of Traumatic Grief) and a self-developed measurement instrument (Grief Assessment Guide) prior, during and post intervention served as observational tools during the process. These instruments are described in more detail in paragraph 5.2.3. Observations on behaviour and notes were made during the in-depth interviews while implementing the CGIP.

- *Early development*

  The early development of the Complicated Grief Intervention Programme (CGIP) was the result of a thorough literature study which lead to the development of a Complicated Grief Intervention Model (CGIM), followed by the Complicated Grief Intervention Programme (CGIP). After development, the Complicated Grief Intervention Programme (CGIP) was implemented and used on a trial basis to establish whether it is can be put to effect in the case of the client who presents with elements of complicated grief.

Although this research did not includethe last two phases namely evaluation and advanced development, and dissemination, it is envisaged that it will be addressed in future research on this topic.

5.2.2. Sample

The researcher included study participants who would give the most complete data concerning the study focus (Morris, 2006:91). The researcher focused on the individual as the unit of analysis. During the initial phase, respondents were screened for elements of complicated grief by means of a standardized measuring scale (Inventory of Traumatic Grief). Only those candidates who answered to the inclusion criteria were included. Since this study involves an intervention programme of 6-12 sessions per individual, the respondents were limited to not more than 15, thus selecting respondents until data-saturation was reached. Non-probability sampling, and more specifically purposive sampling, was utilized as the sampling method (Strydom & Venter, 2005:207). A standardized measuring scale (ITG) was used at the beginning of the initial phase and again at the end of the intervention phase.

5.2.3. Measuring/assessment instruments

The researcher utilized a measurement instrument, *Inventory of Traumatic Grief, (ITG)* (Appendix 2), as well as a self-developed Grief Assessment Guide (GASsG) to assess social functioning pre-, during-, and post-intervention. Screening of respondents to be included in the study was done by applying the *Inventory of Traumatic Grief (ITG)* (Prigerson *et al., 1995*). The Inventory of Traumatic Grief (ITG) is a self-report symptom severity score developed by Prigerson and colleagues (Prigerson & Jacobs, 2001:638-645). Two open-ended questions were added to the ITG to ensure clarity on emotions experienced by the respondents. High internal consistency (Cronbach's alpha = 0.95) of the ITG was proven (Prigerson & Jacobs, 2001:628) and test-retest reliability estimates (0.80) were obtained (Kristjanson, Lobb, Aoun & Monterosso, 2006:34). Permission to utilize the ITG was obtained from Prigerson (Appendices 3-4)

5.2.4. Data-gathering methods

Data was gathered by means of unstructured in-depth interviews and the completion of the Inventory of Traumatic Grief (ITG) before and after the implementation of the Complicated Grief intervention Programme (CGIP). Data was also gathered by means of the Grief Assessment Guide (GASsG) (a self-developed assessment tool), which was completed at the onset of the programme, during the programme and during the last intervention session. Data triangulation (De Vos, 2005b:365; Weyers, Strydom & Huisamen, 2008:208) was done by means of comparing qualitative findings with data obtained from the ITG (standardized scale) and the GASsG (non-standardized self-developed tool). All respondents willing to participate in the study were requested to complete the informed consent letter, after which the respondents were assessed for elements of complicated grief by means of the ITG. Only respondents with clearly defined complicated grief were then included in the intervention program of 6-12 sessions.

5.2.5. Data analysis

Data analysis was conducted simultaneously with data collection, data interpretation and report writing. Qualitative and quantitative questions were included in the measuring instruments which were utilized in the initial phase. Although this study is mainly qualitative in nature, the use of supporting quantitative data resulted in mixed methodology (Creswell, 2003: 208-210; McLeod, 1994:32; Neuman, 2003:16). The advantages of using mixed methods in the study of grief and bereavement is highlighted by Niemeyer and Hogan (2001:113). Quantitative data analysis was done by hand due to the small sample, while qualitative data was analyzed following Tesch's approach of identifying central themes (Poggenpoel, 1998:343). The researchers concluded with a case example, illustrating the implementation of the Complicated Grief Intervention Programme (CGIP).

5.2.6. Ethical aspects

Ethical permission for conducting this study was obtained from the ethics committee of the North-West University (Potchefstroom Campus) (Ethics approval number 07K04). The study also had to comply with the ethical standards as set out by the South African Council for Social Service Professions (SACSSP). Respondents participated on voluntary basis. Informed consent was obtained prior to inclusion in the study with specific emphasis on the confidentiality of information. (Rubin & Babbie, 2005:71-73). This clearly links with the intention of not causing harm to the respondents (Babbie, 2005:63; Monette, Sullivan & Dejong, 2005:49; Strydom 2005:64), as well as maintaining their privacy (Babbie, 2005:65; McLeod, 1994:165; Monette, *et al.*, 2005:49). Cultural differences regarding death and bereavement, as well as the sensitivity of the subject, were respected and dealt with in a professional manner (Welman, Kruger & Mitchell, 2005:181-182).

6. RESEARCH LIMITATIONS

The following limitations were experienced during this research:

- Limited social work literature on complicated grief forced the researcher to explore literature in other professions such as psychiatry, psychology and nursing.
- The empirical research was time intensive due to the fact that the Complicated Grief Intervention Programme (CGIP) is an individualized programme and was implemented over a period of time.
- Recruiting respondents for this study was a difficult task due to the sensitive nature of the research topic.
- Complicated grief, traumatic grief and prolonged grief are used as synonyms in the literature and conceptualization is a dynamic process which constantly evolved during the research period.
- The Inventory of Traumatic Grief (ITG) was individually completed by the respondents prior to inclusion in the programme. This was done without the support of a professional person. Most of the respondents experienced intense emotional reactions during this exercise and had to be followed up during the intervention programme.

7. REPORT LAYOUT

The research report comprises the following sections:

- Section A:Orientation to the research
- Section B:
    - Article 1: Complicated grief in the South African Context.
    - Article 2: Screening clients in the South African context for inclusion in a therapeutic Complicated Grief Intervention Programme.
    - Article 3: A Complicated Grief Intervention Model (CGIM).
    - Article 4: A Complicated Grief Intervention Programme (CGIP) for social workers.

- Article 5: The implementation and evaluation of the Complicated Grief Intervention Programme (CGIP).

- Section C: Summary, conclusions and recommendations.
- Section D: Appendices
- Section E: Consolidated list of references

The author guidelines of the different journals were taken into consideration in preparation of these chapters and are included in the report (Appendices 5-9). The structure of each article depends on the requirements for publication as set out by the editorial committee of the proposed journals. (Appendices 5-9).

7.1. Journals

The following journals were considered for publication:

- The Social work practitioner–researcher. (Article 1).
- Health & Social Work. Journal of national association of Social workers. (Article 2).
- Health SA *Gesondheid*. (Article 3).
- Social work/ *Maatskaplike werk*. (Article 4).
- Journal of Social Work Practice (Article 5).

REFERENCES

AMERICAN PSYCHIATRIC ASSOCIATION. 2000. Diagnostic and statistical manual of mental disorders. 4th ed., text revision (DSM-IV-TR). Washington, DC. : American Psychological Association.

BABBIE, E. 2005. The basics of social research. 3rd ed. Sydney : Wadsworth.

BOWMAN, T. 1999. Shattered dreams, resiliency, and hope: restorying after loss. *Journal of Personal and Interpersonal Loss,* 4:179-193.

BROWN, H.C. 2006. Counselling. (*In* Adams, R., Dominelli, L., & Payne, M., eds. Social work : themes, issues and critical debates. London : Palgrave. p. 139-148.)

CASARETT, D., KUTNER, J.S., & ABRAHM, J. 2001. Life after death: A practical approach to grief and bereavement. *American college of physicians – American society of internal medicine*, 134(3):208 – 215, Feb.

CIGNO, K. 2006. Cognitive-behavioural practice. (*In* Adams, R., Dominelli, L. & Payne, M., *eds.* Social work : themes, issues and critical debates. London : Palgrave. p. 180-190.)

COOPER, M.G. & LESSER, J.G. 2002. Clinical social work practice : an integrated approach. New York : Allyn & Bacon.

CRESWELL, J.W. 2003. Research design : qualitative, quantitative, and mixed methods approaches. 2nd ed. Thousand Oakes : Sage Publications.

DE JONG, P. 2002. Solution-focused therapy. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social workers' desk reference. Oxford, N.Y. : Oxford University Press. p. 112–116.)

DE VOS, A.S. 2005a. Intervention research. (*In* De Vos, A.S., Strydom, H.S., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots : for the social science and human service professions. Pretoria : Van Schaik Publishers. p. 394 – 418.)

DE VOS, A.S. 2005b. Combined quantitative and qualitative approach. (*In* De Vos A.S., Strydom, H.S., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots : for the social science and human service professions. Pretoria : Van Schaik Publishers. p.363-372.)

DOEL, M. 2006. Task-centred work. (*In* Adams, R., Dominelli, L. & Payne, M., *eds.* Social work: Themes, issues and critical debates. London : Palgrave. p. 191-99.)

EATON, Y.M. & ROBERTS, A.R. 2002. Frontline crisis intervention. Step-by-step practice guidelines with case applications. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social workers' desk reference. New York : Oxford University Press. p. 89 – 96.)

FLEMING, S. & ROBINSON, P. 2001. Grief and cognitive-behavioral therapy: the reconstruction of meaning. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 647–669.)

FOUCHÉ, C.B. 2005. Problem formulation. (*In* De Vos A.S., Strydom, H.S., Fouché, C.B. & Delport, C.S.L., *eds.*. Research at grass roots : for the social science and human service professions. Pretoria : Van Schaik Publishers. p. 104-113.)

FOUCHÉ, C.B. & DE VOS, A.S. 2005. Quantitative research designs. (*In* De Vos A.S., Strydom, H.S., Fouché, C.B. & Delport, C.S.L., *eds.*. Research at grass roots : For the social science and human service professions. Pretoria : Van Schaik Publishers. p. 137-149.)

HOROWITZ, M.J., SIEGEL, B., HOLEN, A., BONANNO, G.A., MILBRATH, C. & STINSON, C.H. (1997). Diagnostic criteria for complicated grief disorder. *American Journal of Psychiatry,* 154(7):904–910.

JAMES, J.W. & FRIEDMAN, R. 1998. The grief recovery handbook. New York. HarperCollins Publishers.

KEENE REDER, E.A. 2003. Grief and bereavement. (*In* O'Neill, J.F., Selwyn, P.A., Schietinger, H., *eds.* A clinical guide to supportive and palliative care for HIV/AIDS.) Human Resources and Services Administration (HRSA) U.S. Department of health and human services. p. 329-347.

KELLEY, P. 2002. Narrative Therapy. (*In* Roberts, A.R., & Greene, G.J., *eds.* Social workers' desk reference. New York : Oxford University Press. p. 121 -124.)

KELLY, J. 1997. A Cognitive Equilibrium Model in adapting to loss. 8th Annual Conference. "Confronting suicide together", Oct 29–Nov 1.

KRISTJANSON, L., LOBB, E., AOUN, S. & MONTEROSSO, L. 2006. A systematic review of the literature on complicated grief. Australian Government Department of health and ageing. Commonwealth of Australia. 117 p. [Web:] http://www.dcita.gov.au/cca [Date of access: 2 September 2007].

LEVINE, E.R. 2002. Glossary. (*In* Roberts, A.R., & Greene, G.J., *eds.* Social workers' desk reference. New York : Oxford University Press. p. 829-849.)

LIGHTBODY, T.K. 2005. Neonatal death: a grief intervention framework. *Illness, crisis & loss,* 13(3):191-200.

LIGON, J. 2002. Fundamentals of brief treatment. Principles and practice. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social workers' desk reference. New York : Oxford University Press. p. 96–100.)

MARTIN, T.L. & DOKA, K.J. 2000. Men don't cry... women do. Transcending gender stereotypes of grief. Philadelphia : Taylor and Francis.

MATTHEWS, L.T. & MARWIT S.J. 2004. Complicated grief and the trend toward cognitive-behavioral therapy. *Death Studies*, 28:849-863.

MCLEOD, J. 1994. Doing counselling research. London : SAGE Publications.

MILNER, J. & O'BYRNE, P. 1998. Assessment in social work. Malaysia : Macmillan.

MONETTE, D.R., SULLIVAN, T.J. & DEJONG, C.R. 2002. Applied social research : tool for the human services. 5th ed. Toronto : Harcourt College Publishers.

MONETTE, D.R., SULLIVAN, T.J. & DEJONG, C.R. 2005. Applied social research : a tool for the human services. 6th ed. Victoria : Brooks/Cole.

MORRIS, T. 2006. Social work research methods : four alternative paradigms. Thousand Oaks : SAGE Publications.

NEUMAN, W.L. 2003. Social research methods : qualitative and quantitative methods. New York : Allyn and Bacon.

NIEMEYER, R. A. & HOGAN N. S. 2001. Quantitative or qualitative? Measurement issues in the study of grief. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 89-118.)

OPPERMAN, B.C.D. 2004. The influence of context on complicated grief. Johannesburg : RAU. (Thesis – D Litt. Et Phil.) 274 p.

PARKES, C.M. 2001. Introduction: concepts and issues in contemporary research on bereavement. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. &

Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington D.C. : American Psychological Association. p. 3–22.)

POGGENPOEL, M. 1998. Data analysis in qualitative research. (*In* De Vos, A.S., *ed.* Research at grass roots : a primer for the caring professions. Pretoria : J.L. van Schaik.

PRIGERSON, H.G. & JACOBS, S.C. 2001. Traumatic grief as a distinct disorder: a rationale, consensus criteria, and a preliminary empirical test. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 613-645.)

PRIGERSON, H.G., MACIEJEWSKI, P.K., REYNOLDS, C.F. 3RD., BIERHALS, A.J., NEWSOM, J.T., FASICZKA, A., FRANK, E., DOMAN, J. & MILLER, M. 1995. Inventory of complicated grief : a scale to measure maladaptive symptoms of loss. *Psychiatry Research.* 59(1-2): 65–79.

REID, W.J. & FORTUNE, A.E. 2002. The task-centered model. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social workers' desk reference. New York : Oxford University Press. p. 101-104.)

REYNEKE, R.P. 2004. Die benutting van narratiewe beginsels tydens gemeenkapsontwikkeling. *Social Work/Maatskaplike Werk,* 40(2):125-137.

ROBBEN, A.C.G.M. 2004. Death and anthropology: An introduction. (In Robben, A.C.G.M., *ed.* Death, mourning and burial : a cross-cultural reader. Sydney. Blackwell Publishing. p. 1–16.)

ROSENBLATT, P.C. 1993 . Cross-cultural variation in the experience, expression, and understanding of grief. (*In* Irish, D.P., Lindquist, K.F., & Nelsen, V.J., *ed.* Ethnic variations in dying, death and grief : diversity in universality. London : Taylor and Francis. p. 13–19.)

RUBIN, A. & BABBIE, E. Research methds for social work. 5th ed. London : Thomson Brooks/Cole.

SCHUT, H., STROEBE, M.S., VAN DEN BOUT, J. & TERHEGGEN, M. 2001. The efficacy of bereavement interventions : determining who benefits. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington D.C. : American Psychological Association. p. 705–737.)

SHAVER, P.R. & TANCREDY, C.M. 2001. Emotion, attachment, and bereavement: a conceptual commentary. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C : American Psychological Association. p. 63–88.)

SHEAR, M.K. & SMITH-CAROFF, K. 2002. Traumatic loss and the syndrome of complicated grief. *PTSD Research Quarterly*, 13(1):1-8.

SILVERMAN, P.R. & KLASS. D. 1996. Introduction: what's the problem? (*In* Klass, D., Silverman, P.R. & Nickman, S.L., *eds.* Continuing bonds. New York : Taylor & Francis. p. 3–27.)

STROEBE, M. S. 2002. Paving the way: from early attachment theory to contemporary bereavement research. *Mortality*, 7(2) 127-138.

STROEBE, M & SCHUT, H. 1999. The dual process model of coping with bereavement : rationale and description. *Death Studies*, 23:197–224.

STROEBE, W & SCHUT, H. 2001. Risk factors in bereavement outcomes: a methodological and empirical review. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research :

consequences, coping and care. Washington, DC. : American Psychological Association. p. 349-371.)

STRYDOM, H, 2005. Ethical aspects of research in the social sciences and human service professions. (*In* De Vos, A.S., Strydom, H.S., Fouché, C.B. & Delport, C.S.L. *eds.* Research at grass roots : for the social science and human service professions. Pretoria : Van Schaik Publishers. p. 62–76.)

STRYDOM, H. & VENTER, L. 2005. Sampling and sampling methods. (*In* De Vos, A.S., Strydom, H.S., Fouché, C.B. & Delport, C.S.L., *eds.* Research at grass roots : for the social science and human service professions. Pretoria: Van Schaik Publishers. p. 197–209.)

THOMAS, N.D. 2000. Generalist practice with people of color. (*In* John Poulin and contributors. Collaborative social work : strength-based generalist practice. Sydney : Thomson Brooks/Cole. p. 295–325.)

VESSIER-BATCHEN, M. & DOUGLAS, D. 2006. Coping and complicated grief in survivors of homocide and suicide decedents. *Journal of forensic nursing,* 2(1):25–32.

VONK, M.E. & EARLY, T.J. 2002. Cognitive-behavioral therapy. (*In* Roberts, A.R., & Greene, G.J., *eds.* Social workers' desk reference. New York : Oxford University Press. p. 116-120.)

WATSON, M.S., LUCAS, C.F., HOY, A.M. & BACK, I.N. 2005. Oxford Handbook of Palliative Care. New York : Oxford University Press.

WATSON, D., & WEST, J. 2006. Social work process and practice : approaches, knowledge and skills. Tokyo : Palgrave Macmillan.

WELMAN, J.C., KRUGER, F. & MITCHELL, B. 2005. Research methodology. Johannesburg : Oxford University Press.

WEYERS, M., STRYDOM, H. & HUISAMEN, A. 2008. Triangulation in social work research: the theory and examples of its practical implication. *Social Work/ Maatskaplike Werk,* 44(2):207–222.

WORDEN, W.J., 1991. Grief counseling and grief therapy. A handbook for the mental health practitioner. 2nd ed. London : Routledge.

ZHANG, B., EL-JAWAHRI, A. & PRIGERSON, H.G. 2006. Update on bereavement research : evidence-based guidelines for the diagnosis and treatment of complicated bereavement. *Journal of Palliative Medicine,* 9(5):1188-1203.

SECTION B

PROFESSIONAL JOURNAL ARTICLES

ARTICLE 1

COMPLICATED GRIEF IN THE SOUTH AFRICAN CONTEXT

CM Drenth is a PhD student at the School of Psychosocial Behavioral Sciences (Social Work) at the North–West University (Potchefstroom Campus).
H Strydom is Professor and Head of the Social Work Division. AG Herbst is a Senior Lecturer (Social Work) and KFH Botha is Professor (Psychology) at the North-West University.

Key words:
Grief, complicated grief, risk factors, assessment, South Africa.

Abstract:
This article gives a literature overview on factors leading to complicated grief and at the same time attempts to link these factors to the South African circumstances. South African citizens are not exempted from experiencing complicated grief. Cultural beliefs on death and bereavement, AIDS and cancer-related deaths, and crime and socio-political deaths are but some of the risk factors in South Africa. Death impacts on everyone in South Africa; old and young, rich and poor, and black and white. It leaves children without parents, women without support to raise their children, and families without income. It changes the lives of at least 10%–20% of the population who will experience complicated grief. The number of adult deaths in South Africa increased over a period of five years by 62%. Social workers in South Africa need to include the possibility of complicated grief in their assessment of a client, in an attempt to fully understand the social functioning of a client.

COMPLICATED GRIEF IN THE SOUTH AFRICAN CONTEXT

"How small and selfish is sorrow. But it bangs one about until one is quite senseless". (Queen Elizabeth in a letter to Edith Sitwell after the death of King George VI).

1. INTRODUCTION

Few articles have been written on grief and bereavement in the South African context and even less on complicated grief. This article is an attempt to highlight some of these aspects with specific reference to complicated grief. Recent research on grief and bereavement in South Africa was done by Bopape (1995), Mdleleni-Bookholane (2003), Strydom and Fourie (1998) and Wild (2001). A valuable input in understanding complicated grief in the South African context was developed by Opperman (2004) who researched the influence of context on complicated grief and concluded that there is evidence of relationships between dimensions of context and complicated grief.

2. PROBLEM STATEMENT

Grief is a normal experience felt all over the world by people who have lost a loved one through death. The manner in which the grieving takes place may, however, differ from culture to culture. South Africa is no exception to the rule and the diversity of South African cultures is also displayed in the grieving process. Grief can, however, become complicated (Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka, Frank, Doman & Miller, 1995; Stroebe, Hansson, Stroebe, & Schut, 2001; Worden, 1991) and can lead to impaired social functioning.

Distinctions between normal and complicated grief are not easy to make. The setting of a cut-off point between normal and complicated grief is hampered by aspects such as culture, religion, personality, age, society, mode of death, relationship with the deceased, and many more. It is also not easy to

differentiate between complicated grief and other related disorders such as depression, anxiety disorders and posttraumatic stress disorder (Worden, 1991:75).

The researcher is concerned with the factors leading to the complication of grief and wants to establish whether the South African population is also at risk to develop complicated grief. The researcher furthermore is interested in the risk factors, if any, that may give rise to complicated grief within the South African context.

3. AIM

The aim of this article is to give a literature overview of factors leading to complicated grief and at the same time link these factors to South African circumstances. With this article, the researcher thus attempts to highlight the prevalence of complicated grief in the South African context.

4. NORMAL GRIEF

Grief is a normal process after the death of a significant person and is an individual experience. Grief manifests in symptoms like sadness, social withdrawal, sleeplessness and a decrease in concentration (Horowitz, Siegel, Holen, Bonanno, Milbrath, & Stinson, 1997; Parkes, 2005-2006; Prigerson, 2005:10; Stroebe *et al.,* 2001; Worden, 1991). Yearning, searching and a strong desire to talk about the deceased are also common in the first few months after the death occurred (Monk, Houck, & Shear, 2006:77). Kersting (2004:1) quotes Selby Jacobs who found that 40% of people who lose a spouse experience generalized anxiety symptoms in the first year after death.

Stroebe *et al.* (2001:7) identify the following dimensions of grief manifestations:

- Affective manifestations (i.e. depression, despair, anxiety, guilt, anger and loneliness).

- Behavioural manifestations (i.e. agitation, fatigue, tearfulness, and isolation).
- Cognitive manifestations (i.e. searching and yearning, lowered self-esteem, self-reproach, helplessness and hopelessness, sense of unreality, decreased memory ability and concentration problems).
- Physiological and somatic manifestations (i.e. appetite disturbance, sleep disturbance, lack of energy, physical complaints similar to those of the deceased, somatic complaints, increase in substance intake, and higher susceptibility to illness and disease).

All of the above-mentioned must be assessed within the specific culture of the client as aspects such as the intensity, duration and frequency of symptoms may be prescribed by the specific culture (Stroebe *et al.,* 2001:8).

Littlewood (1992:40) describes grieving as a necessary process associated with pain, confusion and distress. Bernardo (1998:1) quotes research done by Biondi and Piccardi with regards to the biological aspects of loss and stress. These researchers found the occurrence of numerous disruptions in the neuro-endocrine and immune systems for several months following death. These disruptions leave the individual at risk for physical and mental illness for up to two years after the loss.

Some social workers and sociologists are opposing the afore-mentioned medicalization of grief (Parkes, 2005-2006:5). Parkes (2005-2006:5) quotes Stroebe *et al.* who is of opinion that *"assumptions of health and adjustment are by-products of cultural and historical processes"*, thus giving recognition to the influence of the individual's socio-economic environment and cultural heritage.

5. COMPLICATED GRIEF

One of the best examples of complicated grief in the history is that of Queen Victoria whose husband died when she was only 42 years old. She withdrew from all public duties for ten years and only reappeared after her son also

became ill. She never stopped to surround herself with images of her husband (Mander, 2005:42). With this example it is clear that the grieving process does not always proceed as uncomplicated as is expected. Practitioners and researchers are now in agreement that grief can become a prolonged state of distress and impairment and the inclusion of complicated grief as a mental disorder is widely debated by researchers from the medical and psychological disciplines (Boelen, 2006; Shear & Smith-Caroff, 2002; Stroebe & Schut, 2005-2006). Complicated grief has however, not been included in the *Diagnostic and Statistical Manual of mental Disorders (DSM),* partly because of the difficulty to distinguish between Post Traumatic Stress Disorder (PTSD), Major depressive Disorder (MDD) and complicated grief (Prigerson, 2005:12).

Prigerson *et al.* (1995:23) defines complicated grief as *"the failure to return to pre-loss levels of performance or states of emotional well-being".* The researcher is of the opinion that grief may have such a devastating impact on the life of an individual, that he/she wants to get back to the pre-loss state of functioning, but cannot regain that state because of the absence of the deceased. The aim should thus be to get as close to the pre-loss state as is humanly possible by adapting to a life without the deceased, rather than to get back to the exact pre-loss state.

Complicated grief is defined by Stroebe *et al.* (2001:6) as "*a deviation from the (cultural) norm in the intensity of specific or general symptoms",* while Prigerson *et al.* (1995:66) is of opinion that complicated grief is evident, when grief-related symptoms still exist six months after the death. The researcher supports Horowitz *et al.* (1997:905) who insist that a period of 14 months should lapse between bereavement and the diagnosis of complicated grief. A panel of researchers, however, is of opinion that a two-month duration of symptoms should be the focus for determining complicated grief, rather than the amount of time elapsed since the death occurred (Prigerson & Jacobs, 2001:622).

Many factors, however, might lead to a delay in the normal grief process, which in turn can lead to distress in the individual's personal life, family and community. Prigerson (2005:10) found that approximately 10% - 20% of people who have lost a loved one might be susceptible to complicated grief, which she describes as a prolonged grief condition marked by changes in personal relationships, loss of meaning, excessive sorrow, and a radical change in lifestyle.

One must, however be careful not to only focus on the medical aspects of complicated grief but to be constantly aware of the role of society in defining grief. Parkes (2005-2006:6) quotes Averill and Nunley in this regard: *"...the well-socialized individual, who has internalized the relevant norms and customs of society, will experience mourning, not as something enforced from without, but as something coming from within."* The role of society in identifying complicated grief can thus not be ignored and needs to be explored during the initial assessment and before assumptions of the existence of complicated grief can be made.

The intensity of the emotions experienced and the accompanying disruption and inability to regain balance, proofed to be an indication of complicated grief. Piper, Ogrodniczuk & Weideman (2005:2) combine both the intensity and duration of grief symptoms in their description of complicated grief and advocates the usefulness of complicated grief screening questions during the initial assessment of all patients while Worden (1991:70) quotes Horowitz who describes complicated grief as *"the intensification of grief to the level where the person is overwhelmed, resorts to maladaptive behaviour, or remains interminably in the state of grief without progression of the mourning process towards completion"*. The intensity and duration of grief manifestations, coupled with an inability to adapt to the loss, is thus an indication of complicated grief.

The identification of complicated grief is not an easy task, as it is usually masked by other problems. Worden (1991:75-77) assists the social worker in mentioning twelve specific clues to identify complicated grief:

- Difficulty in mentioning the deceased without expressing intense grief.
- A relatively minor event triggers an intense grief reaction.
- The bereaved finds it difficult to part with the material belongings of the deceased.
- Themes of loss continuously come up in conversation.
- The bereaved manifests the same physical symptoms as the deceased.
- Radical life style changes (Prigerson, 2005:12).
- Persistent guilt and a lowered self-esteem, coupled with depression, prevail.
- The bereaved tends to imitate the deceased.
- Suicidal ideation.
- Unaccountable sadness at certain times of the year.
- The bereaved experiences phobias about illness and death.
- The bereaved avoids death related rituals and activities.

The above-mentioned clues will be useful for the social worker when included in the assessment of the client and his tendered problem.

Worden (1991:65–70) identifies five main reasons why people fail to grieve:

- **Relational factors** refer to the relation between the bereaved and the deceased. Fulton (2003:348) is of opinion that the intensity of a grief reaction depends largely on the nature of the relationship between the deceased and the bereaved. Worden (1991:65) also points out that the relationship which suffers from unexpressed hostility, often leads to complicated grief. The reopening of old wounds, incomplete shared goals, and a highly dependent bond between the deceased and the bereaved, are all factors to take into account when addressing the relational factors of a perceived failure to grieve. Watson, Lucas, Hoy and Back (2005:754) mention mental health problems and a perceived lack of social support

under this heading. It could also refer to the multiple deaths of significant others in a short period of time which was not caused by natural disasters.

- **Circumstantial factors** include the existence of multiple losses which could have been caused by either a natural disaster or multiple motor vehicle accidents.. The emphasis is thus on the simultaneous loss of more than one significant person in the life of the bereaved. This aspect is referred to as *bereavement overload* (Worden 1991:67). In circumstances like this, it could become even more difficult to distinguish between Posttraumatic Stress Disorder and complicated grief. Circumstantial factors also refer to suicide, deaths that occur at certain life cycles, deaths that *"cannot be blamed on others and death which evokes a sense of loss of control"* (Lydall, 2004:37).

- **Historical factors** refer to the fact that people who have suffered complicated grief previously in their lives tend to experience complicated grief again. It also refers to insecurity in childhood attachments (Watson *et al.*, 2005:754, and Worden, 1991:67).

- **Personality factors** indicate the influence of a person's character on his/her manner of grief, according to Worden (1991:68). Withdrawal in the face of extreme distress and lowered self-concept fall in this category. Stroebe and Schut (2001:355) conclude that people with high self-esteem and high internal control beliefs will find sudden losses less threatening because they feel that, although the loss is great, it can be dealt with.

- **Social factors**. Worden (1991:69) highlights the fact that grief is a social process and as such needs to be dealt with in a social setting where support can be rendered. Worden (1991:69) quotes Lazare who indicates three social conditions which might lead to complicated grief:
    - ❖ Socially unspeakable loss (for example: Suicide or a love affair with the deceased);

- ❖ Loss is socially negated (people act as if the loss never occurred, for example. loss of ex-spouse) and
- ❖ Absence of a support network due to geography, social isolation or multiple family deaths.

Opperman (2004:254) adds the influence of context to the above-mentioned list of factors why people fail to grieve and states that the risk for complicated grief increases when the survivors' sense of material well-being, emotional security and self-identity are threatened by the death. This author categorizes the socio-environmental context into the following categories: Socio-economic context; family context and personal context. Opperman (2004:255) proofs with this research that the individual will mostly react from his attachment to and relationship with his environment.

6. *RISK FACTORS IN DEVELOPING COMPLICATED GRIEF: THE SOUTH AFRICAN SCENARIO*

South African citizens are not exempted from experiencing complicated grief. On the contrary, South African citizens are exposed to a number of situations which could lead to the development of complicated grief.

6.1. Cultural beliefs on death and bereavement

The experience of grief is most often laid down by the culture in which an individual finds himself (James & Gilliland, 2001:422). Communities have their own assumptions of how an individual should be grieving. Robben (2004:4) points out the great variation about death and dying in cultural beliefs. According to Firth (2005:26) culture is seen as dynamic and is located in the context of the socio-economic condition of the community. This includes shared history, religion, food, life-style and arts. Rosenblatt (2001:286) attributes cultural differences in reactions to loss to factors such as: *"cultural understanding of what has been lost, death rituals, cultural constructions of a survivor's ongoing and future relationship with the deceased, and the cultural construction of culturally deviant grieving".*

Stroebe *et al.* (2001:15) link cultural differences to the following phenomena:

- What has been lost in death;
- Death rituals;
- Cultural constructions of the survivors ongoing and future relationship with the deceased; and
- Cultural constructions of what is deviant grief.

These factors are applicable to the South African community with its eleven official languages and diverse traditional groups. South African traditional groups expect from its members to adhere to the prescriptions as identified and developed by the group. Mdleleni-Bookholane (2003:2) is of opinion that the concept of death among Africans is informed by the broader concept of the African world-view. Mdleleni-Bookholane (2003:9) points out that death is a taboo subject in most of the cultural groups in South Africa. Children are therefore not prepared for death and communities are discouraged to talk about death, unless they regard the deceased as inhuman. This is even more so in the rural areas of South Africa where tradition and cultural beliefs have not yet been influenced to such a great extent by westernized ideas. The following essay written by a fellow social worker, who is from the Basotho tribe, explains the exclusion of children from death and the effect it has on the child ("Mpho", HPCA Psychosocial and spiritual course, 28 February 2007. Cape Town):

"I was 9 years old and in Grade 4, when my seven year old sister died. She was a sister and a friend to me and when she died I felt like part of me also died. I was told about her death, o, I cried, but was not allowed to show my emotions. My friends at school saw that I was sad and all the time that I would think about her, I would cry – they did not want to see me cry- so they would comfort me and say: "please don't cry, because your tears will make it difficult for your sister to see heaven".

The funeral arrangements were underway and nobody said anything to me. Children were not included in the decisions, even though they were affected. At the day of the funeral – I was not part of the ceremony. I, like all other children, was left at home. Only adults attended.

I missed my sister but never talked about her, as talking about the deceased was not encouraged. When I was doing Grade 12, I brought up the issue with my parents, and how they denied me the chance to say goodbye to my beloved sister. They were not aware that I still had those memories and that I was still hurting. They took me to my sister's grave and I eventually had time to say goodbye..."

South Africa is a country of diverse cultures and can therefore be seen as a multi-ethnic society with both well developed urban areas as well as under-developed traditional rural areas. Death therefore, raises profound social and traditional issues in South Africa as a person's culture is challenged by new ideas. The beliefs, customs and practices of the Xhosa and Zulu people are described by Elion and Strieman (2001:32-41) in an attempt to enhance the understanding of the different cultures in South Africa. Elion and Strieman (2001:36–41) mention the two main religious groups amongst the black South Africans namely the African Traditional Religion (who firmly believes in the role of the ancestors) and the African Independent Churches (who are practicing Christianity). The African Traditionalists please the ancestors by sacrificing an animal (goats, sheep or cattle) on special occasions such as births and funerals. An ox is slaughtered to indicate the change in status of the deceased approximately two years after the funeral. Elion and Strieman (2001:39) explain this as follows: *"After this ritual (akubuyisa), the spirit of the deceased changes status from that of an izithunzi (shadow) to an amadhlozi (ancestral spirit)"*. Many businessmen and -women in South Africa, in urban as well as rural areas adhere to these beliefs and customs. Black South Africans tend to bury the deceased in the place of birth, while white South Africans tend to bury mostly in the area where the deceased resided. Elion and Strieman

(2001:49) indicate that the eldest member of a family group takes on the responsibility of funeral arrangements at the tribal home. Elion and Strieman (2001:49) also state that the terms and conditions of the mourning period are determined by the family of the deceased and that mourning comes to a close with a special ritual. Xhosa and Zulu mourners prefer not to use the word "death" but to rather use euphemisms such as "he was taken home", or "taken to the fathers". The researcher experiences that white South Africans also tend to use the same euphemisms and shy away from the word "death". White South African Christians mostly follow the burial or cremation rituals of Western countries. The burial usually takes place within the first week after the death and tea and refreshments are served directly after the burial service.

Apart from the different African religious groups and the white Christian groups, South Africa also has members who believe in Hinduism, (who cremate the dead and then scatters the ashes at a river or in the sea), Jews, (who bury the dead within 24 hours after the death without viewing of the body) and Muslim (who also buries as soon as possible after death).

It is unknown whether the inability to follow cultural and religious prescriptions adds to complicated grief in the South African context. However, Opperman (2004:88) quotes Shapiro who is of opinion that individuals tend to show signs of complicated grief if they are not able to follow the customs and rituals as prescribed by their cultural group. Lydall (2004:38) mentions that communities may lack the resources to bury their dead according to traditional mourning rituals, *"which historically allowed community members to grieve their losses deeply and meaningfully"*. The author specifically refers to AIDS-related multiple losses in the South African communities.

6.2. AIDS and cancer related deaths

The stigma attached to AIDS is still a great matter of concern and families and individuals tend not to break the silence after the death of a significant

person, partly as a result of the stigma attached to the illness and partly to adhere to the cultural requirements of not talking about death. Sikkema, Hansen, Kochman, Tate and Difranceisco (2004:189) point out that people infected with HIV and who experience AIDS-related bereavement may be at high risk to experience complicated grief. The stigma attached to HIV and AIDS may also prevent a person to seek effective support with the grieving process.

South Africa is regarded as one of the Sub-Saharan countries with the highest incidence of HIV and AIDS. In their report on the global AIDS epidemic in South Africa (UNAIDS, 2006), the UN cited the following 2005 statistics:

- Total number of people living with HIV: 5.5 million;
- Total AIDS deaths (adults and children): 320 000;
- Number of orphans due to AIDS: 1, 2 million.

It is the researcher's opinion that these figures can be much higher, due to the fact that HIV and AIDS is not a communicable disease in South Africa and that people are dying in rural areas, far away from government offices and medical facilities.

AIDS in South Africa causes families to suffer multiple losses which in itself have a potential to lead to complicated grief (Lydall, 2004:38). Sikkema *et al.* (2004:189) indicate that it is not only the multiple losses experienced, but also the fact that an individual experiences insufficient time to mourn the loss or to prepare for another. This does not only apply to AIDS-related bereavement, but to all other bereavement where multiple losses take place within a short period of time. Lydall (2004:38) also points out that the age of the deceased tends to complicate grief, especially in the case of an AIDS-related death as the deceased tends to be young.

The World Health Organisation (WHO) (2002) estimates in its Geneva report that there were 0,5 million deaths per year in Africa from cancer and

that by the year 2020, 70% of new cancer cases will be in the developing world. According to the WHO (2002) Cancer rates in Africa are expected to grow by 400% over the next 50 years. The death of a loved one through cancer can in itself cause complicated grief if the uncertainty, hopelessness and agony is taken into account.

6.3. Crime and socio-political related deaths

South Africa is furthermore not exempted from the criminal element and has an exceptionally high incidence of violent deaths. An amount of 18,793 South Africans were murdered during 2004/2005, according to the South African Police Service Crime Information Analysis centre (SAPS, 2006:1).

South Africa is a country with a history of military action prior to the 1994 democratic election. South African residents all suffered losses during this period. The emotional part of these losses was attended to on a certain level during the Truth and Reconciliation Commission. It is the opinion of the researcher that the Truth and Reconciliation Commission, only succeeded in forgiveness and did not focus on the implication of this war on both sides. These losses could have resulted in unattended complicated grief. There is, however, no research done on this topic and therefore will only remain speculation. The above-mentioned is the opinion of the researcher who was a social worker, employed of the South African Defence Force (SADF) (later renamed to the South African National Defence Force) prior, during and after 1994 and was in a position to observe SADF soldiers, as well as integrated soldiers from the Umkhonto we Sizwe (African National Congress), APLA (Azanian Peoples Liberation Army), and the Bophuthatswana Defence Force.

Although few research exist on complicated grief in the South African context, it can be derived from the discussions above, that complicated grief is a possibility amongst at least 10%–20 % of people who suffer the death of a loved one, whether by AIDS, cancer, crime, or socio-political

related deaths. The factors mentioned are but a few and the possibility of adding many more is evident.

7. COMPLICATED GRIEF AS A CONCERN FOR SOCIAL WORKERS IN SOUTH AFRICA

The loss of a loved one through death is an individual experience and the regaining of balance after such an event depends on personal factors (age, relationship to deceased, personality, past experience of loss and mode of death (Mander, 2005:43) as well as community factors (cultural and religious beliefs and community support) (Opperman 2004).

Death impacts on everyone in South Africa; old and young, rich and poor, and black and white. It leaves children without parents, women without support to raise their children, and families without income. It changes the lives of at least 10%–20% of the population who will experience complicated grief, (Prigerson, 2005:10) be it as a result of crime, AIDS, motor-vehicle accidents, chronic illness, cancer or suicide.

James and Gilliland (2001:422) mainly refer to the Western societies when they mention the change that has taken place in societies over the years. There are still rural areas in South Africa where adult life expectancy is low and infant mortality is high. Epidemics such as AIDS are wiping out large numbers of people (UNAIDS, 2006) in both rural and urban areas. Communities in South Africa vary from small (where the community is involved when the death occurs) to very large (where the family does not even have the support of the next-door-neighbour).

The number of adult deaths in South Africa, increased by 62% over a period of five years; from 272 221 in 1997 to 441 029 in 2002. (Statistics South Africa, 2005:9). This means that, from the findings of Prigerson (2005:10), that at least 52 923 individuals (conservatively estimated at one bereaved individual per deceased) might have experienced complicated grief in South

Africa since 2002. Workplaces in South Africa, like elsewhere in the world have established rules which dictate the time employees are allowed to take off from work following the death of a significant person (James & Gilliland, 2001:423). This very often clashes with the traditions embedded in the different cultural and religious groups in South Africa. Hosking, Whiting, Brathwate, Fox, Boshoff and Robbins (2000:437) state in this regard: *"In South Africa political change has resulted in a collision of cultures, so multi-culturism should be embraced and studied but accompanied by an awareness of sensitive issues."* Acculturation, where cultures affect each other, is an increasing phenomenon in South Africa since democratization.

Hepworth, Rooney and Larsen (2002:4) compiled a list of people served by social workers. The researcher adapted this list to fit the grief-related issues experienced by the social work clients:

- Persons who are homeless and without financial means. This includes child-headed families in South Africa due to the death of both parents, mainly as result of AIDS (Lydall, 2004:3) and families left without a breadwinner.
- Couples who experience serious marital conflict after the death of a child (Lydall, 2004:49; Stroebe & Schut, 2001:367).
- Persons afflicted with HIV/AIDS and their families with the emphasis on multiple losses in the family or community (UNAIDS, 2006). James and Gilliland (2001:434) are of opinion that workers with HIV-positive clients should be aware of the constant loss and grief over continuously losing friends and family who die of AIDS.
- Children who present with juvenile delinquency after the death of a parent, sibling or friend. James and Gilliland (2001:430) state the difficulties of adolescents who encounter death more frequently than ever before.
- Substance abuse as result of the loss of a close family member and the inability to adapt to a life without the deceased (Stroebe & Schut, 2001:366).
- Suicidal tendencies after the loss of a loved one.

- Persons whose death is stigmatized by the community, such as AIDS and suicide. Negative cultural messages are given to the families and friends after such a death and the bereaved are often left with intense feelings of guilt, especially in the case of suicide (James & Gilliland, 2001:428). Lydall (2004:4) is of opinion that parents who lose a child due to AIDS might not receive the support of the community because of the stigma coupled to the disease. Isolation of the family and a lack of support complicate the mourning process. Lydall (2004:131) also acknowledges the complications in the grieving process when a death cannot be publicly mourned (disenfranchised grief).

Social workers are committed to enhance human well-being. In doing this, they particularly attend to the needs of vulnerable, oppressed and poor people, and this includes those South African citizens suffering from complicated grief. The general purpose of social work is translated by DuBois and Miley (2002:11) in more specific directions for action: enhance the clients' social functioning, link them with resources, improve the social service delivery network and promote social justice. In saying all this, the following questions come to mind:

- Is loss as a result of death included in the initial social work assessment of all clients?
- What is the knowledge base of South African social workers regarding the impact of normal and complicated grief on the social functioning of the client?
- How many social work programmes and services are available in South Africa for those suffering from complicated grief?
- Is the South African social worker professionally capable of addressing the social problems caused by complicated grief?

It is only when the South African social worker is able to answer positively to these questions, that s/he will be able to execute the purpose of social work regarding the problem of complicated grief.

With the afore-mentioned questions in mind, it is recommended that social workers empower themselves with more knowledge regarding the impact of grief. This will allow for the inclusion of death as a possible cause of impaired social functioning during the initial assessment. No evidence in the South African social work literature could be found regarding complicated grief intervention programmes and services for the South African community, although the earlier mentioned statistics indicate a need for such programmes and services. The development and implementation of such intervention should thus receive more attention from social workers in South Africa.

8. CONCLUSION

Literature mentioned in this article revealed that normal grief turns into complicated grief in the presence of certain risk factors. It also became clear that 10%–20% South Africans who grieve, would fall into the category of complicated grief.

The suffering and misfortune of those who experience complicated grief are basic components of care which must be obligated by social workers in the grief-related field of work. In the light of the before-mentioned discussions, there can be no doubt that South African social workers have an important role to play in at least the following areas considering complicated grief: development of programmes and services, advocacy, and ethical and legal issues relating to complicated grief.

REFERENCES

BERNARDO, M.L. 1998. When grief becomes a disorder. *The national psychologist,* 1(3):1-2.

BOELEN, P.A. 2006. Cognitive-behavioral therapy for complicated grief : theoretical underpinnings and case descriptions. *Journal of Loss and Trauma,* 11:1-30.

BOPAPE, M. 1995. The Bapedi framework of mourning and bereavement and its implications for the helping professions. *Social Work,* 31(3):262-266.

DUBOIS, B. & MILEY, K.K. 2002. Social work : an empowering profession. Boston : Allyn and Bacon.

ELION, B & STRIEMAN, M. 2001. Clued up on culture : a practical guide for all South Africans. Cape Town : One Life media CC.

FIRTH, S. 2005. Minority ethnic communities and religious groups. (*In* OLIVIERE, D & MONROE, B., *ed.* Death, dying and social differences. Oxford, N.Y. : Oxford University Press. p. 25-41.)

FULTON, R. 2003. Anticipatory mourning : a critique of the concept. *Mortality,* 8(4):342–350.

HEPWORTH, D.H., ROONEY, R.H. & LARSEN J.A. 2002. Direct social work practice : theory and skills. 6th ed. Pacific Grove, CA : Brooks/Cole.

HOROWITZ, M.J., SIEGEL, B., HOLEN, A., BONANNO, G., MILBRATH, C., & STINSON, C. (1997). Diagnostic criteria for complicated grief disorders. *American Journal of Psychiatry,* 154(7):904–911.

HOSKING, M., WHITING, G., BRATHWATE, C., FOX, P., BOSHOFF, A & ROBBINS, L. 2000. Cultural attitudes towards death and dying : a South African perspective. *Palliative Medicine,* 14:437–439.

JAMES, R.K. & GILLILAND, B.E. 2001. Crisis intervention. 4th ed. Sydney : Brooks/Cole.

KERSTING, K. 2004. A new approach to complicated grief. *American Psychological Association.* 35(10). November. [Web:] http://www.apa.org/monitor/nov04/grief.html [Date of access: 25 July 2005].

LITTLEWOOD, J. 1992. Aspects of grief : bereavement in adult life. London : Routledge.

LYDALL, A. 2004. Give sorrow words: the meaning of parental bereavement. Johannesburg : RAU. (Dissertation – D.Litt.et.Phil.) 379 p.
MANDER, G. 2005. Bereavement talk. *Therapy Today*, 16(9):42–45.

MDLELENI-BOOKHOLANE, T.N. 2003. The development of an understanding of the concept of death by black African learners in a rural area. Johannesburg : RAU. (Dissertation – D.Litt.et Phil.) 180 p.

MONK, T.H., HOUCK, P.R. & SHEAR, M.K. 2006. The daily life of complicated grief patients – what gets missed, what gets added? *Death Studies,* 30:77-85.

"MPHO", 2007. Essay on the influence of life cycle on the individual. Hospice association of South Africa. Psychosocial course. Cape Town, Feb.

OPPERMAN, B.C.D. 2004. The influence of context on complicated grief. Johannesburg : RAU. (Dissertation – D.Litt.et.Phil.) 274 p.

PARKES, C.M., 2005 – 2006. Symposium on complicated grief. Part I. Introduction to a symposium. *Omega,* 52(1):1-7.

PIPER, W.E., OGRODNICZUK, J.S. & WEIDEMAN, R. 2005. Screening for complicated grief: when less may provide more. *Can J Psychiatry* 50:680-684. [Web:] http://www.cpa-apc.org/publications/archives/cjp/2005/0ctober/piper-OR.asp [Date of access: 10 August 2006].

PRIGERSON, H.G., MACIEJEWSKI, P.K., REYNOLDS, C.F. 3rd., BIERHALS, A.J., NEWSOM, J.T., FASICZKA, A., FRANK, E., DOMAN, J., &

MILLER, M. 1995. Inventory of complicated grief : a scale to measure maladaptive symptoms of loss. *Psychiatry Research,* 59(1-2):65–79.

PRIGERSON, H.G. & JACOBS, S.C. 2001. Traumatic grief as a distinct disorder: a rationale, consensus criteria, and a preliminary empirical test. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research : consequences, coping and care. Washington, DC. : American Psychological Association. p. 613-645.)

PRIGERSON, H. 2005. Complicated grief : when the path of adjustment leads to a dead end. *Healthcare counseling & psychotherapy Journal.* 5(3):10-13.

ROBBEN, A.C.G.M., 2004. Death and anthropology : an introduction. (*In* Robben, A.C.G.M. Death, mourning and burial : a cross-cultural reader. Oxford : Blackwell Publishing. p.1-16.)

ROSENBLATT, P.C. 2001. A social constructionist perspective on cultural differences in grief. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 285–300.)

SAPS. 2006. Crime in the RSA per police area for April to March 2001/2002 to 2004/2005. Crime Information Analysis Centre (Unpublished report.)

SHEAR, M.K. & SMITH-CAROFF, B.S. 2002. Traumatic loss and the syndrome of complicated grief. *PTSD Research Quarterly,* 13(1):1-8.

SIKKEMA, K.J., HANSEN, N.B., KOCHMAN, A., TATE, DC. & DIFRANCEISCO, W. 2004. Outcomes from a randomized controlled trial of a group intervention for HIV positive men and women coping with AIDS-related loss and bereavement. *Death studies,* 28:187-209.

STATISTICS SOUTH AFRICA. 2005. Mortality and causes of death in South Africa, 1997–2003. Findings from death notification. Pretoria : Government Press.

STROEBE, M.S., HANSSON R.O., STROEBE, W. & SCHUT, H. 2001. Introduction: concepts and issues in contemporary research on bereavement. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research : consequences, coping and care. Washington, DC : American Psychological Association. p. 285–300.)

STROEBE, M & SCHUT, H. 2005-2006. Complicated grief: a conceptual analysis of the field. *Omega,* 52(1):53-70.

STROEBE, W & SCHUT, H. 2001. Risk factors in bereavement outcomes: a methodological and empirical review. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research : consequences, coping and care. Washington, DC. : American Psychological Association. p. 349-371.)

STRYDOM, H. & FOURIE, J. 1998. The content evaluation of a bereavement counseling programme for parents after the death of a child. *Social Work,* 34 (4):389–404.

UNAIDS. 2006. Report on the global AIDS epidemic. Geneva : UNAIDS.

WATSON, M.S., LUCAS, C.F., HOY, A.M., & BACK, I.N. 2005.. Oxford handbook of palliative care. Oxford, N.Y. : Oxford University Press.

WILD, L. 2001. Psychosocial adjustment of children orphaned by AIDS. *Southern African and adolescent mental health,* 13(1):3-22.

WORDEN, J.W. 1991. Grief counseling and grief therapy : a handbook for the mental health practitioner. 2nd ed. London : Routledge.

WORLD HEALTH ORGANISATION. 2002. Progress report: community health approach to palliative care for HIV/AIDS and cancer patients in Africa. Geneva :WHO.

ARTICLE 2

SCREENING SOUTH AFRICAN CLIENTS FOR INCLUSION IN A THERAPEUTIC COMPLICATED GRIEF INTERVENTION PROGRAMME

CM Drenth is a PhD student at the School of Psychosocial Behavioral Sciences (Social Work) at the North–West University (Potchefstroom Campus).
H Strydom is Professor and Head of the Social Work Division. AG Herbst is a Senior Lecturer (Social Work) and KFH Botha is Professor (Psychology) at the same North–West University (Potchefstroom Campus).

Key words:
Grief, complicated grief, Inventory of Traumatic Grief, Grief Assessment Guide, screening criteria

Abstract:
The normality of grief is questioned when the grief experience prohibits the individual to regain a state of social functioning as close as possible to the pre-loss state. Complicated grief is regarded by many researchers as a specific condition in need of specific intervention. The efficacy of bereavement intervention in the case of 'normal grief' is questioned and it seems that individuals who experience complicated grief benefit more from bereavement intervention. The authors of this article attempt to clarify the necessity to screen clients prior to including them in a complicated grief intervention programme by discussing the Inventory of Traumatic Grief (ITG) as developed by Prigerson and colleagues. The authors furthermore introduce the Grief Assessment Guide (GASsG) as an assessment tool during the screening process.

SCREENING SOUTH AFRICAN CLIENTS FOR INCLUSION IN A THERAPEUTIC COMPLICATED GRIEF INTERVENTION PROGRAMME

> *"Can it be in a world so full and busy that the loss of one creature makes a void in any heart so wide and deep that nothing but the width and depth of vast eternity can fill it up?"* Charles Dickens

1. INTRODUCTION

There is a global interest in the understanding and identification of people who run the risk of developing bio-psychosocial complications as a result of their loss of a significant other person. Kersting's (2004:1) comment that grief therapists need to "employ careful assessment and tailored treatments" in an attempt not to treat all clients the same, is fully endorsed by the researchers. This statement should also be applied with regard to the intervention processes of complicated grief. There are, however, still no clear guidelines for distinguishing between normal grief and complicated grief. This can mainly be ascribed to aspects such as individual differences, cultural and societal differences and the debate regarding the duration and severity of grief symptoms (Rosenblatt, 2001; Stroebe, Hansson, Stroebe and Schut, 2001; Watson, Lucas, Hoy & Back, 2005; Worden, 1991).

This article discusses the necessity for distinguishing between complicated grief and normal grief for intervention purposes. It also looks into the screening of clients for inclusion in a therapeutic intervention programme, with emphasis on ethical values, recruitment and criteria for inclusion in such an intervention programme. Social work assessment as part of the screening process is also discussed with specific reference to the utilization of the Grief Assessment Guide (GASsG).

2. PROBLEM STATEMENT

Grief is regarded as a normal process after the loss of a close relative or a friend (Prigerson, 2005; Worden, 1991) in spite of the whirlpool of emotions experienced after the loss. It is only when these emotions prohibit the individual to regain a state of social functioning as close as possible to the pre-loss state, that the *normality* of grief is questioned. It is at this stage that the necessity for therapeutic intervention becomes evident. The question to be answered is: "How do we know that we are dealing with complicated grief?" This question is mainly answered through the work of researchers such as Boelen, Van den Bout, De Keijser and Hoijtink (2003); Horowitz, Siegel, Holen, Bonanno, Milbrath and Stinson (1997); Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka, Frank, Doman and Miller (1995); and Worden (1991). Prigerson (2005:10) mentions that the person assisting the bereaved should determine "whether or not the survivor's reaction to loss is within the realm of normal adjustment." The mentioned research assists the social worker in identifying complicated grief and assessing the severity of the symptoms. A second question in identifying complicated grief which requires attention is: "Is the loss of a significant other the reason for the client seeking help or is it due to other factors not related to the loss?"

Barclay and Lie (2005:1) are of opinion that each death leaves an average of five people bereaved. With this in mind, the possible number of bereaved people in South Africa during 2002, was 2,205,145 people, considering the statistics of 441,029 documented deaths (Statistics South Africa, 2005:9). Prigerson (2005:10) established through research that 10%–20% of people who experience loss will suffer from complicated grief. This means that, of the 2,205,145 possibly bereaved persons mentioned above, approximately 220,515 to 441,030 individuals in South Africa might have suffered complicated grief resulting from the death of a loved one during 2002.

These mentioned figures must surely be an indication of the need for complicated grief intervention in South Africa. No evidence, however, could be found in the South African literature on research specifically aimed at

complicated grief intervention. The researchers therefore wish to determine whether the client's reaction to loss falls outside the realm of normal adjustment after death and whether the reason for seeking intervention is due to the loss and not to other factors unrelated to the death.

3. AIM

The aim of this article therefore is to accentuate the necessity to screen clients for complicated grief before embarking on a therapeutic complicated grief intervention programme. To do so, this article focuses on the methods used for the screening of clients for inclusion in such a programme through the following objectives:

- To supply an in-depth literature overview on the assessment of complicated grief.
- To introduce potential instruments for screening clients for the manifestation of complicated grief.

4. ASSESSING COMPLICATED GRIEF

The identification of complicated grief is not an easy task, as it is usually masked by other problems. Prigerson and Jacobs (2001:615) prefer to deviate from the word "complicated" and rather use the term "traumatic" grief. Their reason being that the word "complicated" is too vague, and that the term "traumatic grief" refers to the two core components of the syndrome – "traumatic stress" and "separation distress" (grief). The researchers, however, prefer to use the term "complicated grief" which enables them to include not only traumatic and separation distress, but also the social and cultural factors which might impact on the process of grief.

It is recognised that complicated grief, major depression or posttraumatic stress disorder may develop in response to the death of a significant other. Prigerson and Jacobs (2001:617) contribute to the discussions as to whether complicated grief should be a distinct disorder. Other researchers (Stroebe & Stroebe, 1994; Stroebe & Schut, 2001) add the roles of societal norms and cultural beliefs to the debate. Opperman (2004) also contributes with his study

by adding the effect of the larger environment in complicating grief. Opperman and Novello (2006:375) are of opinion that the socio-environmental context, the family context, and the personal context can have an influence on the development of complicated grief.

Prigerson and Jacobs (2001:621) rightly state that the absence of distinct diagnostic criteria for complicated grief should not prevent efforts to help those who experience more than the normal grief symptoms after the death of a significant other person.

Complicated grief may be reflected in the following: the perceived absence of grief and mourning, an ongoing inability to experience normal (cultural specific) grief reactions, delayed grief, disenfranchised grief or chronic grief (Prigerson, 2005; Prigerson *et al.*, 1995; Shear & Smith-Caroff, 2002; Worden, 1991). An increase in: a) the duration and severity of physical factors (for example, visits to a physician, changes in energy level, weight loss/gain, and increase in substance use); b) psychological factors (tearful for no reason, suicide ideation, dependency on other people, fear of death, fear and avoidance of anniversary dates, searching, and yearning); c) spiritual factors (such as avoidance of faith community, questioning sense of spiritual meaning, and anger aimed at God and church); and d) social factors (such as economic situation, day to day living concerns, unwillingness to engage in social interaction, radical change in lifestyle, exclusion of friends and family associated with the deceased, and an unwillingness to move material belongings of the deceased) are all indicators of complicated grief (Bouton, 2005; Piper, Ogrodniczuk & Weideman, 2005; Prigerson *et al.* 1995; Worden, 1991).

Complicated grief reactions, as formulated by the DSM IV-R, focus on symptoms of depression such as sad mood and poor appetite. Prigerson, Shear, Frank, Beery, Silberman, Prigerson, & Reynolds, (1997:1004) refer to studies that have shown that complicated grief symptoms form a dimension of bereavement-related distress that is distinct from symptoms of depression and anxiety. Major Depression Disorder (MDD) can, however, be diagnosed from

the onset of grief if the following criteria also exist: "1) guilt other than actions taken or not taken by the survivor at the time of death; 2) thoughts about death other than that the survivor feels that s/he would be better off dead or should have died with the deceased; 3) morbid preoccupation with worthlessness; 4) marked psychomotor retardation; 5) prolonged decrease in functional activities; and 6) hallucinations not related to the deceased person (American Psychiatric Association, 1994:886). Raphael, Minkov and Dobson (2001:603) clearly distinguish between the clinical phenomenology of grief and depression. Their distinction is made on cognitive, affect and arousal levels. According to these authors, bereavement focuses on the lost person whereas depression focuses on the negative interpretation of the self and the world (cognitive). Yearning, separation anxiety, externalized anger, and sadness are experienced in bereavement, while agitation, anxiety, internalised anger, and depressive feelings are symptomatic of depression (affect). The bereaved person seeks the deceased and shows variable sleep disturbances, while the depressed person withdraws and experiences disturbance and variation in the sleeping patterns (arousal). In a systematic review of the literature on complicated grief, Kristjanson, Lobb, Aoun, and Monterosso (2006) conclude that there is evidence that complicated grief can be distinguished from depression and anxiety. These authors are also of opinion that many cases of complicated grief will be missed if a diagnosis is based solely on major depressive disorder and anxiety.

The focus of this article, however, is to discuss the screening of clients for inclusion in a complicated grief intervention programme and not to debate the inclusion in or exclusion of complicated grief as a distinct disorder. It is therefore not necessary to further elaborate on the DSM IV-R criteria for grief and on whether complicated grief should be added to the DSM V as a distinct disorder.

A significant percentage of the population (approximately 10%-20% of people who have lost a loved one through death) experience complicated grief (Prigerson, 2005:10). These individuals appear to be at greater risk of experiencing adverse health effects (Kristjanson *et al.*, 2006:6). Watson,

Lucas, Hoy, and Back (2005:754) add the following risk factors for developing complicated grief:

- History of multiple loss experiences,
- previous mental health problems,
- perceived lack of social support,
- mode of death,
- death of a child,
- previous experience of complicated grief,
- insecurity in childhood attachments,
- inability to tolerate extremes of emotional distress,
- socially unspeakable loss (such as suicide, AIDS), and
- socially negated loss (for example, death of ex-spouse).

Opperman (2004:254) is of opinion that the risk for complicated grief increases when the bereaved person's sense of material well-being, emotional security and self-identity are threatened by death. Doka (2005:86) in turn refers to the different complications following sudden death or deaths that follow a long-term illness, while Prigerson (2005:11) compares people experiencing complicated grief with vehicles stuck in a morass whose road to recovery and readjustment has ended in a swamp.

The duration and severity of the symptoms of grief are also a matter of dispute in distinguishing between normal and complicated grief (Horowitz *et al.,* 1995), but the solution of a panel of researchers (Prigerson & Jacobs, 2001) was that of considering the duration of symptoms which have lasted for at least two months, rather than focusing on the length of time that has lapsed since the death.

Watson *et al.* (2005:755) mention some of the warning signs of complicated grief which, to an extent, correspond with the risk factors of complicated grief; long-term functional impairment, exaggerated and prolonged grief reactions, neglect of self-care, themes of loss in conversation, idealisation of the deceased, impulsive decision-making, mental disorders following loss and symptoms of Post Traumatic Stress Disorder (PTSD). Prigerson (2005:11)

furthermore clearly stipulates that complicated grief is not the only complication following death. Major Depression Disorder (MDD) and Post Traumatic Stress Disorder (PTSD) are two of the most common disorders which might follow from bereavement. This explanation by Prigerson (2005:11) and Watson *et al.* (2005:755) emphasizes the necessity for screening clients for complicated grief before including them in an intervention programme. This will determine whether the client is indeed experiencing complicated grief.

The research findings of Barclay and Lie (2005:2) suggest that complicated grief be regarded as a specific condition in need of specific treatment. This is certainly true for South African citizens, especially when one considers the limited research done on this topic in South Africa. The research done by Opperman (2004) was the only documented research found on complicated grief in South Africa. The research which is currently conducted by the author of this article is aimed at developing of a therapeutic complicated grief intervention programme. The aim is also to involve South Africans from all cultural groups to participate in the research. For purposes of this study it is, however, necessary to screen clients for complicated grief before including them in an intervention programme.

The researchers utilize two instruments in the screening process: the Inventory of Traumatic Grief (ITG) (Prigerson & Jacobs, 2001:638–645) and a self-developed Grief Assessment Guide (GASsG). These two instruments are discussed in more detail in the following paragraphs.

4.1. The Inventory of Traumatic Grief (ITG) (Appendix 2)

Much has already been said in this article regarding complicated grief as a distinct disorder to be included in the Diagnostic and Statistical Manual of Mental Disorders. The quantification of complicated grief is still an underdeveloped area. Although attempts have been made to quantify the intensity of grief, relatively few questionnaires have been developed to specifically measure complicated grief, mainly due to the complexity of

distinguishing between normal and complicated grief (Boelen, *et al.*, 2003:228).

Prigerson *et al.* (1995) played a vital role in this regard. The authors developed the Inventory of Traumatic Grief (ITG) (Boelen *et al.*, 2003; Kritjanson *et al.*, 2006; Prigerson & Jacobs, 2001). The ITG is an expansion of the Inventory of Complicated Grief (Prigerson *et al.*, 1995) and is specifically designed to measure symptoms of grief that are expected to prolong and complicate grief.

The ITG (Table 1) is a 30-item self-report questionnaire in which respondents are requested to rate the degree to which the symptoms represented in the items applied to them in the past month on five point scales (Prigerson & Jacobs, 2001). The items representing the frequency of symptoms range from "almost never" to "always", while the items representing the symptoms range from "no sense" to "an overwhelming sense". The total score is a summation of the scores for all items.

The inventory of traumatic grief is divided into four criteria with subdivisions (Table 1) (Prigerson & Jacobs, 2001).

- Criterion A1 is a prerequisite for complicated grief – the person must have experienced the death of a significant person.
- Criterion A2 addresses the aspects of separation distress and includes symptoms such as intrusive thoughts, searching, yearning, and loneliness as a result of the death. This criterion is divided into five questions of which at least three must reach a score of four or more.
- Criterion B defines symptoms of traumatic distress and represents bereavement-specific manifestations after having been traumatised by the death of a loved one. This criterion includes, amongst others, avoidance of reminders of the deceased; purposelessness; numbness; difficulty to acknowledge the death, fragmented trust, and anger. This criterion is divided into twelve questions of which at least six must reach a score of four or more.

- Criterion C concentrates on the duration of the symptoms which must have occurred for at least two months, and
- Criterion D applies to the social, occupational or other areas of functioning. The answer must indicate marked and persistent dysfunction (score of four or more).

Criterion D is of vital importance, seen from a social worker's viewpoint. Impaired social functioning is often the stage when a social worker would become involved and when s/he would be able to recognize impaired social functioning as a result of complicated grief. Kristjanson *et al.* (2006:34) is of opinion that the Inventory for Traumatic Grief demonstrates good convergent and criterion validity. It is also an easy tool to administer.

4.2. Grief Assessment Guide (GASsG) (Table 2)

Assessment is a critical process in social work; thus it also plays a valuable role in screening clients for inclusion in a complicated grief intervention programme as well as in determining and conducting complicated grief intervention. Hepworth, Rooney and Larsen (2002:187) define assessment as follows: *"Assessment involves the gathering of information and the formulation of that information into a coherent picture of the client and his or her circumstances. Assessment includes our inferences about the nature and causes of clients' difficulties, and thus they serve as the basis for the rest of our work with the client – the goals we set, the interventions we enact, and the progress we evaluate."* But, assessment not only includes what is wrong with the client. It also looks at the strengths, available resources, internal and external motivations, and other positive factors (Zastrow, 1992:56).

Social work intervention in utilising the strengths of the client is promulgated by authors such as Hepworth *et al.* (2002); Saleebey (2006); Zastrow (1992). The question to be answered by social workers is: "How do we find the client's strengths in complicated grief and how do we make the client aware of these strengths amidst the agony of complicated grief?"

A Grief Assessment Guide (GASsG) (Table 2) was developed in an attempt to guide social workers in providing answers to the afore-mentioned question. The GASsG is mainly aimed at continuous assessment of the strengths and stressors during bereavement intervention. The GASsG allows the social worker to assess strengths and stressors in the following areas: physical, psychological, spiritual and social. This information is mainly gathered from the narrative given by the client by means of a guided interview. Salkind (2006:190) rightly states that interviews are used "when we want to get to know the story behind the story". The social worker thus relies on the participants' understanding of their complicated grief through narratives and questions, rather than relying on standardised measures (Opperman, 2004:270). The social worker is not restricted to a particular set of questions, but to specific subject areas (Salkind, 2006:191). The GASsG is supported by the interview and serves as a guideline for the social worker during the interview. It assists the social worker in ensuring that all the possible complicated grief factors are explored and enables him/her to address the specific needs of the client regarding complicated grief.

The GASsG is intended to be utilised throughout the intervention in setting intervention objectives which are derived from the initial narrative as presented by the client. The GASsG also serves as a guide to determine whether or not the therapeutic objectives have been met. It is intended that the GASsG be utilised in collaboration with the client, and not as a guideline to be utilised and seen by the social worker only.

Although the GASsG was developed with the intention to assess the client in terms of complicated grief, this guideline also contains an element of measurement which allows the social worker to assess the severity of the impact of the component on the social functioning of the client and to ascertain whether change has taken place over the period of intervention. However, the reliability and validity of the GASsG as a measurement tool was not established.

5. SCREENING CRITERIA FOR INCLUSION IN A THERAPEUTIC COMPLICATED GRIEF INTERVENTION PROGRAMME

In most instances, death of a loved one is a devastating experience, be it anticipated or sudden death. The emotional and practical consequences have a tendency to cause an imbalance in the life of the bereaved, also influencing other individuals directly in contact with the bereaved. Complicated grief develops when this imbalance tends to be prolonged. The research findings of Barclay and Lie (2005:2) suggest that complicated grief must be regarded as a specific condition in need of specific treatment. Prigerson (2005:11) also refers to research which has identified a set of symptoms, distinct from other psychiatric disorders, which typify complicated grief.

Raphael *et al.*, (2002:587) highlight the necessity for screening clients prior to inclusion in a therapeutic programme. These authors ask the following questions: *"What systematic, replicable, and valid assessments indicate that intervention is needed, what guidelines should systematically influence what is done; by what measures are outcomes and effectiveness evaluated?"* Without screening, interventions will be applied randomly and will be without measurable objectives to be reached.

The individual suffering from complicated grief is an emotionally vulnerable human being and various factors, such as ethics, recruitment and research inclusion criteria are taken into account during the screening process so as not to emotionally harm the bereaved individual.

5.1. Ethics

Research on bereavement related topics needs to address ethical issues as priority. The rights and dignity of a participant must be taken into account at all times (Stroebe, Stroebe & Schut, 2003:237). Doka (2005:90) is of opinion that ethical dilemmas never arise in a vacuum and adds the

following: "*Culture, technology, social and individual values, spiritual and religious traditions and legal struggles are among the many factors that frame ethics.*" This is of special importance in the diverse South African culture.

The basic ethical principles for professionals are utilized as the guidelines in the screening of clients for inclusion in a complicated grief intervention programme. These principles are outlined by Cook (2001:120) and are as follows: autonomy (freedom to choose), nonmaleficence (do no harm), beneficence (promoting good), justice (fairness), fidelity (establishing trust and commitment), and veracity (truthfulness). These principles are all endorsed by the general ethical standards of the South African Council for Social Service Professions (2004:11).

Thus with autonomy in mind, a participant's written consent is necessary before s/he can be included in this study. The participants also have a choice to withdraw from the programme at any stage without having to explain the reason for doing so. Stroebe *et al.* (2003:239) conclude in this regard that the researcher is an intruder in the world of the bereaved and must therefore respect the decision of a bereaved person not to partake in a research project, or to withdraw at any stage.

In an attempt to avoid causing harm unknowingly, the researchers assess the following potential risks associated with the study: confidentiality, unanticipated disclosure, violation of cultural norms, and the stigmatisation of receiving therapy for not being "able to cope".

5.2. Recruitment

Bereavement research can easily lead to emotions which the bereaved thought s/he had already dealt with. Therefore aspects such as the recruitment methods, the timing of recruitment and the circumstances related to the loss as well as the influence of culture are taken into consideration during the screening process.

Stroebe *et al.* (2003:239) refer to this matter by asking the following question: "How and how soon can we approach bereaved people to participate in research?" Stroebe *et al.* (2003:239) suggest that the bereaved person must always have a choice to participate in research and to withdraw from the research at any stage. Anonymity and confidentiality are two of the most important aspects to be honoured by the researcher in bereavement research.

Cook (2001:124) asks a few relevant questions regarding bereavement research on or near an anniversary date:

- "Should these dates be avoided when conducting research? and
- Should research still be undertaken on or near these dates?"

This study aims to include only individuals who have suffered a death-related loss at least fourteen (14) months prior to the research, thus affording the bereaved an opportunity of having experienced the first anniversary dates before being included in the study.

5.3. Criteria for inclusion as a participant in the study

The following are utilized as inclusion criteria during the screening process for the current study:

- There must be an indication of complicated grief according to the Inventory of Traumatic Grief (ITG) (Appendix 2). This inventory was developed by Prigerson (1995) and initially named the Inventory of Complicated Grief (ICG). It was later refined by Prigerson, Kasl and Jacobs who renamed it to the Inventory of Traumatic Grief (ITG) (Prigerson & Jacobs, 2001:638). Prigerson and Jacobs (2001:628) describe this tool as a self-report which scores the severity of symptoms. This tool also allows the social worker to select respondents by looking at the impact of death on the social functioning of the respondent.

- The time of death must be at least fourteen (14) months prior to inclusion in the programme and the elements of complicated grief must have been present for at least two months. The researchers support Horowitz *et al.* (1997:905) who insists that a period of 14 months should have elapsed between bereavement and the diagnosis of complicated grief. A panel of researchers, however, is of opinion that a two-month duration of symptoms should be the focus for determining complicated grief, rather than the length of time that has lapsed since the death occurred (Prigerson & Jacobs, 2001:622). The researchers do not aim at making a diagnosis, but are merely assessing the existence of elements of complicated grief in the screening process.

- The client must be over the age of 21. The researchers prefer the individual to be in a position to give consent to be included in the study and not rely on parents to decide whether s/he could participate in a research programme. At the time of the research, South Africans were considered to come off age at the age of 21.

- The client must be a South African citizen. The research is aimed at developing a complicated grief intervention programme within the South African context and therefore needs to focus on South African citizens.

- The client must be able to speak and understand English or Afrikaans. South Africa is in the unique position of having eleven official languages. The researchers are able to speak two of the languages, English and Afrikaans; thus already placing a restriction on the bereaved in South Africa who do not speak the mentioned two languages.

- The client must not have a history of depression or mental illness prior to the death of the significant other person. Complicated grief intervention includes bereavement-related depression, and the

existence of pre-loss depression might influence the research outcome. Raphael *et al.*. (2001:605) is of opinion that high levels of pre-existing psychiatric vulnerability or ongoing treatment of psychiatric disorders will be critical to intervention outcome.

- The client must not simultaneously be involved in any other intervention programme, as this may have an influence on the reliability of the outcome of this study.

The inclusion criteria are an attempt to eliminate factors which could negatively influence the outcome of the study.

6. CONCLUSION

This article discussed the methods of screening clients for complicated grief before inclusion in a complicated grief intervention programme. It also emphasized the necessity of social work assessment to ascertain strengths and stressors of the client. The Grief Assessment Guide (GASsG) is an assessment guideline developed to assist the social worker and the client through this process.

From the discussions above, it clearly seems to be necessary to screen clients for complicated grief before including them in a therapeutic complicated grief intervention programme. This ensures that only clients who are experiencing elements of complicated grief, and not those with normal grief reactions or other disorders, such as Major Depressive Disorder (MDD) and Post Traumatic Stress Disorder (PTSD), are included in the programme.

Screening South African clients for inclusion in a complicated grief intervention programme is mainly made on ethical considerations. It involves aspects such as the individual's choice to participate and ensures that no harm is done by including only those with an indication of complicated grief.

The Inventory of Traumatic Grief (ITG) as standardised measure and the self-developed Grief Assessment Guide (GASsG), which are completed according to the narratives of the clients, are utilised in this study; thus combining quantitative and qualitative research in an attempt to find answers to the research questions.

TABLE 1:

Inventory of Traumatic Grief (ITG)

Criterion A

1. Person has experienced the death of a significant other.

2. Response involves 3 of the 4 symptoms below experienced at least sometimes:

2a. Intrusive thoughts about the deceased

2b. Yearning for the deceased

2c. Searching for the deceased

2d. Loneliness as a result of the death

Criterion B *- In response to the death, 4 of the 8 following symptoms experienced as mostly true:*

1. Purposelessness or feelings of futility about the future

2.Subjective sense of numbness, detachment, or absence of emotional responsiveness

3. Difficulty acknowledging the death

4. Feeling that life is empty or meaningless

5. Feeling that part of oneself has died

6. Shattered world view

7. Assumes symptoms or harmful behaviors of, or related to, the deceased person

8. Excessive irritability, bitterness or anger related to the death

Criterion C

Duration of disturbance (symptoms listed) is at least two months

Criterion D

The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

(Prigerson & Jacobs, 2001:629)

TABLE 2:

GRIEF ASSESSMENT GUIDE (GASsG)

(This assessment guide is aimed at continuous assessment of the strengths and stressors during bereavement intervention.)

Name of client: _____ Assessment date/s: _____

Date of death: _____

LEGEND (Unless otherwise specified): 0 = no change in pre-death functioning.

4 = extreme change in pre-death functioning.

STRENGTHS / STRESSORS

PHYSICAL		PSYCHOLOGICAL		SPIRITUAL		SOCIAL	
Health concerns	0 1 2 3 4	Tearful for no reason	0 1 2 3 4	Involvement in faith community	0 1 2 3 4	Support system	0 1 2 3 4
Visits to physicians	0 1 2 3 4	Mental health problems	0 1 2 3 4	importance of faiths/beliefs	0 1 2 3 4	Social interaction	0 1 2 3 4
Activity level	0 1 2 3 4	Suicide ideation	0 1 2 3 4	Sense of meaning	0 1 2 3 4	Financial resources	0 1 2 3 4
Health status	0 1 2 3 4	Dependency	0 1 2 3 4	Signs of spiritual strengths	0 1 2 3 4	Legal concerns	0 1 2 3 4
Exhaustion	0 1 2 3 4	Anger	0 1 2 3 4	Satisfaction with funeral/ memorial ritual 0=satisfied 4=extremely dissatisfied	0 1 2 3 4	Day-to-day living concerns	0 1 2 3 4
Appetite	0 1 2 3 4	Guilt	0 1 2 3 4			Lifestyle changes	0 1 2 3 4
Weight gain/loss	0 1 2 3 4	Attitude towards life in general	0 1 2 3 4			Quality of relationship with deceased. 0=poor; 4=excellent	0 1 2 3 4

PHYSICAL		PSYCHOLOGICAL		SPIRITUAL	SOCIAL	
Physical appearance	0 1 2 3 4	Fear of death	0 1 2 3 4		Importance of visiting cremation/burial site. 0=none; 4= extremely important	0 1 2 3 4
Accidents	0 1 2 3 4	Fear of anniversary dates. 0=none; 4=extremely afraid	0 1 2 3 4		Excludes friends and family associated with deceased. 0=no exclusion; 4=total exclusion	0 1 2 3 4
Use of alcohol/substances	0 1 2 3 4	Searching 0=none; 4=constant searching	0 1 2 3 4		Unwillingness to move material belongings of deceased. 0 = no unwillingness; 4 = total unwillingness	0 1 2 3 4
Energy level	0 1 2 3 4	Yearning 0 =none; 4=constant yearning	0 1 2 3 4		Advanced preparation for death	Yes No
		Pre-death history of clinical depression	Yes No		Circumstances of death	Sudden Expected
		Currently engaged in bereavement therapy	Yes No			
		Experiencing same physical symptoms as deceased	Yes No			

REFERENCES

AMERICAN PSYCHIATRIC ASSOCIATION. 1994. Diagnostic and statistical manual of mental disorders (DSM-IV). 4th ed., text revision (DSM IV-TR) Washington, D.C. : American Psychological Association.

BARCLAY, L. & LIE, D. 2005 Complicated grief treatment may be better than interpersonal psychotherapy. Medscape. 1-5. Jul. [Web:] http://www.medscape.com/viewarticle/505772 [Date of access: 17 May 2006].

BOELEN, P.A., VAN DEN BOUT, J., DE KEIJSER, J., & HOIJTINK, H. 2003 . Reliability and validity of the Dutch version of the Inventory of Traumatic Grief (ITG). *Death Studies*, 27:227-247.

BOUTON, B.L. 2005. Responding to grieving families. Paper delivered at the 6th annual clinical team conference of the National and Palliative Care Organization (NHPCO) in Atlanta, Georgia. 21–23 April. (Unpublished).

COOK, A.S. 2001 The dynamics of ethical decision making in bereavement research. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research : consequences, coping and care.. Washington, D.C. : American Psychological Association. p. 119 -142.)

DOKA, K.J. 2005. Ethics, end-of-life decisions and grief. *Mortality*, 10(1):83-90, Feb.

HEPWORTH, D.H., ROONEY, R.H. & LARSEN J.A. 2002. Direct social work practice : theory and skills. 6th ed. Pacific Grove, CA : Brooks/Cole.

HOROWITZ, M.J., SIEGEL, B., HOLEN, A., BONANNO, G., MILBRATH, C. & STINSON, C. 1997. Diagnostic criteria for complicated grief disorders. *American Journal of Psychiatry*, 154(7):904–911.

KERSTING, K. 2004. A new approach to complicated grief. *APAONLINE*, 35(10):1-3, Nov. [Web:] http://www.apa.org/monitor/nov04/grief.html [Date of access: 25 July 2005].

KRISTJANSON, L., LOBB, E., AOUN, S. & MONTEROSSO, L. 2006. A systematic review of the literature on complicated grief. Australian Government Department of health and ageing. Commonwealth of Australia. [Web:] http://www.dcita.gov.au/cca [Date of access: 2 September 2007].

OPPERMAN, B.C.D. 2004. The influence of context on complicated grief. Johannesburg : RAU. (Dissertation – D.Litt.et.Phil.) 274 p.

OPPERMAN, B. & NOVELLO, A. 2006. The generation of hypothesis with regard to the influence of context on complicated grief. *South African Journal of Psychology,* 36(2):374-390.

PIPER, W.E., OGRODNICZUK, J.S. & WEIDEMAN, R. 2005. Screening for complicated grief: when less may provide more. *Can J Psychiatry*, 50:680-684. [Web:] http://www.cpa-apc.org/publications/archives/cjp/2005/0ctober/piper-OR.asp [Date of access: 10 August 2006].

PRIGERSON, H. 2005. Complicated grief : when the path of adjustment leads to a dead end. *Healthcare counseling & psychotherapy Journal,* 5(3):10-13.

PRIGERSON, H.G., SHEAR, K.S., FRANK, E., BEERY, L.C., SILBERMAN, R., PRIGERSON, J. & REYNOLDS, C.F. 1997. Traumatic grief: A case of loss-induced trauma. *American Journal of Psychiatry,* 154(7):1003-1009.

PRIGERSON, H.G. & JACOBS, S.C. 2001. Traumatic grief as a distinct disorder : a rationale, consensus criteria and a preliminary empirical test. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research : consequences, coping and care. Washington, D.C.. : American Psychological Association. p. 613–645.)

PRIGERSON, H.G., MACIEJEWSKI, P.K., REYNOLDS, C.F. BIERHALS, A.J., NEWSOM, J.T., FASICZKA, A., FRANK, E., DOMAN, J., & MILLER, M. 1995. Inventory of complicated grief : a scale to measure maladaptive symptoms of loss. *Psychiatry Research,* 59(1-2):65–79.

RAPHAEL, B., MINKOV, C. & DOBSON, M. 2001. Psychotherapeutic and pharmacological intervention for bereaved persons. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research : consequences, coping and care. Washington, D.C.. : American Psychological Association. p. 587-612.)

ROSENBLATT, P.C. 2001. A social constructionist perspective on cultural differences in grief. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research : consequences, coping and care. Washington D.C. : American Psychological Association. p. 285–300.)

SALEEBEY, D. 2006. Introduction: power in the people. (*In* Saleebey, D., *ed.* The strengths perspective in social work practice. 4th ed. Boston : Pearson. p.1-24.)

SALKIND, N.J. 2006. Tests and measurement for people who (think they) hate tests and measurement. London : Sage Publications.

SHEAR, M.K. & SMITH-CAROFF, B.S. 2002. Traumatic loss and the syndrome of complicated grief. *PTSD Research Quarterly,* 13(1):1-8.

SOUTH AFRICAN COUNCIL FOR SOCIAL SERVICE PROFESSIONS (SACSSP). 2004. *Policy guidelines for course of conduct, code of ethics and the rules for social workers.* Pretoria : SACSSP.

STATISTICS SOUTH AFRICA. 2005. Mortality and causes of death in South Africa, 1997–2003. Findings from death notification. Pretoria : Government Press.

STROEBE, M.S., & SCHUT, H. 2001. Models of coping with bereavement: a review. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research : consequences, coping and care. Washington, DC : American Psychological Association. p. 375-403.)

STROEBE, M.S., HANSSON, R.O., STROEBE, W., & SCHUT, H. 2001. Introduction: concepts and issues in contemporary research on bereavement. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *ed.* Handbook of bereavement research : consequences, coping and care. Washington, DC : American Psychological Association. p. 285–300.)

STROEBE, W. & STROEBE, M. 1994. Is grief universal? Cultural variations in the emotional reactions to loss. (*In* Fulton, R., & Bendiksen, R., *ed.* Death and identity. Philadelphia : Charles Press. p. 177–209.)

STROEBE, M., STROEBE, W., & SCHUT, H., 2003. Bereavement research : methodological issues and ethical concerns. *Palliative Medicine.* 17:235–240.

WATSON, M.S., LUCAS, C.F., HOY, A.M. & BACK, I.N. 2005. Oxford handbook of palliative care. Oxford N.Y. : Oxford University Press.

WORDEN, J.W. 1991. Grief counseling and grief therapy. A handbook for the mental health practitioner. 2nd ed. London: Routledge.

ZASTROW, C. 1992. The practice of social work. 4TH ed. California : Wadsworth Publishing Company.

ARTICLE 3

A COMPLICATED GRIEF INTERVENTION MODEL

CM Drenth is a PhD student at the School of Psychosocial Behavioral Sciences (Social Work) at the North–West University (Potchefstroom Campus).
H Strydom is Professor and Head of the Social Work Division. AG Herbst is a Senior Lecturer (Social Work) at the North–West University (Potchefstroom Campus).

Key words:
Grief, complicated grief, Task-Centred approach, Dual Process Model (DPM), Complicated Grief Intervention Model (CGIM).

Abstract:
Complicated grief intervention in South Africa is a neglected area, specifically within the South African context. Complicated grief refers to a prolonged state of grief and indicates an inability of the client to incorporate the death into his/her life. Few social workers in South Africa assess the possibility of complicated grief as contributing factor to impaired social functioning. This can be as a result of limited knowledge, ignorance and/or insufficient skills on the part of the social worker to assess and identify complicated grief. In this article the researchers tabulate some of the models and approaches to bereavement and discusses its applicability to complicated grief Specific attention is given to the Dual Process Model (Stroebe & Schut, 1999) and the Task-Centred approach (a social work approach to therapy) in an attempt to develop a model for complicated grief intervention. This article furthermore proposes the Complicated Grief Intervention Model (CGIM) through the integration of the Dual Process Model and the Task-Centred approach while drawing on intervention techniques from other therapeutic approaches.

A COMPLICATED GRIEF INTERVENTION MODEL

"We cannot teach people anything, we can only help them to discover it within themselves." *(Galileo Galilei)*

1. INTRODUCTION

Complicated grief intervention in South Africa is a neglected area, specifically within the social work profession. Complicated grief is described by Kristjanson, Lobb, Aoun and Monterosso (2006:10) as grief which "occurs when integration of death does not take place". Reasonable time must, however be allowed for normal grief before assuming that a person is experiencing complicated grief. The afore-mentioned authors agree with allowing at least 14 months post-loss, as indicated by Horowitz, Siegel, Holen, Bonanno, Milbrath and Stinson, (1997) before attempting to assess the client for elements of complicated grief. Even then, it must be kept in mind that the symptoms must have been present for at least the last 2 months (Prigerson & Jacobs, 2001).

Few social workers in South Africa assess the possibility of complicated grief as a contributing factor to impaired social functioning. This may be attributed to the following factors as was observed by the authors of this article: the complicated grief knowledge base of social workers is limited; social workers are ignorant of the impact of complicated grief on the social functioning of an individual; social workers do not trust their own emotions when dealing with complicated grief; or social workers do not have sufficient skills to intervene when complicated grief is indicated.

The matters mentioned in the previous paragraph, give rise to ethical and effective practice in social work. If social workers do not include the impact of the death of a loved one during assessment, how ethical and effective is the service? The authors are of opinion that a complicated grief intervention

model will add to better understanding of the client and that it will also enhance ethical and effective social work practice in South Africa, specifically when one considers the impact of multiple losses (AIDS), socially unspeakable deaths (suicide) and crime-related deaths.

2. *PROBLEM STATEMENT*

Various bereavement intervention programmes were developed in the final quarter of the twentieth century ranging from bereavement self-help groups to therapy for people who experienced complicated grief. Researchers, however, have made the statement that some grief intervention efficacy studies turned out to be disappointing and negative (Jordan & Niemeyer, 2003:765; Schut, Stroebe, Van den Bout & Terheggen, 2001:705). Jordan and Niemeyer (2003:767-770) refer to studies done by Allumbach and Hoyt, Kato and Mann, as well as Niemeyer. Allumbach and Hoyt ascribe the low effect of bereavement intervention to the following: a general ineffectiveness of grief counselling; the low statistical power of many of the bereavement studies, or; one or more variables that masked the real effects of the intervention. Kato and Mann give the following reasons for the disappointing effect: interventions for the bereaved are simply not helpful; they are not powerful enough (too few sessions) and that the positive effects are masked by methodological issues (Jordan & Niemeyer, 2003:768).

This confirmation that complicated grief intervention, as opposed to bereavement counselling, is more likely to have positive results, urged the researchers to search for a specific complicated grief intervention model to be able to answer the following research question:

How can the social worker assist the client with complicated grief?

A thorough search for a complicated grief intervention model in the South African literature revealed no such model.

3. AIM

This article aims at giving a condensed literature review on the most significant bereavement models, or approaches. Specific attention is given to the Dual process Model (DPM) and the Task-Centred approach (a social work intervention approach). The article furthermore proposes a Complicated Grief Intervention Model (CGIM) through the integration of the Dual Process Model (DPM) and the Task-Centred approach while drawing on intervention techniques from other models of therapy. The objective for this article is to propose a complicated grief intervention model in an attempt to obtain answers to the research question mentioned above.

4. LITERATURE REVIEW

Literature on bereavement/ grief models ranges from stages, phases, grief work, tasks, attachment, continuing bonds to oscillation between loss-orientation and restoration-orientation (Fleming & Robinson, 2001; Kristjanson *et al.,* 2006; Lightbody, 2005; Martin & Doka, 2000; Parkes, 2001; Silverman & Klass, 1996; Stroebe, 2002; Stroebe & Schut, 1999; Worden, 1991). Literature on some of the most important models/ perspectives is summarized in Table 1.

TABLE 1:
Models of Bereavement and applicability to complicated grief

MODELS/ PERSPECTIVES	COMPONENTS	CRITIQUE	APPLICABILITY TO COMPLICATED GRIEF
Psychoanalytic / grief work Freud	- Emphasizes the necessity to break attachment bond - Never tested his research with regards to bereavement - Necessary to include reality of death to avoid complication of death awareness	- Absence of empirical evidence is questioning its effectiveness - This model perceives that the absence of affect constitutes pathology	- Limited applicability.
Stages Lindeman Kübler-Ross	3 Stages: - Shock and disbelief - Preoccupation with image of deceased - Reenters daily life 5 Stages: -Shock and denial -Anger -Bargaining -Depression -Acceptance	- The stages theory implies that all individuals grieve in the same manner - It gives the impression that grieving is an orderly process - It only focuses on psychological reactions, neglecting the physical, spiritual and social components. - Absence of affect during the grieving process is perceived as pathological	This perspective has limited significance in the sense that it only provides a basic background to some of the emotions attached to the normal process of grieving. It does not include the possibility that individuals can grieve without displaying emotion. Complicated grief is not addressed as such in the stages theories, although Lindeman was one of the first people to note deviations from "normal" grief, but fails to recognize the importance of chronic/ complicated grief.
Phases Bowlby Rando	-Grief is a psychological process which leads to relinquishing the deceased. -Describes phases to compensate for limitations of stages theories: - Numbness - Disbelief and trying to reverse the outcome - Disorganization and reorganization. Introduced early attachment patterns and adult attachment styles. Attachment theory works on the principle of the child's attachment to the mother. - Identifies 3 phases: • Avoidance phase - Recognize the loss • Confrontation phase - React to the separation - Recollect and re-experience the deceased and the relationship - Relinquish the old attachment to the deceased and the old assumptive world • Accommodation phase - Readjust to new world without forgetting the old - Re-invest in new relationships	-The uniqueness of individual grieving patterns does not come clear. -Limited referral to physical, spiritual and social context of grieving. - Concentrates on the display of emotions and does not include the individual who grieves without displaying emotions.	Limited significance in that it is more focused on emotions rather than including all aspects affected by the death of a significant person, such as physical, spiritual and social implications. Of greater significance is the introduction of attachment patterns and attachment styles. Of relevance is the impact of childhood bereavement on attachment patterns or how these patterns impact on end-of-relationship adjustment.
Task model Worden	Four Tasks: -Accept the reality of the loss -Work through the pain of grief -Adjust to an environment without the deceased	Worden recognizes that delayed or disenfranchised grief can lead to complicated or chronic grief. Complicated grief is identified when a person is stuck and experiences	Very applicable when intensity and duration of adjustment are included. The tasks add a framework for complicated grief intervention in explaining the

MODELS/ PERSPECTIVES	COMPONENTS	CRITIQUE	APPLICABILITY TO COMPLICATED GRIEF
	-Emotionally relocate the deceased and move on with life	difficulty moving on to the next task– therapist relies on experience to ascertain whether client is experiencing complicated grief.	process to the client and in developing an understanding of affect, cognitions, spirituality and social adjustment.
Martin & Doka	Added a fifth task: - Reconstruct faith or philosophical systems challenged by loss. Martin and Doka emphasize patterns of grief and identify two types of grievers: intuitive and instrumental	Doka assists in the afore-mentioned process with an explanation of grief patterns.	Significance lies in distinguishing between different patterns of grief to ensure an effective therapeutic intervention programme for each individual. The Grief Pattern Inventory (Martin & Doka, 2000: 167) is a useful instrument.
Dual Process Model Stroebe and Schut	A model of adaptive coping with bereavement. Two processes in adaptation to loss: Loss-orientation and restoration-orientation.		Focuses on emotional aspects as well as practical aspects such as new roles, finances, housing, and overall social functioning. Takes adjustment to all aspects into consideration. Holistic approach.

The models of bereavement mentioned in Table 1 give a brief overview of the development of models and approaches in the field of grief and bereavement.

It is common knowledge that most deaths occur in the age group 65 and older in the majority of communities. Zhang, El-Jawhari and Prigerson (2006:1188) are of opinion that the frequent experience of the death of friends and relatives as they grow older, gives rise to the tendency among clinicians to "normalize and potentially dismiss the distress and disruption evoked by bereavement". But Zhang *et al.* (2006:1188) refer to the fact that research has proven that the death of a loved one is among the most stressful experiences in life. The same authors accentuate the need for clinicians to be able to: distinguish between complicated and uncomplicated grief reactions, identify risk factors for complicated grief and take informed actions to prevent and intervene in order to minimize complications in the grieving process.

Schut *et al.* (2001:731) grouped bereavement interventions into three categories:

- Primary preventive interventions which focus on people who are experiencing normal grief;
- Secondary preventive interventions which focus on people at risk of complications of bereavement;
- Tertiary preventive interventions which focus on those experiencing complicated grief.

The focus for purposes of this article is on the tertiary preventive interventions.

Kristjanson *et al.* (2006:72) contend that most bereavement services to date have been undertaken in a trial-and-error manner, while Bouton (1996;5) recommends the development of bereavement programmes to allow service providers to tailor services. It is with this recommendation in mind, and the researchers own interest that the Complicated Grief Intervention Model (CGIM) was developed.

The Dual Process Model (DPM) (Stroebe & Schut, 1999) as a bereavement model and the Task-Centred intervention approach were utilized in combination to develop the proposed Complicated Grief Intervention Model (CGIM). The Dual Process Model and the Task-Centred approach will thus be explained briefly under the following two headings, before elaborating on the CGIM.

5. THE DUAL PROCESS MODEL OF COPING WITH BEREAVEMENT

The Dual Process Model of Coping with Bereavement was developed by Stroebe and Schut (1999) and describes ways in which people adapt to their grief. The grieving individual occasionally confronts and sometimes avoids the cognitive and emotional processes (Matthews & Marwit, 2004:853). The mentioned model constitutes that a bereaved person's emotions and behaviour oscillate between two distinct domains – loss-orientation and restoration-orientation; thus meaning that a person deals with two different types of stressors in the grieving process. The first domain (stressor), *loss-orientation coping,* refers to activities that deal with separation from the deceased and includes crying, missing, yearning, remembering as well as other activities dealing with the loss itself. The person thus concentrates on the loss and attempts to process the loss experienced. The grief work concept falls within this area of the model. The attachment theory regarding the nature of the lost relationship and the value of grief work are consistent with the loss-orientation concept. Positive and negative emotions are experienced, from happy memories, to painful longing. *Restoration-orientation coping* does not refer to the outcome, but to what needs to be dealt with and how to deal with it. It emphasizes the secondary stressors of bereavement. It also refers to the adjustment to the loss in all areas of

social functioning, for example social isolation and loneliness, and role changes (e.g. from "spouse" to "widow"), all with the accompanied emotional reactions. In this domain the mourner is forced by circumstances to "carry on with life", while s/he actually wishes to stop the world, get off for a while, and then jump on again when s/he is ready to face a life without the deceased.

The Dual Process Model of Coping with Bereavement (Matthews & Marwit, 2004; Shaver & Tancredy, 2001; Stroebe & Schut, 1999; Stroebe & Schut, 2001; Zhang *et al.,* 2006) is found to be the most appropriate for complicated grief intervention, and is described as a model of flexibility, rather than a phases or stages model. The mere fact that it not only addresses the emotional side of bereavement, but also includes the practical issues and demands of grief, makes it the ideal model for social workers whose main focus is the effective social functioning of a client. The model enables the social worker and the client to see the "bigger picture" of moving from complicated grief to an (for the client) acceptable level of social functioning. It allows the client to grieve according to his/her own grief pattern and it allows the client to take "time-out" from grief. The model empowers the client by assisting him/her in taking control again, be it control over new roles or control over aspects which were severed by the loss of the loved one. The Dual process Model enables the social worker to understand what types of cognitions bereaved individuals are experiencing, and how they are regulated throughout the course of bereavement (Matthews & Marwit, 2004:853).

The Dual Process Model (Stroebe & Schut, 1999) acknowledges the task model of Worden (1991), but extends the tasks. The views of these two researchers are compared in Table 2 in an attempt to integrate the concepts of loss-orientation and restoration-orientation with regard to the tasks of grief.

TABLE 2:

Comparison of tasks in complicated grief

	WORDEN (Task Model)	STROEBE & SCHUT (Dual Process Model)
1.	To accept the reality of the loss (Loss-orientation)	To accept the reality of the changed world (Loss-orientation/ restoration-orientation)
2.	To experience the pain of grief (Loss-orientation)	To take time off from pain and grief (Time-out)
3.	To adjust to an environment in which the deceased is missing (Loss-orientation/ Restoration-orientation)	To reconstruct the environment (Restoration-orientation)
4.	To relocate the deceased emotionally and move on with life (loss-orientation)	To develop new roles, identities and relationships (Restoration-orientation)

The concept of oscillation, which refers to *"the alternation between loss- and restoration-orientation coping, the process of juxtaposition of confrontation and avoidance of different stressors associated with bereavement"* (Stroebe & Schut, 1999:215) forms the core of the Dual Process Model. Rando, as quoted by Silverman and Klass (1996:14) says the following: "*In all forms of complicated mourning, there are attempts to do two things: (1) to deny, repress, or avoid aspects of the loss, its pain and the full realization of its implications for the mourner; and (2) to hold onto, and avoid relinquishing, the lost loved one."* This can easily be incorporated in the loss-orientation and restoration-orientation components of the Dual Process Model (Stroebe & Schut, 1999). The bereaved will at times be emotionally and practically confronted with the loss and at times avoid the loss. This avoidance must rather be seen as "time-out" and not denial of the process. During these periods of "time-out", no elements of grieving are observed. The Dual Process Model allows for a back and forth movement between painful thoughts about the loss and future-oriented thoughts such as the need to carry on with life (Shaver & Tancredy, 2001:66).

In summary, the following aspects are highlighted during loss-orientation: grief work; intrusion of grief; breaking bonds/ties/relocation of the deceased person; and denial/avoidance of restoration changes. Restoration-orientation, on the other hand, refers to: attending to life changes; doing new things; distraction from grief; denial/avoidance of grief; and new roles/identities/relationships (Stroebe & Schut, 2001:396).

The Dual Process Model of Coping with Bereavement has definite value for inclusion in the social worker's frame of mind. It includes a dynamic process of coping which refers to the social functioning of the mourner. It includes the total well-being of the mourner and not only one aspect such as the relationship to the deceased as is depicted by many of the other bereavement models.

6. A TASK-CENTRED APPROACH TO COMPLICATED GRIEF INTERVENTION

It is increasingly being expected of social workers to treat individuals in a brief and focused manner (Eaton & Roberts, 2002:95).

Intervention is an integral social work role. Watson and West (2006:51) state that social workers often lack structured planning in their intervention. The intervention then becomes reactive and responds only to specific events or crises. The utilization of methods of intervention provides the opportunity to structure and plan the intervention (Ligon, 2002:96; Watson & West, 2006:51).

Up until the 1970's social workers concentrated on psychosocial casework, after which a gradual movement towards more short-term methods of intervention were identified. The emphasis shifted from the unjust and unequal nature of society to locating the source of the problem and finding the solution in the client (Milner & O'Byrne, 1998:131; Watson & West, 2006:52). It is at this stage that time-limited intervention in social work was introduced. Ligon (2002:97) mentions four essential challenges when working in a time-limited manner:

- "Problems are a normal part of life, not signs of dysfunction or pathology.
- The purpose of therapy is to find solutions, not meaning or insight.

- Social workers believe people and circumstances can change and communicate this to their clients.
- Therapy uses what the client brings – it has value and purpose".

Intervention thus becomes more solution-focused than problem-focused.

Watson and West (2006:53-54) compiled a list of intervention methods which gives a brief overview of potentially useful intervention methods for the social worker. The Task-Centred approach was chosen as supplementary to the Dual Process Model in developing the Complicated Grief Intervention Model (CGIM) for the following reasons (Doel, 2006; Milner & O'Byrne, 1998; Reid & Fortune, 2002; Watson & West, 2006):

- The client knows, or has an idea of where the problem lies and wishes to find a solution. Complicated grief becomes the presenting issue and not the client in person. This in itself is a move away from the "pathology of complicated grief".
- The approach is a short-term design (6 to 12 sessions within a four-month period). It may be limited or extended according to the desired outcome.
- It gives the client a sense of control in the intervention process. Assessment information is shared with the client to ensure commitment and partnership and to develop his/her problem-solving skills. Watson and West (2006:75) are of opinion that dependency is reduced as the client is able to decide what can or cannot be achieved.
- A partnership between the worker and the client is established and the client chooses the tasks which s/he is ready to encounter. The client is the main agent of change in this model.
- The relationship is caring and collaborative.
- It allows the client to visualize the outcome within realistic parameters.
- It empowers the client, especially when successes with tasks become evident.
- It relies on the systematic collection and verification of data from the client him/herself.
- The social worker is allowed to use any interventions which may be effective to bring about change, and which is ethical and relevant.

The Task-Centred approach is a time-limited solution-focused approach to social work. The social worker searches for information on causes and solutions in the *present* situation, but does not negate past experiences (Milner & O'Byrne, 1998:134). The social worker identifies the factors which are aimed at the solution. It involves the completion of achievable and mutually agreed tasks or solution-focused activities. The approach draws selectively on theories and methods of compatible approaches (Reid & Fortune, 2002:101; Watson & West, 2006:54). The Task-Centred approach was initiated and created specifically for social work (Doel, 2006:193; Watson & West, 2006:73). It has the added advantage that it is an effective approach to use with diverse cultural groups.

The Task-Centred approach is an *active* approach in that tasks are negotiated and well planned, implemented and has a specific purpose (Ligon, 2002:98; Milner & O'Byrne, 1998:134). The tasks are the means to an end, the stepping stones towards the ultimate goal. Tasks are more than just physical actions. It can be something such as a client log, cognitive reflections or mental lists. It is the role of the social worker to guide the client through setting realistic targets and to assist the client in breaking these down into achievable targets. Once the tasks are set, both parties enter into an agreement (which preferably needs to be in writing) in terms of who does what, when and why (Doel, 2006:195). The agreement should ideally also specify the frequency of appointments, the venue, the date for the final assessment and the renegotiation of goals if necessary. It is encouraged that the client be empowered to perform most of the tasks, either alone or with the assistance of the social worker. Doel (2006:195) states that the Task-Centred encounter should have the "feel of a highly participative workshop". The advantage of this is that the client gains confidence and improves his/her problem-solving skills.

In the implementation phase of the Task-Centred approach, the tasks are broken down into manageable actions. The social worker has the responsibility to support and enable the client to take as much responsibility as s/he is capable of. Planning plays a crucial role in the Task-Centred approach and the detail of who, what, where and when will have to be discussed in detail between the social worker and the client. Using techniques such as role plays, rehearsals, modelling and visualization is

of great assistance before engaging in a task (Reid & Fortune, 2002:102; Watson & West, 2006:77).

7. THE COMPLICATED GRIEF INTERVENTION MODEL (CGIM)

The theoretical foundation of the Complicated Grief Intervention Model (CGIM) is based on an eclectic and integrative approach. Therapeutic models of practice, such as cognitive-behavioural, narrative and solution-focused models form the basis of intervention in the proposed Complicated Grief Intervention Model. The CGIM is not aimed at the social worker's intellectual ability, but at the skill to openly work with the client to restore social functioning after the loss of a loved one. The CGIM is also aimed at releasing a client's own skills and capabilities to achieve the desired outcome.

The researcher shares the view of Watson and West (2006:9) that *"in an occupation such as social work, the process (what we do) is as important as the outcome (what is achieved)."* The desired outcome of intervention might not be achieved if the effect of complicated grief on the social functioning of the grieving person is ignored or denied.

The proposed CGIM is seen as tertiary preventive intervention (Schut *et al.,* 2001:731) and is based on an integration of the DPM (Stroebe & Schut,1999) and the Task-Centred Model (Doel, 2006; Ligon, 2002; Reid & Fortune, 2002; Watson & West, 2006). The CGIM draws on intervention techniques from other approaches and theories such as the cognitive-behavioural, solution-focused and narrative theories. A brief description of these approaches is necessary for clarification.

- **Cognitive-behavioral therapy** refers to intervention which targets the observable and changeable behaviour of a client (Brown, 2006; Cigno, 2006:186; Vonk & Early, 2002:116; Watson & West, 2006:82). Assessment is crucial in behavioural social work as it takes the manifestation of behaviour and what needs to be changed into account. Frequency and intensity of behaviour leads to clarity of information of what is happening, and how often. Client logs or diaries are examples of how the frequency and intensity can be measured. Once the

baseline is established through the measurement, intervention can be planned. Intervention is aimed at behaviour, as well as at thoughts and feelings and the impact thereof on behaviour. Cognitions such as "I miss her every day", and "I am a single person in a 'couple' society", are but two bereavement-related examples the social worker often is confronted with. Matthews and Marwit (2004:859) are of opinion that Cognitive-behavioural therapy might not be enough to address grief. It is therefore necessary to integrate different practice models in assisting the client to incorporate the loss of a loved one into his/her life.

- **Narrative therapy** aims at assisting the client in deconstructing the stories of their lives by firstly understanding it and then broadening and challenging them by creating new realities (Kelley, 2002:121; Reyneke, 2004:130). Thomas (2000:301) is of opinion that the self-conception, relationships and life experiences become meaningful once the client is allowed to tell his/her story. Key concepts of narrative therapy are externalizing the problem; problem-saturated stories; mapping the problem's domain; unique outcomes; and spreading the news (Kelley, 2002:122). Narrative therapy plays a role in complicated grief intervention. Bowman (1999:179) excellently describes the use of narrative therapy as follows: *"The creation of a new identity after loss can require grieving who or what we were – an earlier story – as a prerequisite for the new or adapted story".*

- **Solution-focused therapy:** The aim of solution-focused therapy (SFT) is to identify solutions to problems (Cooper & Lesser, 2002:193; De Jong, 2002:112) by utilizing existing coping mechanisms and skills to resolve new challenges (Watson & West, 2006:53). The conversations in solution-focused therapy is similar to those of narrative therapy in that the focus is on what the client wishes to change and what is necessary to bring about the change. Research findings by De Jong (2002:112) indicate that clients with clear visions of what they wanted to be different made more progress than those who could not identify what must change. Solution-focused therapy assumes that the client is competent to co-construct goals and strategies and is the expert about his own life. It further construes that something must be done to effect change (De Jong, 2002:113).

The social worker uses different kinds of questions such as goal-formulation questions, exception-finding questions, scaling questions, coping questions and "what's better" questions, during the conversation in establishing the intervention process and the "working together" of the social worker and the client. Questions are aimed at the "who", "what", "where" and "how" of goal attainment (De Jong, 2002:113-114; Cooper & Lesser, 2002:193).

The necessity for a complicated grief intervention model became evident in the researcher's attempt to find such a model with clear guidelines in South Africa. The proposed Complicated Grief Intervention Model (CGIM) (Diagram 1) was developed from this need and must be regarded as a flexible and adaptable programme. The purpose of the proposed CGIM is not to remove the pain of grief, but to enable the bereaved to incorporate the loss into their lives in whatever way feels right for them, thus making them equal partners with the social worker in the intervention process.

8. LAYOUT OF THE COMPLICATED GRIEF INTERVENTION MODEL (CGIM) (DIAGRAM 1)

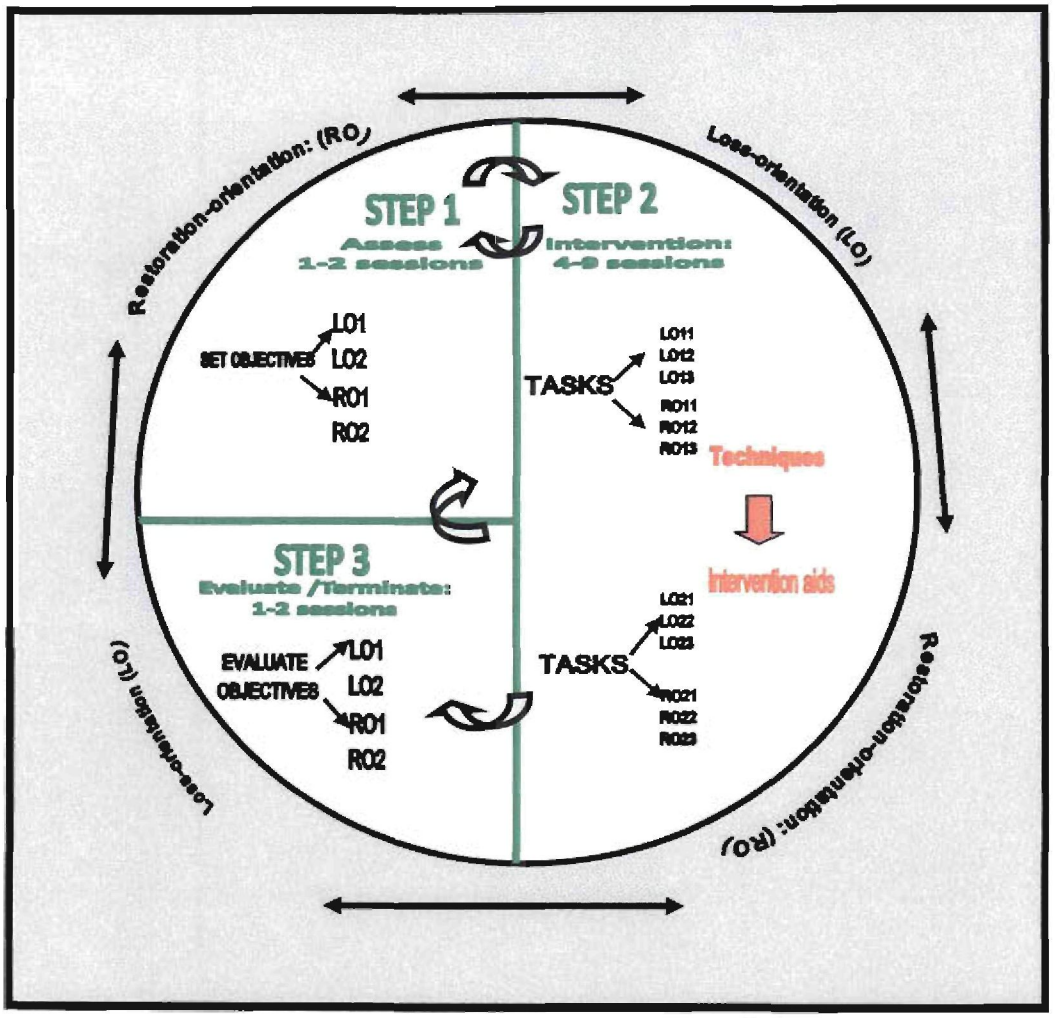
The Complicated Grief Intervention Model (CGIM) is specifically developed for complicated grief intervention. It is thus important to ascertain whether the client is indeed showing elements of complicated grief before commencing with the intervention.

The goal of the intervention, and therefore the goal of the CGIM, is already established, namely to enable the client to incorporate the loss of a significant other into his/her life in whatever way feels right for him/her, taking into account the individual's grief pattern, culture, background and relationship to the deceased. The purpose of this model (CGIM) is to make small, effective measurable changes within the ambit of complicated grief. Ligon (2002:98) and Martin and Doka (2000:133) are of opinion that carefully developed goals and objectives will create a positive effect in the sense that the client is able to experience initial success. The stance of the social worker is to believe that things can change, and to work with what the client brings, such as past successes, survival skills, and life wisdom (Ligon, 2002:97).

The CGIM is set out in Diagram 1 and will be discussed in detail in the following paragraphs.

DIAGRAM 1:

Complicated Grief Intervention Model (CGIM)



The Complicated Grief Intervention Model (CGIM) proposes three steps:

- Step 1: Assessment
- Step 2: Intervention, and
- Step 3: Evaluation and termination

The process is able to revert back to the previous step should the need exist.

8.1. Step 1: Assessment

This step takes up to 2 sessions and is aimed at a thorough assessment of the client's needs by listening to the client's story where-after the social worker and

while *restoration-orientation* is abbreviated to "RO". LO1 refers to the first objective connected to loss-orientation (LO), while LO2 refers to the second objective of loss-orientation. RO1 refers to the first objective connected to restoration-orientation (RO) while RO2 refers to the second objective connected to restoration-orientation. An example of LO1 can be: *"to stop crying every time I see his photo"*, and LO2: "*to visit the graveyard*". An example of RO1 can be *"to attend the work end-year function as a widow"*, and RO2: *"To start thinking of exercising a hobby"*. Table 1 (intervention worksheet Step 1) is an example of the implementation of the process. (The numbering of the **objectives** is printed in orange to add to the conceptualization of the CGIP.)

TABLE 1

CGIP – INTERVENTION WORKSHEET (STEP 1)

(Illustrating the intervention objectives.)

GOAL: To enable (name of client) to incorporate the loss of (name of deceased) into his/her life.

Objectives (STEP 1)	**Priority**	**LO**	**RO**	**Tasks (STEP 2)**	**PPriority**	**Objectives reached? (Outcome) (STEP 3)**	
						Yes (Date)	**No (Date)**
To stop crying every-time I see his photo	P1	LO1		LO11. LO12. LO13. LO14.			
To start thinking of exercising a hobby.	P2		RO1	RO11. RO12. RO13. RO14.			
To visit the graveyard	P1	LO2		LO21 LO22 LO23			
To attend the company's annual function as a widow	P3		RO2	RO21 RO22 RO23 RO24			

This is an important step in the intervention process and more sessions can be allocated if the scheduled two sessions are not sufficient. Constant re-evaluation of the situation is done during step 2, and the objectives and tasks can be altered to ensure the desired outcome.

The social worker includes time at the end of the session(s) to debrief the client and to plan for the next session.

5.1.2. Step 2: Intervention

This step involves the implementation of the tasks set to reach the objectives. This step takes up to 9 sessions and can be extended after reformulation and re-assessment of the objectives, should it be necessary.

- This is the implementation phase and the objectives are prioritized and divided into tasks. It is recommended that the tasks which stand the best chance of success be implemented first to allow the client to gain confidence in the intervention process through the experience of success.
- If, for example, one of the objectives is to start thinking of exercising a hobby, the implementation plan involves determining what kind of hobby, locating a training facility or person, costs involved, dates of new enrolment, the first contact with strangers, etc. A good question for the social worker to ask the client at this stage is: "what will you gain from this?" This question points out the benefits of success and affords the client the opportunity to set future goals.
- The task plan normally calls for implementation before the next session and should be stated as such in the initial agreement.
- The tasks for objective LO1 (loss orientation (LO), objective 1) is numbered as follows :
    - LO11 (first task of the first objective for loss orientation). If LO1 is "*to stop crying every time I see his photo*", then LO11 may be "*to look at the photo for 5 minutes per day*", LO12 will then be the second task of this objective and can be described as: "*monitor your emotions when you look at the photo*". It is important to notice that different tasks can be executed at the same time, and that the tasks are mostly cognitively addressed.
    - LO12 (second task of the first objective), and so forth.
    - The tasks in the CGIP intervention worksheet (table 1) explained in step 1 are completed during step 2 and the following table is an example thereof. (The numbering of the tasks is printed in blue in order to clarify the process. Only two examples from Table 1 are used in Table 2).

TABLE 2

CGIP – INTERVENTION WORKSHEET (STEP 2)

(Example of a completed source document)

GOAL: To enable (client) to incorporate the loss of (deceased) into his/her life.

Objectives (STEP 1)	Priority	LO	RO	Tasks (STEP 2)	Priority	Objectives reached? (Outcome) (STEP 3)	
						Yes (Date)	No (Date)
To stop crying every-time I see his photo.	P1	LO1		**LO11.** To look at the photo for 5 minutes per day	P3		
				LO12. To take out the photo	P1		
				LO13. To monitor my emotions when looking at the photo (use grief log)	P4		
				LO14. To monitor my emotions before looking at the photo (use a grief log)	P2		
				LO15.			
To start thinking of exercising a hobby	P2		RO1	**RO11.** To identify the hobby	P1		
				RO12. To go for training	P4		
				RO13. To find an instructor	P2		
				RO14. To buy whatever I need to exercise my hobby	P3		

- Set as many tasks as necessary to reach the objective. These tasks can be performed during the session or between sessions as mutually agreed upon between the social worker and the client.
- It is important to give further structure to the implementation of the tasks by identifying who is responsible for executing the task and by when. The CGIP task worksheet (table 3) is utilized during this exercise. An example of such a further breakdown is as follows:

the client come to a mutual agreement on the targets to be met and set the objectives to reach the goal. Objectives are set and numbered within the Dual Process Model-framework of loss-orientation (LO) and restoration-orientation (RO): LO1 refers to loss-orientation task 1, while LO2 refers to loss-orientation task 2, and so forth. The same reference is applied to the objectives set for restoration-orientation (RO1, RO2).

8.2. Step 2: Intervention

The CGIM is a model of brief intervention with the aim to start where the client is and work towards a solution-focused end. Each identified objective from step 1 (assessment) is divided into different loss-orientation and restoration-orientation tasks where LO11 refers to task number 1 of loss-orientation objective 1, and LO12 refers to task number 2 of loss-orientation objective 2. The same applies to the restoration-orientation tasks. The social worker and the client collaboratively decide on these tasks, as well as on who will be responsible for executing the task. They collaboratively also decide on whether the task will be attended to during the intervention sessions, or between sessions. Thus allowing the client to make small changes and experience "successes". A re-assessment of tasks during each session will guide the social worker and the client in setting new objectives and tasks or determining whether an objective was reached by fulfilling another task.

Each session of step 2 allows for re-assessment and adjustment and the client's story guides the process.

8.3. Step 3: Evaluation and termination

The CGIM provides for re-assessment and evaluation during step 1 and step 2. However, it is necessary to spend at least one session at the end of the intervention process to evaluate the total process and decide on whether or not the goal was reached. If there is mutual understanding that the desired outcome was reached, the process is terminated. If the desired outcome was not reached, and there is a mutual agreement to re-set objectives, the process starts again from step 1, where new objectives are set.

9. CONCLUSION

This article tabulates some of the most important models/approaches to bereavement and proposes the Complicated Grief Intervention Model (CGIM) in answer to the research question: "How can social workers assist the client with complicated grief?"

The proposed Complicated Grief Intervention Model (CGIM) was developed as a guideline in assisting clients who experience difficulty in adapting to the death of a loved one. The CGIM is a combination of the Dual Process Model by Stroebe and Schut (1999) and the Task-Centred approach which was specifically developed for social work. The CGIM is a time-limited (6-12 sessions) intervention model and consists mainly of three steps; assessment; intervention; and evaluation and termination. Loss-orientation (LO) and restoration-orientation (RO) objectives are set while each objective is subsequently divided into manageable tasks. Objectives and tasks are evaluated and reviewed during each session and both the social worker and the client is actively involved in the process.

Although the proposed CGIM has not yet been scientifically tested, it has the potential to serve as a guideline for social workers working in the field of grief and bereavement.

REFERENCES

BOUTON, B.L. 1996. The interdisciplinary bereavement team : defining and directing appropriate bereavement care. *The Hospice Journal,* 11(4):15-24.

BOWMAN, T. 1999. Shattered dreams, resiliency, and hope : restorying after loss. *Journal of Personal and Interpersonal Loss,* 4:179-193.

BROWN, H.C. 2006. Counselling. (*In* Adams, R., Dominelli, L. & Payne, M., *eds.* Social work : themes, issues and critical debates. London : Palgrave. p. 139-148.)

CIGNO, K. 2006. Cognitive-behavioural practice. (*In* Adams, R., Dominelli, L. & Payne, M., *eds*. Social work : themes, issues and critical debates. London : Palgrave. p. 180-190.)

COOPER, M.G. & LESSER, J.G. 2002. Clinical social work practice : an integrated approach. Boston : Allyn & Bacon.

DE JONG, P. 2002. Solution-focused therapy. *(In* Roberts, A. R. & Greene, G. J., *eds.* Social workers' desk reference. Oxford, N.Y. :Oxford University Press. p. 112–116.)

DOEL, M. 2006. Task-Centred work. (*In* Adams, R., Dominelli, L. & Payne, M., *eds*. Social work : themes, issues and critical debates. London : Palgrave. p. 191-199.)

EATON, Y.M. & ROBERTS, A.R. 2002. Frontline crisis intervention : step-by-step practice guidelines with case applications. (*In* Roberts, A. R. & Greene, G. J., *eds.* Social workers' desk reference. Oxford, N.Y. : Oxford University Press. p. 89–96.)

FLEMING, S. & ROBINSON, P. 2001. Grief and cognitive-behavioral therapy : the reconstruction of meaning. *(In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 647–669.)

HOROWITZ, M.J., SIEGEL, B., HOLEN, A., BONANNO, G., MILBRATH, C. & STINSON, C. 1997. Diagnostic criteria for complicated grief disorders. *American Journal of Psychiatry,* 154(7):904–911.

JORDAN, J.R. & NIEMEYER, R.A. 2003. Does grief counseling work? *Death studies,* 27:765-786.

KELLEY, P. 2002. Narrative Therapy. (*In* Roberts, A.R., & Greene, G.J., *eds.* Social workers' desk reference. New York : Oxford University Press. p. 121-124.)

KRISTJANSON, L., LOBB, E., AOUN, S. & MONTEROSSO, L. 2006. A systematic review of the literature on complicated grief. Australian Government Department of health and ageing. Commonwealth of Australia. 117 p. [Web:] http://www.dcita.gov.au/cca [Date of access: 2 September 2007].

LIGHTBODY, T.K. 2005. Neonatal death: a grief intervention framework. *Illness, crisis & loss*, 13(3):191 - 200.

LIGON, J. 2002. Fundamentals of brief treatment : principles and practice. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social workers' desk reference. New York : Oxford University Press. p. 96 – 100.)

MARTIN, T.L. & DOKA, K.J. 2000. Men don't cry... women do : transcending gender stereotypes of grief. Philadelphia : Taylor and Francis.

MATTHEWS, L.T. & MARWIT S.J. 2004. Complicated grief and the trend toward cognitive-behavioral therapy. *Death Studies,* 28:849-863.

MILNER, J. & O'BYRNE, P. 1998. Assessment in social work. Tokyo : Palgrave Macmillan.

PARKES, C.M. 2001. Introduction: concepts and issues in contemporary research on bereavement. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington D.C. : American Psychological Association. p. 3–22.)

PRIGERSON, H.G. & JACOBS, S.C. 2001. Traumatic grief as a distinct disorder: a rationale, consensus criteria and a preliminary empirical test. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 613–645.)

REID, W.J. & FORTUNE, A.E. 2002. The task-centered model. (*In* Roberts, A.R., & Greene, G.J., *eds.* Social workers' desk reference. New York : Oxford University Press. p. 101–104.)

REYNEKE, R. P. 2004. Die benutting van narratiewe beginsels tydens gemeenkapsontwikkeling. *Social Work/Maatskaplike Werk,* 40(2):125-137.

SCHUT, H., STROEBE, M.S., VAN DEN BOUT, J. & TERHEGGEN, M. 2001. The efficacy of bereavement interventions: determining who benefits. *(In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 705–737.)

SHAVER, P.R. & TANCREDY, C.M. 2001. Emotion, attachment, and bereavement: a conceptual commentary. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 63–88.)

SILVERMAN, P.R. & KLASS., D. 1996. Introduction: what's the problem? (*In* Klass, D., Silverman, P.R. & Nickman, S.L., *eds.* Continuing bonds. New York : Taylor & Francis. p. 3–27.)

STROEBE, M.S. 2002. Paving the way: from early attachment theory to contemporary bereavement research. *Mortality,* 7(2):127-138.

STROEBE, M. & SCHUT, H. 1999. The dual process model of coping with bereavement : rationale and description. *Death Studies,* 23:197-224.

STROEBE, M.S. & SCHUT, H. 2001. Models of coping with bereavement: a review. *(In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C : American Psychological Association. p. 375–403.)

THOMAS, N.D. 2000. Generalist practice with people of color. (*In* John Poulin and contributors. Collaborative social work : strength-based generalist practice. Belmont : Brooks/Cole. p. 295–325.)

VONK, M. E., & EARLY, T. J. 2002. Cognitive-behavioral therapy. (*In* Roberts, A.R., & Greene, G.J., *eds.* Social workers' desk reference. New York : Oxford University Press. p. 116-120.)

WATSON, D., & WEST, J. 2006. Social work process and practice: approaches, knowledge and skills. Tokyo : Palgrave Macmillan.

WORDEN, J.W. 1991. Grief counseling and grief therapy : a handbook for the mental health practitioner. 2nd ed. London : Routledge. .

ZHANG, B., EL-JAWAHRI, A. & PRIGERSON, H.G. 2006. Update on bereavement research : evidence-based guidelines for the diagnosis and treatment of complicated bereavement. *Journal of Palliative Medicine,* 9(5):1188-1203.

ARTICLE 4

A COMPLICATED GRIEF INTERVENTION PROGRAMME (CGIP) FOR SOCIAL WORKERS

CM Drenth is a PhD student at the School of Psychosocial Behavioural Sciences (Social Work) at the North–West University (Potchefstroom Campus).
H Strydom is Professor and Head of the Social Work Division. AG Herbst is a Senior Lecturer (Social Work) at the North–West University (Potchefstroom Campus).

Key words:
Grief, complicated grief, Complicated Grief Intervention Model (CGIM), Complicated Grief Intervention Programme (CGIP), intervention techniques.

Abstract:
The necessity for a complicated grief intervention programme became evident to the authors in an attempt to find such a programme with clear guidelines in South Africa. The proposed Complicated Grief Intervention Programme (CGIP) follows from the Complicated Grief Intervention Model (CGIM) which was developed from the afore-mentioned need. The CGIP is a flexible programme and the purpose of the proposed CGIP is not to remove the pain of grief from the client, but to enable the bereaved to incorporate the loss of a loved one into his life in whatever way feels right for him; thus making him an equal partner with the social worker in the intervention process.

This article aims to explain the Complicated Grief Intervention Programme (CGIP) with the Complicated Grief Intervention Model (CGIM) as framework for intervention. The article briefly discusses some of the intervention techniques, such as desensitization, visualization, use of the client-log, miracle question, metaphors, rituals and humour which assist the social worker and the client towards achieving the goal. The CGIP is a time-limited interventions programme and consists mainly of interventions implemented during the three steps of the CGIM namely, assessment,

implementation and evaluation/termination. Although the CGIP has not been scientifically tested, it holds the potential to serve as a guideline for social workers working in the field of grief and bereavement.

A COMPLICATED GRIEF INTERVENTION PROGRAMME (CGIP) FOR SOCIAL WORKERS

"Grief has a quality of healing in it that is very deep because we are forced to a depth of emotion that is usually below the threshold of our awareness" Stephen Levine

1. INTRODUCTION

The last quarter of the twentieth century marked the development of numerous intervention programmes which range from self-help groups to therapeutic complicated grief programmes. Schut, Stroebe, Van Den Bout and Terheggen (2001:705) question bereavement interventions, and whether the interventions achieve what they are supposed to achieve. However, these authors are of opinion that interventions for complicated grief stand better chances of achieving positive results than those directed at bereavement directly after death.

The authors of this article share the view of Watson and West (2006:9) that "in an occupation such as social work, the process (what we do) is as important as the outcome (what is achieved)." The desired outcome of intervention may not be achieved if the effect of complicated grief on the social functioning of the grieving person is ignored or denied.

This article focuses on a proposed complicated grief intervention programme (CGIP) derived from the complicated grief intervention model (CGIM).

2. PROBLEM STATEMENT

In a literature review on complicated grief, Kristjanson, Lobb, Aoun, and Monterosso (2006:89) identify 25 studies that investigate the effectiveness of complicated grief interventions. These interventions are classified in the following categories: pharmacotherapy, support groups or counselling, psychotherapy-based interventions (group therapy, cognitive-behavioural therapy, psychodynamic therapy, behavioural therapy, interpersonal therapy) and other interventions such as touch therapy and

eye movement desensitization. The authors conclude that, although the outcomes are positive, the effects are only modest due to inherent methodological research problems. It is clear that more research on the development of complicated grief intervention programmes is needed.

The necessity for a complicated grief intervention programme became evident to the researchers when attempting to find such a programme with clear guidelines in South Africa. The proposed Complicated Grief Intervention Programme (CGIP) follows from the Complicated Grief Intervention Model (CGIM) and was developed from this need. The purpose of the proposed CGIP is not to remove the pain of grief, but to enable the bereaved to incorporate the loss into their lives in whatever way feels right for them; thus making them equal partners with the social worker in the intervention process. The research question thus is:
"How does the social worker enable the bereaved person who experiences complicated grief, to incorporate the loss into his/her life?"

3. AIM

This article aims to explain the Complicated Grief Intervention Programme (CGIP) with the Complicated Grief Intervention Model (CGIM) as framework for intervention. The process is mutual between the social worker and the client with the goal to enable the client to incorporate the loss of a significant other into his/her life. This article briefly explains some of the intervention techniques which assist the social worker and the client towards achieving the goal. The objective of this article is to propose a complicated grief intervention programme in an attempt to obtain answers to the afore-mentioned research question.

4. COMPLICATED GRIEF INTERVENTION MODEL (CGIM)

The Complicated Grief Intervention Model (CGIM) has the Dual Process Model (DPM) (Stroebe & Schut, 1999) and the Task-Centred approach (Doel, 2006; Ligon, 2002; Reid & Fortune, 2002; Watson & West, 2006) as theoretical framework. The Complicated Grief Intervention Model (CGIM) is based on an eclectic and integrative approach. Therapeutic models of practice, such as cognitive-behavioural, narrative, and solution-focused models, form the basis of intervention in the Complicated Grief

Intervention Model. The CGIM is aimed at the social worker's skill to openly work with the client to restore social functioning after the loss of a loved one. The CGIM is also aimed at releasing a client's own skills and capabilities to achieve the desired outcome.

The CGIM focuses on the completion of loss-related tasks, as well as tasks related to the restoration after a death-related loss. The CGIM is a three-step process, namely *assessment, intervention and evaluation/termination.*

5. COMPLICATED GRIEF INTERVENTION PROGRAMME (CGIP)

The proposed Complicated Grief Intervention Programme (CGIP) is seen as tertiary preventive intervention and is based on the Complicated Grief Intervention Model (CGIM). The goal of the intervention, and therefore the goal of the CGIP, is to enable the client to incorporate the loss of a significant other into his/her life in whatever way feels right for him/her, taking into account the individual's grief pattern, culture, background and relationship to the deceased. Fazio and Fazio (2005:233) believe in "helping people to move into their loss rather than move on", and this belief supports the goal of the CGIP.

Grief intervention is reviewed by Schut *et al.* (2001:731) at three levels:

- Primary preventive intervention is aimed at preventing the development of bereavement-related problems;
- Secondary preventive intervention focuses on bereaved people with a high risk of developing bereavement-related problems;
- Tertiary preventive intervention is aimed at people who have already developed complicated grief.

Schut *et al.* (2001:731) come to the conclusion that *"the more complicated the grief appears to be or to become, the better the chances of interventions leading to positive results".* The researchers came to the same conclusion in observing clients who grieve.

Complicated grief intervention by the social worker, is aimed at the needs of the client; thus starting where the client is and with what the client is able and willing to

share. The social worker assesses what the client brings to the table and what his/her expectations are. With this in mind, it is clear that the effectiveness of complicated grief intervention will differ from client to client. Kristjanson *et al.* (2006:98) confirm this statement: *"These findings (on the efficacy of interventions) highlight the importance of tailoring interventions, suggesting that the intervention may need to be as individual as the bereavement pattern."* Individualizing complicated grief intervention to suit the needs of the client is thus an important skill the social worker needs to master and is supported by the CGIP. Complicated grief intervention is aimed at mitigating the emotional and practical problems experienced since the death of a loved one. For social work, this implies that the client is assisted to regain his/her social functioning as close as possible to the pre-loss state of social functioning.

McLaren (1998:284) mentions that societal expectations to "let go" of the deceased, occasionally force people into grieving covertly and in secret. It also often denies the person who finds it difficult to exhibit his/her emotions. The CGIP allows for the identification of the grieving pattern of the mourner in an attempt to guide the person through the complicated grief process. Martin and Doka (2000:2) describe the necessity to recognise the mourner who does not show affect during the mourning process and to put aside the assumption that only the mourner who expresses his/her feelings openly can get through the grieving process successfully. Martin and Doka (2000:167) developed the Grief Pattern Inventory which enables the therapist to identify styles of grieving. The Grief Pattern Inventory assists the social worker in optimizing and adapting intervention strategies and techniques to accommodate the grief pattern of the mourner. The mourner is thus seen as an individual and the social worker utilizes the mourner's own adaptive strategies to assist in the process of complicated grief intervention. This approach allows the client to become part of the planning process in getting as close to the pre-loss state of social functioning as possible. It also allows the client to grieve in his/her own manner and to set the objectives and tasks needed to reach the ultimate state of social functioning.

5.1. Outline of the Complicated Grief Intervention Programme

The Complicated Grief Intervention Programme (CGIP) is theoretically supported by the Complicated Grief Intervention Model (CGIM).

5.1.1. Step 1: Assessment

The authors agree with Morris (2006:8) that the personal interview is the most reliable method of data collection – you can see the client; you can make a non-verbal assessment of the circumstances; and it is a sensitive way of making contact.

Step 1 takes up to 2 sessions and is aimed at a thorough assessment of the client's needs by listening to his/her story. The social worker and the client come to a mutual agreement on the targets to be met and set the objectives to reach the goal. Martin and Doka (2000:133) confirm the importance for grievers to clarify goals and objectives.

- The client tells his story with as little interruption as possible. By listening to the client's story, the social worker acknowledges and validates the grief experience of the client. The social worker explores the feelings and thought patterns the client experienced prior, during and after the death. The social worker should at all times be aware that each client has a unique grieving pattern and it is recommended that the Grief Pattern Inventory (Martin & Doka, 2000) be utilized at this stage.

- The story is tape-recorded (with the consent of the client) to enable both the client and the social worker to reflect back on events, emotions and any other aspects which may be of therapeutic value later on in the process. Retelling the story often decreases the grief intensity and enables the client to acknowledge aspects which he did not pay attention to previously. This includes successes since the death occurred.

- A self-developed assessment tool (The Grief Assessment Guide - GASsG) is used during the unstructured initial interview, as well as during and

after the intervention process, to rate the distress of the client. The aim of the GASsG is to create a baseline from where the intervention will take place, and to serve as an assessment guide following from the baseline during the intervention process.

- The GASsG guides the social worker through the following aspects:
- How did the client cope prior to the death?
- What other loss experiences did the client have?
- How did the client cope with these losses? This question does not only allow for the exploration of the client's strengths and weaknesses; it also allows the client to acknowledge past successes. By following the solution-focused approach, the social worker acknowledges that both the social worker and the client have resources that can be utilized. The client's viewpoints are acknowledged and s/he becomes part of the solution.
- What is the client's cultural, social and spiritual background and what influence does it have on his/her grieving pattern?
- What are the exceptions? When does the client NOT experience the problem? (Ligon, 2002:98).
- The Grief Assessment Guide (GASsG) allows the social worker to assess the strengths and stressors in the following areas: physical, psychological, spiritual and social, and the client's knowledge, abilities, responsibilities, resilience, coping and problem-solving skills are assessed during this initial interview.

- Both parties then agree on the desired outcome of the intervention. The social worker should concentrate on questions which will guide him/her on what the client wants the outcome to be.

- The social worker guides the client to set objectives in order to reach the goal. Objectives are divided into those related to loss-orientation and those to restoration-orientation according to the Dual Process Model, and are prioritized. As many objectives as necessary are identified and recorded. For purposes of explaining the programme, *loss-orientation* is abbreviated to "LO"

TABLE 3

CGIP–TASK WORKSHEET (Step 2)

(Example of completed CGIP worksheet)

Objective: LO1 **Date: 4 March 2008**	To stop crying every-time I see his photo			
Priority	**Task**	**Who?**	**When?**	**Intervention techniques (For office use)**
P3	**LO11.** Look at the photo for 5 minutes per day	Client	Start 5/3/08	Systematic desensitization; visualization; miracle question (what will it be like when...); grief log (self-anchored scale; other.
P1	**LO12.** Take out the photo	Client	Start 5/3/08	
P4	**LO13.** Monitor my emotions when looking at the photo (use grief log)	Client	Every day from 5/3/08-19/3/08	
P2	**LO14.** Monitor my emotions before looking at the photo (use grief log)	Client	Every day from 5/3/08-19/3/08	
Evaluation:				

- Continuous assessment of the relevance of the objectives and tasks is an important aspect during the implementation phase. Assessment allows the social worker and the client to evaluate the accomplishments and to assess the success of the tasks.
- The social worker assists the client in pointing out all possible obstacles in achieving success and in shaping plans to avoid these obstacles or in preparing to manage the obstacle. "What if" questions are an excellent way of identifying obstacles during the planning process, for example: "What if I cannot get myself to look at the photo?" (Example of LO11 mentioned above).

5.1.3. Step 3: Evaluation/ Termination

Evaluating the outcomes of the CGIP is the main focus during step 3. The continuous assessment during step 2 will ensure that the client is aware of the nearing termination of service. The social worker can further enhance the

cooperation of the client by reviewing the rationale (Hepworth Rooney & Larsen, 2002:591). The purpose of evaluation is to assess the results achieved against the formulated objectives in Step 1. According to Hepworth *et al.* (2002:591), the outcomes, the process and the social worker should be included in the evaluation process. This should then be the focus of the social worker during this step for the CGIP to be credible.

Continuous assessment is done throughout the implementation of the programme by evaluating objectives and tasks during each session. In step 3, the social worker and the client evaluate the initial objectives and decide whether they were met. The process and also the professional performance of the social worker are assessed. It is during this session that successful solution-focused strategies are identified and discussed. If the client is of opinion that some of the objectives were not met, the process can be extended and objectives and tasks reviewed. However, it is critical to decide what really can be accomplished by extending the service. Ligon (2002:104) is of opinion that little progress by the 12th visit will not show more progress by the 20th visit.

Table 4 (CGIP: evaluation of service) is a source document to assist the social worker and the client during the final step of the CGIP in evaluating the outcome, the process and the social worker.

TABLE 4

CGIP: EVALUATION OF SERVICE (STEP 3)

Evaluation **Date:**	Goal: to enable the client with complicated grief to incorporate the loss of a significant other into his/her life					
Objectives	**Outcomes**		**Process**		**Social worker**	
	Reached	**Not reached**	**Satisfied**	**Not satisfied**	**Satisfied**	**Not satisfied**
LO1						
LO2						
RO1						
RO2						
NOTES: Outcomes: Process: Social worker:						

The client once again completes the Inventory of Traumatic Grief (ITG) (Prigerson, Maciejewski, Reynolds, Bierhals, Newsom, Fasiczka, Frank, Doman & Miller, 1995:65-79) which is to be compared with the initial completion of the ITG prior to the implementation of the CGIP. The comparison of the two questionnaires should be discussed with the client before termination of the intervention. A final mutual assessment is done in accordance with the Grief Assessment Guide (GASsG) and comparisons are made regarding the effect of the therapy and whether the desired outcomes were reached.

In the case of unsuccessful intervention, the social worker should take care that the termination process includes a discussion on the factors which could have influenced the outcome as well as the client's feelings about seeking future additional help. It must also be kept in mind that successful outcomes could include factors not related to the interventions and should be discussed during and after intervention.

6. INTERVENTION TECHNIQUES

The CGIP encourages an eclectic approach in utilizing techniques from various intervention models. The aim is not to be prescriptive but to empower the social worker to utilize the techniques s/he is comfortable with. The techniques utilized will depend largely on the task to be met, as set out in the CGIP. A few possible techniques which could be utilized are briefly discussed in the following paragraphs. These techniques are to be used in collaboration with other intervention techniques utilized by social workers in grief therapy, and merely serve as a guideline in implementing the CGIP.

6.1. Desensitization

Desensitization aims at gradually exposing the client to situations that create anxiety and fear and which the client tends to avoid. Relaxation techniques usually accompany the desensitization process and it can be an imaginary or real-life exposure (Vonk & Early, 2002:119).

6.2. Visualization

Visualization is used to promote cognitive change during complicated grief intervention. The client is encouraged to visualize the positive outcome of a specific task and to envisage the feelings attached to the outcome (Vonk & Early, 2002:119). The visualization technique will be improved if it is accompanied by relaxation exercises.

6.3. Client-log

A client-log is an instrument to identify the client's circumstances, the frequency and the duration of problems. The client-log assists both the worker and the client

in identifying the problems. The log is utilized efficiently in cases where the client finds it difficult to explain the problem and the extent of the problem (King Pike, 2002:190).

6.4. Miracle question

The miracle question assists the client in visualizing the future when the problem is no longer a problem and is a technique utilized in solution-focused and cognitive-behavioural therapy. The miracle question probes the client to envisage in detail a morning when s/he wakes up and the problem no longer exists. The social worker then further cognitively explores possible future behaviour with the client. The social worker thus encourages the perception that change is possible (Corcoran, 2002:592).

6.5. Metaphors

Metaphors are extremely useful in grief therapy. Through the use of metaphors, the therapist is able to illustrate a point to a client, suggest new solutions to the client, decrease the resistance of the client, and reframe a problem to enable the client to find solutions. The important value of the metaphor is that the client experiences that the resources and solutions lie within him/her; thus empowering the client to acknowledge his/her own abilities (Lankton, 2002:384). Metaphors must at all times be relevant to the client's current status or must be aimed at the set goal. The aim of metaphors is to facilitate experience that is helpful in the therapeutic process.

6.6. Rituals

Rituals during intervention provide a framework of meaning, beliefs and behaviour that can enable the bereaved to integrate the loss (Cobb, 2003:137). Rituals are more than just cultural and spiritual activities; it includes activities to assist the client to overcome fear, denial and anger. Rituals are specifically designed actions that are used to change the client's perception of reality. Childs-Gowell (2003:17) is of opinion that rituals consist of three phases, namely preparatory, experiencing and closing, and that certain symbols and meanings

are attached to each phase. A small event is created during the ritual in order to reflect a bigger event.

6.7. Memory work

Memory work is based on the assumption that, in every life, there is a story to be told (Herbst & De la Porte, 2006:40). Memory work refers to different ways of telling the story such as memory books, memory boxes and memory albums. Herbst and De la Porte (2006) have added life maps as a component of memory work and give specific attention to life maps in the face of grief. Memory work facilitates the client's ability to access positive, comforting memories of the deceased and to identify strengths in his/her own frame of mind.

6.8. Humour

Fazio and Fazio (2005:243) are of opinion that laughter relieves the tremendous burden of grief and that laughter connects the bereaved person to other people. Fazio and Fazio describe how humour assisted them in their search for their father following September 11 and how it brought smiles to the faces of other New York citizens. Unfortunately, not enough research has been done on the topic of humour as a technique in grief therapy. Well-timed and respectful use of humour can be a powerful way of easing tensions and facilitating connections. Questions such as: "Tell me something about the deceased that makes you laugh?" and "What is the dumbest thing someone has said to you since the deceased died?" are examples to facilitate laughter during intervention (Fazio & Fazio, 2005:243).

7. CONCLUSION

The proposed Complicated Grief Intervention Programme was developed as a guideline for social workers in assisting clients who experience difficulty in adapting to the death of a loved one. The CGIP is a time-limited (6-12 sessions) interventions programme and consists mainly of three steps, namely assessment, implementation and evaluation/termination. Loss orientation and restoration orientation objectives are set and prioritized. Each objective is divided into manageable tasks and also

prioritized. Objectives and tasks are evaluated and reviewed during each session and both the social worker and the client are actively involved in the process.

Although the proposed CGIP has not been scientifically tested, it holds the potential to serve as a guideline for social workers working in the field of complicated grief.

REFERENCES

CHILDS-GOWELL, E. 2003. Good grief rituals : tools for healing. New York : Barrytown/Station Hill Press.

COBB, M. 2003. Spiritual care. *(In* Lloyd-Williams, M., *ed.* Psychosocial issues in palliative care. Oxford, N.Y. : Oxford University Press. p. 135–147.)

CORCORAN, J. 2002. An integrative framework for solution-focused and cognitive-behavioral therapy. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social workers' desk reference. Oxford, N.Y : Oxford University Press. p. 591-598.)

DOEL, M. 2006. Task-centred work. (*In* Adams, R., Dominelli, L. & Payne, M., *eds.* Social work : themes, issues and critical debates. London : Palgrave. p. 191-199.)

FAZIO, R.J. & FAZIO, L.M. 2005. Growth through loss : promoting healing and growth in the face of trauma, crisis and loss. *Journal of Loss and trauma,* 10:221-252.

HEPWORTH, D. H., ROONEY, R. H. & LARSEN, J. A. 2002. Direct social work practice : theory and skills. 6th ed. Victoria : Brooks/Cole.

HERBST, A. & DE LA PORTE, A. 2006. Memory work: telling your story through life maps. Pretoria : CB Powell.

KING PIKE, C. 2002. Developing client-focused measures. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social workers' desk reference. Oxford, N.Y. : Oxford University Press. p. 189-193.)

KRISTJANSON, L., LOBB, E., AOUN, S. & MONTEROSSO, L. 2006. A systematic review of the literature on complicated grief. Australian Government Department of health and ageing. Commonwealth of Australia. 117 p. [Web:] http://www.dcita.gov.au/cca [Date of access: 2 September 2007].

LANKTON, S. 2002. Using metaphor with clients. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social workers' desk reference. Oxford, N.Y. : Oxford University Press. p. 385-391.)

LIGON, J. 2002. Fundamentals of brief treatment. Principles and practice. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social workers' desk reference. Oxford, N.Y.: Oxford University Press. p. 96–100.)

MARTIN, T.L. & DOKA, K.J. 2000. Men don't cry... women do : transcending gender stereotypes of grief. Philadelphia : Taylor and Francis.

McLAREN, J. 1998. A new understanding of grief : a counsellor's perspective. *Mortality,* 3(3):275–290.

MORRIS, T. 2006. Social work research methods : four alternative paradigms. Thousand Oaks : SAGE Publications.

PRIGERSON, H.G., MACIEJEWSKI, P.K., REYNOLDS, C.F. III., BIERHALS, A.J., NEWSOM, J.T., FASICZKA, A., FRANK, E., DOMAN, J. & MILLER, M. 1995. Inventory of complicated grief : a scale to measure maladaptive symptoms of loss. *Psychiatry Research.* 59(1-2):65–79.

REID, W.J. & FORTUNE, A.E. 2002. The task-centered model. (*In* Roberts, A.R., & Greene, G.J., *eds.* Social workers' desk reference. Oxford, N.Y. : Oxford University Press. p. 101–104.)

SCHUT, H., STROEBE, M.S., VAN DEN BOUT, J. & TERHEGGEN, M. 2001. The efficacy of bereavement interventions: determining who benefits. (*In* Stroebe, M.S.,

Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 705–737.)

STROEBE, M. & SCHUT, H. 1999. The dual process model of coping with bereavement : rationale and description. *Death Studies,* 23:197-224.

VONK, M.E. & EARLY, T.J. 2002. Cognitive-behavioral therapy. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social workers' desk reference. Oxford, N.Y. : Oxford University Press. p. 116-120.)

WATSON, D. & WEST, J. 2006. Social work process and practice : approaches, knowledge and skills. Tokyo : Palgrave Macmillan.

ARTICLE 5

IMPLEMENTATION AND EVALUATION OF THE COMPLICATED GRIEF INTERVENTION PROGRAMME (CGIP).

CM Drenth is a PhD student at the School of Psychosocial Behavioural Sciences (Social Work) at the North–West University (Potchefstroom Campus).
H Strydom is Professor and Head of the Social Work Division. AG Herbst is a Senior Lecturer (Social Work) at the North–West University (Potchefstroom Campus).

Key words:
Grief, complicated grief, Complicated Grief Intervention Model (CGIM), Complicated Grief Intervention Programme (CGIP), intervention techniques.

Abstract:
The necessity for a complicated grief intervention programme became evident in the researchers' attempt to find such a programme in South Africa. The proposed Complicated Grief Intervention Programme (CGIP) flows from the Complicated Grief Intervention Model (CGIM) and was developed from the afore-mentioned need. The CGIP is aimed at enabling the bereaved to incorporate the loss of a loved one into their lives, thus making them equal partners with the social worker in the intervention process. The interventions utilized by the social worker in implementing the CGIP are based on developing and utilizing the strengths of the client. Therapeutic models of practice, such as cognitive-behavioural and solution-focused models form the basis of intervention in the proposed CGIP.

The focus of this article is to explain the research methods utilized during the study, to discuss the findings after implementation of the programme (CGIP) and to evaluate the feasibility of the programme.

IMPLEMENTATION AND EVALUATION OF THE COMPLICATED GRIEF INTERVENTION PROGRAMME (CGIP)

"I did not know how I could reach him, where I could overtake him and go on hand in hand with him once more. It is such a secret place, the land of tears." Saint-Exupéry (1945) (The Little Prince)

1. INTRODUCTION

There is increased interest from psychiatrists for the inclusion of complicated grief as a pathological form of grief in the Diagnostic and Statistical Manual of mental disorders (Shear & Smith-Caroff, 2002:1). The DSM-IV-TR includes a diagnosis of bereavement-related Major Depression if symptoms exist continuously for two months after the loss of a loved one (American Psychiatric Association, 2000:684). It is also debated that there is a correlation between complicated grief and post-traumatic stress (Prigerson & Jacobs, 2001:617). Researchers (Horowitz, Siegel, Holen, Bonnano, Milbrath & Stinson, 1997:905-910; Prigerson & Jacobs, 2001:616) have found that the symptoms of complicated grief are indeed distinct from those of Major Depression Disorder (MDD) and Post-Traumatic Stress Disorder (PTSD).

Social workers in South Africa are increasingly confronted with the challenges faced by bereaved clients. Some of the factors contributing to this are an increase in crime- and AIDS-related deaths in South Africa. The social functioning of families who suffer multiple losses and/or traumatic losses are often impaired, which can lead to complicated grief (James & Gilliland, 2001:434; SAPS, 2006; UNAIDS, 2006). Social workers who are not experienced in the field of bereavement care often fail to acknowledge and address the impact of complicated grief on the social functioning of the client.

The Complicated Grief Intervention Model (CGIM) was developed in an attempt to guide the social worker in addressing the needs of patients who present with

diminished social functioning as a result of unresolved grief. The Complicated Grief Intervention Programme (CGIP) stems from this model with the aim of assisting the client to integrate the loss of a loved one into his/her life. The focus of this article is to explain the research methods utilized during the study, to discuss the findings after implementation of the programme (CGIP) and to evaluate the implementing possibilities of the programme.

2. PROBLEM STATEMENT

Social work intervention with regard to complicated grief in South Africa is not a simple task and the development of an intervention programme has long been the interest of the researchers. The necessity for a complicated grief intervention programme became evident in the researchers' attempt to find such a programme in South Africa. The proposed Complicated Grief Intervention Programme (CGIP) flows from the Complicated Grief Intervention Model (CGIM) and was developed from the afore-mentioned need. The CGIP is aimed at enabling the bereaved to incorporate the loss of a loved one into their lives, thus making them equal partners with the social worker in the intervention process. The research question can thus be formulated as:

- How does the social worker implement the Complicated Grief Intervention Programme (CGIP)?

3. AIM

The aim of this article is to describe the implementation of the proposed Complicated Grief Intervention Programme (CGIP) in the South African context and thereafter to evaluate the CGIP. The aim of this article is not to predict outcomes, but to develop insight and understanding (McCleod, 1994:9). This article is furthermore aimed at evaluating the feasibility of the programme rather than testing its effectiveness. The effectiveness of the programme was not measured, due to the relatively small sample and it is recommended that further research be done on the effectiveness of the CGIP. The interventions utilized by the social worker in implementing the CGIP are based on developing and utilizing the strengths of the client. Therapeutic models of practice, such as cognitive-behavioural (Fleming & Robinson, 2001:647-670;

Peterson, 2002:320-323; Vonk & Early, 2002:116-120) and solution-focused models (De Jong, 2002:112-115) form the basis of intervention in the proposed CGIP.

4. RESEARCH METHODOLOGY

Although the research mentioned in this article is mainly qualitative in nature, the use of supporting quantitative data resulted in mixed methodology (Creswell, 2003:208-210; McLeod, 1994:32; Neuman, 2003:16) The advantages of using mixed methods in the study of grief and bereavement is highlighted by Niemeyer and Hogan (2001:113). According to De Vos (2005c:342), triangulation of method also adds to the trustworthiness of research and this is borne out in this study where triangulation of method increased the insight gained in this study with regard to complicated grief intervention. Quantitative data analysis was done by hand, while qualitative data was analyzed following Tesch's approach of identifying central themes (Poggenpoel, 1998:343).

Recruitment of respondents occurred between June 2006 and April 2008 through personal contacts with individuals who had lost a partner, spouse, child, family member or close friend at least fourteen months prior to the research, and who were of opinion that they experienced difficulty in coming to terms with the death of a loved one. Those who met the inclusion criteria for the study were invited to participate. Inclusion criteria for the study included that (a) there should be an indication of complicated grief according to the Inventory of Traumatic Grief (Prigerson & Jacobs, 2001), (b) the person (deceased) should have died at least 14 months prior to the study, (c) the participant should be older than 21, and (d) the participant should be a South African citizen.

4.1. Participants

Purposive non-probability sampling was used. The ages of the respondents varied between 29 and 65 and were thus representative of individuals in different life cycles. Fourteen (14) persons responded to the researcher's request to participate in the study. Two persons did not show elements of complicated grief and were therefore not included in the study. These two were referred for bereavement counselling. Of the 12 persons who met the inclusion criteria, 3

persons (2 black and one white woman) withdrew after completion of the ITG advanced the reason that they were not ready to deal with their emotions yet. One person indicated that s/he was receiving grief therapy at the time of the study and was therefore not included. One respondent was emotionally unable to complete the ITG and was therefore also not included in the study. Seven respondents eventually completed the Complicated Grief Intervention Programme (CGIP).

Of the 7 respondents who had completed the CGIP, 6 were female (5 white and 1 black) and 1 was a white male. Two respondents were inhabitants of Ermelo (a small town in Mpumalanga Province), while 5 were from Pretoria (a city in Gauteng Province). There is no particular reason for geographically including respondents from Ermelo and Pretoria other than that the respondents who were willing to participate in the study resided in these two cities.

4.2. Measuring instrument

The Inventory of Traumatic Grief (ITG) is a self-report symptom severity score developed by Prigerson and colleagues (Prigerson & Jacobs, 2001:638-645). High internal consistency (Cronbach's alpha = 0.95) of the ITG was proven (Prigerson & Jacobs, 2001:628) and test-retest reliability estimates (0.80) were obtained (Kristjanson, Lobb, Aoun & Monterosso, 2006:34). The Inventory of Traumatic Grief (Prigerson & Jacobs, 2001:638-645) was utilized in screening respondents *prior* to inclusion in the research to ascertain whether the participants showed elements of complicated grief. Persons who were receiving any other form of bereavement counselling were not considered for the study, as this could have an influence on the outcome.

Table 1 is a generic format of the CGIP and sessions 3-10 were customized to fit the individual intervention needs of the seven respondents.

TABLE 1

COMPLICATED GRIEF INTERVENTION PROGRAMME FORMAT

SESSION	OBJECTIVES OF SESSION	METHODS
Session 1-2	**Introduction and orientation of CGIP** -Overview and goals of the CGIP -Contract	-GASsG
	The story of the death -The respondent's experience of the death (pre-, during, and post-death, where applicable) - Develop & prioritize objectives	-Genogram
Session 3-10 (tailored to suit individual needs)	**Develop and prioritize tasks following from the objectives** -Re-assess tasks at regular intervals.	-CGIP intervention worksheet -CGIP Intervention worksheet -CGIP task worksheet
	Complicated grief intervention -Grief information: explain grief-related emotions	-Discussion -Metaphor (example: Whirlpool of grief)
	-Discuss feelings associated with deceased. Focus on positive feelings and what the client gains from this (example: sadness assists in finding ways to revisit comforting thoughts about the deceased).	-Client log -Humour, funny episodes, "feel good" incidents, strengths of deceased (what is the client proud of since the death). -Visualization -Metaphor (example: metal strongbox)
	-Revisit the story of the death (to learn something new).	-Voice recorder -Rituals
	-A trip down memory lane	-Memory work: memory box, memory book, life-maps. -pictures and other memorabilia associated with the deceased. -Focus on what the client wants to remember. -Imaginary conversation with deceased -Miracle question
	-What about tomorrow?	-Visualize and discuss the future without the deceased. -Identify client strengths (example: what was achieved by the client after the death).
	-Self-care	-List and date self-care activities
Session 11-12	**Evaluate outcome** **Terminate CGIP**	-Discussion -CGIP Evaluation of service worksheet

5. RESEARCH FINDINGS

The quantitative and qualitative findings of this study are presented, followed by a case example to demonstrate the implementation of the CGIP.

5.1. Relationship to the deceased and time since death

Table 2 indicates the relationship of the respondent to the deceased as well as the date of death. The aim of this table is to clarify the uniqueness of each respondent who participated in the research. All 7 (100%) respondents who started on the programme completed it. The first contact date between the social worker and the client is added to serve as proof that the time since death is at least 14 months. The respondents are numbered from 1-7 to avoid a breach of confidentiality.

TABLE 2

RELATIONSHIP TO DECEASED AND DATE OF DEATH

Respon-dent	Relationship of respondent to deceased and date of death								Date of first contact between researcher and respondent
	Mis-carriage	Child	Sibling	Nephew/ Niece	Parent	Grand-parent	Spouse	Friend	
1							Nov 2005		16 July 2007
2	Dec 1978	a)May 1978 b)July 1981 c)Feb 2001		Feb1999	a)Sep 1978 b)Dec 1979	Oct 2004			13 June 2006
3		Feb 2006							8 March2008
4					Sep 2005				9 Jan 2007
5		March 1988							12 Feb 2008
6			Sep 2004				Sep 2005		12 Feb 2007
7		Feb 2006							8 March 2008

Fifteen (15) significant losses were suffered between the 7 respondents over the period 1978 to 2006. These losses included both sudden deaths and expected deaths over this period of time. Two respondents (28.5%) experienced multiple losses. One of these two respondents (14.3%)

experienced 8 losses over the period 1978-2004 of which five occurred over the period May 1978 to July 1981, including 2 miscarriages, 3 children, both parents and a niece. This respondent never received therapy or counselling for these losses. The emphasis in this case is thus on the simultaneous loss of more than one significant person in the life of the bereaved. Worden (1991:67) quotes Kastenbaum who refers to this aspect as "bereavement overload". Sikkema, Hansen, Kochman, Tate and Difranceisco (2004:189) indicate that it is not only the multiple losses experienced, but also the fact that an individual experiences insufficient time to mourn the loss or to prepare for another. This does not only apply to AIDS-related bereavement, but to all other bereavement following multiple losses within a short period of time.

Table 3 gives an overview of the number of sessions needed for each respondent during each step. The intervention was delivered during weekly sessions according to the individual need of the respondents. A breakdown of the sessions for each respondent is depicted in Table 3.

TABLE 3

IMPLEMENTATION OF THE CGIP- SESSIONS NEEDED

Respondent	Step 1 Assessment	Step 2 Intervention	Step 3 Evaluate/Terminate
1	2	7	2
2	3	8	2
3	1	3	1
4	3	11	2
5	1	4	1
6	2	14	2
7	1	2	1

One respondent (14.3%) was not satisfied with the outcome and therefore one of the objectives was reviewed. Steps 1, 2 and 3 were repeated and the CGIP could be terminated. Throughout the intervention, the researcher followed a structured protocol, based on the Complicated Grief Intervention Model (CGIM), yet tailored to the individual needs of the respondents. This approach allowed the researcher to evaluate the implementation of the Complicated Grief Intervention Programme (CGIP), while addressing issues specific to the individual.

5.2. *Inventory of Traumatic Grief (ITG) (Appendix 2)*

Data for the research was gathered partly from the completed Inventory of Traumatic Grief (ITG) by each respondent. Respondents completed the ITG before and after the implementation of the Complicated Grief Intervention Programme. The ITG is divided into two distinct sections, a) separation distress and b) traumatic distress. Separation distress is identified by questions 2, 3, 5, 6 and 22 on a five-point scale (almost never (1), rarely (2), sometimes (3), often (4), and always (5)). Traumatic distress is identified by questions 4, 7, 8, 9, 11, 13, 14, 17, 19, 21, 23 and 26, also on a five-point scale as indicated above. Two qualitative open-ended questions were added to the ITG and data were processed by hand due to the small study population.

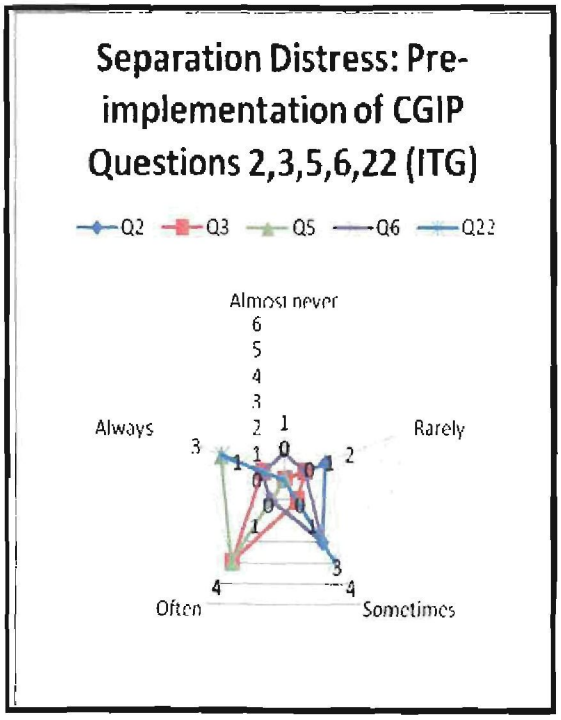
Graph 1 indicates the respondents' responses to the five separation distress questions *prior* to the implementation of the Complicated Grief Intervention Programme (CGIP). The answers to the different questions are indicated in different colours in accordance with the responses of the 7 respondents. It is evident that there is a strong distribution of answers which indicate separation distress (more answers in the sometimes, often and always indicators) in the graph.

Graph 2 indicates the respondents' responses to the separation distress indicators *after* implementation of the CGIP. A significant shift towards less severe distress can be seen in Graph 2. None of the respondents answered "always" to any of the questions (2, 3, 5, 6, 22), and only 1 respondent answered "often" to question 5 of the ITG.

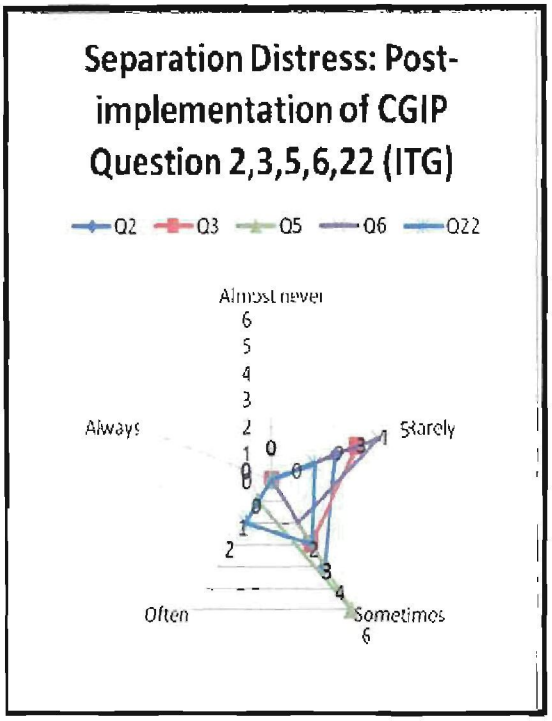
Although this study was not intended to measure the effectiveness of the CGIP, the pre- and post-results from the ITG indicate a definite swing towards grief recovery. *Prior* to CGIP implementation, four respondents (57%) answered "often" to question 3: "*Memories of _____ upset me*", while 0 (0%) respondents answered "often" to question 3 *after* implementation. *Prior* to implementation three respondents (42.8%) indicated "always" to question 5: *"I feel myself longing*

and yearning for____", while four respondents (57%) indicated "often" to the same question in the post-test. *After* implementation no respondents indicated "always" to question 5 and one respondent (14.3%) answered "often" to question 5.

Graph 1: Separation distress (ITG) before implementation of the CGIP



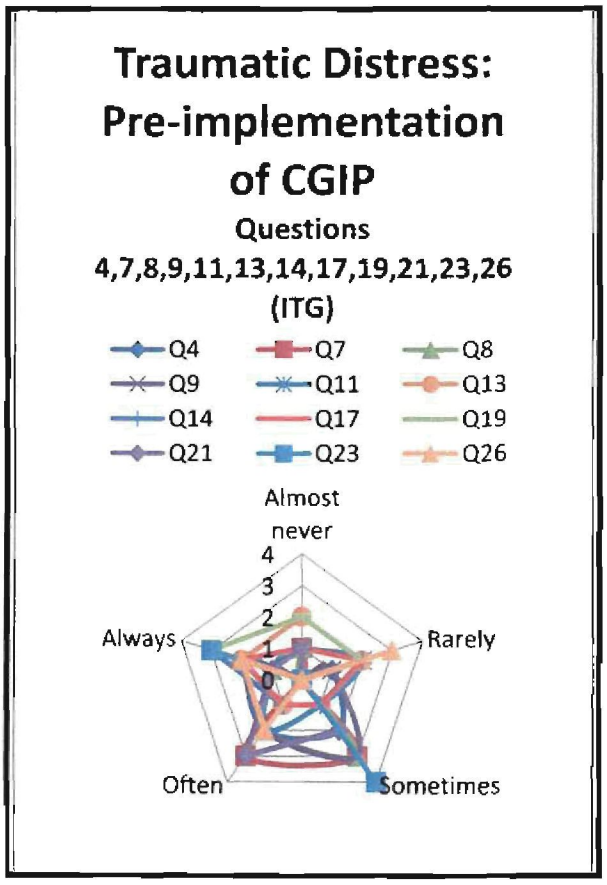
Graph 2: Separation distress (ITG) after implementation of the CGIP



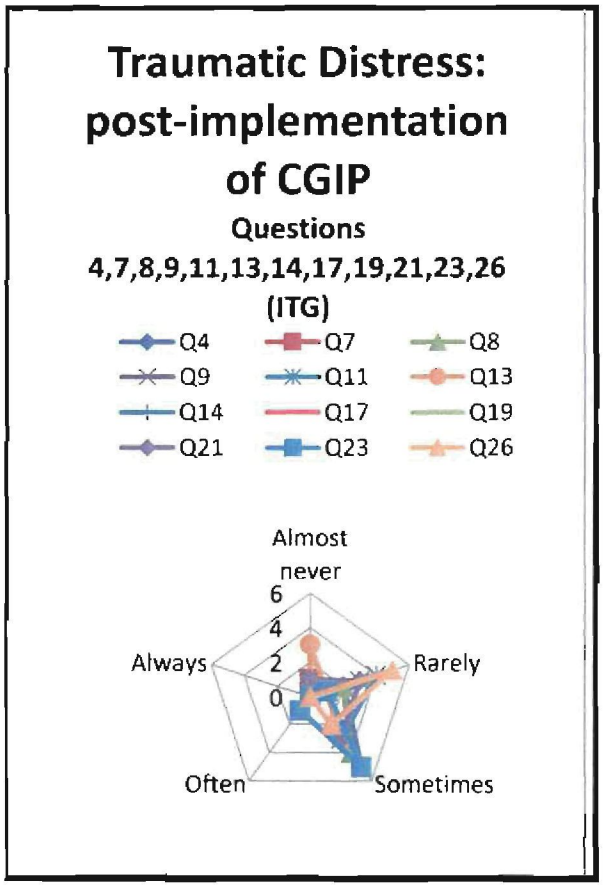
Graph 3 indicates the respondents' responses to the 12 traumatic distress questions of the ITG (4,7,8,9,11,13,14,17,19,21,23,26) *prior* to the implementation of the Complicated Grief Intervention Programme (CGIP). The answers to the different questions are indicated in different colours according to the responses of the 7 respondents. There is a strong tendency towards answers which indicate traumatic distress (sometimes, often and always indicators) on the graph. Each question is indicated in a different colour on the graph and the numbers 0-4 indicate how many responded to the questions.

Graph 4 indicates the respondents' responses to the traumatic distress indicators *after* implementation of the CGIP. A significant shift towards less severe distress can be seen in Graph 4. None of the respondents answered "always" to any of the questions (4,7,8,9,11,13,14,17,19,21,23,26), and only 1 respondent answered "often" to one of the questions of the ITG. Each question is indicated in a different colour on the graph and the numbers 0-5 on the graph indicate how many responded to the different questions.

Graph 3: Traumatic distress (ITG) prior to implementation of the CGIP



Graph 4: Traumatic Distress (ITG) after implementation of the CGIP



5.3. Implementing the Complicated Grief Intervention Programme (CGIP)

In analyzing the needs of the respondents gathered from the initial ITG, the unstructured interviews, and the GASsG as assessment tool, the following table gives a summary of objectives identified in collaboration between the social

worker and the respondents in no particular order. The objectives are divided into loss-orientation objectives and restoration-orientation objectives.

TABLE 4

OBJECTIVES

	Loss-orientation objectives		Restoration-orientation objectives
1.	To understand my "overboard" emotions.	1.	To regain self-confidence by joining a Bible study group
2.	To scatter _____ashes in the Drakensberg	2.	To regain a sense of security
3.	To "readmit" the deceased into the home	3.	To focus on the rest of my family
4.	To understand my anger and my guilt	4.	To handle the work pressure which I could not do since the death
5.	To overcome the feeling that I am living two lives: One life when I am with other people, and the other when I am on my own	5.	To consciously focus on being positive
6.	To relax more	6.	To trust my other family members as much as I trusted the deceased
7.	To use exercise for balance and not as a crutch	7.	To make new friends
8.	To visit places where the deceased and I had good times without fear	8.	To make a career change
9.	To manage my anger	9.	To reach out to other people
10.	To look at our wedding photos again	10.	To break down the wall I built around myself
11.	To talk about the death to someone who will not think that I am "cuckoo".		
12.	To dream about the deceased		
13.	To stop missing the things we would be doing together. He was my soul-mate – a younger version of me		

Fewer restoration-orientation objectives than loss-orientation objectives were identified. A possible explanation for this is that most of the practical issues after a death, such as the estate, finances, living conditions and children's schooling are sorted out after 14 months, which was the cut-off point for inclusion in the study. The restoration-orientation objectives focused mainly on the ability to challenge life without the deceased.

The qualitative research findings allowed the researcher to gather in-depth data. The data were analyzed as they were gathered (De Vos, 2005c:341). Themes were developed from the data obtained during the setting of

objectives which were mutually decided on by the researchers and the respondents (Poggenpoel, 1998:343).

5.4. Themes

Significant cross-over areas were found in analyzing the data for central themes. Findings in one theme often correlated with others. The following themes emerged from the research findings:

5.4.1. Theme 1: Life is empty

Research findings indicated that individuals, who experience complicated grief, find that life is empty without the deceased. The respondents referred to this theme in more than one way. They indicated that the emptiness they experienced after the death was the most difficult bereavement issue to deal with. It was also evident that the emptiness, and accompanying loneliness, was seen as a very personal issue. The respondents were well aware that they were not the first to experience this emptiness, but all of them were of opinion that there is nothing worse than the emptiness left after the death of a loved one. There was an overarching feeling that the community did not understand their loneliness and expected of them to hide their true feelings.

- *I am not able to continue with my responsibilities as a mother. It is hard to perform the responsibilities of my husband. My grief is just so severe that I cannot recall a time without it.*
- *Life will never be the same. All I need is to lie on my bed with no one around me... I want to be alone...I cannot talk to anyone...but then, I don't want to be alone.*
- *I wish I could run away from death. People just don't understand and they expect me to ignore what had happened... [they] want me to act as if nothing had happened. Can't they see that I am so lonely? ... it is impossible to tell them how I feel.*

5.4.2. Theme 2: I've been robbed

Anger and frustration accompanied this sub-theme. The respondents whose children died displayed the intense emotional bond between parents and

children and the fact that death shattered their hope for immortality via their child. These respondents emphasized that they had been robbed of their children's milestones, such as marriages, grandchildren and being taken care of by their children once they become old and frail.

- *We planned to do stuff together, me and my son...*
- *I have the right to see him get married and to cuddle my grandchildren. These milestones are important to me.*
- *People die unnecessarily.*

5.4.3. Theme 3: You get used to death, not over it

All the respondents indicated that life will never be the same without the deceased, whether the time lapsed is 14 months or 20 years.

- *Things will never be the same. A part of your heart, your soul, yourself is gone. You will always seek, but you will never find again...that thing you have lost...*

The respondents were of opinion that one of the most difficult tasks after the death of a loved one is to gain control.

- *One learns to live with death. Sometimes one can touch it, smell it, taste it. Sometimes I think I have control.*
- *People think I am okay, but they don't know that I'm torn apart...*
- *I don't want people to know my feelings. It is not necessary for them to know. I am afraid to hurt again...*
- *It is hard to work in the environment where everybody knew him...I sometimes see him in the other kids...it is unbearable*

Some respondents described *control* as having no emotions at all while others described it as just being able to contain emotions. The definition of control differed from respondent to respondent, thus emphasizing the uniqueness of the bereavement experiences. One respondent described having control as *not being pathetic...*

The lesson learnt from this theme is that during the intervention process, the social worker should constantly be aware that clients get *used* to death, they don't get *over* it. S/he should guard against influencing a detachment

from the deceased, but should rather ensure that the attachment to the deceased is incorporated into the life of the client.

5.4.4. Theme 4: The need for information (Please inform me)

The research findings indicated that it was important for the respondents to understand the process and the duration of grief.

- *If only I can understand my emotions, I will be OK.*
- *Surely I should have felt better by now? I don't understand why I am hurting so much.*
- *Will I ever feel better again?*
- *People tell me that I must be OK now, but they don't tell me HOW to do that.*

Some of the respondents showed remarkable improvement in self-confidence and control after having received factual information on grief. These respondents explained that they were able to share with other people the reasons for their prolonged grief and that they did not experience it as negative, but just as part of the process. Once again the uniqueness of the grief experience and recovery were emphasized. The use of metaphors during these sessions enhanced the respondents' insight with regard to grief and most of them were able to draw comparisons between their own behaviour and emotions. This corresponds with literature cited by Gambrill (2006:639). One respondent even claimed the right to still feel the way s/he did, thus normalizing the prolonged grieving process.

5.4.5. Theme 5: Please listen to me

All the respondents indicated that they had an urge to tell people about their loss, the experience and their feelings even though the death occurred a while ago. One respondent described the experience in terms of wanting to climb on the highest building and shout out her grief for everyone to hear. S/he wanted everyone to stop their daily tasks:

...can't you see my pain? Can't you hear my pain? How can the world just go on turning? Just please stop and listen to me.

The respondents had different motives for wanting people to listen to their stories. One respondent's motive was to feed her own guilt. She did not allow herself to forget about what had happened.

I must not forget...it will be a shame... How can I ever allow myself to be happy? I must not forget...

Four of the respondents indicated that people were only prepared to listen to their stories in the first few months after the death. During the research interviews it became clear that this was an assumption on the part of the respondents and that they did not have proof that people were not prepared to listen to their stories. After exploration the respondents were able to see that they projected their own frustration with their behaviour on the community. Once they realized this, they were more willing to share their stories with outsiders and most of them found relief in being able to talk about the loss. Three of these respondents started reaching out to other people who experienced similar losses.

Even though the respondents were able to share their stories, they realized that people did not know how to react. They commented that they were therefore still very careful in selecting who to speak to.

5.4.6. Theme 6: Don't use that word!

Five of the seven respondents experienced difficulty in connecting the word *death* to the name of the deceased. However, they were able to use the word in general terms. As one respondent put it:

- *Death is okay, provided you do not use it in the same sentence as the name of my beloved child.*

The respondents preferred to use *softer* words or phrases such as: *since he is gone* and *I know he is not here anymore.*

One respondent described it as follows: *Death is hard and cold... and very permanent...* Denial is sometimes indicated by describing death in softer words or phrases in that people tend to think that death did not happen. The denial in these cases was not pathological. It was rather more of a coping mechanism for the respondents to advance towards recovery at their own pace.

5.4.7. Theme 7: Challenge the future

This theme reflects the restoration-orientation of the respondents in that it involved proactive thoughts and actions that had to do with future-oriented planning and goals. Although all the respondents were deeply troubled by the loss of a loved one(s), they all indicated from the onset that they had a future and that life goes on, even though they wished that they could stop the world from turning until they felt better. Five of the seven respondents indicated that they needed someone to assist them in living a life without the loved one(s).

The respondents challenged the future by dealing productively with external stressors. Breaking down an objective into small achievable tasks assisted the respondents in experiencing success. By focusing on their strengths, they discovered that they were able to successfully complete the tasks they set out for themselves.

5.4.8. Theme 8: There is life after death

Despite the painful changes that occurred following the loss of loved ones, most of the respondents reflected an increase in independence, self-efficacy, self-reliance and understanding of others. This correlates with the findings of several other researchers (Satterly, 2000:408; Schaeffer & Moos, 2001:145). It seemed that the improvement in the respondents' coping and social skills added to their personal growth.

- *I am not the same person as before. I am able to attend to my own affairs.*
- *Although the hurt will never go away, I know that I will survive. I know what to expect and that it is normal for me to cry.*

- *I am able to face people again.*

All the respondents indicated strengthened religious beliefs, despite the trauma of death of a loved one.

5.5. Case example

The case example is regarded as a method to clarify knowledge and understanding relevant to counselling practice (McLeod, 1994:103), which in the case of this research highlights the ability to implement the CGIP. The aim in presenting this case example is to illustrate the processes and outcome of implementing the CGIP and not to generalize the findings to other cases. This case example includes both quantitative and qualitative data. The data collected from the Inventory of Traumatic Grief (ITG) (Appendix 2) completed by Mrs X and the data obtained from the Grief Assessment Guide (GASsG) were quantitatively analyzed, while the respondent's progress during the CGIP was qualitatively analyzed. The results obtained are discussed during the case example of Mrs X.

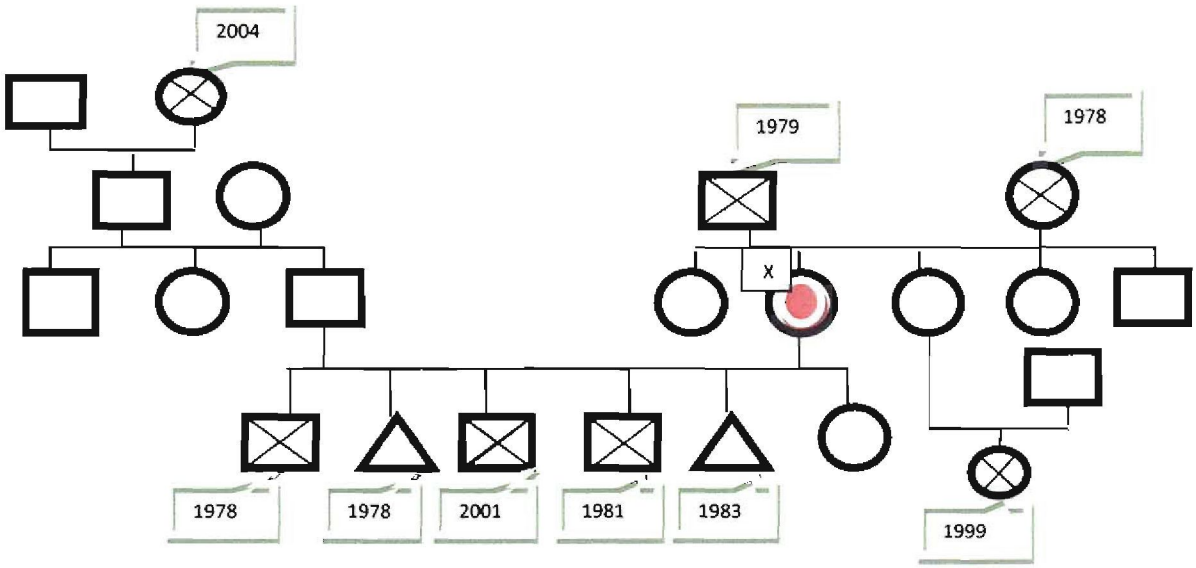
Mrs. X is a 47 year-old married woman who was referred by her general practitioner for bereavement counselling five years after her son, P (21 years old) had died in a motor-vehicle accident. Mrs. X is a trained nurse who sees herself as a caring person and prefers to "do things" rather than to sit around and wait for others. The genogram of this case is summarized in Illustration 1.

Step 1: Assessment

The first two sessions were utilized to assess Mrs. X's circumstances and the extent of her grief. The genogram was utilized as an assessment tool while gathering background information.

ILLUSTRATION 1:

GENOGRAM OF CASE EXAMPLE



Mrs. X was visibly stressed during the first session and acknowledged that the only reason she agreed to counselling, was to get both her husband and her general practitioner "off my back". She also indicated that her way of grieving is to deny facts. Her way of grieving was to "bury the hurt inside myself". Building trust with Mrs. X was therefore very important before any intervention would be possible, and the researcher encouraged Mrs. X to only discuss those events and emotions she felt she could trust the social worker with. During the initial conversation, the researcher started drawing the genogram, which interested Mrs. X so much that she offered to draw the genogram herself, with the assistance of the social worker. By handing over the completion of the genogram to Mrs. X, the social worker empowered her with a feeling of control and observed that she volunteered much more information than when the social worker was drawing the genogram. It also gave an indication of the fighting spirit of the client, which was perceived as a strength which could be positively utilized.

Although it is suggested in the CGIP that step 1 (assessment) be done within the first two sessions, it was not possible during the intervention with Mrs. X. This can be ascribed to her inability to acknowledge her emotions and to share her story with the researcher. Mrs. X was also not comfortable with her story being recorded and the researcher respected her feelings in this regard.

The respondent described her strengths as follows:

- *"I care for people. I don't want to hurt anybody. But it is also my downfall. I am afraid that I am not as strong as I think I am."*
- *"I am a strong believer in Christ."*
- *"I am a creative person and love art, although I have not touched art since my son died."*
- *"I am an extrovert, but I have buried my personality since my son's death."*
- *"I am a hard worker."*
- *"I see the wall I built around myself as a strong point. It does not bother me."*

The CGIP intervention worksheet (setting the objectives and tasks) was completed during the first three sessions and was updated and evaluated during all the sessions of step 2 (see Table 5). This indicates that the CGIP is a dynamic process which should be utilized taking into account the uniqueness of each client. The priorities for the objectives were set by the respondent. Satterly (2000:408) affirms that clients are empowered when they are given the opportunity to develop their own agendas for personal growth. Setting the priorities was difficult, since many of the tasks were addressed simultaneously.

TABLE 5

CGIP - INTERVENTION WORKSHEET for Mrs. X

Goal: To enable Mrs. X to integrate the loss of her son, P, into her life

Objectives (STEP 1)	Priority	LO	RO	Tasks (STEP 2)	Priority	Objectives reached? (Outcome) (STEP 3)	
						Yes (Date)	No (Date)
To accept the reality of P's death	1	LO1		LO11. To talk about P LO12. To tell the story of his accident. LO13. To be able to turn the photos on the wall back to its normal position LO14. To spend time with the photo memories	3 4 1 2		
To feel less guilty about all the deaths that occurred in my life and that I was not able to care for them all	4	LO2		LO21. To understand my anger LO22. To talk about the guilt. LO23. To forgive myself	1 2 3		
To focus on my own survival ("Afraid that I am not as strong as I think I am") ("I will show death!")	2		RO1	RO11. To prepare my garden corner RO12. To engage in my hobbies. RO13. To resume caring for other again	1 2 3		
To regain control over my life	3		RO2	RO21. To prepare my garden corner RO22. To turn the photos on the wall back to its normal position RO23. To clean my house	1 1 1		
To break down the wall I built around myself since P died. *(Added during the 6th session by the respondent)*	5		RO3	RO31. To understand my emotions RO32. To spend time with those I love (Husband and daughter) RO33. To trust people and show it to them	1 2 3		

Step 2: Intervention

The social work intervention was aimed at coping effectively with the multiple stressors involved in the case of Mrs. X. Intervention strategies included assisting Mrs. X in strengthening her fighting spirit – "*I will show death!*" - in a positive way. The strategies also aimed at reframing her grief– "*I have a wall around me and I am comfortable with it*" and at increasing her personal growth.

The course of action was planned according to the set objectives. Mrs. X was encouraged to validate her feelings and experiences during the intervention process. The client-log (King Pike, 2002:190; Poulin & Contributors,

2000:148) was utilized to measure the frequency and the duration of most of the tasks identified by Mrs. X. She remarked after the 9th session that she eventually understood herself and that the client-log is a helpful tool to use in future.

It was decided to utilize the metal strongbox metaphor (Wright, Partridge & Williams, 2001:24) as a technique in addressing objective RO3. The essence of this metaphor is that the possibility of the bereaved to return to a pleasurable existence is locked within a metal strongbox (Wright *et al.*, 2001:24). During intervention the client was guided towards gradually opening the box by addressing the themes which keep the client from seeking pleasure in life again. The respondent gradually gained insight in her behaviours, thoughts and feelings. The following are some of the themes which prohibited Mrs. X from opening her metal strongbox (or breaking down her wall):

- ***I wish.../ If only***. Mrs. X had strong feelings of helplessness and guilt about everything. Attempts to open the box connected her with negative feelings such as *"how can I ever be happy again?"*
- **Fear of opening the box**. Mrs. X experienced intense fear that the box would be empty if she opened it. She feared the rejection of her husband and daughter because she neglected them. She feared that she would never be able to relax again. She feared that the physical pain caused by the grief will go away (she constantly reminded the researcher that she must not forget what happened).
- **How dare you enjoy life?** Seeing other people, and more specifically her husband and daughter enjoying life aroused anger within Mrs. X. The gradual discussion and "opening" of the box gave her insight into her own denial and anger at what had happened.

  Mrs. X identified well with this metaphor and connected it to the emotional wall that she had built around her.

The metaphor of the metal strongbox encouraged Mrs. X in such a way that she, between sessions, secretly started working on a joy box which she

triumphantly presented during the 10th session. The joy box was filled with all the real pleasures in her life, including the memories of her son, and it was clear that she utilized her energy and her art in this project.

Step 3: Evaluation and termination

The last step in the intervention process with Mrs. X was to evaluate the programme and to terminate the professional relationship. The objectives were evaluated in general as it was concluded by Mrs. X that they were all inter-related and that she would prefer to evaluate the outcome, rather than reflecting on each individual objective. The CGIP evaluation work sheet was thus not utilized for the evaluation. The researcher and the respondent did, however, reflect on the process and the meaningfulness of the achievement of smaller tasks and whether the respondent was able to integrate the loss of her loved one into her life.

The Inventory of Traumatic Grief was completed by the respondent to serve as a measuring instrument. She found the post-intervention completion of this instrument less confronting than prior to the intervention. She also indicated that she could relate to and think about the questions, while previously she tried to complete the questionnaire as quickly as possible to avoid being confronted by her emotions.

The social worker invited the respondent to contact her should it be necessary to continue with intervention.

6. EVALUATION OF THE COMPLICATED GRIEF INTERVENTION PROGRAMME

This study explored whether the Complicated Grief Intervention Programme is suitable to be implemented with a small sample of respondents. The effectiveness of the CGIP was not tested and it is recommended that it be included in future research. The advantages and limitations identified after implementation of the CGIP are as follows:

6.1. Advantages of the CGIP

- The findings suggest that the CGIP structured the social work intervention.
- The Complicated Grief Intervention Programme allows the respondents to break down their grief into small manageable tasks, keeping in mind the oscillation between loss-orientation and restoration-orientation. The respondents initially appeared to be sceptical about their own abilities to dissect their grief and to prioritize the tasks. This, however, became easier as the intervention progressed. It was stated by most of the respondents that they have "mastered a technique" to assist with future difficult situations.

- The CGIP has the added advantage that the respondents were able to keep track of their own progress through the successes they achieved. This gave the positive message that they were able to integrate the loss of a loved one into their lives.

- The CGIP allows for positive outcomes, according to the respondents, at the termination of the programme.

- The CGIP is tailored for each respondent's individual needs. It is thus not for the social worker to decide on the success of the outcomes, but for the respondent. If the respondent or client is satisfied with the outcome, this should be respected by the social worker, even though it seems that social functioning is not optimally reached.

- The CGIP allows respondents to grieve actively, to confront their loss, and to understand it through self-reflection. Growth was reflected in increased empathy, self-awareness and self-confidence. Respondents were empowered by the CGIP to move from "*I don't know who I am anymore*", to "*this is who am I now*". The respondents' search for meaning led them to set new priorities, utilizing their strengths and new coping skills in the process.

6.2. Limitations of the CGIP

- The concept of integrating the death of a loved one with the respondent's life was not discussed with the respondents. This resulted in subjective assumptions by the authors about the needs of the respondents. Some respondents were comfortable that they had integrated the loss, while the authors were of opinion that this integration had not been reached.

- The various work sheets attached to the CGIP may be experienced by social workers as tedious and replicating.

- Clients may find it difficult to understand the concepts of objectives and tasks, and more time may have to be spent on initially defining the objectives and the expected outcome, as indicated by the client.

7. CONCLUSION

This study confirms that a complicated grief intervention programme serves as a structured guide to social workers when confronted by complicated grief issues.

It is notable that the themes which emerged in the course of the study correlated with themes associated with *normal* grief. The only difference is the time that elapsed since death and that the person who experiences complicated grief has an inability to return to (or as close as possible to) the social functioning they experienced prior to the death of a loved one. One of the respondents referred to the degrees of comparison of *good* as *bad, good, better* and not as *good, better, best.* According to this respondent, there can never be a *best* again after the death of his/her son. The aim of the intervention is thus to guide the client to reach a level of social functioning as close as possible to the pre-loss social functioning.

It is hoped that this study will contribute to the knowledge that is both practical and useful for social workers and other health professionals working in the specialized field of bereavement. Understanding the factors leading to complicated grief could improve and increase the support that is available to persons who experience complicated grief in South Africa. Finally, social workers have a responsibility to

include the effect of loss in the initial assessment of a client with diminished social functioning, since the authors are of opinion that many clients show impaired social functioning due to complicated grief but present with secondary problems such as substance abuse or relational problems.

REFERENCES

AMERICAN PSYCHIATRIC ASSOCIATION. 2000. Diagnostic and statistical manual of mental disorders. 4th ed., text revision (DSM-IV-TR). Washington, D.C. : American Psychological Association.

CRESWELL, J.W. 2003. Research design : qualitative, quantitative, and mixed methods approaches. 2nd ed. Thousand Oaks : Sage Publications.

DE JONG, P. 2002. Solution-focused therapy. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social work desk reference. New York : Oxford University Press. p. 112-116.)

DE VOS, A. S. 2005c. Qualitative data analysis and interpretation. (*In* De Vos, A.S., Strydom, H., Fouché, C. B. & Delport, C. E. S. *eds.* Research at grass roots : for the social science and human service professions. Pretoria : Van Schaik Publishers. p. 339–355.)

FLEMING, S. & ROBINSON, P. 2001. Grief and cognitive-behavioral therapy: the reconstruction of meaning. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds* . Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 647-670.)

GAMBRILL, E. 2006. Social work practice : a critical thinker's guide. 2nd edition. Buenos Aires : Oxford University Press.

HOROWITZ, M. J., SIEGEL, B., HOLEN, A., BONANNO, G., MILBRATH, C. & STINSON, C. 1997. Diagnostic criteria for complicated grief disorders. *American journal of psychiatry,* 154(7):904–911.

JAMES, R.K. & GILLILAND, B.E. 2001. Crisis intervention. 4th ed. Victoria : Brooks/Cole.

KING PIKE, C. 2002. Developing client-focused measures. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social work desk reference. New York : Oxford University Press. p. 189-193).

KRISTJANSON, J., LOBB, E., AOUN, S. & MONTEROSSO, L. 2006. A systematic review of the literature on complicated grief. Australian Government department of health and ageing. Commonwealth of Australia. 117 p. [Web:] http://www.dcita.gov.au/cca [Date of access: 2 September 2007].

MCLEOD, J. 1994. Doing counselling research. London : SAGE Publications.

NEUMAN, W. L. 2003. Social research methods : qualitative and quantitative methods. New York : Allyn and Bacon.

NIEMEYER, R. A. & HOGAN N. S. 2001. Quantitative or qualitative? Measurement issues in the study of grief. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 89-118.)

PETERSON, L. M. 2002. Treatment planning with individuals. (*In* Roberts, A.R. & Greene, G.J., *eds.* Social work desk reference. New York : Oxford University Press. p. 320-323).

POGGENPOEL, M. 1998. Data analysis in qualitative research. (*In* De Vos, A.S., *ed.* Research at grass roots : a primer for the caring professions. Pretoria : J.L. van Schaik Publishers.

POULIN, J & CONTRIBUTORS. 2000. Collaborative social work : strength-based Generalist practice. Victoria : Brooks/Cole.

PRIGERSON, H.G. & JACOBS, S.C. 2001. Traumatic grief as a distinct disorder : a rationale, consensus criteria and a preliminary empirical test. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 613–645.)

SAPS. 2006. Crime in the RSA per police area for April to March 2001/2002 to 2004/2005. Unpublished report. Crime Information Analysis Centre.

SATTERLY, B. 2000. Generalist practice with people with HIV and AIDS. (*In* Poulin & Contributors. 2000. Collaborative social work : strength-based Generalist practice. Sydney : Thomson Brooks/Cole. p. 385-413.)

SCHAEFFER, J.A. & MOOS, R.A. 2001. Bereavement experiences and personal growth. (*In* Stroebe, M.S., Hansson, R.O., Stroebe, W. & Schut, H., *eds.* Handbook of bereavement research : consequences, coping and care. Washington, D.C. : American Psychological Association. p. 145-168.)

SCHUT, H. & STROEBE, M.S. 2005. Interventions to enhance adaptation to bereavement. *Journal of Palliative Medicine,* 8(1):S140-S147.

SHEAR, M.K. & SMITH-CAROFF, K. 2002. Traumatic loss and the syndrome of complicated grief. *PTSD Research Quarterly.* 13(1):1-8.

SIKKEMA, K.J., HANSEN, N.B., KOCHMAN, A., TATE, D.C. & DIFRANCEISCO, W. 2004. Outcomes from a randomized controlled trial of a group intervention for HIV positive men and women coping with AIDS-related loss and bereavement. *Death studies,* 28:187-209.

UNAIDS. 2006. Report on the global AIDS epidemic. Geneva : UNAIDS.

VESSIER-BATCHEN, M & DOUGLAS, D. 2006. Coping and complicated grief in survivors of homocide and suicide decedents. *Journal of forensic nursing,* 2(1):25–32.

VONK, M. E. & EARLY, T. J. 2002. Cognitive-behavioral therapy. (*In* Roberts, A. R. & Greene, G. J. ,*eds*. Social workers' desk reference. New York : Oxford University Press. p. 116-120.

WORDEN, J.W. 1991. Grief counseling and grief therapy : a handbook for the mental health practitioner. 2nd ed. London : Routledge.

WRIGHT, B., PARTRIDGE, I. & WILLIAMS, C. 2001. A metal strongbox – a metaphor for use in bereavement work. *European Journal of Palliative Care,* 8(1):24-26.

SECTION C

SUMMARY, EVALUATION, CONCLUSIONS AND RECOMMENDATIONS

SUMMARY, EVALUATION, CONCLUSIONS AND RECOMMENDATIONS

1. INTRODUCTION

Section C summarizes and evaluates the research and makes recommendations regarding the value of the research and possible future research on complicated grief in the South African context.

2. SUMMARY OF THE RESEARCH

A great deal is known about the normal grief reactions of a person after the death of a loved one, while it has only recently become the concern of psychologists, psychiatrists and social workers to learn more about complicated grief. The increased interest in the phenomenon of complicated grief gives rise to the need for the development of intervention models, strategies and programmes. There is no doubt that a person's social functioning is impaired while experiencing complicated grief. Social workers aim at improved social functioning for their clients. The social worker is thus invited to become thoroughly engaged in finding ways and means to assist the client who shows signs of complicated grief.

The Complicated Grief Intervention Programme (CGIP) was developed after a literature review on theories and models of grief, and the definition, risk factors and implications of complicated grief were explored. Following the literature review is a thorough discussion of the Dual Process Model and the Task Centered Approach which gave rise to the development of a Complicated Grief Intervention Model (CGIM) for social workers. The Complicated Grief Intervention Programme (CGIP) was compiled and described in detail to demonstrate that the CGIP has the potential to be put into effect.

3. EVALUATION OF THE RESEARCH

This research study was aimed at developing, implementing and evaluating an intervention programme with specific focus on complicated grief to assist social workers to intervene when impaired social functioning is the result of complicated grief. It is hoped that this study will motivate social workers to include the death of a loved one in the assessment of their clients, prior. The aim of this study was not to test the validity and reliability of the programme, but rather to establish its ability to be implemented.

The objectives of this study were:

- To review the literature on complicated grief as relevant to the South African context;
- To screen clients in the South African context for inclusion in a therapeutic complicated grief intervention programme;
- To develop a complicated grief intervention model for social workers.
- To develop a complicated grief intervention programme for social workers in the south African context; and
- To implement and evaluate the proposed therapeutic complicated grief intervention programme in the South African context.

This study is a systematic approach to deal with the emotions and behaviours of the client who shows elements of complicated grief. It aims at identifying the strengths of the client and utilizing these strengths to lead the client towards integrating the loss of a loved one into his/her life instead of cutting the bond between the client and the deceased loved one. It thus also aims at improving the social functioning of the client to such an extent that the client will be able to resume the pre-death activities and functions and to take over the roles of the deceased where applicable.

The Complicated Grief Intervention Programme (GCIP) is an eclectic approach and draws techniques from the behavioural approaches and the solution-focused therapies. It furthermore urges the social worker to be creative in including the client in the therapeutic process and in finding techniques to address the complicated grief issues. The use of visualization, rituals and metaphors specifically requires a

creative mind from the social worker. The implementation of the CGIP furthermore requires extensive preparation for the next session by both the social worker and the client and commitment from both parties is essential for the intervention process to be successful. The CGIP is an approach for the social worker in helping the client who feels stuck in his/her grief, feels blocked from returning to pre-death social functioning, and who needs support and mechanisms to integrate the loss.

Additional comments on this research are:

- An oral presentation based on article 2 was delivered at the 6th Annual Kaleidoscope Conference in Dublin, Ireland during 31 May–3 June 2007.
- Article 3 was presented at the 34th Biennial Congress of the International Association of Schools of Social Work (IASSW) in Durban, South Africa during 20-24 July 2008.
- Article 1 was submitted for review to the Health and Social Work Journal of the National Association of Social Work.
- Article 2 was submitted for review to The Social Work Practitioner-Researcher.
- Article 3 was submitted for review to Health SA Gesondheid.
- Article 4 was submitted for review to Maatskaplike Werk/Social Work
- Article 5 was submitted to Journal of Social Work Practice for review.

4. CONCLUSIONS

4.1. Conclusions on complicated grief in the South African context (Article 1)

The first objective of the research, which was addressed in article 1, was to review complicated grief in the South African context. Research in the field of complicated grief in the South African context is limited.

Conclusions regarding this objective are mostly made on observations from practical experience as a social worker in the South African context and from the literature review.

- It was found that cultural beliefs on death and bereavement, AIDS and cancer related deaths, and crime and socio-political related deaths can all be regarded as possible risk factors for developing complicated grief. This confirms that complicated risk factors are eminent amongst South African citizens.

- It is furthermore concluded that social workers should be more aware of the impact of complicated grief on the social functioning of the client.

- The suffering and misfortune of those who experience complicated grief are basic components of care which must be obligated by social workers in bereavement-related social work. There is no doubt that social workers in South Africa have an important role to play in the following areas regarding complicated grief: development of programmes and services, advocacy, and ethical and legal issues. It is thus of importance for the social worker to enhance his/her knowledge base regarding specifically the identification of possible risk factors leading to complicated grief and the impact of complicated grief on the social functioning of the client.

4.2. Conclusions on screening South African clients for inclusion in a therapeutic complicated grief intervention programme (Article 2)

The efficacy of bereavement intervention in the case of normal grief is questioned and it seems that individuals who experience complicated grief benefit more from bereavement intervention than those with a normal grief experience. The second objective of this research (article 2) was to clarify the necessity to screen clients prior to including them in a Complicated Grief Intervention Programme. Two research questions received attention: *How do we know when we are dealing with complicated grief,* and *Is the loss of a significant other person the reason for the client seeking help or is it due to other factors not related to the loss?* An in-depth literature review on the assessment of complicated grief revealed the extent of the problem when one realizes that 10%–20% of people experiencing the death of a loved one, will suffer from complicated grief.

- It is concluded that people who are referred to social workers often present with a secondary problem such as dependency or relationship problems, and those social workers should be more aware of the impact of death on the social functioning of the client during the initial assessment.

- The literature review indicated that there is still no clear distinction between complicated grief, major depression and posttraumatic stress. But it has been found that the guilt associated with complicated grief is different from the grief associated with Major Depressive Disorder. Complicated grief remarkably changes the client's activities of daily living. Complicated grief comprises a unique cluster of symptoms, occurring in unique circumstances and needs a specific intervention approach.

- This literature review on complicated grief provides a knowledge base for clinical social workers and is a valuable contribution in understanding and assessing clients. Complicated grief is, however, a specialized field in social work and ethical care is necessary in order to do no harm to the client. It is therefore recommended that social workers ensure continuous professional development in this field.

- The Inventory of Traumatic Grief was utilized to screen patients for complicated grief. It did however evoke intense emotional reactions with most of the respondents as they had to complete it prior to therapeutic contact with the researcher. It is recommended that the questionnaire should only be used in a controlled environment rather than being completed by the client on his/her own. This will enable the social worker to support the client while completing the document. The social worker will then also be able to observe the client's non-verbal reactions and the client may feel more secure.

- Assessment is a critical process in social work and plays a valuable role in screening clients for inclusion in a complicated grief intervention programme. The aim of the self-developed Grief Assessment Guide (GASsG) is to continuously assess the client's strengths and stressors in terms of physical, psychological, social and spiritual discomfort during the intervention.

- Although the GASsG was developed with the intention to assess the client in terms of complicated grief, this guideline also contains an element of measurement which allows the social worker to assess the severity of the impact of the component on the social functioning of the client and to ascertain whether change has taken place over the period of investigation. However, the reliability and validity of the GASsG as a measurement tool was not established.

- It was also found that the GASsG needs clearer guidelines on the implementation thereof. The GASsG has the potential to be further developed as a grief recovery measurement tool.

4.3. Conclusions on the Complicated Grief Intervention Model (CGIM) for social workers (Article 3)

The third objective of this study was aimed at developing a social work model for complicated grief intervention.

The researcher came to the following conclusions regarding the Complicated Grief Intervention Model (CGIM):

- It is the researcher's opinion that the Complicated Grief Intervention Model (CGIM) will lead to better understanding of the bereaved client and that it will enhance ethical and effective social work practice in South Africa. The value of the CGIM is evident when one realizes the lack of a model of such nature in the South African context. The purpose of this model is to make small, effective, measurable changes within the ambit of complicated grief. The CGIM urges the social worker to believe that things can change. The social worker focuses on the client's strengths, such as past successes, survival skills and life wisdom.

- The eclectic approach which was followed in developing the CGIM adds to the value of this model in that it aims to address complicated grief from different perspectives.

- The CGIM is a new model and it is anticipated that it will receive comments from social workers and other health care professionals.

- The value of the CGIM lies in the structured intervention process. The words of Watson & West (2006: 9): *"in an occupation such as social work, the process (what we do) is as important as the outcome (what is achieved)"* is embedded in the CGIM.

4.4. Conclusions on the Complicated Grief Intervention Programme (CGIP) for social workers (Article 4)

The fourth objective of the research was to develop a Complicated Grief Intervention Programme (CGIP) for social workers. The goal of the CGIP is to enable the client to integrate the death of a significant other into his/her life in whatever way feels right for him/her. The CGIP takes into account the individual's grief pattern, culture, background and relationship to the deceased.

The following conclusions regarding the fourth objective (article 4) were made by the researcher:

- The CGIP is a generic programme but it is concluded that it must be tailored to suit the needs of each individual client. The CGIP seems to be valuable in mitigating the emotional and practical problems experienced by the client who presents with elements of complicated grief. For social work this implicates that the client is assisted to regain his/her social functioning as close as possible to the pre-loss state of social functioning.

- It is furthermore concluded that the use of the CGIP worksheet and the CGIP task worksheet lead to structured documentation of the intervention process. It serves as a motivational tool for both the client and the social worker in assessing the successes of the intervention. But it is also valuable in re-assessing the relevance of the different objectives throughout the intervention process.

- The intervention techniques mentioned in this study and included in the programme are not the only techniques of relevance in complicated grief. Social workers are urged to be creative in finding ways to explore, develop and research new techniques which could be utilized effectively in complicated grief intervention. It

was however found that the techniques such as desensitization, visualization, client-log, the miracle question, metaphors, rituals, memory work, and humor all added to improved objective outcomes in most of the cases.

4.5. Conclusions on the implementation and evaluation of the Complicated Grief Intervention Programme (CGIP) for social workers (Article 5)

The fifth objective of the research study was to implement and evaluate the proposed Complicated Grief Intervention Programme (CGIP). The actual findings of the study are presented in article 5. The CGIP was individualized to fit the needs and expectations of each respondent. The data collected from the completed Inventory of Traumatic Grief completed by each respondent, and the data obtained from the Grief Assessment Guide (GASsG) were quantitatively analyzed, while themes were identified through qualitative analysis.

The researcher came to the following conclusions regarding the implementation and evaluation of the CGIP:

- Identifying respondents for this study proved to be a difficult process. Due to the sensitive nature of the research, the researcher relied on colleagues, friends and family to refer respondents for inclusion in the research. The researcher's colleagues, friends and family were informed of the inclusion criteria for the study.

- Although it was found to be an emotionally sensitive instrument, it is concluded that the Inventory of Traumatic Grief (ITG) is a valuable tool in assessing complicated grief. It is also useful in analyzing the main themes to be addressed during intervention and is an effective tool to guide the first interview with the client.

- The sample of this research study was too small to test the reliability and validity of the Complicated Grief Intervention Programme (CGIP). It can however be concluded that, taking into account the findings of the research, the CGIP has the ability to be implemented in the South African context, provided that it is adapted to the needs of each individual client. The objective stated in article 5 was thus reached.

- In completing the CGIP intervention worksheet it was found that the column addressing the outcome did not meet the proposed expectations due to the fact that some of the tasks were met simultaneously and were sometimes intertwined. In most instances it was difficult to identify the specific date on which the objective were met. It is thus suggested that the column only indicates whether the objective were met or not, without adding dates. In all other instances, the CGIP intervention worksheet met the proposed expectations and it is concluded that the worksheet adds structure and purpose to the intervention process. It also allows the client to actively participate in the process and to experience the small successes by successfully achieving the tasks. Through this experience the client gains confidence and is able to identify and explore his/her strengths amidst the agony of complicated grief.

- The following themes emerged from the qualitative research:

  - Life is empty.
  - I've been robbed.
  - You get used to death, not over it.
  - The need for information (please inform me).
  - Please listen to me.
  - Don't use that word!
  - Challenge the future.
  - There is life after death.

Although most of these themes seem to be negative, it was found that all the respondents experienced personal growth from their crises.

- A solution-focused approach to complicated grief added to the outcomes of the Complicated Grief Intervention Programme (CGIP).
- The inclusion of the client as an equal partner in the process contributed to the successes gained during the intervention process. Clients were more willing to take responsibility and to search for solutions once they realized ther own strengths and abilities.

- The authors are of opinion that the CGIP can be implemented on all levels of intellectual functioning, gender, age and culture given that the client is engaged as an equal partner.

4.6. Conclusions regarding the objectives

It is concluded that the objectives of this study were achieved:

- Complicated grief in the South African context (Article 1) was reached by analyzing the literature in discussing the differences between normal grief and complicated grief before commencing with a critical analyzing of the risk factors for complicated grief in South Africa.
- Respondents were screened for complicated grief prior to inclusion in the Complicated Grief Intervention Programme (CGIP) by means of the Inventory of Traumatic Grief (ITG) and were only accepted on the CGIP once they adhered to the inclusion criteria as described in article 2.
- A Complicated grief Intervention Model (CGIM) were developed for social workers (Article 3).
- A Complicated Grief Intervention Programme (CGIP) for social workers was compiled (Article 4).
- The proposed Complicated Grief Intervention Programme (CGIP) was implemented in the South African context and evaluated according to the empirical findings (Article 5).

4.7. Conclusion regarding the research aim

The aim of this research, namely to develop, implement and evaluate a therapeutic complicated grief intervention programme, has been achieved. It was clear that the CGIP has the potential to be implemented in social work intervention.

5. RECOMMENDATIONS FOR RESEARCH, POLICY AND PRACTICE

The following recommendations are suggested for future research:

- It is indicated that intervention may be more helpful for individuals experiencing complicated grief. Research on a proactive screening tool to identify

individuals (adults and children) who may be at risk for a complicated grief response may offer preventative health benefits.

- Research is needed to identify most appropriate social work interventions to respond to complicated grief in the following populations: parents who have experienced the death of a neonatal infant, parents who have experienced the death of an infant, parents who have experienced the death of a child/adolescent, and parents who have experienced the death of an adult child.

- Research on the validity and reliability of the CGIP for adults, adolescents and children will be valuable.

- Research regarding the knowledge base of social workers with regard to complicated grief and the inclusion thereof in the assessment of factors leading to impaired client social functioning.

- Research regarding social work skills to individualize complicated grief intervention to suit the needs of the client is needed.

- Further research is needed to develop the Grief Assessment Guide (GASsG) as a measurement instrument in complicated grief intervention.

- Research is needed to examine preparation for death and the perceptions of quality of death by bereaved survivors (including children) as factors associated with complicated grief.

- Research is needed on the impact of multiple deaths as a result of HIV and AIDS in diverse culture groups in South Africa.
- Further research is needed to examine the effectiveness of support group intervention for individuals (adults and children) with complicated grief following the death of a loved one due to HIV and AIDS.

- Research is needed with regard to establish the effectiveness of internet-based complicated grief intervention.

- Further research is needed to identify the most appropriate interventions to respond to complicated grief in all populations.

- Research is needed to identify the elements of a palliative care approach (end-of-life care) that may be protective factors associated with complicated grief.

- Research is needed regarding the role of the social worker in an inter-disciplinary approach to complicated grief.

- It is recommended that South African social workers, psychologists, psychiatrists and professional nurses contribute towards the global discussions on complicated grief through established forums and professional meetings.

- It is further recommended that training programmes on the Complicated Grief Intervention Programme (CGIP) e developed and presented in order for social workers to implement the programme.

6. SUMMARY STATEMENT

Complicated grief is a fairly new concept in all of the human sciences and the risk factors and intervention strategies are thoroughly debated by these professionals. Complicated grief is not only a relatively new concept but it is also a dynamic concept with constant changes and additions. As an example it is relevant to mention that, since the onset of this research in 2006, the term *prolonged grief* is preferred above that of *complicated grief* and *traumatic grief*. Although it is indicated that only a small percentage of the population experience complicated grief, the percentage is high enough (10%-20%) to draw the attention of the human science professionals, including social workers.

This research is certainly of relevance for social workers and one only has to observe the high levels of crime and the increase in AIDS-related and cancer-related

deaths to realize that many South Africans stand at risk of developing complicated grief. While complicated grief is not yet added as a distinct mental illness to the DSM IV-TR, social workers should be more aware of the implications of complicated grief on the social functioning of the client.

This research study adds value to the South African literature on complicated grief. The insights gained through this research study proved the need for South African theoretical models or approaches and for intervention programmes such as the Complicated Grief Intervention Programme (CGIP).

It is hoped that this research will act as motivation for better understanding and intervention of complicated grief following the death of a loved one.

REFERENCE

WATSON, D., & WEST, J. 2006. Social work process and practice: approaches, knowledge and skills. Tokyo : Palgrave Macmillan.

SECTION D

APPENDICES

INFORMED CONSENT TO PARTICIPATE IN RESEARCH ON A COMPLICATED GRIEF INTERVENTION PROGRAMME

You are invited to participate in a study conducted by Cornelia M Drenth (enrolled PhD student at the Northwest University, Potchefstroom). With this study we hope to implement and evaluate an intervention programme to address complicated grief in South Africa. As a participant, you will receive a series (6-12 sessions) of therapeutic interventions. Evaluation of the success or failure of the programme will be done at regular intervals during the intervention period.

All information gathered in this study will be disclosed only with your permission. We promise to protect your confidentiality so that no reports that result from this study will identify you as having been a participant. If you decide to participate, you are free to withdraw from the study at any time without prejudice.

A research committee of the mentioned university has reviewed this study and approved the research.

By signing the consent form below, you indicate that you have read the document and that you voluntarily agree to participate in the study.

Full name of participant: _____

Signature of participant: _____

Date: _____

THANK YOU

INVENTORY OF TRAUMATIC GRIEF (ITG)

Please mark the box that best describes how you have been feeling over the past *month*.
The blanks refer to the deceased person over whom you are grieving.

Almost never = less than once a month
Rarely = once a month or more, less than once a week
Sometimes = once a week or more, less than once a day
Often = once every day
Always = several times every day

1. The death of _____ feels overwhelming or devastating.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

2. I think about _____ so much that it can be hard for me to do the things I normal do.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

3. Memories of _____ upset me.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

4. I feel that I have trouble accepting the death.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

5. I feel myself longing and yearning for _____.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

6. I feel drawn to places and things associated with _____.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

7. I can't help feeling angry about _____'s death.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

8. I feel disbelief over _____'s death.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

9. I feel stunned, dazed or shocked over _____'s death

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

10. Ever since _____ died it is hard for me to trust people.

No difficulty trusting others (1)	A slight sense of difficulty (2)	Some sense (3)	A marked sense (4)	An overwhelming sense (5)

11. Ever since _____ died I feel like I have lost the ability to care about other people or I feel distant from people I care about.

No difficulty feeling close or connected to others (1)	A slight sense of detachment (2)	Some sense (3)	A marked sense (4)	An overwhelming sense (5)

12. I have pain in the same area of my body, some of the same symptoms, or have assumed some of the behaviors or characteristics of _____.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

13. I go out of my way to avoid reminders that _____ is gone.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

14. I feel that life is empty or meaningless without _____.

No sense of emptiness or meaninglessness (1)	A slight sense of emptiness or meaninglessness (2)	Some sense (3)	A marked sense (4)	An overwhelming sense (5)

15. I hear the voice of _____ speak to me.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

16. I see _____ stand before me.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

17. I feel like I have become numb since the death of _____.

No sense of numbness (1)	A slight sense of numbness (2)	Some sense (3)	A marked sense (4)	An overwhelming sense (5)

18. I feel that it is unfair that I should live when _____ died.

No sense of guilt over surviving the deceased (1)	A slight sense of guilt (2)	Some sense (3)	A marked sense (4)	An overwhelming sense (5)

19. I am bitter over _____'s death

No sense of bitterness (1)	A slight sense of bitterness (2)	Some sense (3)	A marked sense (4)	An overwhelming sense (5)

20. I feel envious of others who have not lost someone close.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

21. I feel like the future holds no meaning or purpose without _____.

No sense that the future holds no purpose (1)	A slight sense that the future holds no purpose (2)	Some sense (3)	A marked sense (4)	An overwhelming sense (5)

22. I feel lonely ever since _____ died.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

23. I feel unable to imagine life being fulfilling without _____.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

24. I feel that a part of me died along with the deceased.

Almost never (1)	Rarely (2)	Sometimes (3)	Often (4)	Always (5)

25. I feel that the death has changed my view of the world.

No sense of a changed world view (1)	A slight sense of a changed world view (2)	Some sense (3)	A marked sense (4)	An overwhelming sense (5)

26. I have lost my sense of security or safety since the death of _____.

No change in feelings of security(1)	A slight sense of insecurity (2)	Some sense (3)	A marked sense (4)	An overwhelming sense (5)

27. I have lost my sense of control since the death of _____.

No change in feelings of being in control (1)	A slight sense of being out of control(2)	Some sense of being out of control(3)	A marked sense (4)	An overwhelming sense (5)

28. I believe that my grief has resulted in significant impairment in my social, occupational or other areas of functioning.

No functional impairment(1)	Mild functional impairment(2)	Moderate (3)	Severe (4)	Extreme (5)

29. I have felt on edge, jumpy, or easily startled since the death.

No change in feelings of being on edge(1)	A slight sense of feeling on edge (2)	Some sense (3)	A marked sense (4)	An overwhelming sense (5)

30. Since the death, my sleep has been...

Basically okay(1)	Slightly disturbed(2)	Moderately disturbed (3)	Very disturbed(4)	Extremely disturbed(5)

31. How many months after your loss did these feelings begin?

_____ months.

32. How many months have you been experiencing these feelings?

_____ months. (0= never)

33. Have there been times when you did not have pangs of grief and then these feelings began to bother you again?

Yes (1)	No (2)

34. Can you describe how your feelings of grief have changed over time?

ADDITIONAL REMARKS

35. Please describe the impact of the death on your day to day functioning.

36. Do you sometimes feel that you are different because you are not grieving in the way as prescribed by the community? If your answer is "yes", then please motivate why.

THANK YOU

REQUEST TO USE INVENTORY OF TRAUMATIC GRIEF (ITG)

P.O. Box 43551,
THERESAPARK
SOUTH AFRICA
0155

Dr Holly Prigerson,
Dana Faber Cancer Institute,
44 Binney street,
Shields Warren 440A
Boston, MA 02115

Dear Dr Prigerson,

I am an enrolled PhD Social Work student at the University of Northwest in Potchefstroom, South Africa. My field of research is complicated grief with specific emphasis on developing an intervention programme.

I herewith request your permission to use the *inventory of Traumatic grief* as a screening instrument to ascertain the client's level of complicated grief. I will credit you and the ITG where appropriate.

I thank you for your assistance and look forward to hearing from you soon.

Yours sincerely,
Nelia Drenth
Studies/korresondensie/prigerson