ADULTS' PERSPECTIVES ON LOSS AND GRIEF. A CASE STUDY OF KIAMBU MUNICIPALITY, KENYA

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Adult perspectives on loss and grief: a
DECLARATION

This project is my original work and has not been presented for a degree in any other university or any other award.

Signed ___________________________ Date ______________________

Kamau Grace Wangui

I confirm that the work presented in this project was carried out by the Candidate under my supervision and with my approval as a university Supervisor.

Signed ___________________________ Date ______________________

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DEDICATION

This project is dedicated to my husband Karanja Mbugua for his love, support and faith in me and to my children Karen Ivy and Andrew Mbugua for their patience and understanding.
ACKNOWLEDGEMENTS

This work could not have been completed without the material and moral support from other people which was given freely and generously. To all who played a part I say thank you.

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Special thanks to my husband M.C.Karanja who wholly financed my study and the research. His keen interest, love and support largely contributed to the actualization of this research. In addition I appreciate that he took care of our children during all the time I was doing the research.

My most sincere gratitude goes to Karen Ivy Karanja, My daughter for her faith in me and endless moral support especially during data collection and analysis. She encouraged me most to desire to take the first step towards being a scholar-in her words ‘a famous scholar’ Thank you my baby girl, I hope to lead the way as you follow. My acknowledgements also go to my son for his love and encouragements.

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The need for loss and grief intervention has been recognized in various institutions of health and learning throughout Kenya. Development plans and policy papers have made various recommendations as regards the provision of guidance and counselling in schools and colleges.

In sub-Saharan Africa millions of people die every year as a result of sickness, accidents, famine, war and poverty related issues. In Kenya alone with prevalent rate of 13% HIV/AIDS and mortality rate of 700 adults per day the country is experiencing loss and grief at an alarming rate. Widows are left at the mercy of unscrupulous relatives who are more interested with property inheritance than caring for the children who have been left behind. Widowers on the other hand are left to care for themselves and their children contrary to the normal African practice.

Hitherto, Africans have been known to enjoy the extended family and social support. With everyone seeking to adapt the western lifestyle the close affiliation is slowly being eroded. This poses the danger of experiencing loss and grief in isolation. One must contend not only with the loss but also loneliness. The situation is exacerbated by lack of psychological intervention. This in turn leaves many people unable to process the loss they have experienced in a healthy way.

This research was conducted in Kiambu Municipality and it involved fifty purposefully selected bereaved adults 20 males and 30 females who have experienced grief within the last five years. It further involved 30 practicing counsellors.
Data was collected through questionnaires which were self-administered to the bereaved and the counsellors.

The data was analyzed through descriptive statistics such as frequency distributions and percentages. Qualitative descriptions were also used in the data presentations.

The overall aim of this study was to study how adults perceive the loss of a significant other in their lives. The study focused on adults' perceptions on the loss of a significant other. Included in this study is the loss of a parent, spouse, child and sibling. This study was intended to find out gender disparities in perceptions, age variations in terms of perceiving loss and grief, the role of social and religious support in times of grief. The difference of perceptions in regard to the place of death, the category of death in relation, period of death, the age of the deceased and the marital cum economic status and level of education of the bereaved person.

This study was guided by the principle that the perception of the adult determines his or her desire to seek intervention whenever faced by loss and grief. In addition, perceptions also determines whether one goes through normal or abnormal grief hence regarding to seek possible counselling intervention in mitigating complicated and pathological mourning.

The main findings of this research was that each adult perceives death in a very unique way which majority are aware of. Adults in Kiambu are also aware of counselling services offered as intervention for loss and grief. Those who do not seek professional
support seek social and religious support. The adult’s perceptions to loss and grief range from psychological, physical, social, and spiritual to philosophical.

Further information revealed that counsellors offer loss and grief therapy. According to the counsellors who responded, the study concluded that, there is need for more support from the Health and Education sectors in terms of adequate training, facilities, relevant reading materials and in service courses where therapists can receive more skills and techniques.

Based on the findings, the study concluded that adults going through loss and grief are aware of counselling services available but have limited knowledge of its therapeutic value. Grief therapy has contributed to: - greater self awareness during grief, providing time to mourn and the necessary support during and after grief.
CHAPTER ONE: INTRODUCTION

Loss is an integral part of life. Any event that involves change is a loss that makes it necessary to go through the experience of grief and transition. A loss requires some part of an individual be left behind and grieved before the process of transition and rebuilding can occur.

Adaptation refers to the concept of letting go of that which has been lost, compromising and adjusting to and accepting a new life. This process does not work like a straight line it is rather cyclical in nature. It may involve many painful returns to the beginning and starting the process all over.

An effective resolution involves an interactive involvement between the affected person and a trained helper. This is because loss, grief and mourning violate personal boundaries and remove a sense of security and control. The affected person will never have his/her former identity as before. He/she is no longer attached to a person, treasured object or hitherto familiar activity that used to provide security, meaning and purpose.

In many communities, the process of grieving is perceived as something that can be confined to a specific period of time. However, helping professionals have observed that the process may involve frustrating returns to earlier experiences of grief. It takes different forms and modes for every individual. In essence, every person perceives
loss in a unique way. Some people see each loss independently while others interpret it in connection to other previous losses experienced in life.

Loss is not confined to a specific group of people. The counsellors are not an exception. It is therefore incumbent upon them to be in touch with their own losses before they embark on helping others through various intervention methods.

1.1 Background to the study

In medieval times, death was perceived as a more common occurrence than today. Life expectancy was much shorter than it is now. It is also important to note that the manner of death was more violent, cruel and physically more painful. Death was unpredictable and uncontrollable. Given the infant mortality rates, wars, plagues and natural disasters, everyone was likely to have lost someone. This was mitigated by a belief in an afterlife. A belief that death is not the absolute end and that the soul moves to another place or that one is reborn in another form. It is this comforting idea that has revolved as man continually realises that death is an inevitable part of living.

With the age of enlightenment, scientific understanding grew. Each wave of discovery was followed by biological and medical discoveries. By the end of the nineteenth century both pain and disease were beginning to be controllable. Fewer women died in childbirth, disease had become less random and more controlled through prevention and cure. In addition, life had become longer and more predictable.
In the recent past, with the recent spate of man made disasters in the name of technological advancement, death has returned to be a normal and frequent occurrence. It occurs in different places and forms such as the world wars (1914-1918 and 1945), terrorism gas leak at Bhopal (1986), and the King’s cross underground fire (1987), the war and concentration camps in Yugoslavia (1991) and so on.

In Africa today, death is a daily occurrence. With the HIV/AIDS pandemic, diseases like malaria and tuberculosis, genocides in countries such as Rwanda and Burundi, famine and floods, death looms in every homestead.

1.2 Statement of the problem

In Kenya alone, accidents claim thousands of lives every year. They come in the form of sinking ferries, road carnage, endless fires in slum areas, office blocks and market places, plane crashes etcetera. In the hospitals and homes there are other hundreds of numbers of people dying of cancer, heart diseases, diabetes and others. The Kenyan disaster management journal reports that in 1997, the El-nino caused displacement of 60,000 families and subjected 1.5 million people to starvation. The River Tana floods of the year 2002 caused seventy two deaths.

In Kiambu, the HIV/AIDS is very prevalent; it is rated as the fifth district in the country in terms of transmission and mortality rates related to AIDS. It is also an area where murders related to robbery with violence take place almost on a weekly basis. In addition, the Kenyan disaster management journal reported sixteen deaths as a result of the Riara River flooding in November 2002.
Loss and grief affects people in different ways and for some, especially those whose health are compromised, the loss of a significant other can exacerbate mental and physical health or even lead to death. For most people loss is an integral part of living. It is only those who die young that escape the pain of losing someone they love through death.

The anguish of those left behind has always been an issue of concern for the society. In addition, this country hosts over forty ethnic groups with different cultures and perspectives on loss and grief. Today, the country’s policy makers, educators, social workers and health professionals are becoming more and more concerned about bereavement tolls. There is growing public interest among counsellors and psychologists in the country to prevent stress related illnesses including those that may be precipitated by grief. Almost uniformly, the stress researchers agree that the loss of a spouse is the most potent stressor in life.

As Eisenbruch (1984) has pointed out, it is the western form of grief and mourning which have received most attention in the relevant literature. However, recognition that individual cultural patterns need to be considered in psychiatric practice is growing. Interest in the importance of the subjective meaning of grief would suggest that a person’s culture is of importance in terms of explanation of causes and consequences for one’s system of values in regard to loss.

While there are many ethnographic accounts of different mourning practices the issue of ethnicity in multicultural societies, raises profound problems in connection with the way the grieving process has been conceptualized.
1.3 Purpose of the study

The purpose of this study is to find out the adult’s perspective on the loss of a significant other. The perspectives will be sort on various issues such as; place of death, coincidental losses, successive losses, nature of loss, community support networks, cultural background, intimacy level of lost relationship, life stage of the griever, grief history of the griever, emotional complexity of the griever, degree of isolation and capacity to trust others, ability to express feelings, ability to tolerate feelings, desire for change, preparedness to trust in counselling relationship.

1.4 Research objectives

By the end of this research I should be able to:

1) Define terms associated with loss and grief
2) Discuss major theories of loss and grief
3) Clearly identify types of losses
4) Find out the different perspectives of loss
5) Find out the major manifestations of grief
6) Identify the determinants of grief.
7) Find out the effects of the loss of a significant other
8) Identify the goals of grief counselling.
1.5 Research Questions

The research questions for this study include:

1. What are the major perspectives on loss and grief?

2. What are the major manifestations of loss and grief?

3. How are the determinants of grief?

4. What are the tasks of grieving?

5. How do we identify complicated grief?

6. How do adults adjust to loss?

7. What are the goals of counselling in loss and grief?

1.6 Significance of the study

The counsellor needs a framework in order to clearly comprehend the experience of loss and grief. The framework becomes a holistic tool that allows one to gain fuller access to the client’s private world of his/her grief and his/her unique experience of it.

In this research I will focus on the following four perspectives: philosophical, spiritual, psychological and physical.

This research will improve the effectiveness of the helper in regard to the issues arising as a result of loss and grief. Understanding categories loss and grief provides a framework that encourages the counsellor to examine and organize the effects of prior
losses, to understand the full significance of the present loss and to anticipate secondary or symbolic losses that could occur as a result of the present losses that develop as a consequence of the first loss. This helps the counsellor to fully understand the present behavior of grieving person and what the loss means to him/her. Counsellors using this information can educate, prepare and plan more intervention strategies for coping and grief resolution.

Little research has been carried out in this area in Kenya and therefore it is my hope that it will provoke discussion and further research.

1.7 Assumptions of the study.

This study is will be carried out with the assumptions that

1) The respondents will be telling the truth about their loss and that they have actually experienced loss within the last five years.

2) The instruments of the research are reliable and would consistently produce the same research if replicated elsewhere.

3) The sample selected will be representative of the entire population.

1.8 Scope and delimitations of the study

This research is confined to Kiambu municipality because time, duration and funding cannot allow a research on a wider scale. Therefore any generalization should be done with caution. This is especially so because Kenya is a multicultural country.
On the other hand, one of the variables in this research is perspectives. Being in the affective domain, perspectives keep changing every now and then.

1.9 Definition of terms

Loss

This is the state of being deprived of or being without something one has had, or a detriment or disadvantage from failure to keep, have or get.

Grief

This refers to the process of experiencing the psychological, social and physical reactions to one’s perception of loss. It is also the pain and suffering experienced after loss.

Mourning

This refers to the time or period during which signs of grief are manifested.

Bereavement

This refers to the state of having suffered loss of a close relationship. The bereavement experience includes concept of grief, as pain and suffering is experienced in order to heal and resolve the event. It includes ideas of reactions,
adaptation and mourning process. The bereaved person reacts emotionally as the pain of grief is experienced and gradually reacts cognitively and behaviorally as a new identity is formed and a life is rebuilt. To be bereaved means one has suffered loss.

Anticipatory grief

Anticipating grief refers to the process in which a bereaved person goes through the phases of grief in advance. The person dying goes through bereavement overload. Anticipating death helps the individual involved to process their grief appropriately because they are not caught unaware.

Complicated /pathological grief

This refers to when grief becomes chronic. Prolonged grief may be masked or hidden in psychosomatic symptoms. The causes of pathological grief in the bereavement crisis are dependent on the way the object is used to resolve mourning. Pathological grief is perceived in terms of fear of the future and the expending of energy results in tension in a continuous search towards finding and bringing meaning to the attachment figure. "Pathological grief is the intensification of grief the level where the individual is overwhelmed, resorts to maladaptive behavior or remain interminably in the state of grief without progression of the mourning process towards completion. Pathological mourning involves processes that do not move progressively towards
assimilation or accommodation but instead lead to stereotyped repetitions or extensive interruptions of healing” (Mardi Horowitz et al. 1980, AJP, Vol 137, p1157

Delayed grief

This is when the person who has suffered loss subjectively accepts that fact but due to fear of losing control, guilt, hostility and other feelings keeps hoping that something will happen to change that fact or situation.

Inhibited grief

This is where the affected person consciously or unconsciously refuses to accept the loss for example after one loses his/her job through retrenchment but wakes up every morning and prepares as if he/she is going to work. There are cases of people whose relatives disappeared and they lived as though expecting them to reappear. This has been an observed as a common case where people die of natural catastrophes such as earthquakes, flooding and others. They live expecting them to walk back home any time. Relatives of people who die in plane crash also find it difficult to process their loss through grieving because they are never sure whether one is not lost somewhere in the scene of accident or maybe he/she could be hospitalised. The affected persons prefer not to think negatively and hence keep the hope. In short the mode of loss determines the grief process.

Categories of loss

There are several types of losses. Understanding those categories provides a framework that encourages the counsellor to examine and organize the effects of prior
losses, to understand the full significance of the present loss and to anticipate secondary or symbolic losses that could occur as a result of the present losses that develop as a consequence of the first loss. This helps the counsellor to fully understand the present behavior of grieving person and what the loss means to him/her. Counsellors using this information can educate, prepare and plan more intervention strategies for coping and grief resolution.

Relationship loss

Examples include death of a loved one, illness, divorce and separation, abandonment, rejection, abuse by a trusted person, relocating and others. Any change in relationship as we know it, constitutes a relational loss.

Loss of some aspect of self

As human beings, we cannot experience a relational loss without losing an integral part of ourselves in it. This is mainly because we view ourselves from the feedback we get in the process of interacting with others or through the dynamics of the relationships we. Professional burnout and impairments are involved in. A major component of the grief process involves letting go a former identity, grieving that part of oneself that is gone forever and rebuilding a new identity. The loss of some aspect of self is also experienced in child abuse, rape and other forms of disappointments are also profound losses of self.
Loss of treasured objects

Objects are physical and tangible and their significance is intangible. A treasured object is any object that connects one in reality or memory to an important relationship or some aspect of identity. Loss of a lifestyle is an intangible loss in this category and often occurs after loss in another category such as divorce and death.

Developmental losses

Developmental losses are a natural part of life cycle, and are often not recognizable. Growth, insight and maturation are losses because change is involved and a part of self is relinquished. Maturing, aging and physical changes can bring very poignant losses. Developmental losses often compound or confuse more visible losses.

Children who loss their significant others through death, the grief process may span their developmental stages. For children, at each new stage of development, the loss will be re-evaluated and new meaning will be integrated. Developmental losses can take many forms. To be able to adapt we must grieve to let go, to grow and to make future attachments.

Ethnic group

This refers to a collectivity within a larger society having a real or putative common ancestry, memories of a shared historical past and a cultural focus on one or more symbolic aspects defined as the epitome of that people hood (Schermehorn 1978:12)

Behavioral ethnicity
This refers to the extent to which a person has learnt distinctive values, beliefs and norms of an ethnic group. It also refers to the extent to which these things form the person’s day to day interactions both within that group and within the broader social context (Stein and Hill 1997).

Ideological ethnicity

Ideological ethnicity is based upon customs and belief systems which may be adhered to on certain occasions but do not form a person’s day today life.
CHAPTER TWO: REVIEW OF RELATED LITERATURE

Introduction

There are a number of models and theories of loss and bereavement. They include the classical psychoanalytical theory of Sigmund Freud, psycho dynamism, interpersonal, crisis intervention, cognitive and behavioral theories. Each conceptual framework tries to account for the various normal and pathological processes and outcomes related to bereavement.

2.1 Theoretical Framework

Rather than representing rigidly different schools of thought, the various theories and models of loss and grief models overlap. They tend to differ in the amount of emphasis placed on different aspects of responses and in their therapeutic techniques. Although many psychologists use an eclectic approach, employing concepts from several different schools of thoughts, of particular interest is the convergence between the psychodynamic and cognitive approach. They both place importance on the meanings attributed to the loss and what happens to the surviving person’s self concept as a result. Overlap occurs in conceptualisations regarding impulses and defenses that emerge during grieving, belief systems and in assessment regarding a person’s perceived locus of control.

In regard to essential points of each of these models, it is good to note that theoreticians from the various perspectives may use different vocabulary to describe
the same basic phenomena. What the behaviorists describe as maladaptive social reinforcement may be seen by psychoanalysts as a problem with dependency.

All the models and theories have attempted to explain the complex process experienced after a major loss in life. There is evolution of theory other than creation of distinct new ones. The focus has moved from theories of attachment and loss to concepts of acute grief, to tasks, to stages, to psychological processes and phases. Rando incorporates various theories and integrates various concepts into her 6 ‘R’ process of mourning that occur within three phases of grief and mourning.

2.1.1 Freud psychoanalytic approach on personal attachment

The classical psychoanalytic model rests on the Freudian theory. According to him grieving presents a dilemma because there is need to relinquish the tie to the cherished love object if one is complete the grieving process. ‘Letting go’ of the deceased involves a lot of pain. Initially, the bereaved person is likely to deny that the loss has occurred. He or she may still continue to invest in to the lost person, become more preoccupied with the image of the deceased and loose interest in the outside world. Eventually however the memories are brought forth and reviewed, the person’s tie are gradually withdrawn.

Freud put an emphasis on personal attachment to objects and people and giving up some part of the self following a loss. Attention to this loss of some aspect of self is an integral part of the resolution. However it is the part that is negated and avoided. The importance of healing the internal void within us, or that part that has been
eliminated because of loss, is not often understood as the foundation of self
restoration. Freud offered that the ego has to disengage from that which has been lost
and eventually withdraw energy from the lost object. The bereaved has to grieve and
let go multiple layers of attachments in the form of stored memories and symbols that
are involved in the formation of the relationship in a slow and arduous process, the
reality of loss is accepted by the ego and instinctual energy is withdrawn. Thus the
ego can accommodate the loss and search for new attachments. Freud hence offers an
understanding of the multiple levels of human attachment and the difficulty facing the
bereaved who must undertake the task of grief work. Theoreticians continue to focus
their attention on the internal psychic structures, defense mechanism and intra-
psychic processes. They are also concerned with interpersonal dynamics and the way
in which relationship issues may affect our self concept and that of others

Based on the Freudian theory, psychologists seem to largely agree that
psychological processes do not take place in vacuum. Social cultural factors, values,
and beliefs all play in the way we perceive, interpret and understand loss. The
personality of the grieving person affects the whole grieve experience ranging from
the initial perception of loss to the way the grief is or is not resolved. Habitual styles
of perception, thoughts coping and defense determine how a person experiences and
handles all life's situations and these same modes are called upon to deal with loss
and grief related stress.

Horowitz et al observe that people who are particularly vulnerable to difficulties
following a loss and grief have latent images of themselves as being bad, incompetent
or hurtful. They speculate that loss activates these once dormant negative images and
find distorted thoughts about the self and others intensify the grieving process frequently resulting in pathological grief. Self concepts that appear to complicate grieving include feeling too weak to function without the deceased resulting in overwhelming instead of tolerable sadness, considering oneself hostile and somehow responsible for the death leading to intensified guilt and feeling damaged or defective leading to a sense of emptiness and apathy.

2.1.2 Lindermann study on the six characteristic of acute grief based on families whose members had died in an accidental fire.

Lindermann (1944) did a research with bereaved family members who had died in an accidental fire in 1942. Lindermann came up with six characteristics of acute grief:

1) Somatic distress,

2) Occupation with thoughts and images of the deceased,

3) Guilt related to the deceased or the death event,

4) Hostile reactions,

5) Loss of function and

6) A tendency to assume traits of the deceased in one’s behavior

Lindermann views grief as work with specific tasks to be completed. His tasks include: undoing emotional and psychological attachments with the deceased, readjusting to an environment without the deceased and rebuilding new relationships.
2.1.3 Elizabeth Kubler Ross on death and dying.

She gave a landmark contribution on death and dying (1969). Her focus was on those who were dying. Her tenets of the stages were based on the Freudian concepts. Her primary intention was to understand those who had a terminal prognosis and to facilitate a supportive process of coming to terms with one's own death. She interviewed over 200 patients going through terminal illnesses and identified five predictable stages in those who are dying:

1) denial
2) anger
3) bargaining
4) depression
5) acceptance

2.1.4 John Bowlby Attachment Theories.

In volumes entitled attachment and loss (1969, 1973, 1980) he explores instinctive and attachment behavior of human beings and animals, the course of development (ontogeny) of human attachment, an ethnocological approach to fear and trauma of loss. In addition to his research his clinical work with children and adults on issues of separation and grief has provided a wealth of knowledge and framework of interventions. His professional background was psychoanalytical.
Bowlby (1980) believes that attachments are developed early in life and have a basis of security and survival for individual. When these attachments are endangered and broken, there is a normal human response of anxiety and protest. He bases much of his theory on findings from his work with children separated from their mothers. The reactions had a biological basis, were instinctual and adaptational and provide a basis for survival. Bowlby views mourning as including a variety of psychological process. He cites four general phases:

1) Numbering
2) Yearning and searching
3) Disorganization and despair
4) Reorganization

He maintained that future losses would be influenced and processed by these cognitive biases. Bowlby's intervention focused on cognitive insight and restructuring. He emphasized the need to process information, "for it is only when the detailed circumstances of loss and the intimate particulars of the previous relationship are dealt on in the consciousness that the related emotions are not only aroused and experienced but become directed towards the person's and connected with the situations that originally aroused them." (1980-2000) Once insight is gained and the cognitive and emotional aspects of the relationships have been explored and experienced the bereaved progresses towards changing cognitive constructs. How one viewed one's world and experienced it no longer applies. Life will never be exactly the same. But it can be meaningful again. However this necessitates the creation of a new internal template of how one will view one's world.
2.1.5 Willam Worden theory of counselling

He provides a practical application of established theory in counselling. In his book, Grief counselling and grief therapy (1991) he focuses on counselling for the task of grief. He also emphasizes on assessment and intervention. His tasks of grief were built on Lindemann’s approach that delineated three tasks and Bowlby’s conceptualization of attachment and loss. He views mourning as necessary and sees counselling as a facilitative process that allows the bereaved to identify four specific tasks of grief.

1) Accept the reality of loss
2) To work through the pain of grief
3) To adjust to an environment in which the deceased is missing
4) To emotionally relocate the deceased and move on with life

It is a cognitive acceptance that the loss has occurred. Working through the pain of grief entails a willingness to fully experience the pain of grief and the additional pain that will keep emerging during the task of grief work, adjusting to the environment in which the deceased is missing is pervasive and continuous aspect of grief work. The environment is everywhere; places, people, events, music, holidays and so forth. The environment is ever present and it is a constant reminder of one’s loss.

Lastly to let go emotionally and to reinvest in life again does not mean forgetting nor does it necessarily mean re-marriage. It means the bereaved realize that their emotional output to the deceased cannot be returned to them as it previously had been
2.1.6 Therese A. Rando’s processes of mourning

She proposes 6 r processes of mourning. She mainly addresses loss following death, but states that her model may be reorganized to other types of loss. The model elaborates the grieving tasks and includes phases during which they may occur. She broadens Worden’s work. The phases include:

Avoidance phase

It means to recognize the loss. This includes both the cognitive acknowledgement that the loss has occurred and to take a meaningful understanding about the death or loss event.

Confrontation phase

The bereaved must react to the separation from that which has been lost. This includes fully experiencing the pain, finding appropriate expression for the full range of emotions and identifying and grieving the secondary and symbolic losses that will emerge from the current loss event. It is also necessary to recollect and re-experience the deceased and the relationship through reviewing and remembering. Lastly, during this phase the bereaved must relinquish the old attachments to the deceased and the old assumptive world.
Accommodation phase

It includes the processes of readjusting to a new world without forgetting the old and re investing in a meaningful life.

2.2 Manifestation of grief.

Feelings

Sadness- Sadness may take the form of crying. Sometimes, it may be overwhelming and may lead to feelings of being very low and disillusioned.

Anger -It is a very confusing feeling. It is often a very disturbing reaction especially when directed to the self or others around you. The mourner can also be very angry with the dead person for having left him or her. Anger results from two sources;

1. At the sense of frustration that there was nothing one could have done to prevent the death and

2. From a kind of regressive feeling that occurs after loss.

Guilt and self reproach-Guilt over acts of omissions, is another feeling which often follows the death of a loved one. It is connected to not being kind enough to the dying person or not being there at the time of their death

Worden(1982) has suggested that irrational guilt follows bereavement. For some people however the guilt may become a chronic complication.
Anxiety—It may take different forms such as persistent feelings of insecurity and panic attacks. Worden (1976, 1982) says that anxiety may stem from fear of being unable to survive without the significant other and fear of being overwhelmed by grief. Sometimes the bereaved feels like he or she cannot cope without relying on the emotional support of the deceased. Anxiety may also arise from the increased awareness of one’s own death. One may keep feeling that he or she is next.

Loneliness—As Weiss (1974) has indicated, there are different types of loneliness. One sort of loneliness arises from the loss of someone special to interact with and the other one is lack of company in general.

Helplessness—Excessive dependency predisposes the survivor to difficulty in grieving. Parkes, Weiss and Lopata found out that widows in over dependent relationships tended to be characterized by positions of helplessness, indecisiveness and intense yearning. They also experience frightening levels of anxiety.

Shock—It is usually associated with sudden deaths resulting from accidents, suicide and short illnesses. However, even in situations where death was long anticipated, shock may still be experienced.

Numbness—The bereaved appears to have no feelings at all especially soon after the death has occurred. Sometimes he/she responds in a slow, automatic and cold manner.
Physical reactions

Collin Murray (1986) describes grief appearing in physical form in the following symptoms:

I. Hollowness in the stomach
II. Tightness in the chest
III. Tightness in the throat
IV. Oversensitivity
V. Depersonalization/derealization
VI. Breathlessness
VII. Muscles weakness
VIII. Lack of energy
IX. Dry mouth

Cognitions

Jane Littlewood (1983) observed that certain thoughts and behaviors are prevalent when one is experiencing grief. They are common in the early stages and often disappear with time. When and if they trigger and persist they may lead to depression and extreme anxiety. They include;
Disbelief - It is a common and usually transient reaction to bereavement. It is more likely to be experienced by mourners who were not present in the time of death or who for some reason did not see the body of the dead person.

Preoccupation with the thoughts of the deceased

Most mourners are preoccupied by the images of the dead person. They spend so much energy and time thinking and feeling the pain of the memory. Events leading to the death may be obsessively reviewed in an increasing and desperate attempt to understand what happened. Many people feel that the death could have been prevented or that the review may reveal more details of the cause of the death.

Hallucinations

Many people believe that they see or hear the dead person. These experiences may be interpreted in different ways. They may frighten or comfort some. Littlewood reports in her research that 20% of elderly people living alone reported auditory hallucinations lasting for one year after the death of a close person.

Sense of presence

Parkes (1970) has noted the strong desire to recover the dead person among bereaved persons. This is associated with the belief that this person is still in the immediate environment. Some people who are grieving sense the presence of the dead person in places associated with him or her.
Behaviors

These can range from appetite disturbances to absentmindedness and social withdrawal. The following behaviors are among those reported among bereaved persons:

1) Sleep disturbance
2) Loss of appetite or excess appetite
3) Dreams of the deceased
4) Actively avoiding the reminders of the deceased
5) Searching and calling for the deceased
6) Restlessness
7) Apathy
8) Crying
9) Social withdrawal
10) Substance abuse
11) Forgetfulness

2.3 Determinants of grief.

For some survivors, the grief is an intense experience for others it is mild. For some it begins at the time they hear of the loss while others it is a delayed experience. Grief
can take a short period or long period for some, while it takes forever for others. Experiences are mostly related to the developmental level and conflict issues of the individuals involved. Most determinants fall into the following six categories:

Who the person was; closeness of the deceased person and the survivor determines how long and how severe the mourning will be.

Nature of attachment; this will depend on the level of intimacy, the security of relationship or the ambivalence of the relationship.

Mode of death; how the person died determines the grieving: natural, accidental, suicidal or murder. Other factors would be where the person died geographically and whether the death was anticipated or not. Parkes and Weiss show in their study that young peoples’ death is more disturbing than the old ones.

Historical antecedents; were there previous losses and how were they handled? Are they bringing irresolution? People with previous history of depression were found to have a more difficult and complicated time grieving. Are there other crises to be dealt with? How do the survivors see those crises impinging on themselves?

Personality variables; the personality of the mourner is important to be taken into account when trying to understand an individual response to loss. Age, how inhibited one is with his/her feelings, how one handles anxiety and copes with stressful events are all crucial factors in coping with grief. People with personality disorders may experience complicated grief.
Social variables; in order to know how a person will grieve one needs to know something about the social, ethnic and religious background of the bereaved. Social support in the time of grief helps the survivor to deal with to cope more easily.

Concurrent stresses; these are the concurrent changes and crises that arise following death. High disruptions following death complicate the grief process.

2.4 General aspects of grief therapy.

Most of the support that people tend to get comes from their closest friends and relatives during mourning. Physicians and nurses may also orchestrate mechanism that may facilitate healing after loss. For those going through particularly difficult bereavement specific intervention may be considered. Psychotherapeutic intervention for grief varies widely and includes individual and group methods. They are; time limited dynamic psychotherapy, cognitive and behavioral intervention, hypnotherapy, trauma desensitization as well as guided imagery.

Grief counselling guides uncomplicated normal grief to a healthy completion of the tasks of grieving within a reasonable time frame. Grief counselling can be provided by professionally trained persons or self help groups in which bereaved persons offer help to each other. Grief counselling is particularly good for people who are at special risk or those who deem their families as unsupportive. The goals of grief therapy are;

1) Help the survivor actualize the loss.

2) Help the survivor to identify and express feelings
3) Facilitate the emotional relocation of the deceased

4) Provide time to grieve interpret ‘normal’ behaviors during grief

5) Allow individual differences in regard to mourning

6) Examine defenses and coping styles

7) Assist the bereaved to avoid platitudes

Some of the useful techniques may include:

**Evocative language**-the counsellor can use tough words that evoke feeling in order to facilitate expression and to bring to reality home and stimulate the painful feelings that can easily be repressed.

**Use of symbols**-have the bereaved bring photos of the deceased or letters, videotapes and audios

**Writing**-have the survivor write letters to the deceased to express thoughts and feelings. Keeping a journal of one’s grief or writing poetry can also facilitate the expression of feelings and send personal meaning to the loss

**Drawing**-pictures that reflect one’s feelings as well as the deceased may also prove very helpful.

**Role playing**– helping the bereaved to role play various situations that they fear or feel awkward about are one way to build coping skills.
Cognitive restructuring—the counsellor helps the bereaved to identify covert thoughts and self talk and evaluate them for accuracy. The underlying assumption is that thoughts influence actions and feelings.

Directed imagery—visualizing the dead for example seated on a chair or even closing eyes encourages the bereaved to say what he/she needs to say.

2.5 Perspectives of loss and grief

Philosophical perspective

Numerous questions about one’s own existence emerge in regard to the meaning of life. How much of the invested self has been lost because of this event is a pivotal issue in rebuilding one’s self after loss. Is this particular individual willing and capable to look within himself/herself to find new dimensions of himself/herself? Moreover, loss pf some aspect of self also draws attention to the fact that the loss becomes personalized and real.

Spiritual perspective

As the losses in life are identified and explored, some people find out that the spiritual explanations are a good emotional anchor and this gives them a reason to face their losses and find a reason to go on. An example to illustrate this could be cited in the belief of life after death. Some people interpret their losses as a punishment from God.
for wrongdoing hence they feel guilty. An understanding of this perspective in the life of a client is very essential. Conflicting beliefs may also become an additional issue for an individual seeking to adapt after loss. Where religion plays a role in the client’s life he/she may find a deeper sense of meaning and a purpose. The spiritual perspective emphasizes a relationship with God, a higher being or some cosmic consciousness.

Jackson says that, “There has always been a clear pattern of seeking to speak to the deep anxiety within man that seem to be incident to his mortality. Anxiety usually emerges when there is a threat to man’s value system. Religion seeks to provide a value system that counters that threat by making him aware of other dimensions of his own being that is not biological or mechanical.”

Psychological perspective

Where one has invested a part of himself/herself, his identity and energy to what he/she has lost, the loss has to be acknowledged and grieved. The major contributing factors that may play a big role in recovery include; personality, coping styles, present stressors and overall mental health. In order for healing to take place the bonds that created a tie must be undone. Raphael (1983) calls this a process of reversing all that has gone into the building relationship. It is not only deaths that can severe relations, disagreements and abandonment can too. Grief counselling demands that the painful avoided reality be reviewed, grieved and released.
Sociological perspective

Every culture sets norms on whether its members will grieve in an overt or covert way. Among members of the helping professions there is growing awareness of the need for a working support system, emphasis on spirituality and a return to the use of rituals during times of loss and transitions. Lacks of support systems pose problems for resolution after loss.

Physical perspective

These affect the grieving person biologically or physiologically Engel (1961) proposes that grief process needs to be viewed like healing after illness. It requires time and attention, with a focus on emotional tasks. Grief can also mask itself in somatic complaint.

2.6 Adult’s Grief and the loss of significant family members

2.6.1 Death of a spouse

Depending on the relationship a spouse had with the bereaved death can be a major loss. This person may have been a friend, a lover, partner, confidant, provider, supporter, a sounding board etcetera. The factors that determine the intensity of grieving include the following:
A spouse helps one to define the self emotionally, physically, socially, behaviorally and psychologically.

Spouses share the same worldview on various issues therefore one loses a partner in view.

Since marriage is a form of social self one ceases to be 'us-we' and becomes 'I'.

Redefining boundaries may cause a lot of fear, anxiety and feelings of vulnerability.

Starting to take the role of the other spouse is difficult. Cultural philosophies make it difficult whenever they stigmatize widows and widowers.

Women and men experience loneliness after the death of spouse. The sense of being incomplete can be devastating.

Each of the spouses is made to address the issue of remarriage.

2.6.2 Loss of a child

When a child dies the future dies, because a child represents the future for the parents hence parental grief is particularly intense. It appears to be the most long lasting grief of all. In losing a child parental hopes are dashed. The nature of a parent child relationship is unique due to the more involving and demanding closeness. It takes more energy and time to invest into. These aspects intensify grief. The major stumbling block of resolving the loss of a child is the unnaturalness of a child dying before a parent. It seems to violate the cycle of nature in which the young grow and
replace the old. The very order of the universe is shattered and this is something that most parents are unable to make sense of. Parents experience survival guilt.

With the death of a child parents feel like they have failed in the basic function of parenthood which is taking care of the children and family and keeping them from all harm. Death of a child therefore seems to be a monumental assault to the family’s identity. The parents lose an admirer and one who appreciates them in a very unique way.

If the death was sudden and accidental, adults may experience intense hopelessness and an impending feeling of threat. This is more likely to result in trauma and chronic grief. If the child dies as result of congenital or unexplained medical illness the parents are more likely to experience guilt. Some parents will idealize their children in order to cope.

In some cultures one feels that they have lost someone to take care of them in old age especially if they are particularly older and are already receiving support from that particular child.

There is intense separation pain around the death of a child and the yearning can be excruciating. The death of a child has an impact on the marital dyad. Sometimes disputes about who is the chief mourner occur.

2.6.3 The loss of a sibling in adulthood

It is a relationship that can be quite profound either negatively or positively. Brothers and sisters influence each other’s identity. Existence of an older sibling has implications in the following ways;
1) Birth order

2) Parental attention, affection and expectations

3) The world the younger are born into

Sibling relationships are marked by attachments as well as antagonism, care as well as competition and loyalty as well as resentment. One may therefore have lost someone who was part of him/her during the formative years.

The person lost is the one who knows the script and the myths of your life. One who shares your history may be defined as a constant in your life. This also leads to anxiety and fear.

Grieving for a sibling may arouse feelings of guilt especially when one recalls that they were once close but grew apart with time. If one is accustomed to living far from the sibling the death may not appear real because there is no acute sign of having lost him/her. If your sibling died of long illness the experience may have brought up the old rivalry to attention.

2.7 Conceptual Framework of loss and grief

While anticipating the loss of a significant other one goes through anxiety about the imminent incidental change of the life of the person he or she is attached to. Many questions may cross the mind of the mourner to be; can I cope? Can I survive after this? Failure to accept the impending death may lead to denial. Those that are able to accept when it happens may go into bargain. After bargain follows anger. Anger is followed by withdrawal from ones arsenal of friends and acquaintances. This is
naturally followed by depression. All this may come with an effort to validate social predictions that have proved to a failure. The individual continues to validate the processes that have repeatedly failed to achieve the outcome of preventing or undoing death. The following transitional curve drawn in the form of a flow diagram represents how individuals go through change until they either gradually accept death or go beyond depression into pathological grief;

**Loss and grief conceptual framework based on Therese Randos 6 r’s process of mourning:**

<table>
<thead>
<tr>
<th>Recognize the loss</th>
<th>Deny</th>
<th>Ego remains engaged to the deceased and grief is delayed</th>
</tr>
</thead>
<tbody>
<tr>
<td>React to separation</td>
<td>Deny</td>
<td>Repression/inhibited grief Excessive yearning Audio and visual hallucination</td>
</tr>
</tbody>
</table>
Accept
Rercollect and re-experience

Accept

Accent
Review and remember

Accent
Relinquish attachments

Accept
Readjustment and reinvestment

Deny
Actively avoid reminders of the deceased

Deny
Idealize the deceased

Deny
Chronic grief or pathological grief leading to complicated mourning

Deny
Physical and psychological maladjustment.
CHAPTER THREE: RESEARCH METHODOLOGY

Introduction

This chapter contains discussion on:

1. Research variables
2. Study location
3. Population
4. Sample and sampling strategy
5. Research instrument
6. Pilot study
7. Data collection procedure
8. Data analysis methods
9. Reliability and validity of the instrument

3.1 Research variables

According to Mugenda and Mugenda a variable is a measurable characteristic that assumes different values among subjects. It is therefore a logical way of expressing a particular attribute in a subject. Some variables are attributes that are expressed quantitatively while others are expressed categorically.
The independent variables in this study are loss and grief. They are referred to as independent because they can be manipulated in order to determine their effect on other variables. The dependent variable is perception. Perception takes multifaceted forms and therefore can only be classified categorically depending with the experience of each subject of study.

Perception on loss and grief will be operationalised by referring to indicators of thoughts feelings, saying and deeds of the subject as expressed by individuals.

The role of counselling will be taken as the intervening variable.

3.2 Study location

In geographic terms, Kiambu municipality is located in Kiambu district which is a part of central province. Kiambu neighbours with Nairobi and Thika districts. It has hitherto been predominantly occupied by Kikuyu speaking people. The Kikuyu ethnic group is a part of the Bantu group of East Africa. However, with time it has increasingly become cosmopolitan especially within the municipality.

The area under study include; Kiambu town, Thindigua, Ngegu, Ndumberi and Kirigiti (the map of the region is attached as appendix iii)

3.3 Population

This research dealt with adult who have lost a significant person in their lives and have gone through the process of mourning in Kiambu municipality. Since time, resources and energy could not have allowed the researcher to carry out research among all adults in this area a sample was selected.
The study also sought to collect data from practicing counsellors who live in the same area. The population of the counsellors would have involved all trained counsellors. Again, due to the limitation of time and resources this could not have been possible hence the researcher’s resolve to use purposive sampling.

3.4 Sample and sampling technique

This research used purposive sampling. 50 purposefully selected adults- 21 years and above, who have experienced loss of a close relative such as a spouse, child, sibling or parent were used as the respondents. In addition, 30 counsellors who have worked with adults experiencing loss and grief were sampled.

In order to reach the desired number of respondents the researcher selected those who have attained the age of 21 years and above. A further consideration of their ability to read and write was given in order for them to be able to fill the questionnaire. In addition, the respondents were to have experienced the loss within the last 5 years. In the final analysis, the researcher ended up with 30 adult females and 20 adult males as the sample for the bereaved.

As for the counsellors, the researcher sought to have trained personnel, with at least some experience in the field of counselling. A further consideration was given to age above 21 years. In order to balance the views on gender disparities the researcher purposefully selected 15 male and 15 female counsellors.
3.5 The instrument

A questionnaire was used to collect the data. Kirby et al (1997) describes a questionnaire as “a list of questions which is the primary research tool in social science. Research questions are used when there is a desire to gain information from a given population.”

May 1993 observes, “The theory is that if all respondents are asked the same questions in the same manner and if they express a difference of opinion in the reply to those questions, these variations result from a ‘true’ difference of opinion rather than how the question was asked” (page 67)

Mugenda and Mugenda however caution that a questionnaire that is not well thought out has the following disadvantages:

1. It may confuse respondents as to the nature of information required,
2. It may discourage respondents to the extent of discarding the questionnaire and
3. It may leave out important information required in the study.

The researcher developed a questionnaire to address each specific objective as outlined earlier

Using the five Likert scale, two questionnaires were developed:

1. To be filled by helping persons i.e. the counsellors and
2. To be filled by the loss and grief client
My questions were based on the following themes:

i. General information,

ii. Category of loss,

iii. Perceptions on loss,

iv. Views on bereavement,

v. Breaking of the news on loss,

vi. Emotions experienced- anger, guilt/self reproach, anxiety, loneliness, helplessness, shock and numbness etc.

vii. Physical reactions,

viii. Cognitions and

ix. Behaviours,

x. Determinants of grief,

xi. The process of grieving.

All the items in the questionnaire were positively worded owing to the sensitive nature of the subject matter and the varied cultural perspectives on loss and grief. The Responses were based on the five Likert scales ranging from strongly disagree to strongly agree.

The Likert scale is used to measure subjective and intangible components in research. The scale was attached to help minimize subjectivity and make it possible to do a qualitative analysis. All items used in the questionnaire were declarative in form. The
numbers were ordered in such a way that they indicate the presence or absence of the characteristic being measured.

The instrument was developed after reviewing related literature and consulting other studies in the related areas. The problems of the bereaved were discussed with people currently going through loss.

(The questionnaires are in appendix i and ii)

3.6. Pilot study

In order to validate the study, the researcher carried out a pre-testing activity using 5% of 50 bereaved adults and 30 practicing counsellors. Findings from the field were discussed with the supervisor in order to make amendments to the instrument.

3.7 Data collection procedure

Arrangements were made with the university to provide the researcher with an official letter to allow her to seek permit from the ministry of education. The permit was granted to further allow the researcher seek further official allowance by the Kiambu municipality that is the Town Clerk, the District Education Officer and the District Commissioner. A letter of authorization was issued to the researcher to that effect and a copy was served to each of the relevant authority.

The researcher further consulted with the respondents to arrange dates at the place and time of their own conveniences. The questionnaires were administered individually and the respondents were given ample time to fill them.
Attached to the questionnaires were letters of requesting the respondents to fill them and a brief explanation of the purpose of the research, its importance and significance. Commitment to share results for those who are interested as well as assurance for confidentiality was also assured. For those who took away the questionnaires, personal arrangement for returning them was made individually to avoid unnecessary delays and inconveniences.

3.8 Data analysis

Descriptive analysis was used to analyse data from the field. Measures of central tendency such as the mean as well as distribution in terms of percentages, frequency distributions and pie charts were made use of.

This statistics were found to be ideal for this study because there was no statistical hypothesis to be tested. Therefore this study made great use of frequency tabulation.

3.9 Reliability and validity of the research instrument.

Reliability is the measure of degree to which a research instrument yields consistent results or data after repeated trials. The instrument in this study can be said to be reliable because the questions have been developed after comprehensive look at already existing theories on loss and grief.

Validity on the other hand is correctness, truthfulness or actuality of something. In this study, the research is addressing how subjects perceive loss and grief. Perception is an abstract thing and the validity here largely depends on the source of information.
In other words validity here is supported by the way the society perceives loss and grief.

The body of knowledge as presented by different models and theorists is well represented in the research instrument and we can therefore say it is valid in terms of content. In reference to construct validity the questionnaire is comprehensive and it contains all aspects of the theories of grief in which it is derived.
CHAPTER FOUR: RESULTS OF THE STUDY

Introduction

This research sought to carry out a study into adult’s perspectives on loss and grief with the counselling intervention as the intervening variable. The research was carried out using questionnaires administered to 50 bereaved adults and 30 practicing counsellors.

Data analysis was tabulated and presented in frequency tables, percentages and pie charts. The descriptively analyzed data focused on the research questions that guided the study. The procedure used in data analysis involved groupings of similar responses from the instrument used, that is, similar items from the questionnaire were handled together. In the data analysis, the following order is adopted:

1) Analysis of responses from the bereaved and
2) Analysis of responses from the counsellors.

This chapter is organized according to themes.

4.1 Background information of the respondents

Background information related to age, gender, marital status, religious affiliation, occupation, level of education, age of the deceased at the time of death, year of demise, relationship to the deceased, category of loss, place of death and whether the bereaved was present or absent at the time of death was collected. The purpose was to
establish the effects of these variables on the adult perspectives on grief and loss of a significant other.

4.1.1 The age bracket of the bereaved.

The respondents were drawn from people of 21 years of age and above in order to fit the description of an adult. 36% of the respondents are in the 41-50 age group, followed by 28% in the 31-40 age group. 20% of the respondents are from the 21-30 years age group while 16% are from 51 years of age. The following table represents the age bracket of respondents in groupings of age clusters.

<table>
<thead>
<tr>
<th>Age in years</th>
<th>Male</th>
<th>Female</th>
<th>η</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-30</td>
<td>4</td>
<td>6</td>
<td>10</td>
<td>20</td>
</tr>
<tr>
<td>31-40</td>
<td>5</td>
<td>9</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>41-50</td>
<td>8</td>
<td>10</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>51 and above</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Totals</td>
<td>20</td>
<td>30</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>
4.1.2 Gender representation.

Initially, this study set out to find the perspectives of 25 males and 25 females. However, the return rate for the questionnaire turned out that more women than men were willing to share their loss and grief experiences. The study findings are based on the responses of 20 males forming 40% of the responses and 30 women forming 60% of the responses. The gender representation of this study finding is represented in the following table.

<table>
<thead>
<tr>
<th>Sex</th>
<th>η</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>Females</td>
<td>30</td>
<td>60</td>
</tr>
</tbody>
</table>

4.1.3 Marital status.

The respondents of this research range from single, married, separated, divorced to widowed. 32% are single, 52% are married, 4% are separated, 2% are divorced and 10% are widows/widowers. The separated and divorced form a dismal percentage because majorities prefer to keep to themselves due to the stigma associated with these statuses in Africa. The following table represents the marital status distribution of the respondents.
4.1.4 Religious affiliation.

The findings of this research are the results of a whooping 86% Christian population largely because people of other religious affiliation have not settled in Kiambu municipality. However 2% response is from Muslims, 6% from the adhererents of the African traditional society 6% from people of unspecified religious affiliations. The research found no respondent from the Hindu religion. The respondents were distributed as follows:

<table>
<thead>
<tr>
<th>Religious affiliation</th>
<th>Males</th>
<th>Females</th>
<th>η</th>
<th>Total%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>17</td>
<td>26</td>
<td>43</td>
<td>86</td>
</tr>
<tr>
<td>Muslim</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Hindu</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>A.T.S</td>
<td>2</td>
<td>1</td>
<td>3</td>
<td>6</td>
</tr>
</tbody>
</table>
4.1.5 Occupation.

This research sought to find out differences of perspectives among people of various occupational statuses. It sought to answer the question whether an employed person would view loss and grief in the same way as the self employed and the unemployed. 24% of the respondents were unemployed, 24% self employed and 52% employed.

This information is summarized in the following table:

<table>
<thead>
<tr>
<th>Occupational status</th>
<th>Males</th>
<th>Females</th>
<th>η</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>5</td>
<td>7</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Self employed</td>
<td>7</td>
<td>5</td>
<td>12</td>
<td>24</td>
</tr>
<tr>
<td>Employed</td>
<td>8</td>
<td>18</td>
<td>26</td>
<td>52</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
<td>30</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>
4.1.6 Level of Education.

The research findings of this study represent views of people of various academic qualifications across the board. However, persons with no basic education were not given the questionnaires because of language limitations. The respondents comprised of 18% primary school graduates, 20% secondary school graduates, 22% middle level college graduates and 40% university graduates.

<table>
<thead>
<tr>
<th>Level of education</th>
<th>Males</th>
<th>Females</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic</td>
<td>3</td>
<td>6</td>
<td>9</td>
</tr>
<tr>
<td>Secondary</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>College</td>
<td>7</td>
<td>4</td>
<td>11</td>
</tr>
<tr>
<td>University</td>
<td>7</td>
<td>13</td>
<td>20</td>
</tr>
<tr>
<td>Totals</td>
<td>20</td>
<td>30</td>
<td>50</td>
</tr>
</tbody>
</table>

4.1.7 Age of the deceased at the time of death.

This research sought to find out whether there is a difference in the adults’ perspectives towards loss and grief in relation to the age of the person who has died.

It sought to answer the question whether a parent who losses a teenager would
perceive his/her loss in the same way as the one who is above 51 years of age and has lost a parent due to old age. How does a young mother perceive the death of a newborn in comparison to the death of a spouse? Of the group that responded, 10% had lost children of ages 0-10, 12% had lost significant others of ages 11-20, 10% had lost young adults of ages 21-30, 28% had lost significant others of ages 31-40, 14% had lost significant others of ages 41-50 while 26% had lost family members of ages 51 and above. This information is summarized in the following table.

<table>
<thead>
<tr>
<th>Age in years</th>
<th>Males</th>
<th>Females</th>
<th>η</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-10</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>11-20</td>
<td>2</td>
<td>4</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>21-30</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>10</td>
</tr>
<tr>
<td>31-40</td>
<td>6</td>
<td>8</td>
<td>14</td>
<td>28</td>
</tr>
<tr>
<td>41-50</td>
<td>4</td>
<td>3</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>51+</td>
<td>4</td>
<td>9</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Totals</td>
<td>20</td>
<td>30</td>
<td>50</td>
<td>100</td>
</tr>
</tbody>
</table>
4.1.8 Year of demise.

The intention of the researcher in this study was to find out the adults' perceptions to loss and grief. Part of the sampling technique involved purposefully selecting respondents who have lost a significant other within the last five years. The distribution of loss is represented in the following bar graph:

*Figure 1 death distributions in the last five years*
4.1.9 Relationship with the deceased (who was the deceased to you?)

In addition to the other variables, the researcher intended to find out the relationship of the griever to the deceased. 8% had lost spouses, 26% had lost a child, 36% had lost a parent and 30% had lost a sibling. This information is summarized in the following table:

<table>
<thead>
<tr>
<th>Relationship to the deceased</th>
<th>Males</th>
<th>Females</th>
<th>ɳ</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>spouse</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td>8</td>
</tr>
<tr>
<td>Child</td>
<td>4</td>
<td>9</td>
<td>13</td>
<td>26</td>
</tr>
<tr>
<td>Parent</td>
<td>8</td>
<td>10</td>
<td>18</td>
<td>36</td>
</tr>
<tr>
<td>sibling</td>
<td>5</td>
<td>10</td>
<td>15</td>
<td>30</td>
</tr>
<tr>
<td>Totals</td>
<td>20</td>
<td>30</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

4.1.10 Category of death.

The respondents had experienced different categories of loss. 16%-58° had lost their loved ones though short illness, 44%-158° through long illness, 10%-36° through accidents, 14%-50° had been murdered and 16%-58° had died of unknown causes. The categories of loss are represented in the following chart:
4.1.11 Place of death

The researcher wanted to find out whether the adult’s perceptions towards loss and grief are affected by the place of death. The respondents answered this question in the following ways: 54% had died in hospitals, 16% had died at home, 2% had died abroad, 4% died or disappeared and 24 % had died in unspecified places. The following table is a summary of the information explained above:

<table>
<thead>
<tr>
<th>Place of death</th>
<th>Males</th>
<th>Females</th>
<th>η</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>9</td>
<td>18</td>
<td>27</td>
<td>54</td>
</tr>
<tr>
<td>Home</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Abroad</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>
4.1.12 Presence at the time of death.

Finally the researcher wanted to compare the adult’s preconceptions of loss for those who were present and absent at the time of death. 22% of the respondents were present while 78% were absent at the time of death. This information is represented in the following bar graph:
Figure 3 no. of respondent's present or absent in time of death

4.2 Items analysis for the bereaved

4.2.1 Section I initial reactions.

The responses to the philosophical perceptions of loss and grief are summarized in percentages as follows:
### Table: Reactions and Their Percentages

<table>
<thead>
<tr>
<th>Response</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Death anticipation reduces shock</td>
<td>80</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>2. Prolonged illness prepares the survivor to accept death</td>
<td>80</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>3. The demise of the terminally ill is mourned less</td>
<td>80</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>4. Denial of death reduces shock</td>
<td>80</td>
<td>22</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Gradual breaking of death news reduces shock</td>
<td>40</td>
<td>20</td>
<td>0</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>6. Deeper shock results from sudden deaths</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>

#### 4.2.2 Section ii: Physical reactions

According to the research, 20% agree and 80% strongly agree that the respondents' physical and psychological reactions experienced during loss and grief include; numbness, shock, disbelief, anxiety and sadness. 20% strongly disagreed, 20% disagreed while 60% were neutral in regard to experiencing relief after the death of a significant other. Item 13 attracted 2% strongly disagree, 8% disagree, 20% neutral, 10% agree and 60% strongly agree that adults experience despair in time of grief.
Loneliness and confusion attracted 20% agree and 80% strongly agree. Adults also seemed to vary in their responses in regard to anger. 20% were neutral, 20% agreed and 60% strongly agreed that anger is an emotion experienced during loss and grief. In response to whether guilt is experienced during loss and grief, 20% were neutral, 20% agreed and 60% strongly agreed.

<table>
<thead>
<tr>
<th>Response</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>7. Numbness</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>8. Shock</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>9. Disbelief</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>10. Anxiety</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>11. Sadness</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>12. Relief</td>
<td>20</td>
<td>20</td>
<td>60</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>13. Despair</td>
<td>2</td>
<td>8</td>
<td>20</td>
<td>10</td>
<td>60</td>
</tr>
<tr>
<td>14. Loneliness</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>15. Confusion</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>16. Anger</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>20</td>
<td>60</td>
</tr>
<tr>
<td>17. Guilt</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>40</td>
<td>40</td>
</tr>
</tbody>
</table>
4.2.3 Section iii cognitive and behavioral reactions

This research found out that people do not perceive death in the same way. The following table is a percentage summary of thoughts and behaviors that occur after losing a significant other:

<table>
<thead>
<tr>
<th>Response</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>18. Preoccupation with the image of the deceased</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>19. Yearning for the deceased</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>20. Sensing the presence of the deceased</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>21. Visual and auditory hallucinations</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>60</td>
<td>20</td>
</tr>
<tr>
<td>22. Sleep disturbance</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>23. Appetite fluctuations</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>24. Forgetfulness</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>20</td>
<td>20</td>
</tr>
<tr>
<td>25. Dreaming with the deceased</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>20</td>
<td>40</td>
</tr>
<tr>
<td>26. Actively avoiding the reminders of the late person</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>27. Searching and calling for the deceased</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>28. Restlessness</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>60</td>
<td>20</td>
</tr>
<tr>
<td>29. Finding the world meaningless</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>30. Crying</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>31. Withdrawing socially</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>32. Talking too much or too little</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>20</td>
<td>20</td>
</tr>
</tbody>
</table>
4.2.4 Section IV spiritual reactions

The table below is a percentage representation of the spiritual perspectives of loss and grief:

<table>
<thead>
<tr>
<th>Response</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>33. Belief in after life serves as an anchor to face life</td>
<td>20</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>80</td>
</tr>
<tr>
<td>34. Death is a punishment from God</td>
<td>80</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>35. Faith plays a role in finding the meaning of loss</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>80</td>
</tr>
<tr>
<td>36. Religious affiliation eases the process of grief</td>
<td>0</td>
<td>0</td>
<td>40</td>
<td>0</td>
<td>60</td>
</tr>
</tbody>
</table>

4.2.5 Section v. Community support

During loss and grief neighbours come in handy and supportive. This research found the following percentages in regard to communal/social support:

<table>
<thead>
<tr>
<th>Response</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>37. Financially</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>38. Materially</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>39. Emotionally</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>40</td>
</tr>
<tr>
<td>40. Socially</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>80</td>
</tr>
</tbody>
</table>
4.2.6 Section VI. Death actualization

This research found out that while the death of a significant other is actualized through the viewing of the body and memorial services, it is more actualized by the burial ceremony. The following table represents the adults’ responses in percentages in regard to death actualization.

<table>
<thead>
<tr>
<th>Response</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>41. Viewing the body</td>
<td>20</td>
<td>0</td>
<td>20</td>
<td>40</td>
<td>20</td>
</tr>
<tr>
<td>42. Memorial service</td>
<td>40</td>
<td>0</td>
<td>0</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>43. Burial ceremony</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>80</td>
</tr>
</tbody>
</table>

4.2.7 Section vii Cultural perspective

This research found out that the respondents had varying views in answering items 44 to 46. The percentage responses were as follows;
4.4 Cultural mourning is a form of respect for the dead.

45. Speaking about the dead is a taboo.

46. Memorial service is a positive way of remembering the dead.

<table>
<thead>
<tr>
<th>Response</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>44. Cultural mourning is form of respect for the dead.</td>
<td>20</td>
<td>0</td>
<td>60</td>
<td>20</td>
<td>0</td>
</tr>
<tr>
<td>45. Speaking about the dead is a taboo.</td>
<td>40</td>
<td>0</td>
<td>60</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>46. Memorial service is a positive way of remembering the dead.</td>
<td>20</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>60</td>
</tr>
</tbody>
</table>

4.2.8 Section viii. Therapeutic intervention to loss and grief

The respondents strongly agreed that items 47 to 50 which are aspects of counselling are helpful during grief. The table that follows represents a summary of the percentage responses;

<table>
<thead>
<tr>
<th>Response</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>47. Explanation of what is ‘normal’ during grief</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>48. Review of the relationship with the deceased</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>49. Review of the events surrounding the death event</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
<tr>
<td>50. Assistance to focus on the emotions being avoided</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>100</td>
</tr>
</tbody>
</table>
4.3 Demographic characteristics of the counsellors

Background information about the counsellors who responded was taken. This included their age, gender, marital status, Level of training in the field of counselling and years of experience in terms of practice.

4.3.1 Gender

The gender representation for this research was 15 male and 15 female counsellors each gender accounting for 50% participation. This information is summarized in the following table;

<table>
<thead>
<tr>
<th>Gender</th>
<th>n</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>Females</td>
<td>15</td>
<td>50</td>
</tr>
<tr>
<td>Totals</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

4.3.2 Age in years

The respondents were adult counsellors with the 21-30 years bracket recording a 0% and 31-40 age bracket 43% hence forming the majority. Age bracket 41-50 had 27% participation while 51 and above had a 30%. This information is summarized in the following table;
<table>
<thead>
<tr>
<th>Age</th>
<th>Males</th>
<th>Females</th>
<th>( \eta )</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>21-30</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>31-40</td>
<td>5</td>
<td>8</td>
<td>13</td>
<td>43</td>
</tr>
<tr>
<td>41-50</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>27</td>
</tr>
<tr>
<td>51+</td>
<td>8</td>
<td>1</td>
<td>9</td>
<td>30</td>
</tr>
<tr>
<td>Totals</td>
<td>15</td>
<td>15</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

4.3.3 Marital status

The counsellors responding were of the following marital status; 20% single, 73% married, 0% divorced, 7% separated and 0% widowed. The marital status distribution is summarized as follows:

<table>
<thead>
<tr>
<th>Marital status</th>
<th>Males</th>
<th>Females</th>
<th>( \eta )</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>4</td>
<td>2</td>
<td>6</td>
<td>20</td>
</tr>
<tr>
<td>Married</td>
<td>10</td>
<td>12</td>
<td>22</td>
<td>73</td>
</tr>
<tr>
<td>Divorced</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Separated</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Widowed</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>15</td>
<td>15</td>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>
4.3.4 Level of training in counselling

The counsellors represented in this research were trained and they had different levels of qualification. 7% had the ordinary level certificate, 17% had diploma certificate, 3% had the bachelor's degree, 60% had master's degree and 13% had a PhD in counselling. This information is summarized in the following table:

<table>
<thead>
<tr>
<th>Level of training</th>
<th>Males</th>
<th>Females</th>
<th>η</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Certificate</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Diploma</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>17</td>
</tr>
<tr>
<td>Bachelor</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Masters</td>
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4.3.5 Years of experience in counselling

The purposefully selected respondents had several years of experience to ensure that they were familiar with issues related to loss and grief. 17% of them had 4-5 years of
experience while 87% had 5 and above years of experience in the field of counselling.

This information is summarized in the following table:

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4.4 Item analysis for the counsellors

To confirm the information given by the bereaved respondents the researcher administered a questionnaire to counsellors. They confirmed the following issues:

4.4.1 Section I; Helpful skills in grief counselling

87% of the counsellors responded to strongly agree and 13% to agree that the following skills are helpful in grief counselling:

1. Active listening
2. Reflecting on the clients feelings
3. Deeper empathy.

4. Setting limits and boundaries

5. Clarification of feelings and thoughts

6. Provision of information

7. Assessment skills

8. Referral skills

Putting these findings together, it could mean that the counsellors are aware of the techniques theoretically. They have either heard of them or read about them. However, if the work of the counsellors will be deemed as positively effective in a complex society, therapists must develop more sophisticated means of evaluation, through tested and tried skills and techniques. This way, therapists will be able to whether or not they are being effective in relation to achieving the intended grief therapy goals.

4.4.2 Section ii Grief counselling factors

86.6% counsellors strongly agree and 13.4% agree that in counselling the bereaved the following are some of the factors to be considered;

1) Intimacy level of the lost relationship

2) Life stage of the griever

3) Grief history of the griever

4) Emotional complexity of the griever
5) Degree of isolation of the griever

6) The capacity of the griever to trust others

7) Ability of the griever to express thoughts

8) Ability of the griever to express feelings

9) Willingness to accept the loss

10) Preparedness to go through counselling

Therefore, this study concluded that it is not only the skills of the counsellor that play a vital role in grief therapy. The relationship of the deceased and the survivor, the personality of the griever, his/her social affiliation and his/her desire to accept the loss. Whenever all these conditions are favorable, then the grief therapy as well as the griever’s transition to the normal self is easier.

4.4.3 Section iii: Assessment of complicated grief

This section was aimed at confirming issues related to difficult and complicated mourning. For item 19, 30% of the counsellors agree and 70% strongly agree that delayed grief occurs as a result of postponing the recognition of loss. In this case clients act as if the change has not taken place. They continue to ignore evidence and information contrary to what they want to believe. Prolonged denial or postponement of recognizing the death of a significant other poses a danger when the client continues to operate in as if the death has not occurred. This can have detrimental effects on the individual and the immediate family.
Counsellors had different responses regarding item 20. 20% of them strongly disagree that the absence of grief leads to pathological outcome. 67% remained neutral while 13% agree that it does. While there are many underlying issues such as inability to grief, unfinished businesses and others it is the counsellors role to facilitate the mourning process.

In Africa for instance, one cannot be a hundred percent sure that grief is absent because some cultures do not allow men for instance to mourn publicly. They may mourn without expressing their feelings or thoughts. Therefore it is difficult to determine when grief is present or absent in some cases.

Item 21 attracted 3.3% neutral, 26.7% agree and 70% strongly agree that chronic grief occurs when the bereaved does not recover from the symptoms of bereavement. The 3.3% responses came from the respondents who have reached the certificate level of training. The implication of this is that this level does not equip the counsellor to adequately deal with grief therapy much less than the complicated grief.

Item 22 attracted a 30% agree and 70% strongly agree that counselling helps to mitigate the effects of complicated grief. These results allow room for the role of the characteristics of the therapist, the personality of the clients, techniques at the disposal of the therapist, compatibility of the therapist and the client and the counselling process. If these aspects are not put into practice, then counselling may have a negative spill over effects.

The results of item 23, that there is an association between grief and physical illnesses were, 27% agreed and 73% strongly agreed. This implies that care caution should be exercised while breaking death news to clients who are prone to hypertension,
cardiovascular illnesses and other chronic diseases. Guided grief and follow up should be done to avoid undesirable results. Where medical referral is deemed necessary it should be considered.

Item 24 was an extension of item 23. 30% agreed and 70 strongly agreed that the present health of the survivor is a determinant of the grief process.

Item 25 attracted a 47% neutral, 20% agreed and 33% strongly agreed that drug and substance abuse increases in time of grief for previous users. The item may have attracted these varied responses because the counsellors were regarding the client’s support systems such as immediate relatives and friends as well as one’s societal and religious affiliations. However this notion was neither strongly disagreed nor disagreed. This is to say that, counsellors should be on the lookout of any tell tale signs of drug and substance abuse in the time of grief to be able to apply the required intervention.

Item 26 had 43.3% neutral, 23.3 agreed and 33.3 strongly agreed that excessive guilt is a result of ambiguous relationships. Failing and over depended relationships fall in this category especially where roles, boundaries and limits are not defined. Abusive relationships are also a part of the ambiguous relationships. Guilt arises from the recognition of the inappropriate actions and reactions of previous incidences during the life time of the deceased. The counsellor here should explore the self perception of the client and offer alternative interpretations for the client to redefine the self that is disturbed (John M. Fisher 2000). This aspect of reconstructing the self would tally with George Kelly’s personal construct psychology theories.
In response to item 27, 30% agreed and 70% strongly agreed that the review of the relationship between the deceased and the bereaved helps to clarify feelings.

Finally in this section, the last item attracted a 30% agree and 70% strongly agreed in response to the issue that excessive dependency predisposes the survivor to difficult mourning.

4.4.4 Section IV the goals of grief therapy

In this section, 13% agreed and 87% strongly agreed that the following goals should be aimed at in grief counselling:

1) Encourage client to talk about grief
2) Help the client to cut the dependency tie with the deceased
3) Use evocative language to help client focus on feelings and thought
4) Facilitate relocation emotional relocation
5) Provide time to grieve
6) Affirm the personality
7) Be available to offer support
8) Examine the clients copying styles
9) Examine the client’s defenses
10) Aim at facilitating transition to productivity
11) Examine the client’s support system
12) Provide follow up services to the bereaved
CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS.

5.1 Summary

The study carried out reveals that adults perceive the loss of a significant other in individually unique ways. In Kiambu the results of the study show that adults are also aware of counselling services offered to grieving persons. They also know the benefits that accrue to therapeutic intervention. However, due to various constraints, frustrated efforts, time and other resources, they do not make full use of these facilities.

The study also reveals that, Bereavement is among the most disruptive of all life processes, and it is difficult to put an arbitrary limit on the expected duration of bereavement.

The goal of grief therapy, according to this study, is to identify and resolve the conflicts of separation that interfere with the completion of the tasks of mourning.

The results gathered from the counsellors' responses show that, conflicts of separation may be absent or masked as somatic or behavioral symptoms; delayed, inhibited, excessive, or distorted mourning; conflicted or prolonged grief; or unanticipated mourning.
Most of the support that people receive after a loss comes from friends, family, physicians and nurses. For those who are experiencing particularly difficult problems in their bereavement, specific interventions may be considered. Psychotherapeutic interventions for grief vary widely, and include individual and group methods. Treatment methods found to be effective with various populations of bereaved individuals include time-limited dynamic psychotherapy, cognitive-behavioral intervention, hypnotherapy, and trauma desensitization.

Grief counseling and grief therapy are distinguished from each other. Grief counseling guides uncomplicated (normal) grief to a healthy completion of the tasks of grieving within a reasonable time frame, usually without a time-limited template. Grief counseling can be provided by professionally trained individuals, or in self-help groups in which bereaved persons offer help to other bereaved persons. All of these services can be offered in individual or group settings. Grief counseling seems to be most useful for those bereaved persons who perceive their families as unsupportive or who, for other reasons, are thought to be at special risk.

5.2 Research Conclusions

The following are some of the conclusions that were drawn from the study by the researcher:

5.2.1 The major adults' perspectives of loss and grief

According to the research the major perspectives of loss and grief include:
1. The philosophical perspective: Philosophically, numerous questions about one’s own existence emerge in regard to the meaning of life. How much of the invested self has been lost because of this event is a pivotal issue in rebuilding one’s self after loss. Is this particular individual willing and capable to look within himself/herself to find new dimensions of himself/herself? Moreover, loss of some aspect of self also draws attention to the fact that the loss becomes personalized and real.

3. The psychological perspective:

Psychologically, where one has invested a part of himself/herself, his identity and energy to what he/she has lost, the loss has to be acknowledged and grieved. The major contributing factors that may play a big role in recovery include; personality, coping styles, present stressors and overall mental health. In order for healing to take place the bonds that created a tie must be undone. Raphael (1983) calls this a process of reversing all that has gone into the building relationship. It is not only deaths that can severe relations, disagreements and abandonment can too. Grief counselling demands that the painful avoided reality be reviewed grieved and released.

4. The spiritual perspective:

Spiritually, as the losses in life are identified and explored, some people find out that the spiritual explanations are a good emotional anchor and this gives them a reason to face their losses and find a reason to go on. An example to illustrate this could be
cited in the belief of life after death. Some people interpret their losses as a
punishment from God for wrongdoing hence they feel guilty. An understanding of
this perspective in the life of a client is very essential. Conflicting beliefs may also
become an additional issue for an individual seeking to adapt after loss. Where
religion plays a role in the client’s life he/she may find a deeper sense of meaning and
a purpose. The spiritual perspective emphasizes a relationship with God, a higher
being or some cosmic consciousness.

Jackson says that, “There has always been a clear pattern of seeking to speak to the
deep anxiety within man that seem to be incident to his mortality. Anxiety usually
emerges when there is a threat to man’s value system. Religion seeks to provide a
value system that counters that threat by making him aware of other dimensions of his
own being that is not biological or mechanical.”

5. The sociological perspectives:

Socially, every culture sets norms on whether its members will grieve in an overt or
covert way. Among members of the helping professions there is growing awareness
of the need for a working support system, emphasis on spirituality and a return to the
use of rituals during times of loss and transitions. Lacks of support systems pose
problems for resolution after loss.
6. The physical perspective

These physical reactions affect the grieving person biologically or physiologically. Engel (1961) proposes that grief process needs to be viewed like healing after illness. It requires time and attention, with a focus on emotional tasks. Grief can also mask itself in somatic complaint.

7. The cultural perspective

Grief, whether in response to the death of a loved one, to the loss of a treasured possession, or to a significant life change, is a universal occurrence that crosses all ages and cultures. However, there are many aspects of grief about which little is known, including the role that cultural heritage plays in an individual’s experience of grief and mourning. Attitudes, beliefs, and practices regarding death and grief are characterized and described according to multicultural context, myth, mysteries, and mores that describe cross-cultural relationships.

The potential for contradiction between an individual’s intrapersonal experience of grief and his or her cultural expression of grief can be explained by the prevalent (though incorrect), synonymous use of the terms grief (the highly personalized
process of experiencing reactions to perceived loss) and mourning (the socially or culturally defined behavioral displays of grief).

An analysis of the results of several focus groups, each consisting of individuals from a specific culture, reveals that individual, intrapersonal experiences of grief are similar across cultural boundaries. This is true even considering the culturally distinct mourning rituals, traditions, and behavioral expressions of grief experienced by the participants. Health care professionals need to understand the part cultural mourning practices may play in an individual’s overall grief experience if they are to provide culturally sensitive care to their patients.

In spite of legislation, health regulations, customs, and work rules that have greatly influenced how death is managed in various parts of the world, bereavement practices vary in profound ways depending on one’s cultural background. When assessing an individual’s response to the death of a loved one, clinicians should identify and appreciate what is expected or required by the person’s culture. Failing to carry out expected rituals can lead to an experience of unresolved loss for family members. This is often a daunting task when health care professionals serve patients of many ethnicities.
5.2.2 The major manifestations of grief

Feelings

Sadness- Sadness may take the form of crying. Sometimes, it may be overwhelming and may lead to feelings of being very low and disillusioned.

Anger -It is a very confusing feeling. It is often a very disturbing reaction especially when directed to the self or others around you. The mourner can also be very angry with the dead person for having left him or her. Anger results from two sources;

1. At the sense of frustration that there was nothing one could have done to prevent the death and
2. From a kind of regressive feeling that occurs after loss.

Guilt and self reproach-Guilt over acts of omissions, is another feeling which often follows the death of a loved one. It is connected to not being kind enough to the dying person or not being there at the time of their death

Worden(1982) has suggested that irrational guilt follows bereavement. For some people however the guilt may become a chronic complication.

Anxiety -It may take different forms such as persistent feelings of insecurity and panic attacks. Worden (1976, 1982) says that anxiety may stem from fear of being unable to survive without the significant other and fear of being overwhelmed by grief. Sometimes the bereaved feels like he or she cannot cope without relying on the
emotional support of the deceased. Anxiety may also arise from the increased awareness of one's own death. One may keep feeling that he or she is next.

Loneliness- As Weiss (1974) has indicated, there are different types of loneliness. One sort of loneliness arises from the loss of someone special to interact with and the other one is lack of company in general.

Helplessness – Excessive dependency predisposes the survivor to difficulty in grieving. Parkes, Weiss and Lopata found out that widows in over dependent relationships tended to be characterized by positions of helplessness, indecisiveness and intense yearning. They also experience frightening levels of anxiety.

Shock- It is usually associated with sudden deaths resulting from accidents, suicide and short illnesses. However, even in situations where death was long anticipated, shock may still be experienced.

Numbness-The bereaved appears to have no feelings at all especially soon after the death has occurred. Sometimes he/she responds in a slow, automatic and cold manner.

Physical reactions

Collin Murray (1986) describes grief appearing in physical form in the following symptoms;

X. Hollowness in the stomach

XI. Tightness in the chest
XII. Tightness in the throat
XIII. Oversensitivity
XIV. Depersonalization/derealization
XV. Breathlessness
XVI. Muscles weakness
XVII. Lack of energy
XVIII. Dry mouth

Cognitions

Jane Littlewood (1983) observed that certain thoughts and behaviors are prevalent when one is experiencing grief. They are common in the early stages and often disappear with time. When and if they trigger and persist they may lead to depression and extreme anxiety. They include:

Disbelief-It is a common and usually transient reaction to bereavement. It is more likely to be experienced by mourners who were not present in the time of death or who for some reason did not see the body of the dead person.
Preoccupation with the thoughts of the deceased

Most mourners are preoccupied by the images of the dead person. They spend so much energy and time thinking and feeling the pain of the memory. Events leading to the death may be obsessively reviewed in an increasing and desperate attempt to understand what happened. Many people feel that the death could have been prevented or that the review may reveal more details of the cause of the death.

Hallucinations

Many people believe that they see or hear the dead person. These experiences may be interpreted in different ways. They may frighten or comfort some. Littlewood reports in her research that 20% of elderly people living alone reported auditory hallucinations lasting for one year after the death of a close person.

Sense of presence

Parkes (1970) has noted the strong desire to recover the dead person among bereaved persons. This is associated with the belief that this person is still in the immediate environment. Some people who are grieving sense the presence of the dead person in places associated with him or her.
Behaviors

These can range from appetite disturbances to absentmindedness and social withdrawal. The following behaviors are among those reported among bereaved persons;

1) Sleep disturbance
2) Loss of appetite or excess appetite
3) Dreams of the deceased
4) Actively avoiding the reminders of the deceased
5) Searching and calling for the deceased
6) Restlessness
7) Apathy
8) Crying
9) Social withdrawal
10) Substance abuse
11) Forgetfulness

5.2.3 Determinants of grief.

For some survivors, the grief is an intense experience for others it is mild. For some it begins at the time they hear of the loss while others it is a delayed experience. Grief
can take a short period or long period for some, while it takes forever for others. Experiences are mostly related to the developmental level and conflict issues of the individuals involved. Most determinants fall into the following six categories:

Who the person was; closeness of the deceased person and the survivor determines how long and how severe the mourning will be.

Nature of attachment; this will depend on the level of intimacy, the security of relationship or the ambivalence of the relationship.

Mode of death; how the person died determines the grieving: natural, accidental, suicidal or murder. Other factors would be where the person died geographically and whether the death was anticipated or not. Parkes and Weiss show in their study that young peoples' death is more disturbing than the old ones.

Historical antecedents; were there previous losses and how were they handled? Are they bringing irresolution? People with previous history of depression were found to have a more difficult and complicated time grieving. Are there other crises to be dealt with? How do the survivors see those crises impinging on themselves?

Personality variables; the personality of the mourner is important to be taken into account when trying to understand an individual response to loss. Age, how inhibited one is with his/her feelings, how one handles anxiety and copes with stressful events are all crucial factors in coping with grief. People with personality disorders may experience complicated grief.
Social variables; in order to know how a person will grieve one needs to know something about the social, ethnic and religious background of the bereaved. Social support in the time of grief helps the survivor to deal with to cope more easily.

Concurrent stresses; these are the concurrent changes and crises that arise following death. High disruptions following death complicate the grief process.

5.2.4 Six tasks of grief

The tasks that have been identified that help focus problem-specific therapeutic interventions for bereaved spouses:

1. Develop the capacity to experience, express, and integrate painful grief-related affects.
2. Use the most adaptive means of modulating painful affects.
3. Establish a continuing relationship with the deceased spouse.
4. Maintain one’s own health and continued functioning.
5. Achieve a successful reconfiguration of altered relationships and understand why others may have difficulty empathizing with the bereaved.
6. Achieve an integrated, healthy self-concept and stable worldview.

Complications in grief may arise because of uncompleted grief related to earlier losses. The grief for these previous losses must be managed in order for the current grief to be resolved. Additionally, identification of transitional or linking objects that allow the relationship with the deceased to be maintained externally is useful, as the
objects may be interrupting successful completion of the grieving tasks. Loss and
grief therapy includes dealing with resistances to the mourning process, identifying
unfinished business with the deceased, and identifying and accommodating secondary
losses resulting from the death. Ultimately, the bereaved is helped to accept the
finality of the loss and to picture what his or her life will be like after the grief period.
It is helpful to acknowledge that repetition may be a part of treatment, but only when
in the service of working through the grief.

5.2.5 Complicated Grief

Complicated or pathological grief reactions are maladaptive extensions of normal
bereavement. These maladaptive reactions overlap psychiatric disorders and require
more complex, multimodal therapies than uncomplicated grief reactions. Adjustment
disorders (especially depressed and anxious mood, or disturbance of emotions and
conduct), major depression, substance abuse, and even post-traumatic stress disorder
(PTSD) are some of the more common psychiatric disorders complicated
bereavement. Grief that becomes pathologic is often identifiable by the increased
duration of symptomatology, the increased disruption of psychosocial functioning due
to the symptoms, or by the intensity of intense suicidal thoughts or acts upon the loss.

Complicated or unresolved grief can take many forms. Complications may manifest
as absent grief (i.e., grief and mourning processes are totally absent), inhibited grief
(a lasting inhibition of many of the manifestations of normal grief), delayed grief,
conflicted grief, or chronic grief. Risk factors for pathologic grief include suddenness
of loss; gender of the bereaved; and the existence of an intense, overly close, or
highly ambivalent relationship to the deceased. Pathologic grief reactions that extend
to major depressive episodes should be treated with combined drug and
psychotherapeutic interventions, though the efficacy of these combined approaches is
untested. The bereaved who maintain long-standing avoidance of any and all
reminders of the deceased, who re-experience the loss or the presence of the deceased
in illusions or intrusive thoughts or dreams, and startles and panics easily at reminders
of the loss might be considered for a PTSD diagnosis (even without meeting all the
criteria for a psychiatric diagnosis). Substance abuse in the bereaved is frequently an
attempt at self-medication of painful feelings and symptoms (such as insomnia), and
can be targeted for drug and psychotherapeutic intervention.

5.2.6 Adult’s adjustments to loss.

Adaptation to loss may be seen as involving the following 4 basic tasks:

1) Acceptance of the reality of the loss.
2) Working through and experiencing the physical and emotional pain of grief.
3) Adjusting to an environment in which the deceased is missing.
4) Emotionally relocating the deceased and moving on with life.

It is essential that the grieving person complete these tasks before mourning can be accomplished.

5.2.7 Goals of loss and grief therapy

From the research findings, the goals of grief therapy can be identified as follows;

1) Helping the bereaved to actualize and to accept the loss, most often by helping him or her to talk about the loss and the circumstances surrounding it.

2) Helping the bereaved to identify and to express feelings related to the loss (e.g., anger, guilt, anxiety, helplessness, and sadness).

3) Helping the bereaved to live without the deceased and to make independent decisions.

4) Helping the bereaved to withdraw emotionally from the deceased and to begin new relationships.

5) Providing support and time to focus on grieving at critical times such as birthdays and anniversaries.

6) Normalizing appropriate grieving and explaining the range of individual differences in this process.

7) Providing support in an ongoing manner, usually not on a time-limited basis (as with grief therapy).

8) Helping the bereaved to understand his or her coping behavior and style.
9) Identifying problematic coping mechanisms and making referrals for professional grief therapy.

5.3 Implications

There are several implications of loss and grief as drawn from this study. They include the following:

5.3.1 Why We Grieve.

When we love someone and they die, it can feel devastating. This seems to be a universal part of our human experience. But why do we have to suffer like this?

If we humans lived our lives separately from others, needing and relying on no one but ourselves, then the loss or death of another would have little impact. But we are social creatures. Compared to other animals, we spend a remarkably long period of our lives—18 or more years—living with and depending on our parents. We are born into families. We grow and live surrounded and supported by our social environment. We make friends with, go to school with and work with our neighbors. It is part of our makeup to form strong bonds of caring and affection with other people. The forces that draw us to others are so deeply entwined in our nature. We respond to these forces in powerful and seemingly involuntary ways. We feel these pressures
keenly when we are lonely and bereft of companionship; when we feel ashamed and fear social disapproval; and especially when we fall in love and long for the love of another person.

At their best, these deeply rooted feelings encourage us to help and protect each other. The resulting bonds bring us help when we need it. It is precisely these feelings that have made our incredibly rich, complex human culture possible. Without it we would be spending our lives trying furtively to gather and hunt enough food to keep ourselves alive from one day to the next. We would have neither the reason nor the ability to pass on what we have learned to others. If we were hurt, we would have only the wisdom of our bodies to heal us.

But we are not solitary, and the price we pay for our attachments is vulnerability—the risk of loss. Because we depend on other people—because they do matter to us—they occupy a special place in our hearts. They are like a part of ourselves and cannot be replaced...any more than our hand or some fond memories could be. When someone we love is gone from our lives, it is as if a piece of us has been torn away. The loss rends the fabric of our lives and the wound must be repaired. Grief is that process by which our minds heal this hurt. For us to go on with our lives and again risk caring about others, we need to let go of those we love who are no longer with us. Through this process of mourning, we gradually accept the loss. We allow the dead to be gone from our lives.

At the end of mourning, there is still sadness, but it is a wistful sadness that is tempered by the happy memories that we still possess.
5.3.2 Pregnancy Loss and still birth

Pregnancy is often a time of great hope for the future. The parents decorate a nursery, pick out names and fantasize about future years as their baby grows from childhood into adolescence and adulthood. The start of a new generation may draw in special attention from extended family. The traditions and expectations of relatives add drama and complexity to the process.

More often than one might expect, the dream is shattered. Something goes wrong and the family suffers a miscarriage or a stillbirth. About one in four women miscarry at some stage in their lives. Many people feel that a miscarriage or stillbirth is going to be less distressing than the loss of an older child. After all, no one has gotten to know the unborn child. The miscarriage may mean different things to particular families. To some, the loss feels much greater because they experience the loss of a whole lifetime of memories that will never be. Often the mother feels isolated in her loss. No one else felt the early physical changes, or the first tiny kick. The mother may also feel that her body has somehow let her baby and her family down. Her husband and relatives may not have experienced the baby as a separate person.

In the case of a stillbirth, it often helps the parents to see their baby, hold her, take photographs and give her a name. Even a deformed or premature baby may have features that resemble a parent or relative. If the pictures cause too much pain, they
can be stored away and revisited later. Religious rituals associated with birth and
death express love, and honor the uniqueness of the lost child.

Relatives should ask the parents how they could help. Unless the parents ask,
relatives should not try to smooth things over by disposing of the nursery items. Some
parents may experience this as a denial of the reality of the loss.

Friends should not expect the parents to grieve on any given schedule. Pregnancy loss
means different things to different couples. For some, the grief continues at an
attenuated level for years or even a lifetime.

5.3.3 The finality of death

Your significant other is dead. The words sound so final, so cold. Maybe it was your
spouse, child, parent or sibling. Maybe he died from cancer, a car accident, or by his
own hand. Somehow you can’t bring yourself to believe it. He wasn’t even 18. Aren’t
your parents and grandparents supposed to die first?

If you lose a young child, you may feel a mixture of emotions that will come as a
surprise to you. Some feelings and thoughts are fleeting, and some may stay with you
for a lifetime. Everyone experiences grief differently, but many pass through several
stages of grief. These are denial, anger, bargaining, depression and acceptance. Some
people cycle through some of these stages several times as different experiences or
phases of life remind them of the loss.
Some who are experiencing denial or anger may want to rid themselves of possessions that remind them of the lost friend. If you can’t stand to look at certain objects, put them away for safe-keeping and wait a few weeks or months before deciding what to do with them. These mementos may be a source of comfort later.

Talk to friends. Share funny and happy stories about your child’s life. This helps make the loss more real and helps make sense of the death by celebrating the life. If you have questions about how the death occurred, ask the physician.

You may feel plagued by feelings of responsibility or “What ifs?” Tell yourself that you are not responsible for the death. Cry and shout if you need to do so. Some find comfort in action. Join with others to create a memorial or to raise awareness about the illness that led to your significant other’s death.

Take care of yourself. Some adults become depressed and even suicidal themselves after the death of a family member. Talk, write or compose music. Keep active. If you feel that you are losing control, seek adult guidance.

5.3.4 Making a Meaningful Memorial

Often it is difficult to make sense of the death of a child or adolescent. One of the ways to deal with grief is to take action. By doing so, one can celebrate and memorialize the life of the family member you have lost.
There are many kinds of memorials. Every culture, from ancient to modern, has developed unique ways for the living to pay tribute to the dead. Some believe that these rituals give special benefits to the deceased, but others see the funeral and memorial arrangements as powerful source of comfort and support for the living. The most common in our culture is the grave marker, which provides a specific place for family and friends to visit. But there are many other types of memorials that one can create himself/herself. These may be based on one's interests and talents or the relationship to the dead significant other.

The affected person and his/her friends may organize meaningful memorial service with different individuals providing anecdotes, and simply a place to weep and laugh together. Photographs, videotape, or sports items may serve as reminders of the life led by the deceased.

If one is artistically or musically talented, he/she might compose music or a painting to express grief, anger or love. A particular painting or musical arrangement may evolve and change the mourner as he/she moves through your grief. If you write, you may embark on a series of stories or poems.

The school or place of worship may allow one to build a memorial garden. Working in the earth can be therapeutic, and planting can express hope in the future.

Anger is a form of energy. Can one transform this energy into something strong and positive? One might organize a group to promote awareness of the condition that
caused the death. If he died as a result of drunk driving, you might promote S.A.D.D.
(Students Against Drunk Driving.) one might organize discrete rides home for classmates who become intoxicated at parties.

Celebrating and commemorating a life may not mean that one agrees with the way he/she died. Seeking to understand someone’s reasons for drunk driving or suicide is not the same as condoning a self-destructive act.

5.3.5 How Families Mourn Together

In order to understand bereavement, we need to make the distinction between grief and mourning. Grief is a person’s internal experience, thoughts and feelings related to the experience of a great loss. Mourning is the external expression of one’s grief. Thus, a person may experience extremely painful grief but, because of a need to appear stoic, may not mourn.

Grief and mourning are intensely personal and unique experiences. We often refer to stages of grief, but these often do not occur in an orderly progression. Depending on the situation and the individuals involved, one may not experience some stages, or may cycle in and out of the same emotional state several times.

A major loss often brings up echoes of past losses. If the family members still have intense unresolved grief, it may complicate the way that they mourn.
Loss often happens in a family context. The family members grieve and mourn individually and as a group. The method of death, sudden or the culmination of a long illness is an important factor. A sudden or violent death may be particularly difficulty for the family to process because of the intense anger often involved. “It didn’t have to happen.” However even if the death is the long expected release from a painful illness, it can still be a powerful experience.

If a parent dies, the children may experience a double loss. One parent has died and the other is too overwhelmed to provide much nurturance. At this time, extended family and the community can step in to support the grieving family.

Marriages may be strained and even fall apart under the strain of death and mourning. Spouses may grieve differently and may resent the way that the partner behaves. Each may be too overwhelmed to reach out to the other.

Those in non-traditional family structures may face additional complexities in their process of mourning. They may be denied legal protection afforded to other families. Church and extended family may not recognize their grief.

Mourning, though a painful process can also be a way for families to grow together. Petty conflicts seem less important in the face of loss. Relationships seem more precious because they are fragile and impermanent. Family members may learn to support each other and truly listen.
5.3.6 Talking about terminal Illness

When one first hears the news that he/she has a serious illness, the first reaction is often to shut it out of awareness. Denial is not all bad. In limited amounts, it may serve a protective function. However, one must eventually take a careful look at the situation. At such a time, it may become helpful and even necessary to talk to friends and loved ones about your illness and your life plans.

Many of us are not used to sharing deeply personal feelings with others. Our society has tended to avoid open discussion of illness and dying. Should you share your concerns with others? If you express your fears, will it make them come true? Will your talk of illness and medical procedures burden your friends and relatives? Will they become embarrassed if you start to cry?

Many people loath to reveal their true wants and needs. However, you may discover that others may be wondering what you want. They are often happy to get a clear message from you. They may be at a loss as to what to say to you. If you bring up the subject of your illness, it breaks the ice and may eliminate an awkward barrier. You may start to cry. This is not necessarily bad. It may actually make it easier for both of you to express your intense emotions. Discussing your illness or impending death with someone else may lead to a new and special sense of closeness. Crises can strip away artificial barriers and help us focus on what we really value in each other.

When one confronts a serious health crisis, he/she needs support. Friends and relatives can provide that. Some of the thoughts and feelings may seem grotesque or
morbid. If a friend is able to hear your concerns, he or she may reassure you that these concerns are normal. You may have to make significant life decisions. Discussing these decisions aloud with a confidant may help you clarify what you truly want to do.

When you talk to someone about your illness, it is good to be open about any strong feelings you experience or that you feel your friend is showing. This ultimately eases any sense of awkwardness. You do not always have to use words to express your thoughts or feelings. Silence, hugs, or holding hands may express a great deal. Tell the other person what he or she has meant to you. Be open about any regrets for past actions or omissions.

Every moment in a person’s life carries the potential for growth and a new sense of meaning. You always hope for a reprieve or even a cure, but whether or not it comes, you can still experience growth personally and in closeness to others.

5.4. Recommendations

5.4.1 Loss and grief training

Thorough training on grief and loss intervention should be carried out at all levels of training in counselling throughout the country and particularly in the institutions of higher learning such as the universities. Counsellors should not practice grief therapy if they are not qualified. It is clear that attaining equilibrium after loss and grief goes beyond identifying the grief tasks into processing issues arising from the death of a
significant other. As such, therapy demands more from the therapist than learning a few sets of skills. Assessment and referral skills should equally be emphasized.

The therapists further needs to understand types of personalities, their coping mechanisms, their defenses, and other overall abilities and weakness. Exercises carried out during training should illustrate interplay between the client and the therapist past and present, reality and make belief and insight into the constituent elements that contribute to the development of significant others’ relationship, attitudes preconceptions and beliefs. For each package of training there should be existing rationale for use of particular methods of intervention, duration, instructions and debriefing.

5.4.2 Therapeutic techniques.

Some of the useful techniques a therapist should use in intervention;

**Evocative language**-the counsellor can use tough words that evoke feeling in order to facilitate expression and to bring to reality home and stimulate the painful feelings that can easily be repressed.

**Use of symbols**-have the bereaved bring photos of the deceased or letters, videotapes and audios

**Writing**-have the survivor write letters to the deceased to express thoughts and feelings. Keeping a journal of one’s grief or writing poetry can also facilitate the expression of feelings and send personal meaning to the loss.
Drawing pictures that reflect one’s feelings as well as the deceased may also prove very helpful.

Role playing – helping the bereaved to role play various situations that they fear or feel awkward about are one way to build coping skills.

Cognitive restructuring—the counsellor helps the bereaved to identify covert thoughts and self talk and evaluate them for accuracy. The underlying assumption is that thoughts influence actions and feelings.

Directed imagery—visualizing the dead for example seated on a chair or even closing eyes encourages the bereaved to say what he/she needs to say.

5.4.3 Consultative supervision in mitigating counsellors’ burn out

Counsellors involved in loss and grief therapy should carry out consultative supervision to avoid the overwhelming impact laid upon them throughout the loss and grief sessions. This will go along way in mitigating stress and burnout through using other therapists as their safety valves in terms of feelings and ideas. Often times consultative supervision will help check out any personal biases and stereotypes of the therapist while using other counsellors as their sound board. Supervision also assists counsellors in dealing with fixed images whenever they are dealing with grisly murders and accidents and they have to be present.

5.4.4 Therapeutic intervention and use of referral

Grief therapy can be provided on an individual basis or group therapy. Regardless of setting, a therapeutic contract should be established with the patient. Such a contract
should define the time-limited basis of the therapy, any fees, and the expectations and focus of the therapy. If the patient presents with physical complaints, medical illness must be ruled out through referral to medical practitioner.

Grief therapy requires talking about the deceased, and recognizing whether there are minimal or exaggerated emotions surrounding the loss. Persistently idealized descriptions of the deceased can be indicators of the presence of more ambivalent, angry feelings. Grief therapy may allow the individual to see that anger, guilt, or other negative or uncomfortable feelings do not preclude more positive ones and vice versa.

The focus of grief therapy is dependent on an assessment of the four tasks of mourning. Human beings have a tendency to make strong affectional bonds or attachments with others. When these bonds are severed, as they are in death, a strong emotional reaction occurs. The tasks of mourning serve as a means whereby grief may be resolved. After one sustains a loss there are certain tasks of mourning that must be accomplished for equilibrium to be established and for the process of mourning to be completed.

5.5 Recommendations for Further research.

5.5.1 Children’s perspectives to loss and Grief.

At one time children were thought of as miniature adults and their behaviors were expected to be modeled as such. Today there is a greater awareness of developmental differences between childhood and other developmental stages in the human life cycle. Differences are recognized between the grieving process of children and that of
adults. It is now believed that the real issue for grieving children is not whether they grieve, but how they exhibit their grief and mourning.

Although loss is unique and highly individualized, several factors can influence a child’s grief. This includes the child’s age, personality, stage of development, previous experiences with death, prior relationship with the deceased, the environment, the cause of death, patterns of interaction and communication within the family, stability of family life after the loss, how the child’s needs for sustained care are met, availability of opportunities to share and express feelings and memories, parental styles of coping with stress, and the availability of consistent relationships with other adults.

5.5.2 Cross-Cultural Responses to loss and grief

Helping family members cope with the death of a loved one includes showing respect for the family’s cultural heritage and encouraging them to decide how to commemorate the death. Clinicians consider the following 5 questions particularly important to ask those who are coping with the emotional aftermath of the death of a loved one:

1. What are the culturally prescribed rituals for managing the dying process, the deceased’s body, the disposal of the body, and commemoration of the death?

2. What are the family’s beliefs about what happens after death?
3. What does the family consider an appropriate emotional expression and integration of the loss?

4. What does the family consider to be the gender rules for handling the death?

5. Do certain types of death carry a stigma (e.g., suicide), or are certain types of death especially traumatic for that cultural group (e.g., death of a child)?
Appendix 1

Questionnaire 1 - for the bereaved only.

Dear respondent,

This research attempts to find out the adult’s perspectives on loss and grief of a significant other. It is hoped that the information gathered will assist counsellors, educators and hospital staff in helping people to process their loss and in developing proper intervention for grief therapy in Kenya. Your response will be of great value to the study. Please answer the questions frankly and to the best of your knowledge. Utmost confidentiality is assured.

Basic information

1. Age [ ] 21-30 [ ] 31-40 [ ] 41-50 [ ] Above 50

2. Sex [ ] male [ ] female

3. Marital status [ ] Single [ ] Married [ ] Separated

4. Religious affiliation [ ] Christian [ ] Muslim [ ] Hindu
Divorced □  A. T. S □
Widowed □  Any other □

5. Occupation □ unemployed □ employed □ self employed □ any other

6. Level of education □ No formal education □ primary □ secondary □ University

7. Age of the deceased at the time of dying □ 0-10 □ 11-20 □ 21-30 □ 31-40 □ 41-50 □ 51 and above

8. Year of demise □ 2001 □ 2002 □ 2003 □ 2004 □ 2005

9. Who was the deceased to you? □ Spouse □ child □ parent □ sibling

10. Category of loss □ Short illness □ Long illness □ Accident □ Suicide □ Murder □ Any other – specify--------------------------
11. Place of death
   □ Hospital       □ Home       □ Abroad
   □ Unknown       □ Any other- specify---------

12. Where were you at the time of dying?
   □ Present       □ absent

Fill in by ticking the appropriate number that represents your answer;

   □ Strongly disagree
   □ Disagree
   □ Neutral
   □ Agree
   □ Strongly agree

Section I

1. Death anticipation reduces shock. □ □ □ □ □

2. Prolonged illness prepares the survivor □ □ □ □ □

3. The demise of the terminally ill is received more calmly □ □ □ □ □ □

4. Denial of death reduces shock □ □ □ □ □

5. Gradual breaking of death news reduces shock □ □ □ □ □

6. Deeper shock is associated with sudden death □ □ □ □ □
Section II

Physical reactions experienced during loss and grief include;

7. Numbness  
8. Shock  
9. Disbelief  
10. Anxiety  
11. Sadness  
12. Relief  
13. Despair  
14. Loneliness  
15. Confusion  
16. Anger  
17. Guilt  

Section III

The following thoughts and behaviors occur after losing a significant other;

18. Preoccupation with the image of the deceased  
19. Yearning for the deceased  
20. Sensing the presence of the deceased
21. Visual and auditory hallucinations

22. Sleep disturbance

23. Appetite fluctuations

24. Forgetfulness

25. Dreaming with the deceased

26. Actively avoiding reminders of the deceased

27. Searching and calling for the deceased

28. Restlessness

29. Finding the world meaningless

30. Crying

32. Withdrawing socially

Section IV

33. Belief in after life serves as an anchor to face loss

34. Death is punishment from God

35. Faith plays a vital role in finding the meaning of loss

36. Religious affiliation eases the process of grief

Section V

During loss and grief, neighbours and friends come in handy and supportive;
37. Financially
38. Materially
39. Emotionally
40. Socially

Section VI

The death of a significant other is more actualized through;
41. Viewing the body
42. Memorial service
43. Burial ceremony

Section VII

44. Cultural mourning is a form of respect for the dead person
45. Speaking about the dead is taboo
46. Memorial service is a positive way of remembering the dead

Section VIII

The following aspects of counselling are helpful during grief;
47. Explanation of what is ‘normal’ during grief
48. Review of the relationship with the deceased
49. Review of events surrounding the death event
50. Assistance to focus on the emotions being avoided
Appendix ii

Questionnaire 2- counsellors only.

Dear respondent,

This research attempts to find out the adult's perspectives on loss and grief of a significant other. It is hoped that the information gathered will assist counsellors, educators and hospital staff in helping people to process their loss and in developing proper intervention for grief therapy in Kenya. Your response will be of great value to the study. Please answer the questions frankly and to the best of your knowledge. Utmost confidentiality is assured.

Basic information

1. Age □ 21-30 □ 31-40 □ 41-50 □ 50 and above

2. Sex □ male □ female

3. Marital status □ single □ married □ divorce □ Separated □ Widowed
4. Level of training in counselling

- Certificate
- Diploma
- Bachelor
- PhD
- Any other

Years of experience in counselling

- 0-1
- 1-2
- 3-4
- 4-5
- above 5

Fill in by ticking the correct number representing your answer;

1. [ ] Strongly disagree
2. [ ] Disagree
3. [ ] Neutral
4. [ ] Agree
5. [ ] Strongly agree

Section I

The following skills are helpful in grief counselling;

1. Active listening
2. Reflecting the experience and feelings
3. Deeper empathy
4. Setting limits and boundaries
5. Clarification of feelings and thoughts
Section II

In counselling the bereaved the following are some of the factors to be considered:

9. Intimacy level of the lost relationship
10. Life stage of the griever
11. Grief history of the griever
12. Emotional complexity of the griever
13. Degree of isolation of the griever
14. The capacity of the griever to trust others
15. Ability of the griever to express thoughts
16. Ability of the griever to express feelings
17. Willingness to accept the loss
18. Preparedness to go through counselling
Section III

19. Delayed grief occurs when recognition of the loss and the grief is postponed

20. Absence of grief leads to pathological outcomes

21. Chronic grief occurs when the bereaved does not recover from the symptoms of bereavement

22. Counselling helps to mitigate the effects of complicated grief

23. There is an association between grief and physical illnesses

24. The health condition of the survivor is a determinant of the process of grief

25. Drug and substance abuse increases in times grieve for previous users

26. Excessive guilt is a result of ambiguous relationships

27. Review of the relationship of the deceased and the bereaved helps to clarify feelings

28. Excessive dependency predisposes the survivor to difficulty in mourning
Section IV

In grief counselling the counsellor should;

29. Encourage client to talk about grief

30. Help the client to cut the dependency tie with the deceased

31. Use evocative language to help client focus on feelings and thoughts

32. Facilitate emotional relocation

33. Provide time to grieve

34. Affirm the personality of the griever

35. Be available to offer support

36. Examine the clients copying styles

37. Examine the client’s defenses

38. Aim at facilitating transition to productivity

39. Examine the client’s support system

40. Provide follow up services to the bereaved
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