

MODIFIED COMPLICATED GRIEF THERAPY IN TREATMENT OF  
COMPLICATED GRIEF AMONG ORPHANED CHILDREN IN SELECTED  
PUBLIC PRIMARY SCHOOLS IN SIA YA COUNTY, KENYA

by

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A dissertation presented to the School of Human and Social Sciences

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APPROVAL

MODIFIED COMPLICATED GRIEF THERAPY IN TREATMENT OF  
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## DECLARATION

MODIFIED COMPLICATED GRIEF THERAPY IN TREATMENT OF  
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PUBLIC PRIMARY SCHOOLS IN SIAYA COUNTY, KENYA

I declare that this dissertation is my original work and has not been submitted to any other college or university for academic credit.

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## ABBREVIATIONS AND ACRONYMS

APA	American Psychological Association
AIDS	Acquired Immunodeficiency Syndrome
BAI	Becks Anxiety Inventory
BDI	Becks Depression Inventory
BGQ	Brief Grief Questionnaire
CBT	Cognitive Behavioral Therapy
CDI	Child Depression Inventory
CG	Complicated Grief
CGD	Complicated Grief Disorder
CGT	Complicated Grief Therapy
CT-OVC	Cash Transfer for Orphans and Vulnerable Children
DSM-5	Diagnostic and Statistical Manual for Mental Disorders, 5th Edition
GOK	Government of Kenya
HIV	Human Immunodeficiency Virus
IEBC	Independent Electoral Boundaries Commission
ICG	Inventory for Complicated Grief
IPT	Interpersonal Therapy
KCPA	Kenya Counseling and Psychologists Association
KNBS	Kenya National Bureau of Statistics
KODI	Kenya Open Data Initiative
MCGT	Modified Complicated Grief Therapy
MDD	Major Depressive Disorder
MoEST	Ministry of Education, Science, and Technology

NACC	National Aids Control Council
NACOSTI	National Commission for Science, Technology, and Innovation
NASCOP	National AIDS and STI Control Program
NCCS	National Council for Children Services
OVC	Orphans and Vulnerable Children
PCBD	Persistent Complex Bereavement Disorder
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	Persons Living with HIV
PSS	Psychosocial Services
PTSD	Posttraumatic Stress Disorder
REBT	Rational Emotive Behavioral Therapy
SSA	Sub-Saharan Africa
UNAIDS	The Joint United Nations Programme on HIV and AIDS
UNICEF	United Nations Children's Fund
WHO	World Health Organization

## ABSTRACT

This quasi-experimental study tested the efficacy of a Modified Complicated Grief Therapy (MCGT) in treating complicated grief (CG) among orphaned children in selected public primary schools in Siaya County. The study had 241 participants comprising orphaned children aged 10-15 years. The participants were grouped into treatment and control groups, and only the treatment group received 12 weeks of the MCGT intervention. Descriptive statistics were used to determine the participants' grief prevalence and sociodemographic characteristics. Pearson correlation coefficient ( $r$ ) and linear regression helped to determine the risk factors associated with CG, while t-tests were used to assess the efficacy of the MCGT intervention. The prevalence of grief among the participants was 66%. Over half of the participants were paternal orphans (56.5%), most had lost their parents through sickness (74.2%), and almost half had also lost a sibling (48.9%). The number of siblings, separation from siblings, and perceived level of closeness to deceased mother (prior to her death) showed significant association with CG. In contrast, age, gender, perceived level of closeness to deceased father (before his death), and cultural factors did not show significant association with CG. The MCGT was effective in the reduction of CG symptoms with an average total reduction of 16.75 points in the 12 weeks, and a weekly average reduction of 1.29 scores. The study recommends that MCGT be included as a component in all programs targeting orphaned and vulnerable children, be adopted as a school-based grief program, and be used in capacity building for guidance and counseling teachers and practicing therapists.

## DEDICATION

I dedicate this work to psychologists, social workers, teachers, caregivers, and all other mental health professionals who have devoted their lives to ensure the psychosocial wellbeing of children.

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## CHAPTER ONE: INTRODUCTION AND BACKGROUND TO THE STUDY

### 1.1 Introduction

This chapter introduces the background of the study. It provides an overview of complicated bereavement among orphaned children and the negative impact of the same on academic performance. Complicated grief therapy (CGT) - a recent approach in grief work that combines cognitive behavioral therapy (CBT), psychodynamic, and interpersonal therapy (IPT) among other treatment models - is introduced. The section further contains the problem statement regarding bereavement and academic performance, the study purpose, objectives, hypotheses to be tested, justification, significance, limitations and delimitations, and the study scope.

It is normal to feel immense sadness, numbness, and anger following the death of a loved one. Experts in grief have indicated that the duration and intensity of the grief can sometimes prove to be a challenge for some mourners predisposing them to grief complications (Boelen & van den Bout, 2005; Ito et al., 2012; Maciejewski, Maercker, Boelen, & Prigerson, 2016). Studies have since determined that children, just like adults go through a period of mourning after experiencing death; and grief may go on for an extended period before the child can begin to understand the meaning and finality of death (Akerman & Statham, 2014).

Moreover, Akerman and Statham (2014) argued that although many of children's reactions to bereavement are below the level that would indicate a disorder, several orphaned children experience significant difficulties, warranting clinical diagnosis and treatment. Unfortunately, grief in children may go undetected, especially in cultures that do not engage in the discussion of death with children (Limo & Kibowen, 2017).

As the family members are in mourning, children are basically left out with no one to explain what is happening at that moment (Limo & Kibowen, 2017). The situation is direr for AIDS orphans due to their exposure to the ailing and sufferings of a parent and in some cases have to assume adult roles such as caring for the ill parent. Often, no one explains the disease process to the bereaved child; resultantly, children end up drawing their own irrational conclusions. Secondly, the exposure to the suffering of a parent can further predispose the child to grief complications when the parent eventually dies (Heeke, 2018; Lee et al., 2014).

Since grief impairs socio-cognitive functioning (Thwala, 2013), grief that is left unmanaged can have a detrimental negative impact on the academic performance of orphans enrolled in formal school programs (Kiambi & Mugambi, 2017). Socio-cognitive impairment in children, especially for school-going children, is manifested in their behavior and academic performance (Huyah, 2017). Research has so far confirmed a relationship between the existence of grief and the academic performance of orphans, that is, grief has a significant negative impact on academic performance (Akerman & Statham, 2014; Limo & Kibowen, 2017; Olela, 2014).

In most cases, some orphaned children may take up adult roles such as caring for the parent and at times becoming a parent to their younger siblings (Limo & Kibowen, 2017). According to Huyah (2017), the following aspects are likely to be found in a child who takes on adult roles: restricted access to education, increased school absenteeism, reduced school participation, lack of concentration, and inability to complete school homework. These factors are considered key in influencing the academic performance of school-going children.

Environmental factors also significantly contribute to psychological vulnerability to complicated grief (CG). These include scarcity, the situation of one's family, being highly dependent, insufficient mediation approaches, and stigma (Ener & Ray, 2018; Heeke, 2018). When these aspects are put together, they hinder the development of resilience and further expose the child to chronic disorders (Heeke, 2018). Such mental disorders are linked to poor academic performance among orphans (Crivello & Chuta, 2012; Dyregrov, Dyregrov, Endsjø, & Idsoe, 2015). Socio-cultural expectations based on gender and age such as girls having more domestic responsibilities also have a significant effect on academic performance of girls. (Dyregrov et al., 2015; Lee et al., 2014; Olela, 2014).

According to the “diagnostic and statistical manual for mental disorders, 5th edition” (DSM-5), unmanaged grief may result in CG. (American Psychiatric Association [APA], 2013). The DSM-5 has referred to CG as a ‘persistent complex bereavement disorder (PCBD)’. The disorder is still listed among disorders needing further investigation (APA, 2013) and has listed tentative symptoms that can be used to distinguish normal grief from complex bereavement.

In the DSM-5's diagnostic criteria, PCBD is characterized by an inability to accept the death of a loved one, a deep yearning and desire to die to be with the person who has died, emotional cognitive and social difficulties, and a high intensity of the grief symptoms (APA, 2013). However, for a diagnosis to be established, the symptoms must have existed for one month and still presenting at least 12 months after losing the loved one for adults, and six months for bereaved children (APA, 2013). These symptoms may warrant psychological intervention and a grief

therapist's key role is to help the client resolve the grief and realign their lives back to a level of functionality without the loved one (Corey, 2009).

Therapy techniques from the rational emotive behavioral therapy (REBT) model have been modified and extensively used in the treatment and management of complex grief symptoms (Duffy & Wild, 2017; Malkinson, 2010). As presented by Malkinson and Ellis (2000), REBT for grief targets irrational beliefs, and trains bereaved clients to have more adaptive thinking about death. It seeks to re-organize the lives of the clients and sustain their healthy bonds with the deceased, eventually improving their overall biopsychosocial functioning (Malkinson, 2010).

Although used in grief treatment, the REBT model's significant shortcomings have mainly been that it is too cognitive and that it disregards emotions. In REBT, negative emotions are viewed as a pure result of irrational thoughts and beliefs, and clients are not allowed to dwell much on their emotions (Malkinson, 2010). Given these challenges, Shear and Shair (2005) developed the complicated grief therapy that was based on the integration of cognitive behavioral techniques (CBT) and techniques from Interpersonal therapy (IPT).

In general, as established by efficacy studies across different populations in Western and Asian countries, CGT is effective for bereaved persons. Specifically, clinical trials on children have confirmed its efficacy in treating bereavement in children (Wetherell, 2012). Since its introduction in 2005, one challenge that has remained ripe when it comes to the adoption of CGT has been the fact that since the theory combines different treatment models, it can be challenging for therapists inclined to specific models to adopt the varied techniques within CGT. Clients who

are, for example, inclined to cognitive modalities may find CGT to be emotionally draining.

The training process for CGT is intensive, prolonged, and requires expert supervision which may not be readily available in some countries. Wetherell (2012) maintained that a less intensive CGT manual would be beneficial in increasing access to mental health services for the public. He hence recommended further efficacy tests involving “less stringent, less time-intensive training process” to determine if the intervention would still produce positive therapy outcomes and significantly reduce CG symptoms (Wetherell, 2012).

Losing a parent is perceived as a critically distressing experience for a child. AIDs orphans account for more than 12%, translating to about 17 million, of all orphans across the globe. A 2018 report by The Joint United Nations Programme on HIV and AIDS (UNAIDS) revealed that in the year 2017, on average, the number of adults who succumbed to ailments linked to AIDS were 940 000. Moreover, SOS Children’s Villages (n.d.) reported that in 2017, the world had more than 150 million children orphans; and according to UNAIDS (2018), eight out of every ten of these orphans lived in sub-Saharan Africa (SSA).

The high proportions of HIV and AIDS in the countries within SSA significantly contribute to the high prevalence of orphanhood in these countries (Selamu & Singhe, 2018). In Kenya, specifically, the HIV and AIDS prevalence rate remains high, particularly among adults living in counties in the western regions of Kenya. As of 2016, Siaya County was ranked third highest in the prevalence of adults living with HIV. The HIV rate in the county stood at 24.3%, which was almost four times the national prevalence (National AIDS Control Council [NACC], 2016).

Besides, over 2,206 AIDS-related deaths were recorded in Siaya County in 2015, with data showing that the county had approximately 107,301 orphans (NACC, 2016).

This researcher did not find any evidence of a structured grief management or assistance given to orphaned children in Kenya. Current interventions have prioritized provision of food and shelter (Ministry of Labour Social Security and Services, [MLSS&S], Department of Children Services [DCS], 2015).

Within the African context, relatives usually take over the responsibility of taking care of the orphaned child (Save the Children, 2015). In the case where one of the parents is alive, the child continues to stay with a bereaved parent who is still processing their own grief and therefore unable to be of much help to the child (Huyah, 2017). When the children resume school, the expectation is that they will continue with their studies as usual. Regrettably, while the adults are occupied with managing their own grieving process, and getting on with their lives, the children do not receive sufficient attention through their own grieving process (Akerman & Statham, 2014; Huyah, 2017).

In Kenya, certain ventures have been initiated towards bettering the delivery of care to orphans in the country. The 'cash transfer program for orphans and vulnerable children (CT-OVC)', initiated in 2006 by the DCS in the MLSS&S (Ward et al., 2010) is one of such ventures. The program was meant to build the capacity of communities and families to cater for the needs of OVCs. CT-OVC has been expanded over the years, and in the financial year 2015/2016, it was reported that it covered 246,000 households in the 47 counties of Kenya (Huang et al., 2017). Each household included in the program receives Kenya Shillings 2000 (approximately 20 USD) per month (Huang et al., 2017).

The CT-OVC program has focused on supporting orphaned children, and it also encourages caregiving for these children by relatives (Handa, Halpern, Pettifor, & Thirumurthy, 2014). However, Ayuku et al. (2014) found that the CT-OVC program showed minimal impact since the money is given unconditionally without the restriction of how families spend it. Furthermore, although about 54,000 households were caring for an orphan, only 24% of these households were benefiting from the CT-OVC programs as of 2015, leaving out over 75% with no economic support (Ayuku et al., 2014). Sadly, even for those covered in the CT-OVC programs, psychosocial care is not a component of the program.

In 2014, a comprehensive guideline for alternative family care whose focus was on deinstitutionalizing care for orphans back to families and other alternative care was published (Government of Kenya [GOK], 2014). Additionally, an updated directory guiding service providers who deal with children was published in 2015. As per the publication, of the over 1000 institutions listed across the country, none had a specific focus on psychological wellbeing (National Council for Children's Services, 2015). The report simply outlined specific tasks for each of the organizations. The tasks were to ensure food and nutrition, as well as shelter and care for the children; awareness of children's rights; meet the children's educational needs; reintegrate the children with families; strengthen the households economically; and rehabilitate abandoned children.

A 2015 report by the DCS stated that "although the government had put in place policies on interventions for OVCs, most of the interventions for these children have mainly focused on addressing needs such as food, clothing and shelter with little focus on the invisible needs among them psychosocial support" ( MLSS&S, DCS,

2015, p. 1). The DCS noted that there were significant gaps in offering psychosocial support in the country. Among the key gaps identified were the lack of capacity to offer psychosocial services (PSS), unavailability of the service providers, and the lack of a proper understanding of the qualification required to provide effective psychosocial services.

Informed by the stated gaps, in 2015, the DCS released a policy document titled “national psychosocial support guidelines for OVC in Kenya”. In the document, the department called for rapid implementation of psychosocial support for OVC. The psychosocial services were divided into physical, cognitive, emotional, spiritual, and social support. Notably, the policy document added a section on support in traumatic and emergency situations. Although the document targeted psychosocial care for OVCs, it is unfortunate that it failed to recognize the death of a parent as a traumatic event, as it limited traumatic events to natural disasters and violence. Secondly, it stated that guidance and counseling should be offered to OVCs but failed to give a proper framework on how this should be done.

As research on the provision of psychosocial services for orphans continues worldwide, some scholars have maintained that school-based mediations particularly for areas predisposed to HIV, should be given priority (Skeen et al., 2017). Similarly, Mwoma and Pillay (2015) viewed the school as being better placed to support school-going children psychosocially, given that a significant portion of these children’s time is spent in school. It is hence, necessary for guidance and counseling teachers to be adequately equipped so that they can support OVCs psychosocially (Richter et al. as cited in Mwoma & Pillay, 2015), and by doing so, enhance the OVCs’ psychosocial wellness.

It is evident that orphans do experience psychosocial troubles that adversely impact on their academic outcomes. Despite this, in Kenya, the psychosocial concerns of orphans have not been granted due attention since economic necessities receive priority. Additionally, in Kenya, CG in orphans can persist undetected due to low literacy concerning mental wellbeing, and inadequate and economic unattainability of mental health treatment.

Research has demonstrated the existence of impaired psychosocial functioning in bereaved children. Despite this, in Kenya, there has not been any grief management program, specially formulated for use by school counselors in treatment of complex mourning in children who have lost their parent/s through death. The designing and testing of such a manual in Kenya requires obtaining massive data capable of describing the manifestations of grief as well factors that could pose as risks unique to orphans in the rural areas. The Western treatment manuals, though not entirely suitable for the Kenyan environment, and especially for the rural areas, can guide in the design of manuals fit for orphaned children in Kenya and other developing countries. Programs of these nature have proven workable in countries that have limited resources and low access to mental health services (Tol et al., 2008).

Based on the above, this study investigated the efficacy of MCGT (a modified CG therapy) among orphaned children in selected primary schools in Siaya county. To develop MCGT, the current CGT's 16 sessions were shortened to a program of 12 sessions. This was accomplished through the selection of techniques considered less rigorous in regard to training. The goal was to attain a school-based grief management program that would be adaptable, affordable, and sustainable. The researcher aimed at

determining whether such a program could sustainably offer psychological support to the high numbers of bereaved children in Siaya County in Kenya.

## 1.2 Background to the Study

Complicated bereavement, also known as CG, is a condition that is clinically substantial, yet until lately, its existence had not been given due attention (Enez, 2018). As observed by Enez (2018), it was in 1995 that a team of researchers, under the leadership of Holly Prigerson, performed the first probable CG diagnosis. The team's original interest was to identify symptoms distinct to CG, and which would, with clarity distinguish it from bereavement-associated depression or distress. Secondly, the team sought to determine if indeed complicated bereavement could lead to significant functional impairments (Prigerson, Frank et al., 1995).

Prigerson, Frank et al. (1995) studied a group of 82 women who had become widows three to six months ahead of the study commencement. At baseline, the team collected information guided by symptoms of CG. A follow-up, done 18 months after the baseline, assessed 56 subjects for CG symptoms (Prigerson, Frank et al., 1995). The goal was to assess the psychological changes and functioning of bereaved clients (Enez, 2018). Specifically, the tools measured the mood, sleep patterns, self-esteem, anxiety, and the general medical illness burden - with the results showing a distinction between CG factor and a bereavement-depression factor (Prigerson, Frank et al., 1995). The study identified these seven symptoms as key in CG: "searching, yearning, preoccupation with thoughts of the deceased, crying, disbelief regarding the death, feeling stunned by the death, and lack of acceptance of the death" (Prigerson, Frank et al., 1995, p. 22). The team then concluded that CG was distinct from depressive symptoms that result from bereavement.

In the years that followed, more research on complicated bereavement continued as researchers sought to verify the claims by Prigerson and his team. For example, by 1999, a new term, traumatic grief, had emerged (Enez, 2018). At present, more terms have emerged as controversy continues on whether these names indicate distinct grief disorders or whether they can be used interchangeably. Such names include prolonged grief, complex grief, and pathologic grief.

Interestingly, as debate and research continued on distinguishing the terms above, a new twist emerged in the DSM-5 with the latest use of the term persistent complex bereavement disorder (PCBD) (Maciejewski et al., 2016). The arguments and debates notwithstanding, researchers on grief disorders have conceded that some individuals may require clinical intervention to help them grieve normally and restore their lives. PCBD is considered a 'trauma- and stressor-related disorder' and as one of the other specified disorders. It also appears under 'conditions for further study' (Enez, 2018). However, the amount of research work that led to the decision to include this condition in the DSM-5 has contributed to the legitimization of 'grief disorder' as a condition causing significant impairment and one that warrants clinical intervention (Shear, 2015).

Similarly, with increased prevalence of incidences of CG, there was the need to give attention to a possible diagnosis of CG. Research has since confirmed that although a majority of bereaved persons are more likely to go through healthy grief by readjusting to life without the deceased, a significant number of them may be stuck in the grieving process leading to complications and impairment in their daily functioning. Such persons are said to be undergoing CG (Enez, 2018; Shear, 2015).

The response to death is an individual experience and is as unique as our lives (Holland, 2014). Grief has a devastating negative impact on the body, emotions, and thoughts with research showing significant negative impact on even the spirituality of the bereaved (Burke & Neimeyer, 2014). Elizabeth Kubler-Ross, who is known for her study on death and grieving, acknowledged that grief after bereavement is normal, and concluded that although there are contentions on what differentiates a normal from an abnormal reaction after a loss, everyone is bound to grieve when faced with loss (Kübler-Ross, 1978).

According to Maciejewski et al. (2016), all grief is normal, but it is the severity and duration of it that determines the type of abnormal grief a bereaved person could be going through. In their argument, Maciejewski et al. sought to establish differences in symptoms of prolonged grief, CG, and the current DSM-5 diagnosis of PCBD. They concluded that prolonged grief was based more on the duration that the person has been grieving. For example, in children, grief that lasts beyond six months following the death of a loved one is considered prolonged grief. In this case, the intensity of the symptoms does not matter.

Complicated grief, on the other hand, means that the grieving process is interfered with by other symptoms that are not related to the grief per se, and that may hinder the bereaved person's recovery from the grief (Simon, 2013). Such symptoms may manifest themselves in the form of other mental disorders, and the focus would then be on how to deal with these symptoms first to allow for normal grieving to happen (Simon et al., 2011). A diagnosis for PCBD can only be done if the symptoms have persisted for 12 months for adults, and six months for children after the death of an attachment figure or loved one (APA, 2013).

Parental involvement in a child's education has been associated with better education outcomes and motivation to perform academically, and the more a parent motivates the pupil, the more the pupil is likely to realize the importance of the education and will be prompted to work harder in school (Boonk, Gijsselaers, Ritzen, & Brand-Gruwel, 2018; Chowa, Masa, & Tucker, 2013). Unfortunately for orphans, they do not get to benefit from parental engagement in their education. Orphaned children are likely to drop out of school to take up adult roles with girls being the most affected (Limo & Kibowen, 2017). Research has shown that girls may drop out of school to take up caregiving roles when a parent is ailing and also to continue taking care of their siblings when the parent eventually dies (Limo & Kibowen, 2017).

These discussions demonstrate that the psychological effect of grieving a parent's death affects the child's concentration and inspiration in school and contributing to the possibility of reduced academic performance. When the parent dies, the orphans are taken up by caregivers. The caregivers may not be able to take care of the children and may not afford to meet their education needs forcing them to leave school prematurely. Absence of direct engagement in a child's schoolwork, in particular by caregivers, is deemed to impact on the child's academic performance negatively. Children who were previously performing well in school are likely to record reduced academic performance after the death of a parent (Akerman & Statham, 2014; Kiambi & Mugambi, 2017; Limo & Kibowen, 2017).

Consequently, there have been efforts to address the psychological needs of orphans to improve their psychological wellbeing (Datta, 2009; Mumo, 2005; Skinner et al., 2006; Snider & Daves, 2006). Specifically, the studies have aimed at

developing sustainable mitigation for orphans to enhance their resilience (Biemba et al., 2010; Okawa et al., 2011; O'Sullivan, Bosqui, & Shannon, 2016; Tol et al., 2008). The focus of any grief work is to have a meaningful life, even in the absence of the deceased person (Thompson, 2016). Grief work is a psychological term used to describe interventions geared at helping the bereaved to resolve significant loss and resume functionality (Malkinson, 1996; Stroebe & Schut, 1999).

Emotional, cognitive, and behavioral models of psychological intervention have been used in grief treatment as they focus on core components of grief (emotions and cognition/thought). Specifically, REBT has been empirically evaluated as a grief intervention and is a modality within the larger CBT therapies. CBT is one of the most investigated and well-used treatment approaches in psychotherapy (Corey, 2009). These psychological approaches focus on the current thought content of a person and their emotional state while working with the client to resolve the grief (Stroebe & Schut, 1999). Towards sustaining the impact of the therapy, behavioral techniques are used to train the bereaved on how to resolve grief symptoms, should they recur. The intervention may work, but the client will have to engage in constant deliberate actions to resolve these negative feelings (Thompson, 2016).

According to Huyah (2017), not only do orphans have to deal with loss and grief, but they are also faced with environmental stressors such as inadequate food, inadequate caregiving, and limited access to health facilities. Unresolved grief, new family set-ups, and other environmental factors are also linked to negative psychological outcomes for an orphan's mental development resulting in social and cognitive impairment (Akerman & Statham, 2014). Further, Huyah (2017) explored external environmental issues that could worsen the grieving process and increase

vulnerability. Attending to sick and dying parents and the eventual death of a parent exacerbates the grieving process. The orphans are exposed to psychological vulnerability putting them at the risk of developing mental disorders (Limo & Kibowen, 2017).

Some environmentally related aspects also significantly contribute towards psychological vulnerability to complicated grief (CG). These include scarcity, the situation of one's family, being highly dependent, insufficient mediation approaches, and stigma (Ener & Ray, 2018; Heeke, 2018). These aspects, when combined, are likely to add to the complicated grieving process, and thus expose the child to complex bereavement. Using the REBT model or CBT as a standalone ignores the above-mentioned critical risk factors and may impede the treatment of CG. Introducing IPT model in combination with CBT models is hypothesized to have more impact in reducing grief symptoms among orphaned children.

Shear's (2015) CGT manual combines the techniques of CBT with interpersonal psychotherapy for depression components. It is centered on Margaret Stroebe and Henk Schutt's 'dual processing model of grief' which articulates that the person grieving alternates between the loss and recuperation from the loss (Stroebe & Schut, 1999). On the other hand, in 2006, a CBT based treatment of grief which incorporates exposure therapy and cognitive restructuring was developed (Malkinson, 2010). The focus of the approach was to psychoeducate on death by elaborating on the concept of death, modifying any negative thinking and beliefs, identifying any maladaptive grief reactions, and targeting any depressive or anxious symptoms (Malkinson, 2010).

Asukai, Tsuruta, & Saito (2011), Shear et al. (2014), and Wetherell (2012) noted that in recent years, a new therapy model referred to as CGT has emerged. It combines techniques from CBT and IPT, and after being investigated among different populaces, its effectiveness has been proven. All the same, the CGT's high dependency on the techniques of CBT and its lengthy implementation have been pointed out as its weaknesses. Original CGT therapy required 26 sessions with additional sessions for parents and caregivers. The CGT was later revised, and the current version contains 16 sessions.

Considering the limited research on CG among children in Kenya, lack of studies showing effectiveness of CGT within the Kenyan population, and lack of school-based grief programs, this researcher deemed that there was an urgent need to test the efficacy of a modified CGT as a school-based intervention. By having such an intervention, grieving children could be assisted to resolve their grief and reduce incidences of complex bereavement.

### 1.3 Statement of the Problem

Orphanhood deprives children of the guidance of their primary caregivers, making them vulnerable to negative health outcomes, mistreatment, and poor academic attainment (Christian Alliance for Orphans, 2018). Furthermore, in cases where parents are HIV positive, children begin to face the impacts of the disease when the parents start to ail. If the parent eventually dies, the effects continue throughout the child's development (Aleem, 2018; Heeke, 2018).

The death of a parent is rated as one of the most traumatic and stressful events for children (Enez, 2018). Unfortunately, in low socioeconomic areas, mental disorders can go undetected and untreated due to poverty and lack of mental health

care (Hodgkinson, Godoy, Beers, & Lewin, 2017). Unresolved grief can develop into CG, which impairs sociocognitive functioning for school-going children, and is associated with poor academic performance.

Even though CGT is proven to treat CG in children and adults, some of its requirements make it stringent and unsuitable for implementation in low social-economic areas and in areas with limited mental health care professionals. These requirements include its (CGT) recommended 16 sessions and the need for specialized training for the application of some of its techniques. As such, researchers such as Wetherell (2012) recommended the need to develop and test less stringent interventions that can be adopted in such areas. This researcher therefore argued that the current CGT may be unsuitable for adoption as a school-based intervention for orphaned children in rural Kenya due to the limited number of trained mental health professions in the schools.

Towards improving the psychological wellbeing of orphaned children, it is critical to have programs that consider the mitigation of grief complications. This researcher, thus, tested the efficacy of an MCGT intervention which contained techniques that can be trained to teachers who have limited mental health training; and that would be implementable as a school-based grief program as a way to manage CG within the school setup.

#### 1.4 Purpose of the Study

The purpose of this study was to determine whether MCGT would reduce symptoms of CG among orphaned children in public primary schools in Siaya County, Kenya.

#### 1.5 Objectives of the Study

The following were the broad and specific objectives of this study.

#### 1.5.1 Broad objective

The broad objective of this research was to establish the efficacy of MCGT in the treatment of CG among orphaned children enrolled in public primary schools in Siaya County.

#### 1.5.2 Specific objectives

The specific objectives of this study were as below:

1. Document sociodemographic characteristics of orphaned children in selected public primary schools in Siaya County.
2. Determine the prevalence of CG among orphaned children enrolled in selected public primary schools in Siaya County.
3. Determine risk factors associated with CG among orphaned children enrolled in selected public primary schools in Siaya County.
4. Assess the correlation between perception on academic performance after the death of parent and levels of CG among orphaned children enrolled in selected public primary schools in Siaya County.
5. Evaluate the efficacy of MCGT in the treatment of CG among orphaned children enrolled in selected public primary schools in Siaya County.

#### 1.6 Research Questions

1. What are the key sociodemographic characteristics of orphaned children in selected public primary schools in Siaya County?
2. What is the prevalence of CG among orphaned children enrolled in selected public primary schools in Siaya County?

3. Which risk factors are associated with CG among orphaned children enrolled in selected public primary schools in Siaya County?
4. What is the relationship between CG and perception on academic performance among orphaned children enrolled in selected public primary schools in Siaya County?
5. What is the efficacy of MCGT in the treatment of CG among orphaned children enrolled in selected public primary schools in Siaya County?

### 1.7 Justification for the Study

Although among the Western countries a CGT manual exists and has been used for group grief management, the said manual has not been tested as a school-based program. Testing the MCGT manual proposed in this study would seal this knowledge gap and present empirical evidence on the effectiveness of such a manual for grief management. Secondly, testing this tool in an area faced with a high prevalence of HIV and AIDS and increased cases of orphanhood would provide new grounds for further research, especially in standardizing MCGT - through testing its validity and reliability in orphan populations in schools across the country.

Additionally, in Kenya, a policy gap exists in the current psychosocial care and support frameworks for orphans. The existing policies do not provide any specific grief program with most of them addressing general psychosocial care and provision of basic needs such as food and shelter. Moreover, although there exists a policy that each school should have a school counselor, there is a lack in terms of the capacity and expertise that would ensure professional counseling services. This researcher anticipated that the testing and determining the efficacy of MCGT would lead to the development of national policies that would enable the adoption of the MCGT

program as a school-based grief work. Such policies could also be adopted as part of training for school counselors towards building their capacity in grief management, ultimately leading to timely intervention for bereaved children who present with CG.

### 1.8 Significance of the Study

Neglecting the psychosocial needs of orphans has dire consequences not just on the orphans but also on the county and country at large. An evidence-based record on the prevalence of orphanhood and unresolved grief, and on the effectiveness of the MCGT program in resolving grief would ensure the implementation of effective school intervention programs. Such would be programs that target the holistic development of orphans by managing grief and improving academic performance. With such evidence, the government and humanitarian organizations can adopt the proposed MCGT manual as a component of the overall PSS care programs. The goal would be to ensure that they (government and humanitarian organizations) promote school enrollment, financial provisions, the general psychosocial needs; and also, that orphans presenting with CG receive treatment.

Secondly, since all schools in Kenya are currently required to have a school counselor, schools could adopt the proposed 12 session CGT treatment manual so that the school counselors can use it to help grieving children. The development and proven efficacy of this MCGT could also provide a training base for professional bodies in counseling such as the Kenya Counseling and Psychologists Association (KCPA). This would enable such bodies to train school counselors, hence increase their competence in grief management. Finally, the outcomes of this study could challenge stakeholders in the education sector to consider implementing school-based

manuals towards managing grief and other mental health issues that the school-going children face.

### 1.9 Assumptions of the Study

In conducting this study, the researcher was guided by some assumptions, one of them being that in the selected public primary schools, there would be a good enough sample of orphans still struggling with grief following the death of their parents. A good number of these orphans were facing challenges related to school attendance, participation, and general academic performance. An additional assumption was that the participants would provide truthful information regarding their daily life experiences both at home and in school. The final assumption was that the participants would remain in the study for the entire period of the intervention.

### 1.10 Scope of the Study

This study covered orphaned children aged 10-15 years, both male and female, and who were enrolled in 12 public primary schools in Siaya County, Kenya. The 12 schools were selected from each of the six sub-counties in the county of Siaya, with a representation of two schools per sub-county. Only the orphaned children who met the criteria for complex bereavement were included in the study. The study sought to evaluate the effectiveness of MCGT on CG among orphaned children. Caregivers were not engaged in the study.

### 1.11 Limitations and Delimitations of the Study

Some of the participants in the study had limited competence with regard to the English language. Therefore, there was the possibility that they could give responses that would not reflect their actual thoughts or feelings. To address this, the

screening tool was interviewer-administered, thus allowing the participants and the researcher to ask for clarification where needed. Another limitation observed is that some of the participants were resistant about openly discussing the challenges they were going through under caregivers and in school, especially concerning maltreatment and stigma. This limitation was addressed by assuring the participants of confidentiality and anonymity.

Similarly, due to cultural attitudes and practices relating to death and mourning, particularly regarding bereaved children, some of the teachers and administration heads were unaware of the concept of grief and were resistant to allow their students to spare time to attend the therapy session. To mitigate this, a brief psychoeducation program for the teaching staff was done. The researcher sat with the school staff to explain to them the research and its importance in not only treating grief but also in improving the social and relational wellbeing of the orphaned child. The researcher did a short presentation on orphan vulnerabilities and challenges, facts on symptoms of CG and how it presents in school children, and the impact of CG on academic performance. These facts were drawn from the literature review.

#### 1.12 Definition of Terms

Academic performance: The outcome of education; and measures the extent to which a student or institution has achieved their educational goals (Kyoshoba, 2009). It is characterized by performance on tests and examinations. Academic performance is influenced and also assessed through other constructs such as class participation and motivation levels to complete school tasks. In Kenya, the primary school education program assesses academic performance through examinations given at the end of each of the terms with each year comprising three terms. For this study,

academic performance was used to mean observable improvement as seen in school-based examination report cards.

**Bereavement:** The mental state of losing a loved one through death (Maciejewski et al., 2016). For purposes of this study, the term bereavement was used to describe children who had lost their parent or parents through death. The term bereaved child was used interchangeably with an orphaned child.

**Child:** According to the Kenya children's act, a child is defined as an individual below the age of 18 years (National Council for Law Reporting, 2012). For purposes of this study, the term child/children referred to participants aged 10-15 years.

**Complicated grief (CG):** Complicated grief is defined as intense symptoms of grief that continue to exist 12 months after the death of a loved one, and six months in the case of children (Shear, 2015). This study adopted the definition by Shear (2015) to define CG as a set of symptoms of grief that are considered intense beyond normal grief and extended beyond the duration of six months for children.

**Orphan:** The national definition of orphans in Kenya is children below 18 years who have lost one or both parents and can be classified as single and double orphans respectively (Datta, 2009; Lee et al., 2014). However, other authors have argued that orphanhood should only be considered significant if the child has lost a mother through death (Skinner et al., 2006). In the context of this study, Lee et al.'s (2014) definition was adopted, and the term was used to refer to a child who had lost one or both parents.

**Persistent complex bereavement:** A term used in the DSM-5 to refer to grief that is both intense and prolonged beyond the given time (APA, 2013). Other

researchers have since determined that persistent complex bereavement and CG define a similar set of symptoms and that these terms can be used interchangeably (Maciejewski et al., 2016). In this study the definition by APA (2013) was adopted. The term CG has been used interchangeably with complex grief/bereavement.

Primary school child: A school-going child is one that is enrolled in a formal school program in Kenya. The official age of primary school enrollment is seven years and if one goes through eight years of primary education, then they will be approximately 14 years when they complete their class eight. In this context, a primary school child is one aged between 7-14 years. For this study, the functional definition of the term primary school child was used to refer to participants enrolled in a public primary school.

### 1.13 Summary

This chapter has given an overview of CG, the grieving process for children experiencing parental death, and the effect of unresolved grief on the academic performance for orphans. In particular, the background of the study covered the prevalence of orphanhood and CG. Also included in this chapter are the study objectives, purpose, scope, justification, and significance. The key terms used in this document have been defined, and the assumptions and limitations of the study resented. The next chapter covers the literature review, and the theoretical and conceptual frameworks of the study.

## CHAPTER TWO: LITERATURE REVIEW

### 2.1 Introduction

Covered in this chapter is a discussion of the theoretical framework and further reviews of literature as guided by the objectives of the study. The section also includes a conceptual framework which is an illustration of the interaction between the key variables of the study, such as CG, academic performance, and CGT.

### 2.2 Theoretical Framework

This research was informed by loss and attachment theory by John Bowlby, and rational emotive behavioral theory (REBT) by Albert Ellis. The theory of loss and attachment addressed aspects of attachment and loss that may predispose a child to develop CG disorders. On the other hand, the theoretical understanding of REBT helped to elaborate on the premise of grief as psychopathology and how irrational cognitions played a part in the development of complex bereavement.

#### 2.2.1 Loss and attachment theory

According to John Bowlby, there are four distinct characteristics of attachment, namely proximity maintenance, safe haven, secure base, and separation anxiety (Bretherton, 1992). In these four constructs, Bowlby stated that a child always desires to be in close proximity with the loved one, can return to them for comfort when they need it, and sees them as a source of the secure base when they are exploring the environment (Holmes, 1993). Orphaned children are denied all these when their parents die, leaving them disorganized in the absence of the attachment figure. The children then suffer separation anxiety (Aleem, 2018).

Based on this, Bowlby determined that when this bond is broken due to death, the child goes through four stages of mourning: they become numb, start to yearn and search for this attachment bond, when they do not get it they become disorganized, and then start to reorganize themselves (Shear & Shair, 2005). Therefore, according to this theory, how a child resolves grief is determined by the nature of attachment the child had with the attachment figure (Shear et al., 2011). This study's need for intervention was, therefore, to offer a support system to help the child through the four stages and ensure that they resolve and reorganize their lives without the attachment figure.

The theory draws from psychoanalysis and cognitive psychology. The quality of the relationship between the bereaved child and the deceased parent is a major risk factor making the attachment theory a major pillar for this study (Shear & Shair, 2005). Previous attachment and bereavement studies have argued that the quality of the parent-child relationship is a pre-determinant of how the child resolves grief in the wake of loss. This means that the poorer the level of parent-child relationship, the higher the levels of anxiety and hence the harder it is for the child to resolve grief in the event they are faced with bereavement (Stroebe, Schut, & Stroebe, 2005).

Normally, infants respond to separation from the primary caregiver by anxiety, protesting, and crying hysterically (Shaver & Tancredy as cited in Aleem, 2018). This reaction is considered normal, but the question is how long it lasts and how it impacts the child's readjustment to other tasks before the caregiver returns. When the responses to the separation are not addressed, the child develops disinterest in activities as they long for the return of their loved one. In Bowlby's understanding of loss, children assess permanent separations as if they were temporary and they may

remain stuck in his lack of motivation, disinterest, and anxieties as they await the return of their loved one who unfortunately will never return (Krepia, Krepia, & Tsilingiri, 2017). Such is the attachment predisposition to complex bereavement, and it requires that children be assisted in negotiating the complexity, realigning their lives back to normal, and creating a new attachment with alternative caregivers. Reactions to loss can be seen through physical symptoms such as refusing to feed, bedwetting, and fear (Shear et al., 2011).

Loss and attachment theory significantly informed this study given that CGT is based on understanding the prior attachment or closeness between the bereaved and the deceased, saying goodbye, and rebuilding new relationships with other attachment figures (Shear & Shair, 2005). One of the main goals is to help the bereaved reestablish new relationships with the deceased person and then develop new attachment and relationships with others. Once the bereaved has been helped to identify another attachment figure and develop a relationship with them, the possibility of overcoming the CG grief increases (Shear & Shair, 2005).

The loss and attachment theory debate were furthered in the development of CGT. According to Shear and Shair (2005), when individuals are faced with stressful situations, they tend to run to their attachment figures for comfort. This proximity seeking is what Bowlby referred to as running back to a secure base (Aleem, 2018). The availability of an attachment figure protects the individual from the development of intense reactions and mitigates the development of emotional dysfunctions. When a loved one dies, it means that the attachment figure is also gone, and as the stress of bereavement begins to settle in, the child may attempt to run to her secure base only to find that they are no longer there because they are dead. The child is left

disorganized and the stress intensified (Holmes, 1993). The attachment figure serves as a regulator of emotions and behavior. A client who is not able to integrate and comprehend that death is permanent and that the attachment figure will not be coming back, gets stuck in the grief leading into CG (Shear & Shair, 2005).

For purposes of this study, the argument was that the who child has lost an attachment figure and was likely to be experiencing emotional detachment and dysfunction. The child tries to run to the attachment figure, but unfortunately, the attachment figure is no longer there. The stress intensifies and the child, unable to understand that, remains stuck waiting and yearning for the return of the attachment figure. With each passing day, the waiting and yearning becomes intense sadness, confusion, and rumination and eventually develops into CG. Finally, CGT incorporates IPT techniques to reduce some of the very cognitive and forceful CBT techniques. IPT has its origin in psychodynamic and attachment theories which are well explained in Bowlby's theory of loss and attachment.

### 2.2.2 Rational emotive behavioral therapy (REBT)

Rational emotive behavioral theory is one of the major theories in cognitive and behavior therapy and was developed by Albert Ellis. The theory's main assumption is that people are largely responsible for their own psychological disturbances because of the way they have chosen to think (Corey, 2009). According to (Ellis, 2001), humans make themselves sick by the way they think about the stressing situation. The theory postulates that cognitions, emotions, and behavior are interrelated and integrative; implying that a distortion in cognition/thinking would lead to a negative emotional reaction and negative behavior (Mkangi, 2010).

Based on this, the theorist hypothesized that irrational thinking led to an irrational belief system which led to emotional disturbances. It is from this hypothesis that the treatment procedure proposed by Ellis is seen to be an attempt to reverse the episodes back to the thinking stage so that the client can reorganize their thoughts to more positive thoughts (Zisook et al., 2014). One of Ellis's profound statements was that people disturb themselves not by the events that happen to them but by the way they interpret these events (Mkangi, 2010).

Based on the ABC framework, Ellis was able to convince us that indeed activating events does not lead to emotional disturbance, that is to say for instance, that divorce (A=activating event) does not cause depression (C=consequence), but that irrational beliefs (B) about the divorce can cause depression (Corey, 2009). It is difficult to disagree with Ellis on this view since human beings face similar stressful events, with each individual reacting to the event differently. Therefore, focusing on how the client interprets events could be considered a strength of this theory.

The REBT theory informed this study, specifically to understand how cognition leads to the onset of emotional disorder. Similarly, since the CGT model was developed from CBT and given an attachment approach, Shear and Shair (2005) still believed that the cognitions that the bereaved person establishes after realizing that the attachment figure is gone influences whether the person will resolve the grief or not.

Secondly, the development of CGT was informed by specific shortcomings of CBT techniques that were considered too forceful and which did not help the client in rebuilding a new relationship with other loved ones who are still alive. One major shortcoming about REBT is that the theory ignores other sources of emotional

disturbance, mainly those related to biopsychosocial issues. For example, a genetic disposition to disorders such as depression is not considered by an REBT therapist since the therapist has a preconditioned mind that the emotional disturbance is caused only by irrational thinking (Bennet, 2003). According to the author, this assumption can lead to poor therapy outcomes since emotional disturbances can be as a result of other environmental factors.

The REBT theory does not consider the role of past events in predisposing the client to emotional disturbance and how these past experiences may be a hindrance to therapy. This is a challenge for CGT which is highly grounded on attachment theory. The main focus of REBT therapy is to equip the client with skills to be able to dispute irrational thoughts with the hope that the client will employ the skills in future situations. While Shear and Shair (2005) probably believed that it was crucial to consider past attachment and relationships, they still adopted one of the REBT's strengths which is to dispute irrational thoughts and conclusions that may be further complicating the grief. In CGT, the focus is on changing the thinking of the clients not only to solve the presenting grief, but also to be empowered to resolve future life stressors.

Emotive techniques in REBT were criticized for being too direct and intense (Corey, 2009). Techniques such as rational emotive imagery are intense mental practices that require intense training on the part of the therapist. Such kind of intensive training may not be easily accessible for all therapists (Wetherell, 2012), especially those practicing in low marginalized areas or rural areas in Africa. Moreover, the intense nature of this therapy has been found to be unsuitable for

children who are yet to achieve cognitive maturation, for they may find the technique too forceful.

The REBT and other CBT techniques such as those founded under Aaron Beck's cognitive theory may be unsuitable for children. Nevertheless, other techniques, for example, role-playing, homework, relaxation techniques, and shame attacking activities have been found to work well in boosting the self-esteem in children and helping them overcome emotional disturbances.

These two theories: REBT and loss and attachment, together helped to blend in specific focus in the proposed MCGT, while at the same time guarding the researcher against removing elements that may make significant differences in the outcome of the treatment. The strengths and weaknesses of REBT informed this study in areas where REBT emotive techniques were found to be too forceful and intense. In the treatment of children, alternative IPT techniques were considered as a replacement and as more 'child-friendly' emotion-focused techniques.

The researcher argued that such an integration of techniques in the proposed MCGT would be adoptable in a school set-up so as to treat CG. The proposed MCGT was to be a holistic approach that considers how the participants developed these irrational thoughts while at the same time understanding how the level of attachment to the deceased parent may increase the risks of CG.

By helping the child to resolve grief, the attachment style is rectified, restored, and the participant's cognition is reframed, leading to a new understanding and experience of life without the attachment figure. This is what forms the fundamentals of Bowlby's attachment and loss theory which argues that the role of grief work is to

assist the bereaved to restore and readjust their lives healthily without the presence of the attachment figure who is already deceased.

### 2.3 Sociodemographic Characteristics of Orphaned Children

As early as 2002, researchers had analyzed the mass orphanhood that resulted from the increase in HIV prevalence. In their article, Matshalaga and Powell (2002) confirmed that “AIDS has devastated the social and economic fabric of African societies and made orphans of a whole generation of children” (p. 185). In 2014, Lee et al. noted that the global prevalence of AIDS orphans had increased from 3.5% to 32% in the last two decades.

The United Nations Children’s Fund (UNICEF) recorded that in 2015, there were over 140 million orphans across the globe. The distribution was as follows: 7.3 million in Europe, 61 million in Asia, and 52 million in Africa. Out of these orphans, 15.1 million were double orphans (lost both parents) (UNICEF, 2017). Globally, over 12%, which is approximately 17 million orphaned children are AIDS orphans with 8 out of 10 orphans living in SSA countries. The high number of AIDS orphans living in SSA account for 27% of the total 56 million orphans in these regions (UNAIDS, 2017).

In South Africa, there are over 3.7 million orphans with the number expected to increase by the year 2020 if new strategies are not implemented to curb the HIV epidemic (Government of South Africa, 2017). In West Africa, Nigeria recorded a total of 1.6 AIDS orphans in the year 2016 (Awofala & Ogundele, 2018). In 2016, NACC reported that there were at least 2.5 million orphans in Kenya, and World Without Orphans (2016) placed the figure at 2.4 million: a figure that represents at

least 13% of the population of children in Kenya (NACC, 2016). Out of these 2.4 million orphans, approximately 47% are AIDS orphans (NACC, 2016).

In Kenya, as of 2016, there were 36,000 HIV related deaths and 62,000 new infections recorded and an HIV prevalence of 1.6 million (NACC, 2017). The HIV prevalence in Kenya is based on geographical location with more HIV cases being reported in the Western part of Kenya. In a 2016 report by NACC, it was noted that counties in Western Kenya recorded the highest prevalence, with Siaya County coming third at a prevalence rate of 24.8% (NACC, 2016). The same report indicated that there were over 126,411 persons living with HIV (PLHIV) in Siaya County. The county's HIV infections were also reported to be four times higher than the total Kenya's national prevalence of HIV and at least 2645 deaths were recorded in Siaya County in the year 2015 (NACC, 2016). As of 2018, NACC reported that Siaya County was leading with an HIV prevalence of 21% (Oketch, 2018).

According to NACC (2016) data, there were about 6,062 households living with an orphan in Siaya County. Moreover, The Kenya National Bureau of Statistics (KNBS, 2018) documented that Siaya County recorded the second highest number of orphaned children, at 12.7% after Migori County which recorded 18% of the total child population as orphaned.

World Without Orphans (2016) reported that despite the increase in the number of orphans, only an approximate of 50,000 were identified as living in registered or regulated children's homes, while at least 300,000 were found to be living on the streets. Although there are many children homes in Kenya, only about 1,014 are registered and regulated and the number of unregistered is yet to be determined (GOK, 2014).

The Kenya guidelines for the alternative care of children was launched in 2015, and in the report, it was noted that only 45% of the 2.4 million orphans in Kenya were in institutionalized care. Children's homes are popular care centers for OVC. However, studies have confirmed that they are not the best alternative when it comes to caring for children lacking parental care. As a result, there has been a general call for the establishment of alternative care with more proposal on Kinship care (Milligan, Withington, Connelly, & Gale, 2016).

Kinship care is family-based care where orphans continue to live within a familiar environment under the care of caregivers who in most cases, are grandmothers and other extended family members. Deinstitutionalization of children aims at reuniting them under institutional care with their families to promote better welfare and care for orphaned and vulnerable children. Due to poverty rates and dependency ratios, Kinship care has continued to reduce as more and more families are unable to care for an extra child in the family, leading to the increasing number of children homes in SSA (World Without Orphans, 2016).

Care for orphans in Kenya has been limited to the provision of basic needs and general psychosocial support. In an attempt to improve the form of care provided to orphans in Kenya, some policies have been formulated. One of the policies is the CT-OVC program whose main goal is to ensure orphans have basic needs and are enrolled in school. The CT-OVC program also promotes the care of orphans within families in what is referred to as kinship care where immediate family members accept the caregiving responsibilities of orphaned children. In the program, each household hosting an orphan is eligible to receive Sh2000 per month for each orphan

(Handa et al., 2014). In 2014, the government of Kenya published a guideline for alternative family care for children in Kenya.

The comprehensive guideline focused on the proposal of alternative care whose main agenda was to deinstitutionalize care for orphans back to families and other alternative care (GOK, 2014). In 2015, an updated directory for organizations providing services to children was published. In this publication, over 1000 institutions across the country were listed, but unfortunately, none of them had a specific focus on psychological wellbeing (National Council for Children's Services, 2015). The report showed that the specific tasks of each of the organizations were to ensure food and nutrition, shelter and care, awareness of children's rights, educational needs, reintegration with families, household economic strengthening, and rehabilitation of abandoned children. It is unfortunate that despite the existence of these policies, none of the organizations listed in the directory directly targets grief management for orphaned children.

Lack of targeted grief care among orphaned children is detrimental to the orphans' psychological wellbeing and socio-cognitive functioning. There is an urgent need for the consideration of direct psychological interventions for children who are grieving after having lost their parents through death. In the case of children living in HIV prone areas, the risk of parental death and orphanhood is higher. Since these areas are also more likely to be poverty prone, access to medical care and specifically mental health services is very minimal. This researcher argues that the children in these areas are at a high risk of developing CG, which may go undetected, eventually resulting in adverse effects on the mental and socio-cognitive functioning of the children.

## 2.4 Prevalence of CG among Orphans

According to the APA (2013), grief is a psychological reaction to a loss (APA, 2013). Despite it being commonly associated with death, grief can also happen during social losses, for example, the loss of employment or source of income, or loss of a relationship (Kübler-Ross, 1978). While bereavement is the state of losing a loved one through death; mourning is the cultural response to death and bereavement (Kübler-Ross, 1978). According to the DSM-5, a person in grief can present with symptoms similar to those found in depressed clients such as sadness, loss/gain of appetite, insomnia/hyposomnia, crying, and weight loss (Maciejewski et al., 2016). These symptoms are characteristic of grief and are considered a normal reaction to the death of a loved one. However, when the intensity and duration of the grief go beyond the expected levels or period, the symptoms become a focus for clinical intervention (APA, 2013).

Bereavement is a severe stressor that typically incites painful and devastating symptoms of acute grief (Holland, 2014; Kübler-Ross, 1978; Schumer, 2009). Researchers in the area of grief and grief management consider bereavement as a normal process of dealing with loss either through death or the loss of livelihood. Grief is a normal reaction to a loss and in most cases, the bereaved person will not require any treatment or intervention. Unfortunately for some bereaved persons, the grief can become intense and prolonged leading to acute grief symptoms referred to as CG. (Shear et al., 2011). Researchers such as Stroebe and Schut (1999) and Thompson (2016) noted that eventually, some bereaved people will have to be clinically diagnosed and treated. Nonetheless, a caution is issued on the approach that grief therapy uses for it may lead to either under-diagnosis or misdiagnosis.

Although majority of bereaved persons will go through grief normally, it is estimated that at least 7%-10% of bereaved population may experience CG (Kersting, Brähler, Glaesmer, & Wagner, 2011). These estimates of prevalence of CG was also confirmed by Enez (2018) who noted that on average, only 10% of the bereaved population are likely to develop CG symptoms. However, despite this low prevalence rates, Enez (2018) further noted that the risks of developing CG increases among risk populations such as in sudden death, traumatic death, parental death, prolonged chronic illness. For example, among bereaved persons who have lost close relatives, caregivers of patients of prolonged illnesses such as dementia or HIV patients, the prevalence can rise to about 20%-50% among such risk populations. Prevalence of grief has been found to be as high as 78% in violent deaths (Papa, Rummel, Garrison-Diehn, & Sewell, 2013).

Bereaved persons who experience CG have difficulties adjusting adapting and even accepting the finality of death and that the loved one is gone forever. The bereaved person has difficulties readjusting back to normal functioning (Simon, 2013). Usually, in the grieving process, the bereaved person has to redefine their lives and their goals and begin to restore their life to a meaningful level without the deceased loved one and continue to bounce back and live a satisfying life even without the deceased (Koon & Neo, 2016). Unfortunately, for bereaved persons with CG, the process is slowed and there is intense impairing general psychosocial functioning of the individual (Simon, 2013). The grieving process among children is similar, and just as in adults, a bereaved child goes through a period of grieving that can be exhibited through their behaviors (Akerman & Statham, 2014). Unfortunately, because in most cases it is assumed that children are not aware or are not grieving like

the adults, the grieving process among children is in most cases not noticed. Consequently, when it is not managed, the bereaved child could be predisposed to development of CG.

According to the National Alliance for Grieving Children (as cited in Shear, 2015), children go through a similar grieving process as adults. In the study, which examined the difficulties faced by grieving children and adolescents, it was found that at least 39% of children indicated that they were having sleep problems, while 45% were having difficulties concentrating in school. The same report also found that among bereaved children, orphans were most likely to drop out of school due to lack of motivation leading to low school completion rates and low transition rates from primary to secondary (National Alliance for Grieving Children as cited in Shear, 2015).

Normal grief is listed in the DSM-5 diagnostic criteria as “uncomplicated bereavement’ under the V codes, which represent psychosocial issues that may warrant clinical attention (APA, 2013). The intensity of the bereavement and the duration may vary and that is what forms the focus of intervention (Shear, 2015). The DSM-5 diagnostic criterion is keen on distinguishing grief from other mental disorders. Particularly, grief is not to be confused with other mental disorders such as anxiety, depression, and adjustment disorders.

According to Maciejewski et al. (2016), all grief is normal but its severity and duration are what determines the type of ‘abnormal grief’ a child could be going through. In his argument, Simon (2013) described CG as the grieving process that is interfered with by other symptoms that are not related to the grief itself, and that may hinder the child from recovering from the grief. Such symptoms may manifest in the

form of other mental disorders, and the focus then would be on first dealing with the symptoms to allow for normal grieving to happen (Simon et al., 2011). Some of the symptoms of 'abnormal' grief include feelings that one should have died with the loved one, life is not worth living, feeling disconnected from others, and reduced functionality more than 12 months after the death of the loved one.

Maciejewski et al. (2016) argued that there was no distinct difference between prolonged grief, CG, and PCBD, and hence concluded that the difference was just in the name yet the constructs to be measured were majorly similar. PCBD, the most recent diagnosis in the DSM-5 (though listed as conditions that require further research), seems to combine both intensity and duration of the grief as a point of clinical intervention (APA, 2013). The diagnostic criteria based on DSM-5 is presented in Table 2.1.

*Table 2.1: Persistent Complex Bereavement Disorder (DSM-5)*

PERSISTENT COMPLEX BEREAVEMENT DISORDER DSM-5

- 
- A. The individual experienced the death of someone with whom he or she had a close relationship
- B. Since the death, at least one of the following symptoms is experienced on more days than not and to a clinically significant degree and has persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children.
- Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play and behavior, including behaviors that reflect being separated from, and also reuniting with, a caregiver or other attachment figure.
  - Intense sorrow and emotional pain in response to death.
  - Preoccupation with the deceased.
  - Preoccupation with the circumstances of the death.
  - In children, this preoccupation with the deceased may be expressed through the themes of play and behavior and may extend to preoccupation with the possible death of others close to them.
- C. Since the death, at least six of the following symptoms are experienced on more days than not and to a clinically significant degree, and have persisted for at least 12 months for bereaved adults and 6 months for bereaved children:
- Marked difficulty accepting death. In children, this is dependent on the child's capacity to comprehend the meaning and permanence of death.
  - Experiencing disbelief or emotional numbness over the loss.
  - Difficulty with positive reminiscing about the deceased.
  - Bitterness or anger related to the loss.
  - Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame).
  - Excessive avoidance of reminders of the loss (avoidance of individuals, places, or situations in children, avoidance of thoughts and feelings regarding the deceased).
- D. Social/identity disruption
- A desire to die in order to be with the deceased.
  - Difficulty trusting other individuals since the death.
  - Feeling alone or detached from other individuals since the death.
  - Feeling that life is meaningless or empty without the deceased or the belief that one cannot function without the deceased.
  - Confusion about one's role in life, or a diminished sense of one's identity (e.g., feeling that a part of oneself died with the deceased).
  - Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities).
- E. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- F. The bereavement reaction is out of proportion to or inconsistent with cultural, religious, or age-appropriate norms.
- 

Source: APA (2013)

As seen in Table 2.1, bereaved persons are said to meet clinical the criteria for PCBD only if they have been having the symptoms for at least 12 months (6 months

for children); and the symptoms are causing significant socio-cognitive impairment on the bereaved (APA, 2013).

Findings have shown that at least 10-20% of the bereaved persons are at risk of developing CG (Enez, 2018; Kersting et al., 2011). Although CG in adult bereavement has been highly studied, studies relating to its development and prevalence in bereaved children, and specifically those faced with parental death are still minimal. Children who lose close family members, such as parents and siblings, are more at risk of developing complicated bereavement (Abel et al., 2014).

In addition, research done in Canada also determined that children faced with parental death have an increased risk of developing complications during the grieving process and are at more risk of developing other distinct mental disorders such as depression and PTSD (Bolton et al., 2016). Similar studies in the Netherlands revealed that among children aged 8-18 years, 35.2% exhibited symptoms of prolonged grief disorder (PGD), while at least 26.2% had symptoms of both PGD and PTSD (Bolton et al., 2016). In populations at high risk, the grief prevalence shoots to highs of 20-50% among parentally bereaved individuals, close relatives, and caregivers of terminally ill patients and can increase to a high of 78% among bereaved persons who lost loved ones through violent deaths (Papa et al., 2013).

In comparison to various research that has focused on the prevalence of CG in the Western countries, little can be said on the same when it comes to CG among orphans in African countries. Many of the existing literature in the African context seems to focus more on the process of mourning and concepts of death. As determined by Drenth, Herbst, and Strydom (2013), death is regarded as a taboo in most African contexts and specifically across all cultural groups in South Africa. For

this reason, children are rarely involved in discussions of death and are seemingly protected from such talk with the hope of saving them emotional turmoil.

The mode of mourning is culturally based, and the duration is predetermined by specific cultural practices and rituals (Drenth et al., 2013; Nwoye, 2005). Secondly, most grief studies in the African context have focused on traumatic grief in relation to disasters such as terrorist attacks and accidents; with limited studies on the prevalence of grief disorders and management strategies for coping with grief for school-going children.

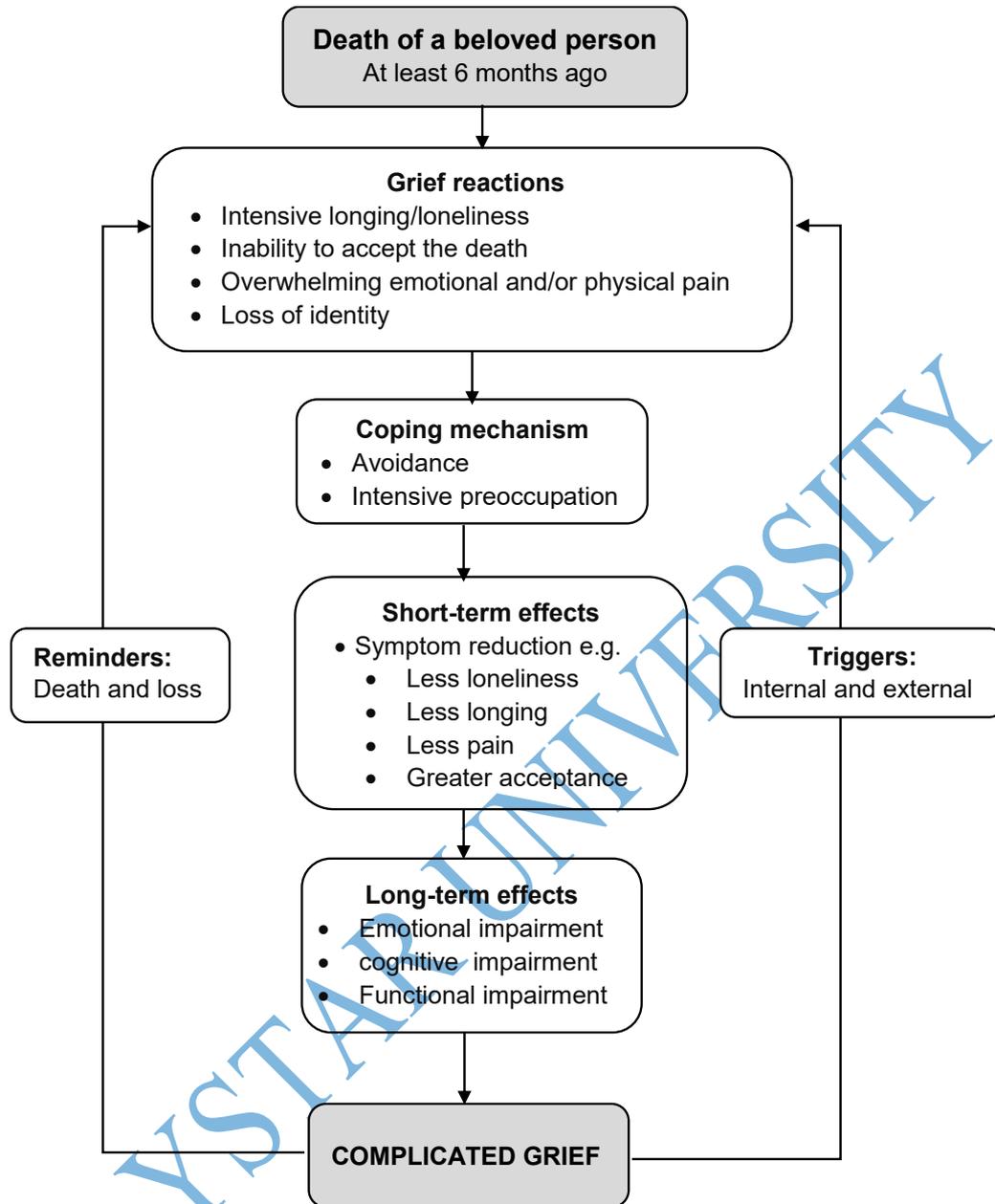
In 2005, Nwoye took issue with the westernized approach of pathological grief patterns when dealing with African clients. In his article, he asserted that the western approach to grief only viewed it as pathology. That pathological grief was rare in the African context because of the collective nature within which the community supports and mourns with the bereaved (Nwoye, 2005). Further, Nwoye argued that the very rituals and experiences that accompany the mourning process help in healing the clients and that intervention for grief in the African context should be seen within this spectrum and not through clinical settings (Nwoye, 2005). Perhaps of most importance is the understanding of grief as presented by Nwoye in which the mourning and burial rights become a pattern and a series of predetermined activities that lead to the healing of psychological wounds.

As already determined, the DSM-5 diagnostic criterion is keen on distinguishing grief from other mental disorders. Particularly, grief is not to be confused with other mental disorders such as depression and PTSD (APA, 2013). This distinction of complex bereavement from major depressive disorder (MDD) and PTSD is of help to clinicians in terms of enabling them to do a proper diagnosis. In

this manner, the clinicians are helped to avoid what some researchers refer to as over-diagnosis of grief symptoms and giving bereaved persons no time to resolve their grief at their own pace (Bui et al., 2015; Shear, 2015).

This notwithstanding, research continues to show that there are increased chances of development of CG, which means that the bereaved is unable to resolve the grief. To understand how CG develops, Rosner, Pfoh, and Kotoučová (2011) described the disease model of this kind of grief as seen in Figure 2.1.

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*Figure 2.1: Disease Model of CG*

Source: Recreated from Rosner et al. (2011)

As illustrated in Figure 2.1, immediately after the death of a loved one, bereaved individuals get immediate coping mechanisms such as avoidance which give them temporary or short-term relief. The short-term benefits are less loneliness and less pain, but then these do not last long. Eventually, long-term effects of the maladaptive coping mechanism begin to present themselves and are seen in socio-cognitive impairment. The individual is stuck and taken back to the fresh feeling of

the grief, and the cycle continues. Similarly, reminders and triggers can take the bereaved person back to the grieving process.

## 2.5 Risk Factors in the Development of CG

According to Huyah (2017) and Thomas, Hudson, Trauer, Remedios, and Clarke (2014), not only do orphans have to deal with loss and grief, but they are also faced with some biopsychosocial and environmental factors that may predispose them to CG. As already stated, about 35.2% of bereaved children develop grief complications. This means that there are other factors at play that may predispose someone to CG (Abel et al., 2014; Fujisawa et al., 2010). These factors comprise biological aspects (age and gender); socioeconomic status (poverty dependence levels); relational factors, such as attachment to the deceased parent; cultural and religious factors; and the nature of death. The factors are discussed at length in the subsequent sections.

### Biological factors

Clinicians working with children who are experiencing grief should be able to recognize the expressions of grief that are typical for each developmental stage. They should then address the child's corresponding needs. In trying to understand grief in children, most of the theories have relied on Jean Piaget's cognitive development theory to understand how children interpret and conceptualize death at different developmental stages (Heeke, 2018).

As observed by Griese, Burns, Farro, Silvern, and Talmi (2017), prior to the age of three years, babies may start to sense that the primary attachment figure/caregiver is not around but because they cannot differentiate permanent and temporary absence, they keep longing for the return of the caregiver. Although infants

may not be able to understand death from an intellectual perspective, they still experience the loss that is observed through their change of behavior such as irritability and experiencing sleep and eating challenges. Toddlers who also lack the intellectual ability to conceptualize death tend to express their grief through reduced emotional responses, and in some cases they may regress in development, experience irritability, have reduced appetite, and have an increased separation anxiety and tantrums.

Children at the age of five years can notice the absence of the caregiver and may talk and ask about his or her return. They are still not able to tell that death is permanent and may be expecting the person to come back (Aleem, 2018). Children between ages 3-6 years may understand death but may fail to understand the permanence of it. In their thinking, the person is simply sleeping and hence they may continue to hope and yearn for the return of the loved one (Emswiler & Emswiler as cited in Enez, 2018). This period in the child's development is referred to as the preoperational period, and the child is very inquisitive about death and will always want to know when the person will come back to visit (Heeke, 2018).

Children at age nine may begin to understand that death is permanent. They now know that it is irreversible (Worden, 2009). Those between ages 7 and 11 years express their grief through play and enactment. They often understand that death is permanent but think that it only happens to older people. Since most of them are now attending formal schooling, grief may also be displayed through anxiety, phobias, somatic complaints, aggression, and withdrawal (Heeke, 2018). Abstract reasoning begins after the age of 11 years. During this stage, grief may be accompanied by anxiety and depressive symptoms, guilt and isolation, problems with eating and

sleeping, impulsivity, and yearning (Heeke, 2018). Regardless of their age, when children are unable to process and integrate the loss, they can experience persistent distress and impairment.

Wing, Callaway, Clance, and Armstead (2001) determined that several reasons could explain gender differences in how grief is presented and expressed. In the attempt to give structured distinctions in gender differences in grief, the terms intuitive and instrumental grief are used. Intuitive grief is considered more feminine and is characterized by more feeling than thinking (Zonnebelt-Smeenge & DeVries, 2003). The feelings expressed mirror the exact feelings within the individual. Intuitive grieving focuses more on exploring and expressing the feelings while seeking support externally. It is experienced through waves of emotional reactions (Wing et al., 2001).

Most researchers concede that intuitive grief is most likely experienced among women than among men. It is a grief, characterized by open displays of intense affect, support seeking, and sharing of emotions with others (Zonnebelt-Smeenge & DeVries, 2003). Instrumental grief, on the other hand, is masculine and engages a lot of thinking rather than feeling. The expressions are usually the opposite of what the person is feeling inside. In instrumental grief, the person is more likely to express the grief cognitively or through behavior (Shear & Shair, 2005). Although numerous studies have shown the presentation of grief by age and gender, there is limited research specifically showing a predisposition to CG based on developmental stages among orphaned children.

Although there is literature on grief presentations for specific developmental stages, this researcher did not find any literature on specific statistical analyses regarding the effect of age and gender on the development of grief.

### Socioeconomic factors

Attending to sick and dying parents and the eventual death of a parent is traumatic for children. The orphans are exposed to psychological vulnerability putting them at the risk of developing mental disorders (Akerman & Statham, 2014; Lee et al., 2014; Limo & Kibowen, 2017). Vulnerability and predisposition to development of complicated grief is further increased by environmental factors such as family living situation, poverty, dependency levels, stigma, and lack of proper grief interventions (Mwoma & Pillay, 2015). When these factors are combined, they hinder the development of resilience and this further exposes the child to CG disorders. Moreover, socio-cultural expectations based on gender and age, such as girls having more domestic responsibilities may deny the girls a chance to grieve normally.

Although there is limited research on the impact of socioeconomic status of the family and the risk of complex grief especially among children, this concept has been well evaluated when it comes to its impact on bereaved adults. Bereaved persons who are confronted with both severe loss and economic hardship may not be able to cope with either of the two. Furthermore, limited resources mean that the person is unable to afford therapy and may therefore not seek treatment (Roulston et al., 2017). The relationship between poverty and bereavement can be assessed by understanding how poverty in itself causes psychological vulnerability in children.

Children raised in low socioeconomic status are more at risk of child neglect and abuse (Nichols et al., 2014). Such children are already harboring anxieties and fears in their lives that can complicate grief. Perhaps, a more direct association between socioeconomic status of the family and CG is that these children may not be able to access medical care nor psychological intervention when grief starts to get

complicated (Jacob, 2017). If these children are adopted into a new family set-up which is equally poor, the priority is more on giving them the basic needs, namely food, shelter, and clothing - meaning that the children's psychosocial wellbeing is not considered.

Children from poor families can be easily turned into caregivers as the family is unable to pay for care services (Limo & Kibowen, 2017). As the child cares for a sick parent, they are constantly observing the pain and suffering of the parent, a situation further associated with CG. With this in mind, a therapist should consider brief time-limited therapy techniques to reduce the symptoms associated with grief.

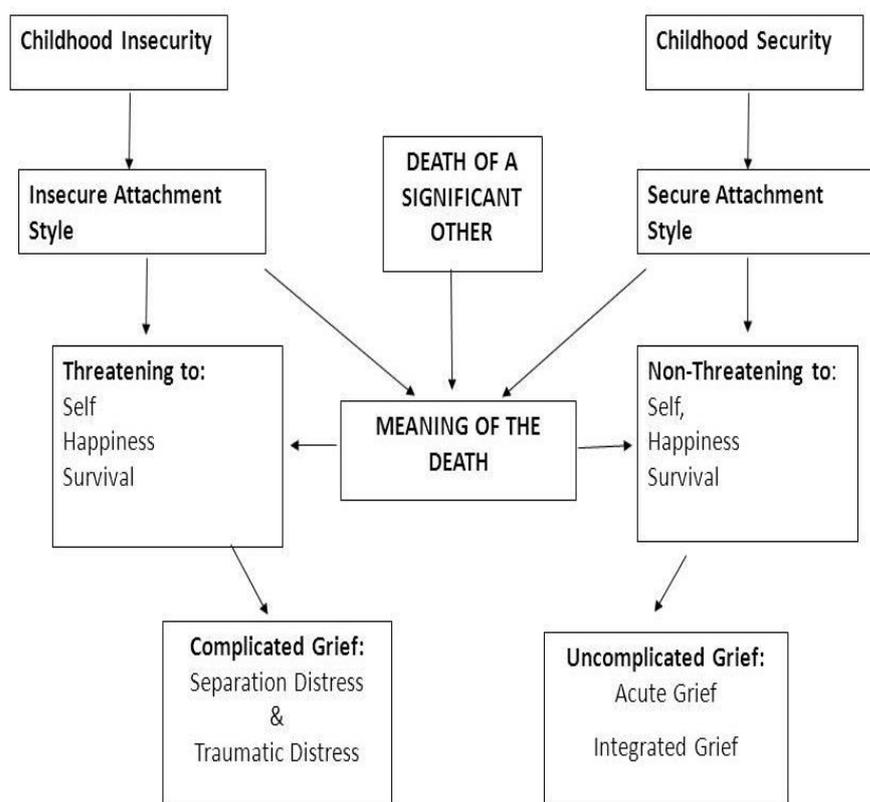
Absent and unhelpful family/caregivers have also been termed as a risk factor for the development of CG (Jordan & Litz, 2014; Neimeyer & Burke, 2002). When a child is grieving and living with an absent caregiver, the grief may go unnoticed for a long time limiting the success of an intervention. In poor families, parents are absent most of the time as they try to earn extra money to make ends meet and when they return home, they are too tired for any meaningful interaction with their children.

Additionally, family structures could be a predisposition to complex grief. A high dependency rate may hinder the availability of care as families become economically overstretched to take in any new child (Wang et al., 2016). In addition, if a family does take in the child, the possibility of quality care for the child becomes very minimal. The researcher argues that availability and quality of care are paramount in assessing the psychosocial wellbeing of orphans.

### Relational factors - attachment style

There is growing research evidence in support of the relationship between attachment style and CG (Mancini, Sinan, & Bonanno, 2015; Piper, Ogradniczuk, Joyce, & Weideman, 2011; Schenck, Eberle, & Rings, 2016). According to these studies, the coping mechanism is better explained through attachment perspectives. In general, although Tofthagen, Kip, Witt, and McMillan (2017) were convinced that insecure attachment in adults was associated with higher risks of developing CG when a loved one dies, they confirmed that the complex interaction between attachment styles and CG are yet to be fully understood. The researchers endeavored to describe risk factors of CG and recommended further research on attachment-informed CG treatment modalities. They argued that if indeed the risk of developing CG if one has an insecure attachment does exist, then there is a need for evaluation and assessment of attachment styles as a component for any grief work (Tofthagen et al., 2017).

In the 1970's Mary Ainsworth introduced the concepts of attachment styles. In an experiment referred to as the 'strange situation,' Ainsworth determined that there were three major styles of attachment: secure attachment, ambivalent-insecure attachment, and avoidant-insecure attachment (Main & Solomon, 1990). A fourth attachment style, the disorganized insecure attachment, was added by Main and Solomon in 1986. Attachment develops when caregivers allow its development. For example, the caregiver must be in physical proximity with the child for there to be an opportunity for attachment. The different types of attachment styles based on the quality of care provided by the parent and caregivers are shown in Figure 2.2.



*Figure 2.2: CG and Child Attachment Styles*  
Source: Neimeyer, Prigerson, and Davies (2002)

As demonstrated in Figure 2.2, a child's emotional responses are related to specific types of attachment styles. For example, children who have insecurities are most likely presenting with insecure attachment style and when faced with the death of a significant other, may interpret the meaning of death negatively leading to separation and traumatic distress which are major components of CG. On the other hand, children who are securely attached have higher chances of going through non-threatening forms of grief such as acute grief and integrated grief which are considered as normal grief that one can resolve on their own.

Houwen et al. (2010), in their study of 195 bereaved individuals, indicated that avoidant but not anxious attachment predicted higher levels of CG. However,

Bonanno et al. (2002) examined avoidant/dismissive attachment in a study of 205 conjugally bereaved people and found that both were unrelated to grief. Bereaved individuals who are securely attached were found to be able to resolve grief faster as they were able to recreate new relationships and bonds. In contrast, those who showed more anxiety in their attachment styles were found to face more difficulties in moving past the loss of a loved one (Piper et al., 2011). Mancini et al. (2015) also confirmed this notion and concluded that anxiously attached individuals were prone to increased and prolonged emotional distress and also displayed maladaptive behavior.

Similarly, Schenck et al. (2016) found high levels of CG among bereaved persons who had an insecure attachment. In regard to cognitive processes, Boelen, Van Den Hout, and Van Den Bout (2006) confirmed that individuals with insecure attachment have negative cognitions that make them dwell on the sadness and belief that they cannot survive without the loved one, or have the guilt that they may have caused the death of the loved one.

Mancini et al. (2015) opined that these negative cognitions have a great impact on prolonged CG and suggested that tackling them (the cognitions) should be the focus of intervention in grief work. Individuals who exhibit CG were found to have dependency tendencies, yet they hold negative thoughts about any care or support accorded to them. They are suspicious of anyone trying to come close and form a new bond with them and as a result will continue to be stuck in a situation yearning for the return of the deceased and guarded from forming any new relationship (Boelen et al., 2006; Mancini et al., 2015; Piper et al., 2011).

Individuals who demonstrate higher levels of resilience during the mourning and bereavement are open to support, share their feelings openly, have less worry, and

seek out available support when they need it (Mancini et al., 2015). According to Piper et al. (2011), bereaved persons with insecure attachment also showed an unwillingness to be part of community social supports and preferred to keep to themselves. They are unwilling to seek help compared to the securely attached persons.

#### Cultural factors

In the observation of Shiino (1997), in Africa, many cultural traditions consider death as a rite of passage and have the belief that the dead take up other forms and continue to live in the community with the living. The idea of ancestors has been a prominent theme in understanding the African context of death. Similarly, there is a particular obsession with giving the dead a proper burial, and, in some communities when these rites are not observed, the deceased is believed to turn into a ghost that becomes a menace to the living (Bondi, 2015). Many communities also believe that the dead have some supernatural powers that can harm the living, hence giving a proper burial ceremony is usually a form of protection to please the dead. The dead are believed to be close to the supreme being. It is believed that the rites are important in strengthening social, local, and psychological ties.

The Luo ethnic group, a Nilotic tribe living in the shores of Lake Victoria, believes in the afterlife. Although numerous clans within the Luo tribe have distinct traditions, the tribe shares certain rites that accompany the death of a family member. The structured mourning process is a series of events, and the belief exists that if the process is not done then the transition of the deceased into an ancestor is interrupted (Ogola, 2015). The customary belief that death is not the end is evident in the Luo belief in ancestors and the element of a spiritual transformation. As seen in Table 2.2,

burial rites associated with the Luo tribe are systematic, and each of the stages is seen to carry a cultural meaning.

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*Table 2.2: The Luo Burial Rites*

Local Name	Translation	Description
(budho)	Death announcement Vigil	Announced through the deafening women's long, quivering wail, Close relatives sit in all day and night in the compound of the deceased. The nights are full of feasts and dancing and consumption of local brews all night.
(kunyo)	Gravedigging	Within the community, gravediggers are identified, usually, they are intoxicated before they begin the digging and the grave is dug at night.
(iko)	Burial	If the body is in a mortuary it arrives the day before the burial and spends the night in the house so that people can view it all night. The surviving family budget for those who attend the burial
(tero buru matin)	Accompanying the spirit	The night after the burial there is the heavy dancing and feasting to accompany the spirit of the deceased. Two weeks after the burial the tero buru happens and more dancing and crying happens
(liedo)	Shaving	The procession becomes longer and noisier as people sing and play and cry In some areas, shaving is done four days after the burial
(kee)	Mourner's departure for their homes	Mourners leave the bereaved home
(keyo nyinyo)	Dividing articles left by the deceased	The property of the deceased especially if a man is shared out
(rapar)	Remembrance	Happens one year after the burial

Source: Ogola (2015)

#### Nature of death

Studies comparing the impact of the nature of death and development of CG have indicated that people bereaved from sudden traumatic deaths are at greater risk of developing complex bereavement compared to those who lose loved ones through natural deaths (Enez, 2018). It has since been confirmed that a bereaved person may have complications in dealing with the loss of a person if the death involved suicide or violence, especially if the bereaved witnessed the death, or the person died in unusual circumstances (Nakajima, Ito, Shirai, & Konishi, 2012). The predisposition to

CG is explained in that in traumatic death, and especially those that are sudden, the bereaved person had no time to prepare for the loss (Shear, Ghesquiere, & Glickman, 2013).

Risks of CG could be higher when the loved one dies after a chronic illness (Shear et al., 2013). The author stated that when death of a loved one happens after a difficult and prolonged illness as seen in terminal patients, the bereaved family members are likely to suffer CG. Witnessing the suffering of an ailing parent is traumatizing for the child, and the stress and worry in anticipation of the death of the parent predisposes children to a complicated grieving process when the parent eventually dies (Akerman & Statham, 2014; Limo & Kibowen, 2017). This may further impair the children's sociocognitive functioning, which ultimately negatively impacts their academic performance as they will not be able to be attentive or concentrate in their school work (Akerman & Statham, 2014).

In a case of prolonged illness, the parent is unable to work or earn a living, and the little resources available are directed towards treatment. This puts the family in an economic strain which is worse for poor families who are already struggling economically. Children living with ailing parents are sometimes forced to take up adult roles such as working for financial gain so as to make some money for the family's basic needs. As a result, the children may have irregular school attendance, and worse still may eventually wholly drop out of school (Limo & Kibowen, 2017).

In an attempt to determine if there were any significant differences in the grief manifestations in children and in comparison to how the parent died, Melhem, Porta, Shamseddeen, Payne, and Brent (2011) worked with 7-18-year-olds who had lost a parent between 2001 and 2006. They established that 10% of the participants still

showed symptoms of prolonged grief, three years after the death of the parent (Melhem et al., 2011). Children whose parents died through sudden and violent deaths recorded slightly higher scores on the inventory of complicated grief (ICG) scale.

## 2.6 CG and Academic Performance among Orphaned Children

Psychological vulnerability occasioned by grieving the loss of a parent could be intensified by environmental factors. Psychological vulnerabilities are characterized by a sociocognitive impairment making it difficult to negotiate life stressors, thus exposing the child to internalized mental disorders (Abel et al., 2014). Some characteristics of grieving children are anxieties, depression, and lack of resilience. As a result of these emotional instabilities, there is a significant reduction in cognitive functioning. In the case of orphans, reduced cognitive functioning is evidenced by low academic performance (Akerman & Statham, 2014; Limo & Kibowen, 2017).

Attending to sick and dying parents and the eventual death of a parent leads to loss and grief. The orphan is exposed to psychological vulnerability putting them at risk of developing mental disorders (Limo & Kibowen, 2017). Vulnerability and predisposition to the development of CG is further increased by environmental factors such as family living situation, poverty, dependency levels, stigma, and lack of proper grief interventions (Mwoma & Pillay, 2015). These factors combined, hinder the development of resilience - further exposing the child to chronic disorders such as depression. These mental disorders are linked to poor academic performance among OVC (Crivello & Chuta, 2012; Dyregrov et al., 2015).

Sociocultural expectations based on gender and age such as girls having more domestic responsibilities would have a significant difference in the type of disorder,

and level at which academic performance is affected (Lee et al., 2014). Studies have shown a significant relationship between grief, mental disorders, and poor academic performance (Dyregrov et al., 2015). Consequently, there have been efforts to address the psychological needs of orphans in order to improve the orphans' psychological wellbeing (Datta, 2009; Mumo, 2005; Skinner et al., 2006; Snider & Daves, 2006). Specifically, the studies have aimed at developing sustainable mitigation for orphans to enhance their resilience (Okawa et al., 2011; O'Sullivan et al., 2016; Simon, 2013; Tol et al., 2008).

Parental involvement in the education of children has been associated with better education outcomes and motivation to perform academically. A study done in Latin America confirmed that parental involvement showed positive education outcomes (Araque, Wietstock, Cova, & Zepeda, 2017). A study by Bailey (2017) also ascertained that children whose parents were engaged in the children's education process showed better success and performed better in school. Studies have further indicated that parent's engagement is a very strong influence on the achievement of a child and that the more a parent motivates the pupil, the more the pupil is likely to realize the importance of education, thus getting motivated to work harder in school (Boonk et al., 2018; Chowa et al., 2013). These studies confirm that a student's capacity to perform well in school is increased by the parental engagement and encouragement the student gets at home. Unfortunately, orphans do not get to benefit from parental engagement in their education.

Before the parent dies, children, especially in low economic areas may have to take care of their sick parents, and this may lead to irregular school attendance. They may even be forced to assume jobs to be able to feed their family members. Taking up

adult roles is quite common, especially in African countries, and significantly more for girls (Limo & Kibowen, 2017). Girls were also more likely to drop out of school to take up caregiving roles when a parent is ailing and also to take care of their siblings when the parent eventually dies (Limo & Kibowen, 2017). When the parent does die, the orphans are taken up by caregivers. The caregivers may not be able to take care of the children and may not afford to meet the children's education needs. This forces the children to drop out of school.

Similarly, the lack of direct engagement in the schoolwork of the child, specifically by caregivers, has been found to impact on the academic performance of these children negatively. It has been found that children who were previously performing well in school are likely to record reduced academic performance after the death of a parent. Loss of a parent affects the child psychologically, and this can have a negative impact on the ability to remain focused, motivated, and to concentrate in school work, hence leading to poor academic performance (Limo & Kibowen, 2017).

Consequently, there have been efforts to address the psychological needs of orphans towards improving their psychological wellbeing (Datta, 2009; Mumo, 2005; Skinner et al., 2006; Snider & Daves, 2006). Specifically, the studies have aimed at developing sustainable mitigation for orphans so as to enhance their resilience (Biemba et al., 2010; Okawa et al., 2011; O'Sullivan et al., 2016; Tol et al., 2008).

## 2.7 Efficacy of CGT

The focus of any grief work is to enable a meaningful life, even in the absence of the deceased person (Thompson, 2016). "Grief work" is a psychological term used to describe interventions geared at helping clients resolve significant loss and resume functionality (Spuij, Dekovic, & Boelen, 2015; Stroebe & Schut, 1999). Emotional,

cognitive, and behavioral models of psychological interventions have proven to be effective in the management of grief as they focus on its core components (emotions and cognition/thought). CGT is a holistic and relatively new psychotherapy that was designed based on a collection of different orientations drawn from CBT, IPT, Gestalt, and psychodynamic theories (Shear, 2015).

On the other hand, IPT techniques target interpersonal issues and help the client to establish new bonds and relationships while at the same time giving new meaning to life through setting goals. CGT is said to be a flexible model. However, the manual that was used in this study contains 16 sessions (Shear, 2015), with each session lasting at least 45 minutes to one hour. The model draws on the CBT structure, and each session has an agenda. A session process shows content and transition from one agenda to another and from one session to another. In each of the sessions, the previous week's activities are reviewed in session work, and tasks assigned for the next session. Typically, clients attend one session a week, and the therapy covers a total of 16 sessions to held per week (Shear, 2015).

Complicated grief therapy is divided into three phases which draw on the structure of IPT. The three phases are the introductory phase, which contains three sessions; the intermediate phase, which has six sessions; and the final phase, which contains seven sessions. Each of these phases has particular goals that are set collaboratively with the client (Shear et al., 2014).

The efficacy of CGT has been evaluated in clinical randomized samples across various population groups in the United States. In 2005, the first trials were done to compare treatment outcomes. Since then, research has provided empirical evidence for the use of this treatment as a recommendation for grief work. After the 2005 pilot

studies, another study was conducted to compare the effectiveness of CGT and IPT, using a group of 83 adults who tested positive for CG (Wetherell, 2012).

In the empirical study discussed above, each of the participants was subjected to sixteen individual CGT sessions using the CGT manual. Individual sessions of psychotherapy were assessed and given a score of 'very much improved' and 'much improved.' In determining the treatment improvement, a reduction of symptoms by 20 points or more was considered an improvement (Wetherell, 2012). Grief responses were found to be higher in both groups, and after treatment, the CGT group recorded more improvement than the IPT group at a rate of 51% and 28% respectively (Wetherell, 2012).

The effectiveness of a modified version of CGT was also tested in Japan in 2011. In the study, the goal was to modify the CGT to make it suitable for the Japanese population and to test if the modified version was still effective in the treatment of CG. Bereaved women who lost loved ones through violent death were engaged in the study (Asukai et al., 2011). The modified manual contained psychoeducation, imaginal and in vivo exposure, imaginal conversations with the deceased, and memories about the deceased (Asukai et al., 2011). The 13 participants in the study presented with PTSD resulting from the traumatic grief and were subjected to 12-16 weeks of the Japanese modified CGT program. Clinical assessments were done using the ICG tool and the impact of event scale revised.

The participants were also clinically assessed for depression using the Centre for Epidemiological Studies of Depression Scale (Asukai et al., 2011). The participants were monitored across a period of 12 months. Throughout the evaluation period, symptoms of traumatic grief were found to reduce significantly. At the end of

the intervention, the participants were assessed using Jacobson's reliable change index, and the results showed that at least 46% of participants showed improvement on the change index (Asukai et al., 2011).

In another study conducted in 2014, in New York, CGT was found to be effective in treating CG among an elderly bereaved sample of 151 participants (Shear et al., 2014). In the study, 151 participants aged 50 years and above with a mean age of 66.1 (SD 8.9), were engaged in a study to compare the effectiveness of CGT and IPT interventions in grief treatment. At baseline, the mean grief score of the sample was 30 grief points. Participants were assessed at baseline and then subsequent tests were done at week eight, twelve, sixteen, and finally at week twenty. After analysis, it was determined that only 35.2% of those who went through CGT and 64.1% of those who went through IPT were still showing significant symptoms of CG ( $P=.001$ ). The findings from the study showed that CGT had better efficacy with an average reduction of 1.05 grief scores on a weekly basis [ $t_{633}=3.85$ ;  $P<001$ ] in comparison to 0.75 reduction points for IPT for a similar period (Shear et al., 2014).

While empirical evidence has demonstrated that CGT works, a major gap has been observed regarding its effectiveness as a group therapy, particularly as a school-based intervention. The main question has been whether CGT therapy is feasible, sustainable, and adoptable in low socioeconomic zones and rural areas. Fortunately, research is ongoing on how to develop feasible programs which ensure that children and the general population access mental health care. Attempts to respond to this, albeit in relation to trauma-focused cognitive behavioral therapy (TF-CBT), are in progress. The closest study that has been done targeting a similar population of orphaned children was by Dorsey and Whetten (2017), which commenced in 2013

and was completed in 2016. The study tested the effectiveness of TF-CBT in the treatment of traumatic grief in sub-Saharan Africa.

Dorsey and Whetten's (2017) study targeted two countries, that is, Kenya and Tanzania. A total of 654 orphaned children from Moshi, Tanzania and Bungoma, Kenya aged between 7-13 years were recruited for the randomized controlled trial. The researchers aimed to determine whether there was any significant difference between orphans who were treated using TF-CBT in comparison to those who went through the usual orphan care in the treatment of traumatic grief. The approach used in the 2017 study is referred to as a "task-shifting approach" in which individuals with no mental health knowledge are trained as counselors (Woods-Jaeger, Kava, Akiba, Lucid, & Dorsey, 2017).

Apart from the lead investigators, local researchers and HIV and AIDS organizations were engaged as collaborators in Dorsey and Whetten's (2017) study. In total, six individuals were trained in each country to handle 20 groups in each of the study sites. In each of the two countries, the study had 320 children in the experimental group, and another 320 in the control group (Dorsey & Whetten, 2017). The assessment was done at 12-14 weeks, immediately the treatment was concluded. Post-treatment assessment was done at six months and again at 12 months. The researchers were optimistic that the results would help in scaling up mental health through sustainable and feasible psychological programs targeting low- and middle-income countries (Dorsey & Whetten, 2017).

## 2.8 Conceptual Framework

A conceptual framework is a graphical representation of the relations between a study's variables and their specific attributes. The conceptual framework for this research is presented in Figure 2.3.

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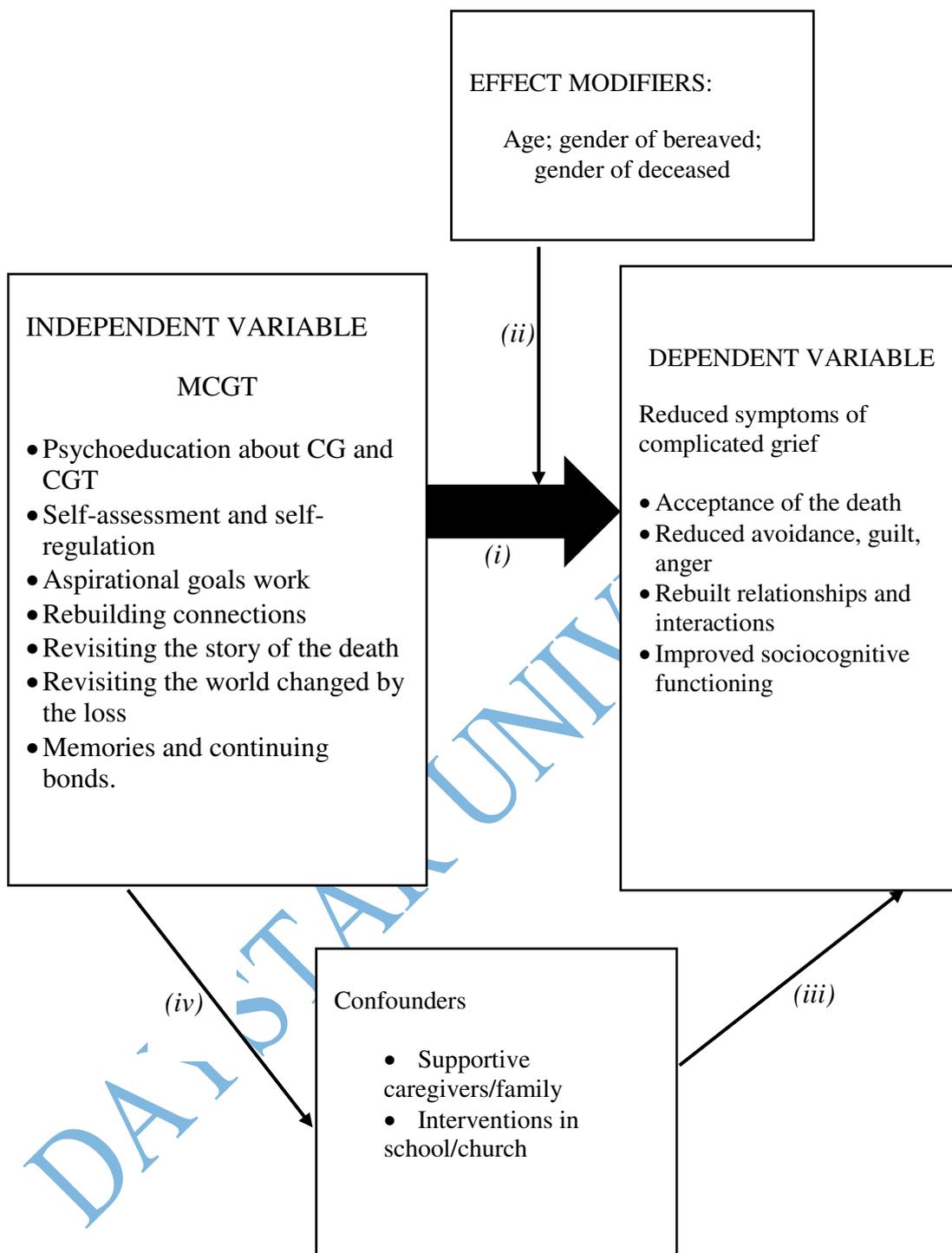


Figure 2.3: Conceptual Framework  
Source: Author (2020)

## 2.9 Discussion

The death of a parent is bound to cause grief and bereavement among children, and this is perceived to impair the children cognitively and socially. Cognitive impairment could have adverse effects on learning outcomes, leading to poor academic performance on the part of the grieving children. Also, psychologically the children may develop complicated bereavement.

In this study, MCGT was the independent variable and reduced symptoms of complicated grief, the dependent variable. Arrow (i) represents the hypothesis that implementing CGT therapy will lead to the outcome, that is, reduced symptoms of CG; acceptance of the death; reduced avoidance, guilt, anger; rebuilt relationships and interactions; and improved sociocognitive functioning.

Furthermore, even if CGT is found to work, the level of effect will vary based on several factors. These factors are called the effect modifiers and, in this study, they included the age of the bereaved, the gender of the bereaved, the gender of the deceased parent, attachment/relationship to the deceased parent, and the nature of death. Therefore, arrow (ii) represents the interaction of these factors with the independent variable and which would then determine the level of effectiveness of the CGT therapy.

Confounding factors, in this case, are those that could in themselves cause a reduction of CG symptoms even without CGT therapy. Arrow (iii) indicates that the confounding factors can independently cause the desired outcome, which is the reduction of CG symptoms. In this study, the identified confounders were the availability of emotionally supportive caregivers, access to other psychosocial support services such as church or home, and resilience level of the bereaved person. Resilient

persons are perceived to bounce back to normal functioning and generally can resolve stress with time. Similarly, participants living with supportive caregivers or have access to psychosocial support from church or children's homes may show higher reduced symptoms of CG.

Nonetheless, this researcher could guarantee that the entire reduction can be attributed to the independent variable, in this case, the CGT. Therefore, key confounders based on availability and access to support and psychosocial service were controlled for. For example, the confounding variable for existing intervention was catered for by ensuring that there was no other existing intervention happening in any of the schools during sampling, screening, intervention, and post-intervention assessments. At SDQ administration, the researcher inquired on the availability of psychosocial services or psychosocial support and only an insignificant number of respondents indicated that they had received any psychosocial intervention. Controlling for confounders ensured that only the impact resulting from direct interaction with MCGT was reported.

Nevertheless, although the confounding variables can independently lead to the outcome, there was a notable interaction between the confounding variables and the independent variable. Arrow (iv) shows an interaction in which the independent variable can itself lead to more increased awareness of the need for psychosocial care and the school may introduce programs or have talks with the caregivers on ensuring psychosocial support for the bereaved child. In addition, the intervention can also lead to increased resilience on the participants, which could then lead to the resolution of CG.

## 2.10 Summary

In this chapter, two theories: Bowlby's loss and attachment theory, and REBT by Albert Ellis have been reviewed. Loss and attachment theory is concerned with the role of attachment in resolving stress and grief after the loss of a significant other; while REBT is focused on how cognition can lead to irrational beliefs which then lead to maladaptive meanings of death, resulting in the development of grief disorders. The theories informed the study in the sense that the intervention, that is, CGT was derived from attachment models of loss, and dysfunctional cognitions that may lead to irrational beliefs.

The prevalence of orphanhood regarding HIV prevalence has been discussed, and it was observed to be higher in HIV prone regions. Differentiation of CG and other comorbid disorders such as depression and PTSD has also been discussed. Biological, socioeconomic, relational, cultural, religious, and nature of death - as risk factors in the development of CG have also been addressed. Additionally, a detailed account of the CGT model and a review of empirical literature supporting the efficacy of CGT has been presented. Finally, a conceptual framework showing the interactions of the variables in this study has been demonstrated and discussed. The next chapter will discuss the methodology that guided this study.

## CHAPTER THREE: RESEARCH METHODOLOGY

### 3.1 Introduction

This chapter presents a description of the methodology adopted by the study. Encompassed, also in the chapter, is the research design that was applied in determining the effectiveness of a grief management program adoptable in schools and based on CGT. Other areas outlined are the target population; the size of the study sample; techniques applied in sampling; the process of data collection, including the instruments and procedures applied in collecting data; the pretesting process; and the process that was used to analyze the data. The last section of the chapter focuses on the ethical aspects that the study put into consideration

### 3.2 Research Design

Research design has been defined as an “arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure” (Kothari, 2004, p. 31). A quasi-experiment, also termed ‘empirical interventional study’ was adopted for this study. This design was preferred as it was considered suitable towards establishing the impact of an intervention on a target population, but without relying on random assignment (Mugenda & Mugenda, 2003).

The quasi-experimental design was also preferred since this study required pretesting before the intervention and post-testing after completion of the intervention (Shadish, Cook, & Campbell, 2001). The study consisted of baseline, midline, and endline assessments. Secondly, the quasi experimental research design was deemed

suitable for this study because it allowed for flexibility in the control of the variables and did not require full randomization (Mugenda, 2013).

Moreover, quasi-experimental studies work best when the selection of a study location is done purposively. In this study, the area of study, Siaya County, was selected based on its high ranking in the prevalence of HIV and AIDS infections, adult related deaths, and the number of orphans. Finally, unlike in pure experiments which involve complete randomization, quasi-experiments allow for purposive sampling and decisions on locations and participants are based on the criteria set for participants' inclusion and exclusion (Kothari, 2004). In this case, inclusion and exclusion criteria was applied to determine the participants to be included in the study. For example, to be included in this study, the participants had to have lost one or both parents through death, and the death of the parent should have occurred not less than six months at the time of study commenced.

### 3.3 Area of Study

Geographically, Siaya County is located approximately between latitudes 0° 26' South to 0° 18' North and between longitudes 33° 58' and 34° 33' East (County of Siaya, 2017). The county's surface area is approximately 2,530 km<sup>2</sup>, while water bodies cover an area of approximately 1,005 km<sup>2</sup> (County of Siaya, 2017). Further, the county is subdivided into six sub-counties, namely Alego-Usonga, Bondo, Gem, Rarieda, Ugenya, and Ugunja (Independent Electoral and Boundaries Commission, 2012), as depicted in Figure 3.1.

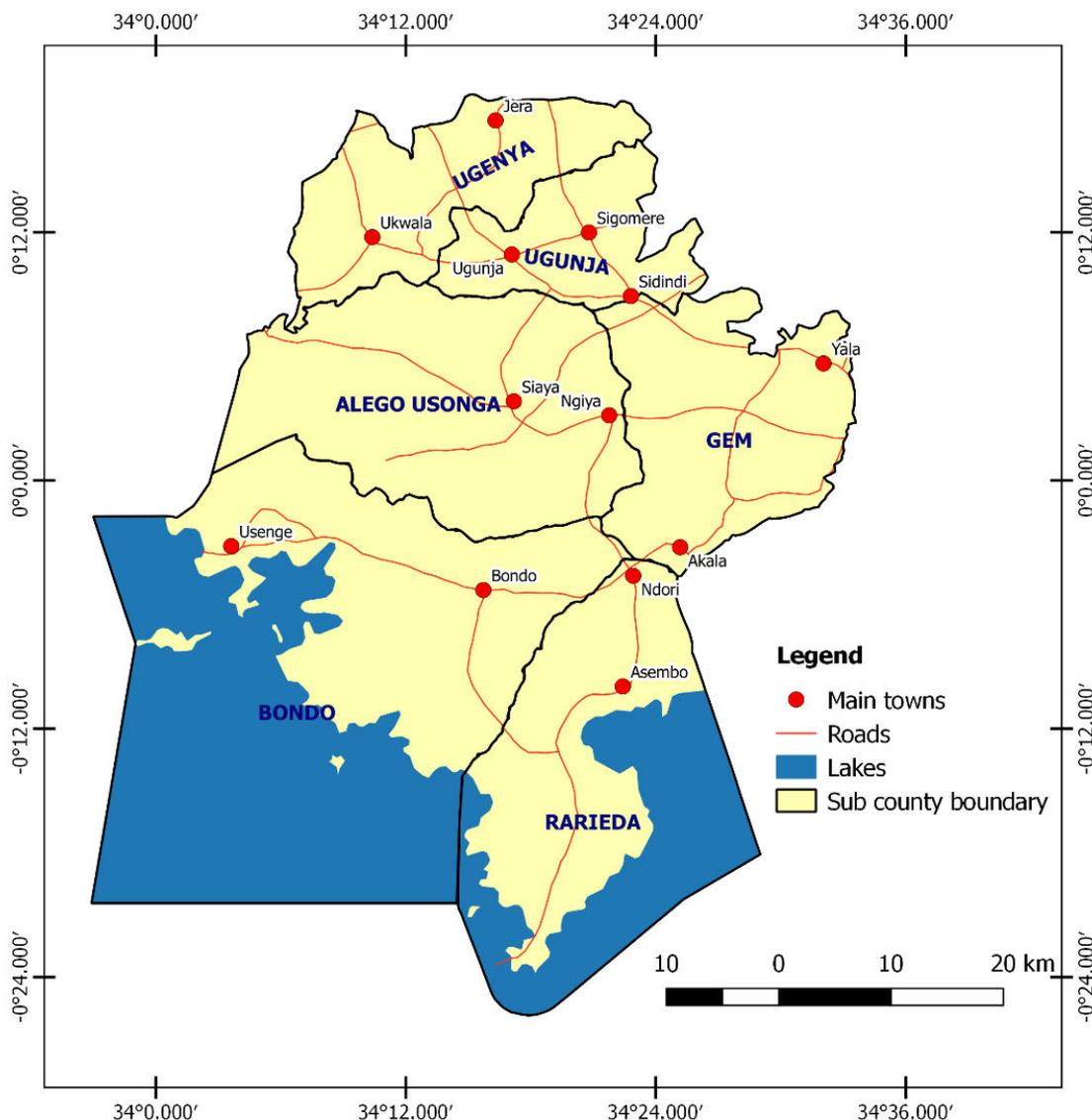


Figure 3.1: Map of Siaya County

Source: Independent Electoral and Boundaries Commission (2012)

In the 2019 Kenya population and housing census, the total population of Siaya County was estimated to be 993,183 people comprising approximately 471,669 males and 521,496 females (KNBS, 2019a). Looking at the population of the target group, that is, children aged ages 10-15 years, it was projected that there were 178,587 children aged between 10-15 years comprising approximately 90,008 males and 88,577 females (KNBS, 2019a).

The population density of Siaya County was approximated at 398 people per square Kilometer in 2019 (KNBS, 2019b). The most densely populated sub-county was Ugunja, with approximately 550 people per square Kilometer; while Bondo sub-county was the least densely populated, with approximately 330 people per square Kilometer (KNBS, 2019b).

The overall poverty level in Siaya County was estimated to be approximately 33.8% (KNBS, 2018) which was a significant reduction from the poverty levels a decade earlier. In terms of food poverty, 27.3% of individuals in the county were considered to be food poor “with at least 3.1% individuals estimated to be severely food poor” (KNBS, 2018, p. 46). In terms of child poverty or the level of deprivation in basic needs, 48% of the children in the county were estimated to be deprived of 3-6 dimensions of necessities (KNBS & United Nations Children’s Fund, 2017).

The prevalence of HIV in Kenya as of 2018 was 4.9%, with the prevalence found to vary across various counties (NACC, 2018). According to the Kenya Population HIV 2018 report, the highest prevalence was in Homabay County with 19.6%; Kisumu County 17.5%; with Siaya County coming third at 15.3% (Kajilwa, 2020).

### 3.4 Study Sites

There are 833 primary schools registered in Siaya County. Out of these, only 8.3% are private schools, while 92% are public schools (Republic of Kenya, Ministry of Education [RoK, MoE], 2016). The public primary schools located in Siaya County are largely rural schools at 95%, while urban schools only form 5% of the total number of primary schools (RoK, MoE, 2016). The study sites chosen for this study

were 12 public primary schools in rural Siaya. Figure 3.3 illustrates the locations of the 12 schools that were the sites for this study.

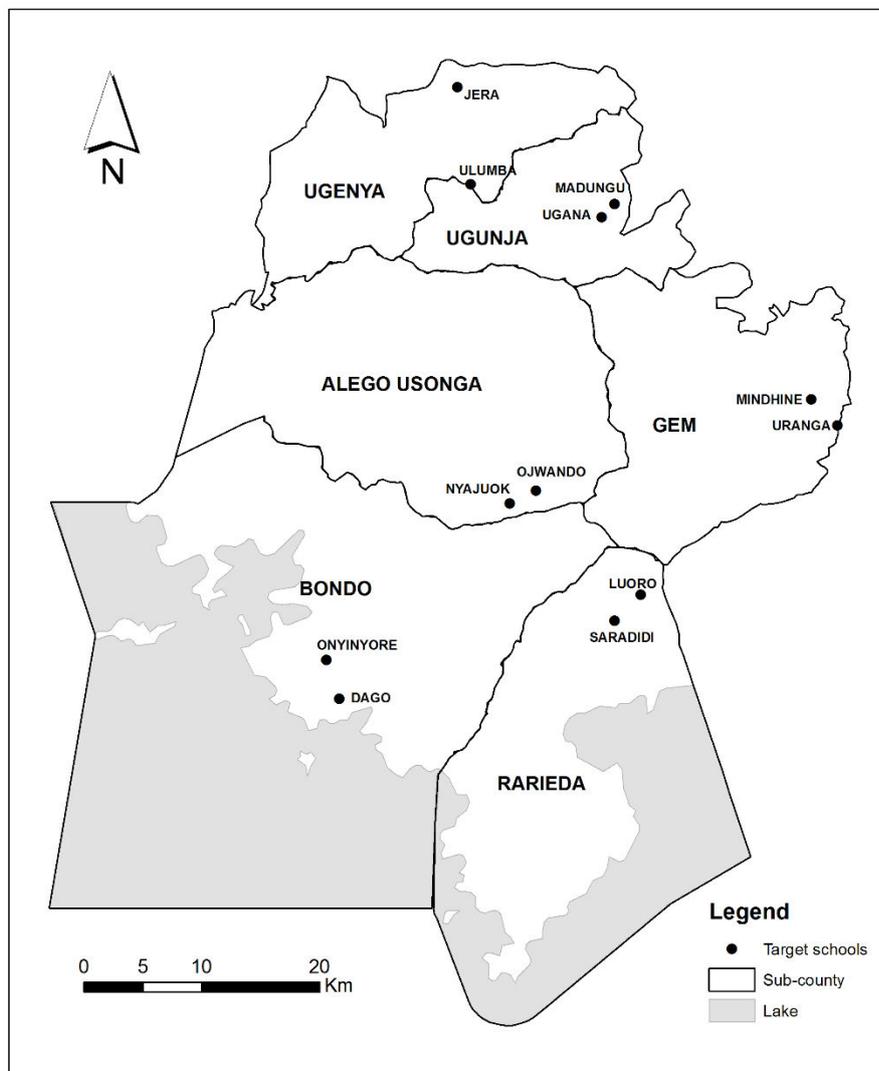


Figure 3.2: Location of Selected Public Primary Schools Used as Study Sites

Source: GIS mapping (Oloo, 2018)

### 3.5 Study Population

The study population is the “entire group of individuals, events, or objects with common characteristics that conform to specific requirements as placed by the researcher and determined by the study” (Mugenda & Mugenda, 2003). The

participants in this study were sampled from twelve public primary schools in the county of Siaya, Kenya. All the schools were government public day schools and of mixed gender. The study population was the orphaned children enrolled in public primary schools.

According to the basic education statistical booklet (2016), Siaya County had a total of 669 public primary schools. The total enrollment in primary schools in the county, as of 2016, was approximately 267,408 pupils. Public schools hosted the majority of the pupils, with an enrollment of 250,040, that is, 94% of the total enrollment (RoK, MoE, 2016). The average school size population in Siaya is 321 pupils per school.

In relation to gender distribution, the RoK, MoE (2016) report showed that there was an almost even distribution of gender among children enrolled in primary schools with a gender parity of 0.2%. Specifically, the enrollment in the public primary schools in the county comprised 25,455 boys and 124,585 girls (RoK, MoE, 2016). A study to evaluate the state of education among primary school-going children in Kenya who were between ages 7-13 years found out that generally, the share of basic literacy and numeracy skills increases with age (UWEZO, 2015).

In Siaya County, “at age seven, only 35% of the children had basic literacy and numeracy skills while at age 13, the share increased to 96%” (UWEZO, 2015, p. 44). The same study found out that while the enrollment rate at the pre-school level in the county was approximately 91%, the completion rate of primary school for children between 14-16 years old was approximately 38%, at which point only 68% of the children showed basic literacy and numeracy skills (UWEZO, 2015).

### 3.6 Target Population

The targeted population for this study was orphaned children, aged between 10-15 years, and enrolled in upper primary schools in Siaya County. Based on the 2019 population census, the number of the children aged 10-15 years was 178,587 with 50.4% boys (n=90,008) and 49.6% of girls (n=88,577) (KNBS, 2019a). Based on the education system, children aged 10-15 years are likely to be between classes 3 to 8. The targeted enrollment classes in this study were classes 3 to 7. Classes 1 and 2 were exempted due to language and comprehension. Class 8 pupils were sitting their national exams, meaning that they would not have been available throughout the study, and for this reason, they were exempted.

As indicated in the 2016 basic education statistical booklet, the total number of children enrolled in classes 3 to 7 were 163,680 out of which 50.2% (n=82,272) were boys, and 49.7% (n=81,408) were girls; again showing a parity of only 0.6% when enrollment by gender was observed (RoK, MoE, 2016). These results indicate that the enrollment for girls and boys was mainly equal for public primary schools in Siaya. In Siaya County, “the rate of orphanhood in 2018 was estimated at 16.0%, translating to approximate 519,000 children under the age of 18 years” (KNBS, 2018, pp. 25-26). The rate of orphanhood “among children aged 0-14 years was approximated at 12.5%, translating to approximately 430,000 children in Siaya County” (KNBS, 2018, pp. 27-28).

Records from the selected schools' registries and from lists of orphaned children as provided by class teachers were used to determine the number of children falling within the targeted population. Table 3.1, presents the projected overall population for the 12 public primary schools in the study, the population for the pupils 10-15 years; and the total number of orphaned children enrolled in classes 3 to 7 who

fell under the age bracket of 10-15 years (as per schools' records obtained in September 2018).

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*Table 3.1: Total Population and No. of Orphaned Children in the 12 Schools*

Sub County	Schools	Group	Enrolment	Males	Females	Population sample	Orphan_Sample(10-15)	Orphans males	Orphans Females
Ugunja	Madungu	Exp	671	341	329	273	87	41	46
Ugunja	St Patrick	Exp	526	269	258	252	59	36	23
Alego	Nyajuok	Exp	616	305	311	332	89	42	47
Alego	Ojwando	Exp	471	237	234	470	76	40	36
Gem	Mindhine	Exp	315	162	153	148	56	27	29
Gem	Uranga	Exp	201	103	98	93	29	13	16
Ugenya	Jera	Ctr	405	207	198	190	51	28	23
Ugenya	Ulumba	Ctr	509	263	246	270	74	35	39
Rarieda	Luoro	Ctr	299	137	162	142	62	35	27
Rarieda	Saradidi	Ctr	248	131	117	123	46	25	21
Bondo	Onyinyore	Ctr	319	164	155	167	53	28	25
Bondo	Dago	Ctr	484	273	211	214	84	43	41
Total			5064	2592	2472	2674	766	393	373

Source: School records provided by the schools' administrators (2018)

The targeted population for this study was orphaned children enrolled in 12 public primary schools in Siaya county. As seen in Table 3.1, there was a total population of 5064 children enrolled in the 12 selected primary schools. The enrollment by gender was 50.2% (n=2592) for boys, and 49.8% (n=2572) for girls. Out of this total population, the targeted population were those aged 10-15 years, which was 2674. From this target group, the total number of orphans was 766: 393 males and 373 females.

### 3.7 Sample Size

Sampling entails the selection of cases representative of a whole population, so as to draw inferences about the population under study (Polit & Beck, 2012). For

this study, the sample size was derived using the Casagrande sampling formula, as seen in Figure 3.3.

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$$2N = \frac{2 \left\{ Z_{\alpha/2} \sqrt{2\bar{p}(1-\bar{p})} + Z_{\beta} \sqrt{p_A(1-p_A) + p_B(1-p_B)} \right\}^2}{(p_A - p_B)^2},$$

Where: A refers to the existing overall orphan care

- B refers to the proposed MCGT
- $P_A$  is the proportion of failures expected on treatment estimated at 0.45
- $P_B$  is the proportion of failure expected on treatment B, estimated at 0.3
- $\alpha$  is the probability of type I error at 95% confidence level
- $\beta$  is the probability of type II error (0.1), so that  $1-\beta = 0.9$
- $Z_{\alpha/2} = 1.960$  is the critical value at 95% confidence level
- $Z_{\beta} = 1.282$  when  $\beta = 0.1$

*Figure 3.3: Casagrande Formulae for Sample Size Calculation*

This formula shown in Figure 3.3 has been validated as effective for experimental studies in the clinical field that seeks to test the effectiveness of new treatment in comparison to old existing treatment (Casagrande, Pike, & Smith, 1978). Based on the above, Figure 3.4 provides a step-by-step calculation of the sample size.

$$2N = \frac{2 \left\{ Z_{\alpha/2} \sqrt{2\bar{p}(1-\bar{p})} + Z_{\beta} \sqrt{p_A(1-p_A) + p_B(1-p_B)} \right\}^2}{(p_A - p_B)^2},$$

$$\bar{p} = \frac{0.45 + 0.30}{2}$$

$$\bar{p} = 0.375$$

$$2N = \frac{2 \left( 1.960 \sqrt{2 \times 0.375(1 - 0.375)} + 1.282 \sqrt{0.45(1 - 0.45) + 0.30(1 - 0.30)} \right)^2}{(0.45 - 0.30)^2}$$

$$2N = \frac{2 \left( 1.960 \sqrt{0.75(0.625)} + 1.282 \sqrt{0.45(0.55) + 0.3(0.7)} \right)^2}{(0.15)^2}$$

$$2N = \frac{2[(1.960(0.6847) + 1.282(0.6764))]^2}{(0.0225)}$$

$$2N = \frac{2(1.3420 + 0.8671)^2}{0.0225}$$

$$2N = \frac{2(2.2091)^2}{0.0225}$$

$$2N = \frac{2(4.8803)}{0.0225}$$

$$2N = \frac{9.7606}{0.0225}$$

$$2N = 433.8$$

$$N = 216.9 = 217$$

Figure 3.4: Sample Size Calculation

In Figure 3.4, N=217 represents the calculated sample size. To cater for participants who would have likely pulled out of the study, and/or for disqualification of participants, a 10% attrition rate was applied. Therefore, an additional 22 participants were added to the calculated sample leading to 239 participants. This

figure was rounded off to 240, and the members were then divided into control and experimental groups.

### 3.8 Sampling Technique

A multistage sampling procedure - incorporating cluster sampling; purposive sampling; and simple random sampling at different stages, was applied. Cluster sampling is ideal when the elements of the population are spread over a wide geographical area (Kothari, 2004). According to Mugenda and Mugenda (2003), purposive sampling is a technique allowing the use of cases that have the required information regarding the intended purpose of the study. Kothari (2004) also stated that purposive sampling involves making a deliberate selection of specific participants to represent the population.

At stage one, the population was first grouped through cluster sampling by considering the geographical boundaries of Siaya County. The population was clustered as per the existing sub-counties as follows: Gem, Alego, Ugunja, Ugenya, Rarieda, and Bondo. In the second stage, sampling was done purposively and then randomized. To identify schools in each of the sub-counties, purposive sampling was used. This was done through referrals from contacts who had either schooled or lived within these sub-counties. In total, 26 schools were identified purposively through these referrals. Four sub-counties, that is, Alego, Gem, Ugunja, and Bondo had four schools each; while two sub-counties: Ugenya and Rarieda had five schools each.

To minimize bias, at least three schools from each of the sub-counties were selected through random sampling. The process involved writing the names of the schools on pieces of paper and placing the papers within the respective sub-county group. The researcher then picked three schools from each group to form 18 schools.

Purposive sampling was again done at this stage considering ability to access the school and the likely availability of the population targeted and from which the sample was to be drawn.

The literature review on school enrollment and prevalence of orphanhood in Siaya County indicated that the average school population in the county was 321 pupils per school and the rate of orphanhood among children aged 0-14 years was approximately 12.5%. Therefore, a good enough population would be 12.5% of 321 amounting to at least 40 orphaned children enrolled in the school. From each of the 18 schools, the researcher requested for a list of orphaned children; and assessed the level of accessibility to the school, and the receptiveness of the school heads concerning their engagement in the study. Based on the outcome, two schools were selected to represent each of the six sub-counties and therefore, a total number of 12 schools were used in the study.

In stage three of the sampling procedure, the researcher made use of purposive sampling to specifically pick out the orphaned children who met the inclusion criteria. The participants were required to be in the 10-15 years age category, to have lost a parent not less than six months by the time the study was commencing, and to have scored 5 point in the brief grief questionnaire (BGQ). To screen for the possibility of elevated grief scores, the BCQ was utilized. Through this tool, the participants who had elevated grief scores were identified. Finally, at stage four, to determine which schools would form the control and experimental groups, random sampling was done. The names of the sub-counties were written on pieces of paper. Three sub-counties: Gem, Alego, and Ugunja were randomly picked, thus forming the experimental

group. The schools in Ugenya, Bondo, and Rarieda sub-counties formed the control group.

### 3.8.1 Inclusion and exclusion criteria

The participants who were included in this study were aged 10-15 years and enrolled in classes 3 to 7 in the selected primary schools, which were 12 in number. The participants should have lost at least one parent, with the loss not having happened more than six months at the time the study was commencing. Participants who scored 50% on the BGQ were enrolled in the study.

Ideally, only students in classes three to seven were included in the study, as they fell within the age group desired for this study, and were expected to have a good enough understanding of the English language. It was observed that most of the participants had a good understanding of the English language. Further, since all the tools were administered by the interviewer, participants were able to get clarifications where needed. Only one item on the ICG (item 8), proved challenging specifically on the term 'dazed'. Therefore, further description of the word was provided, in this case, 'a state in which one is temporarily in a state of confusion and unable to act normally/or do anything'.

Those who scored less than 50% and below in the BGQ were not included as participants in the study since grief below this cut-off was considered normal. The lower primary level (classes one and two) were excluded due to their inability to comprehend and be able to express their feelings well enough to efficiently provide responses that would be useful for diagnosis and intervention.

### 3.9 Data Collection Instruments

In this interventional study, the researcher utilized quantitative data collection tools. This section will discuss the tools and the proposed MCGT manual.

### 3.9.1 Brief grief questionnaire (BGQ)

The BGQ was used to screen for elevated grief scores. This tool is made up of five key criteria for CG. These include avoidance of things that remind the bereaved of the loss; having intrusive images of the deceased person, having trouble accepting that the person has died, feeling detached and numb, and finally impairment that causes interference with the ongoing life of the bereaved person. The items are scored on a Likert scale in which the respondents self-report on the frequency of the individual symptoms on the tool. The frequency is ranked as follows: 0=not at all; 1=somewhat; 2=a lot. Respondents who scored 5 points and above (50%) were considered to be having elevated symptoms of grief, thus, an indicator of the possibility of CG. The BGQ is the recommended tool for screening when using the CGT as a treatment intervention (Shear, 2015), and its validity and reliability has been proven. In a sample of Japanese population, BGQ had a Cronbach's alpha of 0.75, and an internal consistency of 0.39 (Ito et al., 2012). The tool was used to measure the prevalence of CG among orphaned children in Siaya county.

### 3.9.2 Inventory of complicated grief (ICG)

The participants who scored 50% on the BGQ were further subjected to the ICG tool. The tool was also used to collect grief scores at baseline, midline, and endline. The ICG mean scores were used to monitor change of symptoms and analyze the efficacy of the intervention. The ICG tool was developed by Holly Prigerson and colleagues in 1995 to screen for specific indicators of maladaptive grief such as disbelief, anger, and hallucinations (Prigerson, Frank et al., 1995). The ICG is a 19-

item tool with each item scored on a 5- point Likert scale describing the frequency of occurrence. The scales are 0-never, 1-seldom, 2-sometimes, 3-often, and 4-always, and has a maximum score=76 (Wagner & Maercker, 2010). The 19 items in the ICG target six dimensions considered critical in the diagnosis for CG. These dimensions are anger and bitterness; yearning and preoccupation with the deceased; hallucinations about the deceased; shock and disbelief; social avoidance; change in behavior, such as avoidance; and proximity seeking with things that remind the bereaved about the deceased (Shear, 2015).

Participants scoring greater than 25 points are considered to be having symptoms of CG grief needing clinical intervention. The stipulated scoring template indicates 0-25=normal grief, 26-30=CG, and  $\geq 30$ =severe symptoms of CG (Shear, 2015). Participants who record scores greater than 25 in the ICG tool are more likely to report impaired social, cognitive, and emotional functioning; and may exhibit general mental and physical health challenges characterized by body pains and maladaptive thinking (Bui et al., 2015).

Prigerson, Maciejewski (1995) tested the tool on 97 bereaved widows and widowers of the mean age of 66.9 years. The ICG tool recorded a high internal consistency with a Cronbach's alpha of ( $\alpha=0.94$ ;  $P<0.001$ ), and test-retest reliability was found to be 0.80. In comparison to other grief assessment tools, ICG showed higher concurrent validity with a strong correlation with other measures of grief symptoms, for example, the Texas revised inventory of grief ( $r=0.87$ ;  $P<0.001$ ), and the grief measurement scale ( $r=0.70$ ;  $P<0.001$ ). ICG also showed a strong association with Becks depression inventory ( $r=0.67$   $P<0.001$ ) (Maciejewski et al., 2016; Prigerson, Maciejewski et al., 1995).

Replication studies across different populations have been done and have continued to show consistency and reasonable reliability and validity. The reliability (internal consistency) of the Spanish version of ICG was high (Cronbach's  $\alpha=0.92$ ) (Masferrer, Garre-Olmo, & Caparrós, 2017). The test-retest reliability was measured using 30 individuals and it was also high (0.81). The ICG convergent validity was assessed in relation to other scales: Becks depression inventory (BDI) and Becks anxiety inventory (BAI). The total score of ICG showed a positive and statistically significant correlation with the BDI ( $r=0.67$ ;  $p<0.001$ ), and BAI ( $r=0.243$ ;  $p<0.01$ ) (Masferrer et al., 2017). Consequently, this tool was preferred given that it was the recommended clinical screening tool used in the CGT intervention manual and that it is used to assess progress from baseline to endline.

### 3.9.3 Sociodemographic questionnaire (SDQ)

A self-developed SDQ was used to gather the sociodemographic data of the participants. The data collected through the questionnaire included age, gender, class level, family details, religion, history of abuse since parental death, and other information pertinent to this study. To ensure that the data collected was reliable, truthful, and useful for diagnosis of CG, the ICG tool and the self-developed SDQ were administered on a one-on-one basis by research assistants. The research assistants had undergraduate training in counseling and psychology and had also received prior training on the MCGT manual.

### 3.9.4 School records

The targeted population of orphaned children was identified from a total of 12 public schools in Siaya County as follows: Ugunja sub-county - Madungu Primary

and Ugena Primary; Alego sub-county - Nyajuok Primary and Ojwando Primary; Gem sub-county - Mindhine Primary and Uranga Primary; Ugenya sub-county - Jera Primary and St Thomas Ulumba; Rarieda sub-county - Luoro Primary and Saradidi Primary; and Bondo sub-county - Dago Primary and Onyinyore Primary. School records from the 12 schools were obtained from the schools' administrations.

Each of the 12 schools provided information on the total population of its pupils as of 2018, plus the total population of children enrolled in classes 3 to 7. This particular group (classes 3 to 7) was selected because the targeted population was children aged 10-15 years. Additionally, each of the schools, through the class teachers, provided a list of names of all orphans (single and double) who were enrolled in the specific classes. A summation of these records was then done to determine the total school population, population of the targeted group, and the number of orphaned children aged 10-15 years and enrolled in the selected primary schools.

Initially, the researcher intended to obtain the participants' academic performance information, but during the data collection noted that the academic results were not available for most of the orphaned children. This was because many of the orphans had at times missed exams due to inability to pay the required examination fees. In three of the schools, the orphans were expected to pay SH20 for each set of exams such as term opening, midterm, and endterm exams. Secondly, because the orphaned children had lost parents at different periods, it was not possible to access some of their academic records before the death of their parent/s.

In addition, it was noted that due to other factors beyond the researcher's control, the academic performance of each school varied and could not have been

used for any statistical analysis. The academic performance of orphans has been associated with many other socioeconomic factors that are beyond the fact that the orphaned child is grieving. For example, lack of parental engagement, irregular school attendance due to taking up caregiving roles, and lack of school amenities/fees due to inability of the caregiver to cater for expenses (Akerman & Statham, 2014; Kiambi & Mugambi, 2017; Limo & Kibowen, 2017). Orphaned children do not benefit from parental involvement in their education, are likely to miss school because they are home caring for their sick parent or taking up jobs to feed their siblings when parents die, and are likely to be unable to afford school expenses. In this study, it was not possible to control for these factors. Therefore, due to the unavailability of consistent academic records in some of the schools, the researcher opted to instead measure the participants' perception on academic performance.

### 3.9.5 Modified complicated grief therapy manual (MCGT)

A major limitation in the existing CGT manual is the prolonged sessions and the need for intensive training. Hence, and as already discussed, the proposed MCGT is a targeted intervention that is trainable and implementable by the school counselors or persons with minimal counseling skills. The order and number of sessions, and some content were simplified to make it more targeted to the population of the study. The researcher also argued that the current 16 session CGT therapy which requires that caregivers be engaged in the study may not be feasible especially for group interventions for orphaned children in a school set up and were therefore removed.

Secondly, considering that the current model incorporates techniques that require intensive training, such training may not be accessible to many professionals in low-income areas such as Siaya County. Therefore, in deciding the sessions and

techniques to remove, the researcher only considered techniques that can be implemented in a group session and only included those techniques that do not require intense expertise or clinical experience to administer. Since MCGT was proposed to be implemented as a school-based program, trained teachers, who in their course work undergo counselling units, were preferred as research assistants.

The six research assistants used were final year Bachelor of Education Students who had just completed their final exams (in April 2019). They had undergone guidance and counseling units more specifically, in their third year of course work; and had done a course on grief symptoms and grief counseling. By the time the study commenced in May 2019, the research assistants had completed their final exams and were awaiting graduation which was to happen in November 2019.

The original CGT uses specific forms and tools in the intervention. In this version, more conversational interaction was preferred since the intervention was a group one. Therefore, only two tools were adopted from the original CGT. The first tool was the screening tools, and the original CGT also recommends screening using the BGQ. This was also adopted in this trial. Secondly, the ICG was borrowed from the original CGT by Shear et al (2015) and is purely for quantitative analysis of grief scores at baseline, midline and endline. The ICG is a 19-item rating of grief symptoms. When going for sessions, the research assistants were expected to have the MCGT manual, plain papers, and pencils.

As depicted in Table 3.2, the MCGT manual proposed by the researcher was a 12-session program that could be administered as a group intervention. It only contained techniques that are trainable and administrable by a person with basic training in counselling. The effectiveness of MCGT as a school-based intervention,

when administered by trained teachers, was tested. The intervention's reliability and validity were established at data analysis.

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*Table 3.2: Differences between Current CGT and Proposed MCGT*

Description	Current CGT	Proposed MCGT
Total number of sessions	16	12
Introductory Phase	3 sessions Session 1-3 History taking, Overview of CGT, Grief monitoring	2 sessions: Session 1-2 History taking Psychoeducation on grief Training on Grief monitoring
Intermediate Phase	7sessions: Sessions 4-10 Restoration work Imaginal revisiting Imaginal conversation Memory work Progress evaluation	6 sessions: Sessions 3 – 8 Narrative of the death story Narrative of memories with the deceased Life changes after the death Grief monitoring of thoughts/beliefs Grief monitoring of emotions Grief monitoring of behaviours Psychoeducation on relationship between thoughts, emotions and behaviours
Final Phase	6 sessions: Session 11-16 Restoration work Imaginal revisiting Imaginal conversation Memory work Progress evaluation Preparation for termination	4 sessions: Sessions 9-12 Progress evaluation of thoughts, emotions and behaviour Saying goodbye: imaginal conversation with deceased for closure Rebuilding new relationships Adaptive coping skills Preparation for terminations Evaluation of grief symptoms Review of participants after 3 months

Source: Author (2020)

#### Introductory Phase (Session 1 and 2)

The CGT is a semi-structured treatment. We use structure to provide a framework for the treatment, to allocate time in the session, to assist in both gathering and providing information, and to plan for the interval between sessions. Structural elements provide a useful framework for the treatment, though this does not mean you should use them rigidly. There is a lot to cover in each session, and it is easier to get it all done if you set an agenda and follow it through.

People with CG feel lost and out of control and find predictability reassuring. At the same time, participants vary in their willingness and ability to accept and use an agenda, complete questionnaires, read handouts or follow interval plans. One of

the challenges in learning a new treatment approach is that prior beliefs about how best to work may not be the best guide to decision making.

It may be difficult to effectively encourage participants to work with an agenda if you have not done structured treatments before, and you might find it awkward at first. It is best to follow the treatment as closely as possible, at least until you are comfortable working this way. Each session begins by setting an agenda that divides the session into three parts.

1. Intro - a brief introduction to discuss the plan for the session and review the past week
2. Middle - a longer period of time in which you implement the main session content
3. Ending - a brief ending of the session in which you summarize and get feedback from the participant, and plan for the upcoming week.

CGT sessions can be very intense and emotional. You need to track participants empathically, and it is easy to lose track of time. You may want to set a timer to remind you when to shift the focus.

### *Session One: Rapport Building & History Taking*

Duration: 60 minutes

The main goal of this session is to welcome the participants and to know as much as possible about them and the loss they experienced. In a group session, each of the participants gets a chance to introduce themselves, their families, and the loss they experienced. The group session will consist of a maximum of 6 participants. The specific areas of queries are as follows:

1. Self-introduction - your name, how many siblings you have, something about what you were like when you were in primary school, something that happened when in primary school. This helps to bring the therapist back to the level of the children and enhance rapport.
2. History of early family relationships, siblings (allow the participants two minutes to say their name, how many siblings they have and who they are currently living with (use the spin the bottle game to give each child a random chance to introduce themselves).
3. Introduce the fact that they are in the group because they have lost a parent. Introduce the deceased person - who died? Have they lost another loved one?
4. Discuss participant's current life situation, what are some of the stresses and sufferings that the stressors
5. How have they been coping? (coping resources). In simple language ask them what they do when they are feeling sad and stressed
6. Provide a very brief introduction to the rationale and processes involved in CGT. Explain that the sessions are mainly to help them with this sadness and grief and support them through it.

Grief Support - Participants name one or two people they feel have been of support to them and that they could open up to.

### *Session Two: Monitor and Assess Grief*

Duration: 60 minutes

The main goal of this session is to introduce grief monitoring and discuss complicated grief and how this relates to what the participant is going through. Remind the participant of the importance of the therapy and the need to be honest and

open. In case resistant can still be felt from one of the participants, the PI should be informed immediately.

Resistance is a process of avoiding or blocking the self-disclosing communication requested by the interviewer because it makes the interviewee uncomfortable or anxious. It can be seen through overreaction, noncompliance, lack of motivation, limits the amount of information communicated to the counsellor, silence, and minimal talk

Understand that there is a reason the participant is resistant. It could be related to the stages of grief, that is, the participant could still be in denial, angry and is yet to start the processing of the grief.

1. Review of the week - grief monitoring will be done at the beginning of each subsequent sessions as it is a main source of understanding the participant's emotional state. Basically, ask the participants to discuss some of the low moments they had in the week, things or events that may have triggered memories of the deceased
2. Discuss triggers that the participants feel make the grief worse. It could be what someone does, said, or just reminders.
3. Discuss times when grief was/is relatively manageable. When does the participant seem not to think about the deceased parent? Can you identify some patterns?
4. Encouraging the participant to think about personal aspirations, activities that have the potential for reawakening the capacity for joy and meaning in life. What would they love to be in future? Can the participant describe a future?

### Intermediate Phase (Sessions 3 to 9)

This phase includes focused work on loss and restoration that is designed to revitalize the natural healing process. The main goal of revisiting exercises is to encourage the participant to reflect on the death. We seek to help participants to come to terms with the death in a way that integrates participant and the deceased.

The goal is to restore an effective transition between confrontation with painful information related to the loss and relief from that pain. The purpose of focusing on the loss is for the participant to acknowledge the finality and consequences of the death fully and to integrate this knowledge into cognitive and emotional memory systems that contain models of self, others, and the world at large.

The focus on the restoration is aimed at restoring the participants' capacity to envision a future, and to participate in life in a way that allows them to find joy and satisfaction even without the person who died. Several strategies are used to achieve loss-focused goals., and they include the following:

1. Decrease the emotional impact of the story of the death and help the participant comprehend the painful reality
2. Introduce and discuss the concepts of acceptance and faith
3. Reflect on the troubling aspects of the death and come to terms with the finality of the loss
4. Reduce behavioral and experiential avoidance of reminders of the loss
5. Facilitate the process of integration of memories with the reality of the death
6. Help identify and begin to incorporate long-term aspirations and plans
7. Encourage re-engagement in ongoing daily life and relationships
8. Facilitate the experience of genuine positive emotions

*Session Three: Processing the Death*

Duration: 60 minutes

The main goal of this session is to help the participants come to terms with the death of the loved one by helping them process the death at both the emotional and cognitive levels and integrate these processes. This is an emotionally intense session and must be handled with care.

Imaginal Revisiting is a method for helping people to honor the death of a loved one and grapple with the painful reality (Shear et al., 2015).

If the participant's reactions are too intense, the session should be halted, and the participant given time to process. If in a group session, the individual participant can be given extra time or an individual follow-up session. The session also acts as the debriefing period. Imaginal revisiting simply makes the participant relive these painful moments again so that the situation can start to become a reality to the participant. For participants who are yet to accept the death, the emotional reaction may be intense, and in such a case the session should be halted. Participants who are resistant may not be forthcoming with disclosure and therefore, further probing and encouragement to make the participant comfortable is necessary.

1. Introduce Imaginal revisiting - allow the participant 3-5 minutes to visualize and tell the story of when they learnt about the death, where were they? Who told them? How was the news broken to them? Were they there? Debrief and allow them to narrate what they did.
2. Help the participant to process the loss at an emotional level - what did they feel at that point? Also, help them to process at the cognitive level - what did they think? What did they know about death then?

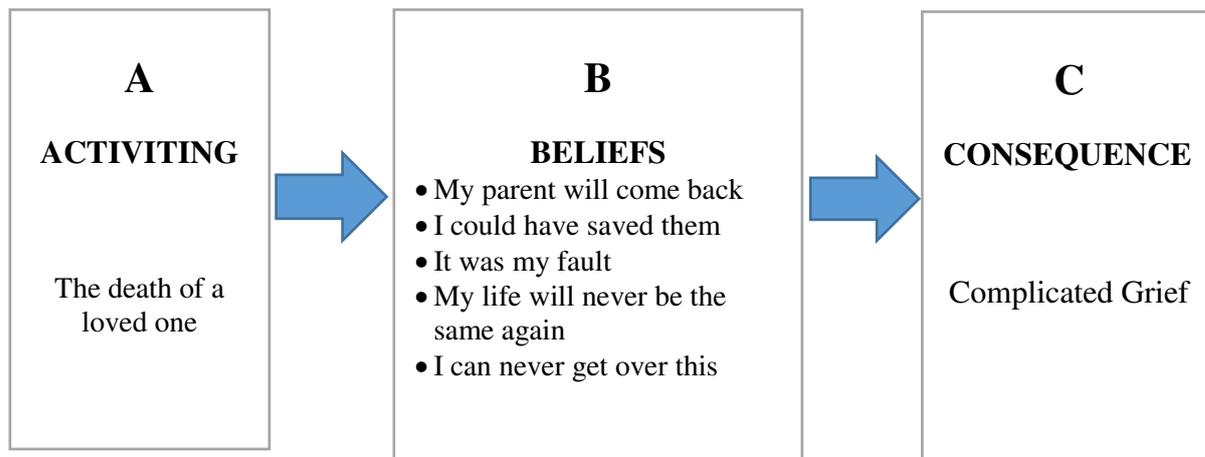
3. Reward participant - A reward is given for doing the hard, painful work of revisiting the painful memories. Participants will be given a pencil and rubber.

*Session Four: Assessing Thoughts and Beliefs*

Duration: 60 minutes

The main goal of this session is to introduce restoration work by assessing thoughts and beliefs that may be leading to CG. Sometimes the irrational beliefs and distorted thoughts on death could be the reason the participant is still stuck in the grief.

One of Albert Ellis's profound statements was that people disturb themselves not by the events that happen to them but by the way they interpret these events (Mkangi, 2010). Based on the ABC framework, activating events do not lead to emotional disturbance (Corey, 2009). This is to say, for instance, that death of a loved one (A=activating event) does not cause CG (C=consequence), but that irrational beliefs (B) about the death can cause CG. Therefore, focusing on how the participant interprets death helps to dispute some of the thoughts and replace them with more rational beliefs.



1. Review the week - weekly grief monitoring exercises. Participants openly discuss and talk about some of the low moments they have had in the week.
2. Psychoeducation on ABC model and how maladaptive thinking can lead to grief complications.
3. Brief psychoeducation on common maladaptive thoughts and beliefs that complicate grief
4. Allow the participant to discuss thoughts emotions and behavior. Can participants tell when their thoughts are causing them to get stressed and think more about the deceased.
5. Encourage positive thinking to stop the negative thoughts?

The following questions seek to understand what participants thoughts are concerning the death of their parent.

Thoughts and belief

1. Do you still think your parent will come back?
2. Since your parent died, have you had thoughts that your loved one did not have to die?

3. Since your parent died, have you had thoughts that life is unbearable without them?
4. Since your parent died, have you had thoughts that the only thing that can really help you is to have this person back?
5. Since your parent died, have you had thoughts that you could have done something to stop the death?
6. Since your parent died, have you had thoughts that relatives/doctors did not do enough to stop the death?
7. Since your parent died, have you had thoughts that you have no one to turn now that your loved one is gone?
8. Since your parent died, have you had thoughts that something is wrong with you because you are grieving so much? You should be over this by now?

*Session Five: Revisiting Relationships*

Duration: 60 minutes

This session's main goal is to revisit the relationship the bereaved had with the deceased loved one. The participants revisit memories of life when the deceased was still alive and the changes in their current life.

1. Introduce relationship revisiting - the participant talks about the deceased and the relationship
2. Research assistant and participant engage in discussing memories shared with the deceased.

Positive memories

1. *List the most enjoyable times you had*

2. *What did you love most about them?*

Negative memories

1. *What are some of the things you did not like about them?*

2. *List the worst moments you had with the deceased*

The therapist then does the following

1. Introduce situational revisiting - the participant identifies activities or places they previously did or visited together. Situational revisiting of reminders of the loss.
2. What specific aspects of life can the participant pick out as been different since the death of the loved one.
3. The participant is encouraged to engage in a situational revisiting activity every day.

Engage in session break activities to enhance relaxation (stretching and singing).

### *Session Six: Facing Difficult Times*

Duration: 60 minutes

This session aims to address the difficult times during which the participant seems to feel intense grief. Such include specific events or calendar dates that tend to trigger these intense feelings. By pointing these out, the research assistant and the participant can discuss how to cope better during these periods.

1. Review the week
2. Difficult times - Participants identify calendar dates or months that are difficult or remind them of deceased
3. Participant identifies the activities and places that have been avoided because they trigger grief or serve as reminders of the loved one.

4. How has the participant been coping?
5. Psychoeducation on stress management - breathing exercises and relaxation techniques
6. The participant is encouraged to practice the skills learned on a daily basis

#### *Session Seven: Restoration Work*

Duration: 60 minutes

The main goal of session seven is restoration work. The participant and research assistants review the grief diaries and the situational revisits to see the progress made by the participant. Memory work continues with the introduction of both positive and negative memories

1. Review the week - how was the week for the participant after the last session of revisiting relationship and situational exercise?
2. Participants write a paragraph describing best moments with the deceased.
3. Participant writes a paragraph describing worst moments with the deceased
4. How does the participant feel about the sessions so far? Allow the participant to be as expressive as possible
5. Affirm and acknowledge the progress and discuss reward

#### *Session Eight: Rebuilding Relationships*

Duration: 60 minutes

Specific to this session is discussing alternative significant other that participant can start to rebuild relationships with. This can be an adult relative, caregiver, older sibling, church member/pastor, teacher, among others.

1. Weekly review

2. Who is the participant currently close to? - why? how accessible is the person  
Rebuilding attachment?
3. Social interactions and relationships - friendships and interactions, allow the participants to talk about their friends and what they do together
4. New social support - has the participants met or established new support?
5. Emerging stressors and triggers - have there been new events or occurrences that have brought in new stress? Are there things that used not to bother them but now do?
6. Participant asked to go home and imagine that they could get a final chance to talk to their loved one before they died. They should think of what they would like to tell the deceased loved one in the next session. They can also write a direct letter to the deceased. The participant will read out the letter in the next session.

#### *Session Nine: Imaginal Conversation*

The goal of this session is to allow the participant to address the deceased loved one through imaginal conversation and role-playing. This exercise will help the participant have closure and be rid of any negative feelings of guilt or anger that he or she may be going through. It is about engaging in imaginal conversation and giving the participant a chance to say goodbye to the loved one. The participant imagines that the loved one has just died but is able to hear and speak. The participant plays both the role of the self and also of the loved one.

1. Weekly review
2. Saying goodbye - telling the deceased that their death, though painful has been accepted and discussing how they plan to cope. The participants can

even ask the deceased to allow him or her to move on with life under the care of the new attachment figure

3. The session ends with research assistant recapping the achievements so far and introducing the news that the sessions are now drawing to the end and that participant has said goodbye

#### Final Phase (Sessions 10 to 12)

This session mainly seeks to assist the participant to say goodbye to the loved one and also marks the beginning of termination. The strategy for discussing termination is to begin by inviting the participant to think about it. It is expected that people will feel freer to engage in their ongoing life in a way that has the potential for joy and satisfaction. Ask the participant if he or she has had any thoughts about the completion of the treatment. Depending on what the participant says, you will explore these thoughts and feelings and encourage continued reflection on the same.

Preparation for termination includes reviewing with the participant what they have learned in the treatment and discussing progress on loss- and restoration-related issues. The research assistant also helps the participants to identify and deal with any feelings, both positive and negative, about ending the treatment and about their future prospects.

Plans for using and managing these feelings are discussed. Plans regarding continued work on personal goals and on any other component of the treatment that has not been fully completed are also addressed.

Termination can sometimes evoke feelings of loss that can trigger some of the participant's grief. This usually emerges on the grief monitoring. If grief intensity rises in the last few sessions concerning termination of the treatment, the opportunity

arises to illustrate how different experiences about loss may trigger grief about the participant's deceased loved one.

Termination is also an opportunity for the research assistant to summarize and comment on her view of the treatment and the progress the participant has made. It is useful to summarize the CGT model and the individual formulation and to discuss how the participant has or has not yet come to see things a little differently. It is also important to summarize the participant's strengths.

A second evaluation of the grief symptoms based on ICG is done at end of session 12.

#### *Session Ten: Role Transition*

Duration 60 minutes

In this session, the participant and the research assistant discuss the former's current situation with the knowledge that the sessions are ending. The focus is to equip the participants with coping skills and help them to understand that the sessions are ending. The outline of role transition work in the case of transition out of therapy is discussed below.

1. The ways in which the therapy has been supportive and helpful and feelings about losing this helpful support
2. The parts of the therapy that have been difficult, including things such as the time it requires, travel, and other inconveniences; ways that the therapy has been difficult and time consuming; and other things that may have been distressing or problematic.
3. Problems the person foresees in the future, for example, managing difficult times, as well as other problems that the participant may anticipate. This may

include issues the person feels are not yet resolved and might not be resolved by the end of the treatment,

4. Opportunities and positive aspects of ending the treatment. These include having more time, the chance to test new learning, and the opportunity to develop a sense of confidence in having assimilated something new that remains even when the meetings with the research assistant are over. Also, to be included is a range of positive aspects of the future.

*Session Eleven: Retelling the Story and Coping Skills*

Duration: 60 minutes

This session aims to give the participants a chance to retell the stories. Specifically, the research assistant should be able to gauge how the participant is fairing by now. The participants talk about their current life situation in the past few weeks of therapy. The session also prepares the participants for the termination of the treatment.

1. Weekly review - how has the week been emotionally?
2. Participant does their own self-evaluations - how does the participant feel about their progress?
3. Overview of stress management skills - relaxations techniques and positive self-talk.
4. Where and in what ways is the participant still stuck?
5. Revert to the personal goals and aspiration from session two - how can they be implemented even after the session

*Session Twelve: Termination*

Duration: 60 minutes

This is the last session of therapy, and its goal is to help the participants to feel ready to be on their own and be stable enough to continue with their lives without the deceased.

1. Weekly review
2. Research assistant's affirmation on the progress the participant has made
3. Some participants may feel as if this is another loss, but the research assistant empathetically explains that they believe the participant can make it through with the skills they have learned in therapy.
4. Final reward for participants on work well done – The participants are given stationery.
5. Close of therapy
6. Grief evaluation

The therapy layout plan described above is summarized in Table 3.3.

*Table 3.3: Therapy Layout Plan for the Proposed MCGT*

INTRODUCTORY PHASE		
Session No.	Agenda	Tasks
Session 1	Orientation/Welcoming History taking Orient participants to CG and its treatment	History- who has been lost? The relationship with the deceased Participants' current life situation, It provides a very brief introduction to the rationale and processes involved in CGT.
Session 2	Review the grief what were some of the low moments. Provide an overview of the treatment.	Examining triggers of grief to look for patterns. Participants are encouraged to think about personal aspirations, activities that have the potential for reawakening the capacity for joy and meaning in life.
INTERMEDIATE PHASE		
Session 3	Introduction of imaginal revisiting. Debriefing	The story of the death- bereaved describes the day and how they learned of the demise and help the participants come to terms with the loss by processing it at an emotional level. Debriefing bringing the emotions and the reality that the loved one is gone Participants identify a reward they can give themselves for doing the hard, painful work of revisiting the painful memories. Participants begin to visualize life with the capacity for joy and satisfaction without the loved one who died.
Session 4 -5	Review of the grief Imaginal revisiting Restoration work	Situational revisiting is a new element introduced during this session, in which the participants identifies activities or places previously avoided because they trigger grief or serve as reminders of the loved one. The participants are encouraged to engage in a situational revisiting activity every day.
Session 6- 8	Review of the grief Imaginal revisiting Restoration work	The participants write down pleasant and non-pleasant memories of the deceased Participants talk about the memories in the group

Session 9	Role transitions Solving disputes Progress evaluation	Identify “stuck” points. Current life situation revisited
FINAL PHASE		
Session 10-12	Preparation for termination Bringing a sense of closure Review grief diaries Imaginal conversation work	Participants continue with grief situational revisiting exercises, and aspirations work. Imaginal conversation to bring out closure. The participants imagine that the loved one has just died but is able to hear and speak. The participants play both the role of the self and also of the loved one. Participants may also choose to engage in other work that is less related to CG and is usually consistent with the IPT targets of role transition or relationship conflict. The final task of sessions 11 to 16 is termination with the therapist. Participants, the discussion is required to process the feelings of loss of the therapeutic relationship

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Source: Recreated from Shear et al. (2015)

### 3.10 Data Collection Procedures

As pre-study procedures, the researcher did site visits to the proposed schools for an official introduction and to ascertain availability of the desired target population. All the headteachers were approached and briefed on the study. In this initial briefing, the researcher also assessed the accessibility of the schools, the availability of good enough population, and if the headteachers would be interested or agreeable to having their schools as study sites. These visits formed part of the purposive sampling processes in identifying the study sites.

The sampling process identified 12 schools, and preliminary meetings were held in the 12 schools. The prior meetings with the schools’ administrations helped to

minimize resistance or refraining of participants from attending the sessions. The researcher then sought for, from the schools' administrations, official lists of orphans in the respective schools; and the population for pupils in the classes of interest, verified through the class registries. This information was crucial this early in the research because it confirmed the availability of the target population from which the sample size was to be later drawn.

Formal approvals were then sought from Daystar University Ethical Review Board (DU-ERB), the National Commission for Science, Technology, and Innovation (NACOSTI), and the Ministry of Education, Siaya County - in that order. After this, the headteachers gave the researcher approval to conduct the study. Towards reducing resistance from the teaching staff, brief psychoeducation on the importance of the study was done, highlighting the effect of CG on children.

The researcher then commenced the recruitment process of the research assistants. Six Bachelor of Education final year students were recruited after a series of interviews. They were all from Jaramogi Oginga Odinga University, Bondo campus - a public university in Siaya County. This university was selected as it was the only university in the county. The advertisement for research assistants was done through the university's department of education and special education, after obtaining consent from the head of the department. The requirements were that the applicant needed to be a final year student in the department, and with good academic performance; and needed to have done a number of courses in counseling within their four-year program in the University. Through the department, a total of eight applicants' CVs were received.

The researcher reviewed the CVs and did telephone interviewing. The principal researcher further interviewed the eight applicants, specifically to assess their level of knowledge on basic counseling skills, and the ability to speak good English. Knowledge of the local community language, Luo was also important to enhance interaction within the community and with children in the identified schools. The process culminated with the recruitment of six research assistants, who, the researcher then trained on MCGT using the MCGT manual that they would later use in the 12 weeks of intervention. The full-day training encompassing an overview of grief, and all the sessions and activities contained in the MCGT manual was conducted in Bondo town, Siaya County. The schedule that was used for the training is presented in Table 3.4.

*Table 3.4: Training Program Manual for Research Assistants*

TRAINING PROGRAM FOR RESEARCH ASSISTANTS 6 <sup>TH</sup> APRIL 2019			
TIME	ITEM	OBJECTIVE	FACILITATOR
7:30AM - 7:45AM	Arrivals & Registration	Record keeping	Training assistant
8:00AM - 8:30AM	Introduction The adjective introduction game/Memory exercise Presenting our history /self-disclosure	EXERCISE 1 & 2 Meeting our clients and remembering their names and their unique history	Principal researcher
8:35AM - 9:30AM	Overview: Counselling Micro Skills EXERCISE 3: The broken telephone Game Therapy Notes	To equip the assistants with basic knowledge of counselling and psychotherapy	Principal researcher
9:30AM - 10:20AM	Introduction to Grief Stages of grief Complicated Grief The MCGT manual Overview General Therapy	To introduce the trainees to the concept of grief and complicated grief To introduce the trainees to the manual and adhering to the structure of therapy	Principal researcher

Structure		session in MCGT	
TEA BREAK			
10:45AM- 11:30AM	The Introductory Phase Session One: Rapport Building and History taking Session Two: Monitor & Assessment of Grief	Training on the techniques to be used in the session. Based on the manual itself	Principal researcher
11:30AM- 12:30PM	EXERCISE 4: Session breaker exercises (123 count exercises) The Intermediate Phase Session Three: Processing the Death Session Four: Assessing Thoughts and Beliefs Session Five: Revisiting Relationships Session Six: Facing Difficult Times Session Seven: Restoration Work	These sessions include role playing and open discussions to prepare the trainees for the activities required of both the therapist and the participants for each individual therapy session. Description of the specific techniques and activities are contained in the manual.	Principal researcher
12:30PM- 1:00PM	Question and answer session	Clarification of areas that may have not been clear/emphasis on techniques	Principal researcher
LUNCH BREAK			
2:00PM - 2:30PM	Introduction to relaxation techniques EXERCISE 5 Muscle Relaxation Breathing focus and Guided imagery	To equip trainees with techniques to break sessions if participants look tired, bored, or fatigued. These exercises will also be useful in session six	Principal researcher
2:30PM - 3:30PM	The Intermediate Phase (continued) Session Eight: Rebuilding Relationships Session Nine: Imaginal Conversation	Training on the session delivery. Description of the specific techniques and activities are contained in the manual.	Principal researcher
3:30PM - 5:00PM	The Final Phase Session Ten: Role Transition Session Eleven: Retelling the story and Coping Skills Session Twelve: Termination	Train on the session delivery. Description of the specific techniques and activities are contained in the manual.	Principal researcher

5:00PM - 5:30PM	Question and answer session /Evaluation	Clarification of areas that may have not been clear/emphasis on techniques	Principal researcher
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To ensure uniformity during the study, the principal researcher and the research assistants would on Sunday evenings convene at the designated residence where they were all hosted. They would then review the session that would be covered in the week and do the ice exercises done. At the end of each day, a review of the day's session would be done to address any emerging issues. These after session reviews also acted as group debriefing and supervision sessions for the research assistants led by the principal researcher. The research assistants would be released on Wednesday morning to go back home to their families.

At the end of the sampling procedure, and with consent from the respective schools' headteachers, the screening using BGQ was done. At the screening stage, the participants were required to provide the following details: their full names, age, and when their parent or parents died. Those who were prequalified, based on the criteria - aged 10-15 years, lost a parent at least six months before the commencement of the study, and scored 50% and above in the BGQ - were listed as the potential sample for the study. The researcher then used the names to code the participants by school and class and assigned them a unique identifier. This number was used throughout the intervention and collection of baseline, midline, and endline.

Based on the list of those who met the criteria, the researcher sought informed consent from the parents and the guardians. She also made confirmed to the school heads that the participation in this study was voluntary and that the parent/guardian and the child both needed to assent to participation in the study. Depending on the preference of the school, participants were given the guardian/parent consent form to

take home to their parents to sign. Only those who returned the signed forms were engaged in the study. In two of the schools, there were school meetings where the headteachers organized for principal researcher to talk to the parents/guardians whose children had been listed as potential participants. The researcher explained the purpose of the research to the parents/caregivers.

After the meeting, parents who did not want their children to participate were asked to see the researcher and write down the names of the children so that these names could be struck out of the list that the principal researcher had created after screening. In these two schools, only two guardians indicated that they would not want their children in the study and the names of the children were removed from the list. The school also supported in reaching out to parents/guardians who did not attend the meetings. In total, only seven informed consents were not received, and therefore, the respective children were not involved in the study.

Those who met the ICG criteria were then coded. The experimental group was assigned the code: EXP; while the control group's code was: CTR. Each participant in every school and every class was given a number.

The baseline data was based on the ICG score. Those who met the criteria for ICG were issued with the SDQ. During the intervention, the participants in the experimental group were grouped into groups of 5 (minimum) to 10 (maximum) participants. Each of the research assistants was assigned one sub-group per school. The groups' sessions were conducted on a weekly basis for 12 weeks. In grouping participants, age was considered. The timing for the interventions was discussed with the administration. The interventions were done during the early morning prep hour; during lunch hour; and after classes (at 3 p.m.) - to guard against interfering with the

normal school program. To ensure that the intervention flowed smoothly across the six schools, a comprehensive schedule was developed and strictly observed.

At week 12 (session 12), an assessment (midline) was done for both experimental and control groups. During the collection of data for the control groups, no intervention was offered. Participants in the control group were informed that the research team was assessing how they were doing, that is, if their emotions were improving. After the endline data was collected, the control group received their first sessions of the therapy: condensed support in which the research team would have large group psychoeducation on grief, based on the manual used in the intervention.

All the tools were reviewed and sorted, and the data entered. Only data on the participants who had completed the questionnaire and the interventions; and had complete scores for ICG at baseline, midline, and endline was entered into the Statistical Package for the Social Sciences (SPSS), version 25. This was then followed by automatic recording using SPSS to ensure a sequential order.

In the recording, each sub-county was assigned a unique code. The codes ranged from 01-06. Each of the schools was also given a unique code. The experimental schools' codes ranged from 01-06, while those for the control groups ranged from 07-12. Each of the class levels took up its respective number. For example, class four was given code 04. Finally, the respondents were each given a code, for example, 001. Finally, the data were analyzed and summarized in tables. A summary of the data collection procedure is shown in Figure 3.5.

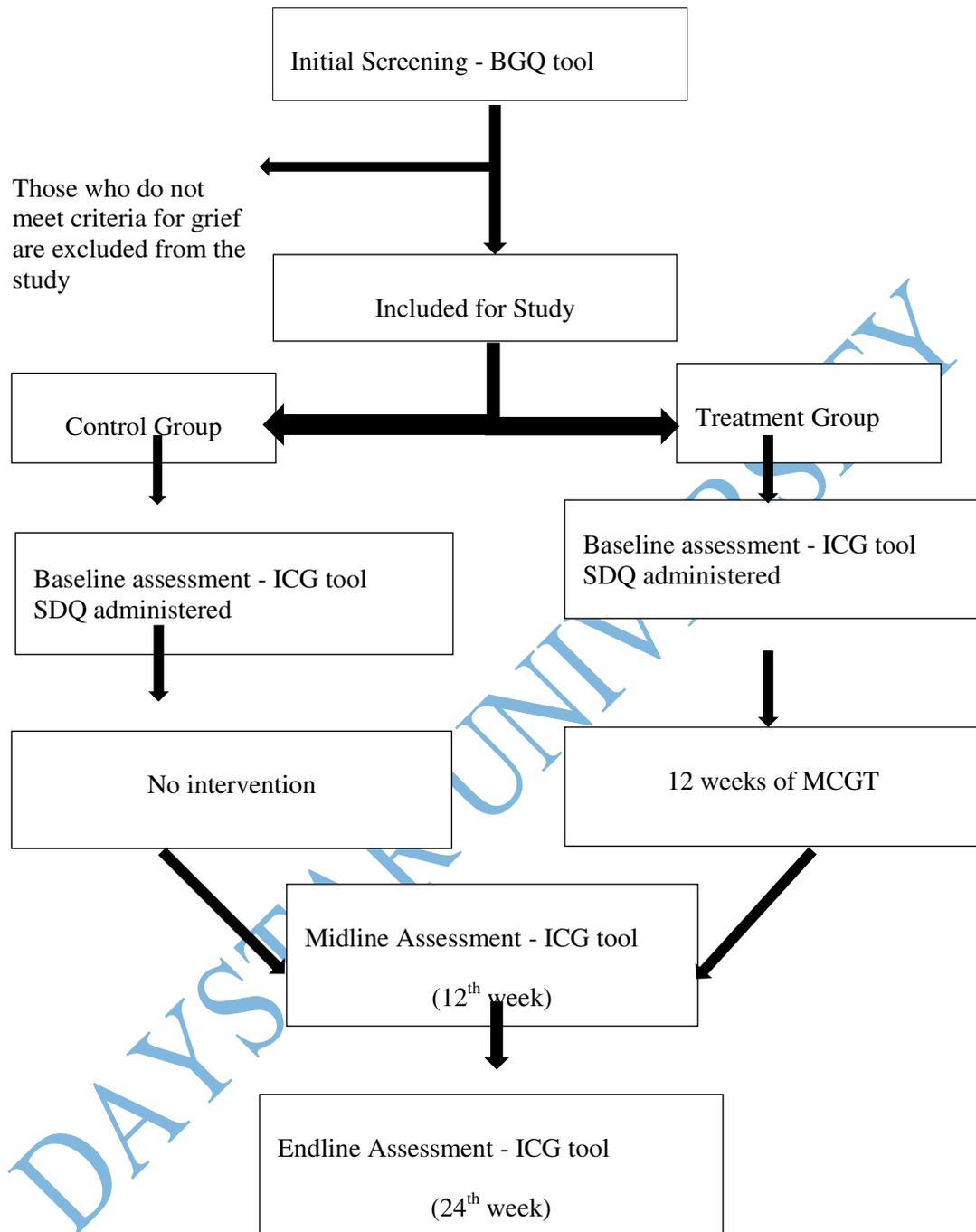


Figure 3.5: Data Collection Procedure

Source: Author (2020)

### 3.11 Pretesting

Pretesting of the data collection tools was done in Rakuom Primary School in Alego Sub-county. The school has similar demographic characteristics with the 12 schools targeted in this study. The SDQ was administered to 27 students (10% of the study sample) to test if they could understand the questions. The 27 students were also subjected to specific sections of the MCGT manual to assess their ability to understand and follow the instructions.

In general, during the administration of the BGQ, ICG, SDQ, and a readout of the instructions in some sections of the manual, participants showed a good understanding of the items in the tools and where it was not clear the researcher gave further description. The BGQ was straightforward and with five items was the easiest tool to administer. The Likert scale (0=not at all; 1=somewhat; 2=a lot), was also clear, and participants confidently gave instructions. The BGQ was considered fit to administer within the study population, hence, nothing was changed.

The ICG tool, on the other hand had two challenges. Because of its length, its administration on one client took longer than was expected. However, since this is a clinically tested, validated, and standardized tool; and the recommended tool in the CGT manual, the researcher did not take out any questions, hence, all the 19 items were administered. Secondly, the use of the terms 'stunned' and 'dazed' in item 8 of the ICG tool could not be understood by many of the participants during the pretest (8. I feel stunned or dazed over what happened). An additional description had to be given to most participants who expressed that they did not understand what it meant. The description was 'a state of shock and confusion and prevents one from doing anything but just remain immobile.'

Also, the understanding of the Likert scale for the ICG tool was not as straightforward as the BGQ. The scales have a score ranging from 0-4 points; 0-never, 1-seldom, 2-sometimes, 3-often, and 4-always. Scale 0 (Never) and scale 1 (sometimes) were easy to understand. There was a bit of confusion between scale 3 (often) and scale 4 (always). The researcher gave more information indicating that 'often' meant 'many times;' while 'always' meant 'all the time' (daily basis).

The researcher developed SDQ was also pretested. Just like for other tools, the goal was to determine if the items in the tool could be clearly understood and that the respondents could understand the questions. Based on the pretest, several things were changed on the SDQ. It was realized that the 75 items in the tool were too many, and as a result, the participants in the pretest got fatigued. To address this, several items that were not directly corresponding with the objectives were taken off the SDQ. For example, the initial tool had a section on physical and sexual abuse that were not adding value to the objectives of this study. The revised SDQ had 53 items and was manageable.

Some questions were difficult to answer correctly, as they were not clear, or had difficult terms, making many of the respondents continually ask for clarification. For example, in the initial questionnaire had an item asking respondents for the month and year of death. It was noted that many did not remember the month but could remember the year. Similarly, it was noted that many of the respondents were not sure of the month or year of their birth, but when asked how old they were they could answer. The question on the year of birth was removed and replaced with age, hence participants would be asked how old they are, and the interviewer would tick

accordingly. The tools validity and reliability were also tested, and the results are shown in chapter four of this document.

### 3.12 Data Management and Analysis Plan

According to Whyte and Tedds (2011), data management in research is the process of controlling and organizing information gathered during research in preparation for analysis. The organization of data starts from its collection to the dissemination of results. In this study, data was managed by the principal researcher with the technical assistance of a data entry clerk and a statistician.

Considering that the ICG and the SDQ were interviewer-administered, fewer errors were recorded regarding uncompleted items. Each member of the research team was in charge of the specific groups assigned to them and helped in confirming that all the questionnaires were filled appropriately, after which, the researcher cleaned the data. Data entry from both the treatment and control groups was done into the SPSS, version 25 by a data entry clerk under the supervision of the researcher.

With the help of a statistician, the data was cleaned, validated, backed up, and stored by the researcher. The manuals and any other printed documents used in the research were also stored safely by the researcher under lock and key. Safekeeping of raw data is essential for reference purposes and avoids any unauthorized access and protection from damage.

According to Kothari (2014), analysis is the working out of the data to determine relationships; while Gelman, Carlin, Stern, & Rubin (2014) defined it as the process of transforming raw data into usable information - by examining the data and making inferences that lead to a conclusion. A combination of descriptive, bivariate, and multivariate analysis was done to draw a conclusion on the data.

Descriptive analysis was carried out on the various variables. Specifically, categorical variables were summarized as frequencies with corresponding percentages, while continuous variables were summarized as means with corresponding standard deviations. This type of univariate analysis helped to respond to objectives one and two. Objective one sought to describe the sociodemographic characteristics of orphans, while objective two sought to document the prevalence of CG among orphaned children in selected public primary schools in Siaya County.

In responding to objective three, bivariate analysis was done to determine the correlation between the variables. For example, Pearson's Chi-Square test determined the effect of specific risk factors and the level of grief. ANOVA tests were applied to assess if the differences in means were statistically significant. The correlation's strengths were determined against a confidence interval of 95%. Finally, to determine the effectiveness of MCGT on CG, inferential analysis, precisely, t-tests were used to test the difference in means between the treatment and control group. The focus was on the change of grief scores at three timelines, that is, baseline, midline, and endline, with the statistical significance being determined at a p-value of 0.05. The effect size was calculated based on Cohen's d. Figure 3.6 shows the data management plan.

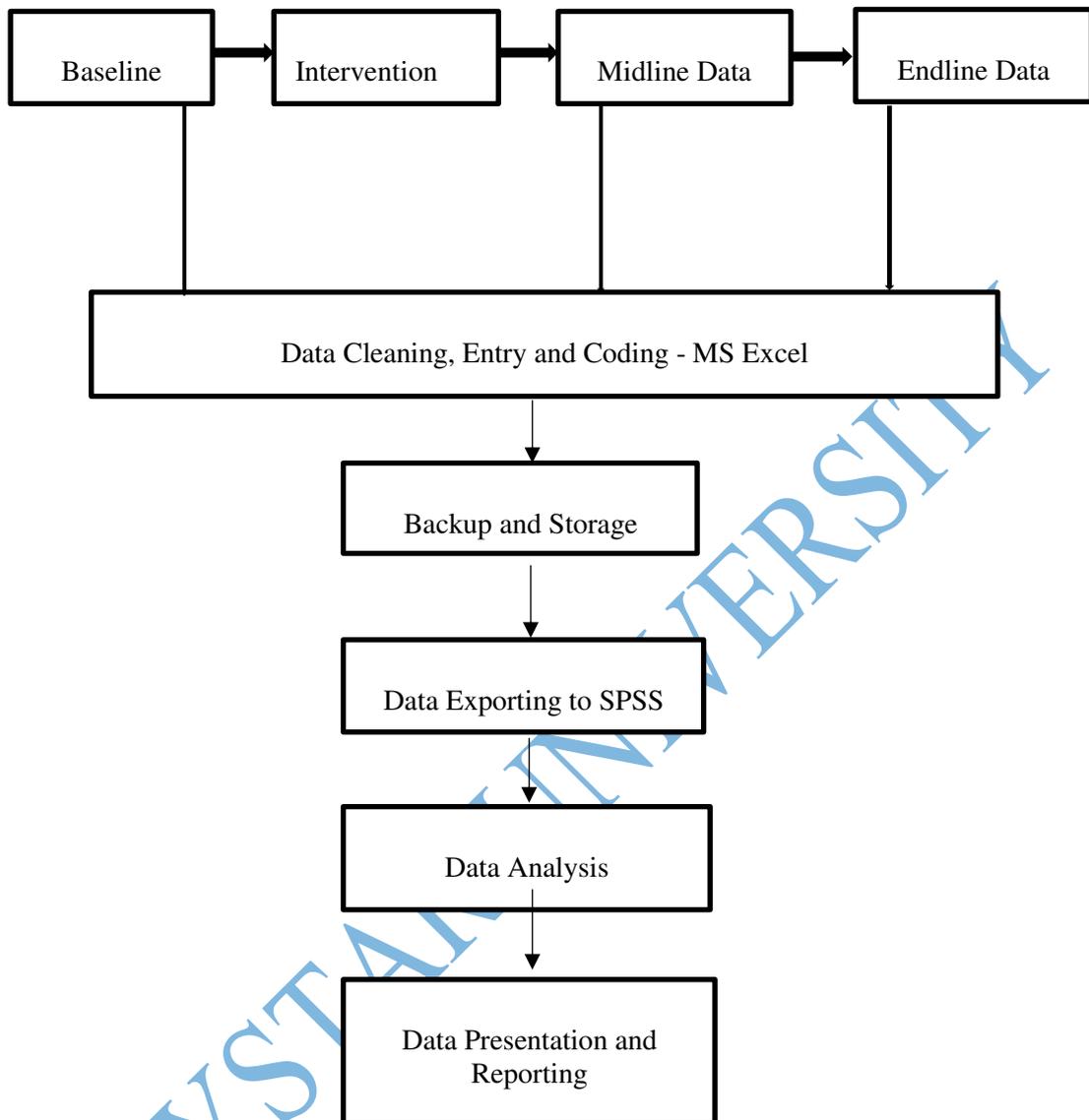


Figure 3.6: Data Management Plan

Source: Author (2020)

### 3.13 Ethical Considerations

Before commencing this study, relevant authorizations and approvals were sought from concerned institutions and individuals. First, approval was sought from the School of Human and Social Sciences, Daystar University. This was followed by application to the DU-ERB to confirm that study had addressed all the necessary ethical concerns. The researcher then submitted the research proposal to NACOSTI, who gave authorization for the study to be conducted in Kenya. Considering that the study sites were primary schools, further approval was sought from the Ministry of Education, Siaya County, who issued a letter to the school heads to allow for the research to be conducted in their schools.

After all the approvals were obtained, the researcher sought direct consent and assent from the schools' administrations, the pupils' caregivers, and the pupils themselves. The consent entailed the researcher seeking the participants' willingness to participate in the study. The headteacher signed the approval document, and the informed consent letters were released to parents through the schools' offices.

In the informed consent, relevant details of the study, which included the study purpose, and its benefits to the psychological wellbeing of the respondents were provided. Similarly, for the informed assent, the minors were given information on the importance of the study. The researcher ensured that the information given was clear and was understood by the intended recipients before they could sign the consent and assent forms.

Since it would have been impossible to track down individual caregivers who were living with the orphans, the school headteachers assisted by informing the parents about the research, including the benefits the study would have on the

participants. Further, verbal approval was sought from the teachers, though they were not necessarily required to sign any document. This approval from teachers was critical to the smooth operation of the research process. Before the approval was sought, a general talk/psychoeducation was done to help the teachers understand the benefits of the study in order to enhance cooperation between them and the research assistants.

In seeking consent and assent, the researcher first assured the participants of confidentiality. She also guaranteed the privacy of the information the participants, who were minors, would provide. Assuring confidentiality was important, especially given that this was a school set-up, and participants may have been worried about sharing private information for fear that the information could be used against them. The researcher also explained to the school administration beforehand that the information received from the participants would only be used in the research, hence no private information was to be released to them (administration). The limits of confidentiality also applied such that if there was any confirmation of abuse or life-threatening situation, necessary protocols were adhered to, to guarantee child safety. The researcher explained the details of confidentiality to the participants, as well as their limits.

The result of the study was kept confidential through the use of codes to identify participants. The list of the names with codes remained in the custody of the researcher so that no one else would be able access it.

In recruiting participants for the study, voluntary participation was recommended. The study was done in a school set-up, thus, there was a risk of participants being forced to take part in the study. Before the consent was received,

the headteachers were advised to consider voluntary participation, and that none of the participants was to be coerced to be in the study, should they not be willing to participate. It was hoped that once the participants were aware of the psychological benefits of participating in the study, they would willingly take part. Additionally, the students were assured of their protection from intimidation and also that there would be no repercussions for those who drop out of the study or choose not to participate.

Beyond confidentiality was the consideration for anonymity. This ethical consideration calls for the protection of the identity of the respondent. In this case, no names were used. Based on the list of orphans identified by the class teachers, the researcher went to the field for initial screening. The screening was interviewer based, and the respondents were given unique codes on the screening day. Once the screening results were computed, participants who met the inclusion criteria were coded and another list generated based on the above results. The code given at screening acted as the identifier of the respondent, and therefore, their names were dropped.

There were psychological risks of emotional distress among participants during the administration of the intervention, especially when the respondents were required to revisit the death of their parent and retell the story. Even as seen in the CGT manual, such reactions were anticipated. This allows the bereaved a chance to begin to face the death of their loved one and offer catharsis. Emotionally intensive sessions, such as retelling the death of the parent were followed by restoration exercises. Restoration sessions focused on restoration and balancing of the participant's emotions to minimize mental distress. Such exercises included muscle

relaxations and activities and games that research assistants had been trained to use at the end of emotionally intensive sessions. No case was found that required referral.

The participants were made aware beforehand that there would be no monetary benefits either to themselves or to their schools as compensation for their participation in the study. In terms of benefits, all participants and the school administration were informed of the psychosocial benefits of the study, which was treatment of CG for improvement of the participants' psychological wellbeing.

Direct benefits were identified as participants receiving relief from the CG, meaning that they would have improved on their sociocognitive functioning. They would then be able to continue with their lives by rebuilding new relationships and focusing on their life goals. The headteachers of the schools forming the control group were informed that their schools would receive treatment after the completion of the study. Considering that the control group did not receive any intervention during the period of study, the researcher offered debriefing sessions and psychoeducation to the group after the endline data had been collected. The sessions began soon after the endline data was collected and lasted for five weeks. Debriefing was also done on the experimental group. This gave the researcher the opportunity to talk to the participants after the study, thus being able to get a feeling of what the latter obtained from the study, and consequently correct any misconceptions.

Another benefit of engaging in this study was that while the participants resolved their grief, the sessions on rebuilding relationships and thoughts and memories would also lead to increased coping skills and thoughts' management. By engaging in this study, there was expected increased awareness of mental health in general, especially within the school administration. To ensure the sustainability of

the grief management program, the teachers attended a brief presentation by the researcher where they learned a few facts on grief, symptoms of CG, and its effects on the wellbeing of the child. These psychoeducation sessions lasted two hours and were facilitated by the researcher.

Reporting of the research results is a key ethical consideration, and as such, the findings from the research were presented accurately with no fabrication. The researcher took full responsibility for the results and undertook reasonable steps and measures to correct any significant errors during entry, analysis, and report of the results.

The findings released did not disclose the identity of the participants. Rather, the general state of the situation was given more importance than the need to know the participants. Besides, the researcher purposed to disseminate the study findings through publications and conference presentations. Finally, all measures were taken to eliminate plagiarism, and all works cited in the final document and publications were duly accredited.

#### 3.14 Summary

The chapter has focused on the research methodology adopted in the study. The research design has also been described. Other areas that have been addressed include the techniques applied in sampling; the size of the study sample; the process of data collection, including the instruments and procedures applied; the method used for pretesting; and the process that was applied in analyzing the data. The last section of the chapter has focused on the ethical aspects that the study put into consideration. The focus of the subsequent chapter is on the presentation, analysis, and interpretation of the collected data.

DAYSTAR UNIVERSITY

## CHAPTER FOUR: DATA PRESENTATION, ANALYSIS, AND INTERPRETATION

### 4.1 Introduction

This chapter's focus was on the presentation of the collected data, its analysis, and interpretation. This process was done in light of the study objectives. The gathered data were analyzed using SPSS, version 25.

### 4.2 Analysis and Interpretation

#### 4.2.1 Response rate

Using the BGQ screening tool, a total of 426 orphaned children were screened for participation in the study. The screening tool was considered valid if the respondent had answered all the five questions. Based on this, 397 responses were valid, giving a response rate of 93%. Out of the 397 valid responses, 263 participants had elevated grief scores: an indication of CG. Further, out of the 263 who met criteria at screening, only 259 were present in the school at baseline assessment.

The participants were then grouped into control and experimental groups based on the sub-counties. Three sub-counties formed the experimental group, while the other three formed the control group. Based on this grouping, the experimental group had 128 participants while the control had 131. The experimental group (N=128) was enrolled for the 12-week MCGT intervention. while the control group (n=131) was not given any intervention. At the end of the intervention, and at endline assessment, only 241 participants were still in the study (experimental group n=123; control group n=118). The attrition rate in the study was 8.3%. The reduction in the number of participants in both groups was mainly due to absenteeism on the day of

subsequent clinical assessments (midline and endline), and some participants transferring to other schools.

#### 4.2.2 Validity and reliability of data collection tools

##### Brief grief questionnaire (BGQ) validity and reliability test

The validity of the BGQ was evaluated by computing the bi-variate correlation between the individual questions that make up the BGQ score.

*Table 4.1: Validity of the BGQ*

		BGQ 1	BGQ 2	BGQ 3	BGQ 4	BGQ 5	BGQ score
BGQ I	Pearson Correlation	1	-0.096	0.059	-0.142*	-0.024	0.342**
	Sig. (2-tailed)		0.137	0.362	0.028	0.715	0.000
	N	241	241	241	241	241	241
BGQ II	Pearson Correlation	-0.096	1	-0.060	0.040	-0.025	0.382**
	Sig. (2-tailed)	0.137		0.357	0.534	0.695	0.000
	N	241	241	241	241	241	241
BGQ III	Pearson Correlation	0.059	-0.060	1	-0.088	-0.070	0.339**
	Sig. (2-tailed)	0.362	0.357		0.174	0.279	0.000
	N	241	241	241	241	241	241
BGQ IV	Pearson Correlation	-0.142*	0.040	-0.088	1	0.001	0.394**
	Sig. (2-tailed)	0.028	0.534	0.174		0.987	0.000
	N	241	241	241	241	241	241
BGQ V	Pearson Correlation	-0.024	-0.025	-0.070	0.001	1	0.565**
	Sig. (2-tailed)	0.715	0.695	0.279	0.987		0.000
	N	241	241	241	241	241	241
BGQ score	Pearson Correlation	0.342**	0.382**	0.339**	0.394**	0.565**	1
	Sig. (2-tailed)	0.000	0.000	0.000	0.000	0.000	
	N	241	241	241	241	241	241

\*. Correlation is significant at the 0.05 level (2-tailed).

\*\*. Correlation is significant at the 0.01 level (2-tailed).

As observed in Table 4.1, the significance value in (p-value<0.05) means that all the questions in the tool were considered valid.

To test the reliability of the BGQ tool, a reliability test was executed based on the questions that make up the BGQ tool. The result is shown in Table 4.2.

*Table 4.2: Reliability Statistics for the BGQ Tool*

Reliability Statistics for the ICG tool		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
0.546	0.420	6

The BGQ reliability statistics shown in Table 4.2 demonstrate a Cronbach's Alpha value of 0.546, thus indicating that the tool was reliable.

Inventory for complicated grief (ICG) - validity and reliability tests

To determine the reliability of the ICG tool, a bivariate correlation of the 19 items within the ICG tool was done, and the outcome was as presented in Table 4.3.

*Table 4.3: Reliability of the ICG Tool*

Reliability Statistics for the ICG tool		
Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
0.695	0.743	20

As shown in Table 4.3, results for the reliability analysis of the ICG tool at the baseline stage resulted in a Cronbach's Alpha value of 0.695, indicating high reliability of the tool in estimating the ICG scores.

The validity of the ICG items was found to be statistically significant, with a value that is less than 0.05 (p-value <0.05). Therefore, the correlation of each of the 19 questions was found to be statistically significant, hence the tool was valid in capturing the ICG scores.

Correlation between BGQ grief scores at screening and ICG grief scores at baseline.

Participants were initially screened at baseline using the BGQ. Also, ICG was used to assess clinical scores at baseline. A comparison of the scores was then done to determine the prevalence of grief among 10-15-year old's by performing a binomial test based on the ICG scores. In order to execute the binomial test, the ICG scores at baseline were first categorized into two classes, with the category of respondents showing the incidence of CG being those who scored 25 and above in the ICG test (ICG $\geq$ 25). This is captured in Table 4.4.

*Table 4.4: ICG Grief Scores at Baseline*

Category	N	Observed Proportion	Test Proportion	p-value
ICG $\geq$ 25	201	0.83	0.50	<0.001
ICG<25	40	0.17		
Total (N)	241	1.00		

According to the data captured in Table 4.4, 0.83(83%) of the participants who scored positive for BGQ also scored positive in ICG (ICG $\geq$ 25), while 17% of those who scored positive for BGQ scored negative in ICG (ICG<25). These scores show that a majority of those who scored positive on BGQ also scored positive of ICG.

A Pearson's correlation coefficient was calculated between BGQ and ICG scores at baseline stage, and the outcome was as depicted in Table 4.5.

*Table 4.5: Correlations between BGQ and ICG*

		BGQ score	ICG total score at baseline
	Pearson Correlation	1	0.188**
BGQ score	p-values		0.003
	N	241	241

A correlation-coefficient of  $r=0.188$ , ( $p=0.003$ ) was determined (see Table 4.5). This demonstrated a weak positive linear correlation between the BGQ tool and the ICG tool, implying that while the BGQ tool can give a general indication of CG at

screening, it may not give a final estimation of the clinical level of the CG. Consequently, BGQ is not applicable in assessing change in clinical grief symptoms over time.

#### 4.2.3 Sociodemographic of orphaned children in selected primary schools

##### Distribution by age and gender

The results on the distribution of participants by age and gender are presented in Table 4.6.

*Table 4.6: Age and Gender of Respondents*

		Count (N)	Percent
Age	10-11(preteen)	95	39.4%
	12-13(early teen)	85	35.2%
	14-15(mid teen)	61	25.3%
Gender	Male	123	51%
	Female	118	49%

The results captured in Table 4.6 show that the participants in the 10-11 years (preteen) category were the majority at 39.4% (n=95), followed by those aged 12-13 years old (early teen) at 35.2% (n=85), and finally, those aged 14-15 years (mid-teen) at 25.3% (n=61). In terms of gender distribution, males were 51% (n=123), and females were 49% (n=118). These results demonstrate that there were slightly more males than females though the difference was minimal. Results on other key demographics were as summarized in Table 4.7.

*Table 4.7: Key Demographic Characteristics*

		Count (N)	Percent
Subcounty	Ugunja	57	23.7%
	Alego	39	16.2%
	Gem	27	11.2%
	Ugenya	53	22.0%
	Rarieda	31	19.9%
	Bondo	34	14.1%
Which parent did you lose through death?	Both parents	47	19.4%
	Mother	58	24.1%
	Father	136	56.5%
Did you attend the burial of your Parent?	No	24	10%
	Yes	217	90%
Whom are you currently living with	Mother	90	37.4%
	Father	28	11.6%
	Relative	108	44.8%
	Children's home	5	2.1%
	Guardian (not relative)	9	3.7%
	Other	1	0.4%
If you are living with a family /relative, what is the relationship between you and your caregiver?	Aunty/Uncle	26	27.1%
	Grandparent	79	65.5%
	Older sibling	9	7.4%
How did your parent die?	Sickness	179	74.2%
	Accident/Sudden	33	13.6%
	I don't know	29	12.2%
Were you with your parent when he/she died?	No	141	58.7%
	Yes	99	41.3%
If your parent was sick, did you take care of your parents when they were sick?	No	108	46.8%
	Yes	123	53.2%
Apart from your parent, have you ever lost another loved one?	No	59	24.4%
	Yes	182	75.6%
If YES above which other loved one did you lose?	Sibling	89	48.9%
	Friend	4	2.1%
	Other close relative	88	48.3%

As demonstrated in Table 4.7, the highest number of participants were from Ugunja and Ugenya sub-counties at 23.7% (n=57) and 22% (n=53) respectively;

while the lowest number were from Alego and Gem sub-counties at 16.2 % (n=39) and 11.2% (n=27) respectively.

On parental death, the results show that in total, 56.5% (n=136) of the participants had lost only a father, 24.1% (n=58) had lost only a mother, while 19.5% (n=47) had lost both parents. These results point out that over half of the participants were paternal orphans. Also, the majority 90% (n=217) had attended their parent's burial giving an indication that children are not shielded or kept away from burial ceremonies.

Regarding the participants' living situation after the death of a parent, the results display that 44.8% (n=108) were living with a relative, and 2.1% (n=5) were living in a children's home. This implies that the majority of the participants were being taken care of by relatives as opposed to institutionalization.

For the participants who live with their relatives (other than their surviving parent), the nature of the relationship with this relative was also assessed. It was also observed that for the majority of the participants who were living with relatives, the relative was a grandparent 65.5% (n=79), and for 7.4% (n=9), the relatives were older siblings. These results conveyed that grandparents took over the burden of caregiving for orphaned children following parental death.

The results about the nature or cause of parent's death indicate that those who cited sickness at 74.2% (n=179) were the majority, whereas 13.6% (n=33) cited accidents. Others - at 12.2% (n=29) did not know the cause of their parent's death. These results are indicative that the major cause of parental death was sickness. Out of those who revealed that their parent/s had died out of sickness, over half of them,

53.2% (n=123), mentioned that they had taken care of their sick parents before the latter's death.

These results suggest that most of the participants were taking up caregiving roles of sick parents. This can be explained by the fact that due to poverty; the majority of the sick parents cannot afford caregiving services and cannot afford to be in hospitals. As a result, they are taken care of by family members and their children watch them suffer, even in some cases the children take care of their ailing parents.

In addition, most of the participants, 58.7% (n=141), stated that they were home with their parents at the time the parents died. As per these results, the majority of the participants' parents had died at home and the participants were present at the time of death. As explained above, this could be related to the inability to afford hospital care.

The study also enquired from the respondents whether they had lost any other close relatives apart from their parents, and the majority of them, 75.6% (n=182), revealed that they had lost other close relatives. Out of those who indicated that they had lost a loved one, a higher number, 48.9% (n=89), stated that they had lost a sibling; followed by 48.3% (n=88) who had lost a close relative such as aunty/uncle/grandparents; while only 2.1% (n=4) indicated they had lost a friend. This denotes that the majority of the participants had experienced multiple losses.

#### 4.2.5 Prevalence of CG among orphaned children in Siaya County

The prevalence of grief was calculated at the screening by use of the BGQ, which is a five-item validated grief screening tool. A score of 5 or greater on the BGQ indicated the presence of CG. The participants were clustered into groups 0= for those who scored less than 5, meaning they had none to minimal grief symptoms; and 1=for

those who scored 5 and above, implying that they had elevated symptoms of grief.

The BGQ screening results are displayed in Table 4.8.

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*Table 4.8: BGQ Screening Results*

		Frequency	Percent
Valid		1	.3
	none/minimal grief	134	33.7
	Elevated grief symptoms	263	66.1
	Total	397	100.0

As seen in Table 4.8, out of the 397 valid screens, 134 participants (34%) scored less than 5 points out of a possible 10 points in the BGQ. The implication of this result is that the 134 participants showed low grief symptoms; hence, did not meet the requirement for inclusion in the study. On the other hand, 263 participants (66%) scored 5 points and above, indicating that they had significantly elevated grief symptoms that warranted further assessment and intervention.

To test whether the prevalence was statistically significant, a binomial test with a test proportion of 0.35 was used. The 0.35 test proportion was based on existing literature that the prevalence of CG among orphaned children was 35% and increases to 78% in cases of prolonged illnesses and traumatic/sudden deaths (Enez, 2018). Table 4.9 provides the binomial test outcome.

*Table 4.9: Binomial Test- Prevalence of Elevated Grief at Screening*

		Category	N	Observed Prop.	Test Prop.	Exact Sig. (1-tailed)
BGQ screening	Group 1	Elevated Grief	264	0.66	0.35	0.000
	Group 2	No grief	134	0.34		
	Total			397	1.00	

The results presented in Table 4.9 reveal that the prevalence of elevated grief was 0.66 (66%) in the observed data. This was greater than the expected proportion of 0.35 ( $p=0.000$ ). The high prevalence could have been because the participants in this study are high-risk populations, considering that the death of a parent is regarded as the most traumatic event to a child.

Another possible explanation is that most of these participants had lost their parent/s through sickness, which again is believed to be a high-risk factor for CG among the bereaved. Considering that Siaya County was among the top-ranked counties in relation to the prevalence of HIV and HIV deaths (NACC, 2016), there is a possibility that most of the deaths resulted from HIV and AIDs, indicating that the participants experienced the suffering of their parents before the parents died: an experience that would further predispose them to CG.

#### Prevalence of CG by age

Descriptive statistics were applied in determining the prevalence of CG by age. The results are displayed in Table 4.10.

*Table 4.10: Prevalence of CG by Age*

		Age Grouping			Total
		10-11 (preteen)	12-13 (early teen)	14-15 (mid teen)	
BGQ Screening Results	none/minimal grief	N 37	74	23	134
	% within	27.6%	55.2%	17.2%	100.0%
	Elevated grief	N 105	91	67	263
	% within	39.9%	34.6%	25.5%	100.0%
Total		N 135	165	91	397

As seen in Table 4.10, of the 263 participants who showed minimal or no grief symptoms: 39% were aged 10-11 years (preteens), followed by those aged 12-13 years at 35%. It was also revealed that 26% of the participants with elevated grief scores were aged 14-15 years. These results demonstrate that the majority of the participants with elevated grief scores were younger children as compared to older teens.

This outcome (seen in Table 4.10) could be explained by the fact that the younger the child, the more the need for an attachment figure. Hence, losing an attachment figure, in this case the parent, is likely to disorient the younger participants more compared to the older ones who may already be gaining some level of individuation and independence.

#### Prevalence of CG by gender

The CG prevalence by gender was also assessed, and the finding was as seen captured in Table 4.11.

*Table 4.11: Prevalence of CG by Gender*

			Male	Gender Female	Total
BGQ		N	78	56	134
Screening	none/minimal grief	% within	58.2%	41.8%	100.0%
Results		N	133	130	263
	Elevated grief	% within	50.6%	49.4%	100.0%
Total		N	212	186	397

From the screening results portrayed in Table 4.11, the gender composition for the respondents who scored less than 5 points (none/minimal grief) was males at 58.2% (n=78), and females at 41.8% (n=56). For those who had elevated grief scores, the gender distribution comprised 50.6% (n=133) - males, and 49.4% (n=130) - females.

#### 4.2.6 Risk factors for CG among Orphaned Children in Siaya County

In determining if there was any significant association between elevated grief and specific risk factors, univariate analysis was done to describe the means against the risk factors, followed by a linear regression analysis to test the specific relationship. For some variables, a one-way analysis of variance (ANOVA) test was done to determine if the differences in means were statistically significant.

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### Association between number of siblings and CG

In terms of number of siblings, the participants were to indicate how many siblings they had as follows: one, two, three, or four and above. Table 4.12 gives the results of mean grief scores by the number of siblings.

*Table 4.12: Descriptive Statistics on Grief Mean Scores by Number of Siblings*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
One	30	34.10	6.01	1.09	31.85	36.34	19.00	44.00
Two	42	32.31	7.53	1.16	29.96	34.66	17.00	57.00
Three	48	30.79	8.94	1.29	28.19	33.39	11.00	48.00
Four and above	121	31.97	8.42	.765	30.46	33.49	10.00	55.00
Total	241	32.06	8.12	.523	31.03	33.09	10.00	57.00

The results (as captured in Table 4.12) show that about half of the participants, that is, 50.2% (n=121), had four or more siblings. Participants who mentioned that they had one sibling showed higher grief scores with a mean of 34.10 (SD=6.01), while those with three siblings had relatively lower grief scores at 30.79 (SD=8.94). These scores could be suggestive that having siblings may be a source of comfort for the bereaved child, and thus reduce the risk of developing CG. To test the correlation between number of siblings and CG, a linear regression test was done, and the results were as presented in Table 4.13.

*Table 4.13: Correlation between Number of Siblings and CG*

Correlations		ICG total score at baseline	Number of siblings
Pearson	ICG total score at baseline	1.000	-.068
Correlation	Number of siblings	-.068	1.000
Sig. (1-tailed)	ICG total score at baseline		.047
	Number of siblings	.047	
N	ICG total score at baseline	241	241
	Number of siblings	241	241

The linear regression test results (see Table 4.13) show that there was a weak negative correlation between the number of siblings and CG: this was statistically significant ( $r=-0.068$ ,  $p=0.047$ ). These results are indicative of a likelihood that having other siblings sharing the grief following the death of a parent may lead to some comfort, hence reducing the chances of having elevated grief scores.

#### Association between sibling separation and CG

Participants were asked to indicate if they were still living with their siblings after the parents died. Table 4.14 outlines the results.

*Table 4.14: Mean Grief and by Sibling Separation (Descriptive Statistics)*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
No	88	32.44	8.85	0.94	30.56	34.31	10	57
Yes	153	31.84	7.69	0.62	30.61	33.07	13	51
Total	241	32.06	8.12	0.52	31.03	33.09	10	57

According to the results captured in Table 4.14, 63.4% ( $n=153$ ) of the participants were living with their siblings. Participants who were not living with their siblings had higher grief scores 32.44 ( $SD=8.85$ ). Loss and grief happen in death and in separation. High grief levels among participants who said they were not living together with their siblings may be attributed to the child's interpretation of the situation as a double loss. The child may also be worried and longing to be with his or

her siblings, and this may further complicate the healing processes - resulting in high levels of grief.

To determine if there was any association between the number of siblings and CG, a linear regression was computed. The results are presented in Table 4.15.

*Table 4.15: Correlation between Living with Siblings and CG*

Correlations		ICG total score at baseline	Do you currently live with any of your brothers or sisters?
	Pearson Correlation	1	-.036
	Sig. (2-tailed)		.038
ICG total score at baseline	Sum of Squares and Cross-products	15832.066	-33.523
	Covariance	65.967	-.140
	N	241	241
Do you currently live with any of your brothers or sisters?	Pearson Correlation	-.036	1
	Sig. (2-tailed)	.038	
	Sum of Squares and Cross-products	-33.523	55.867
	Covariance	-.140	.233
	N	241	241

A linear regression analysis was done to determine if there was any significant relationship between sibling separation following parental death and the level of grief scores. As demonstrated in Table 4.15, there was a weak negative correlation between sibling separation and CG, and the relationship was statistically significant ( $r=-0.036$ ,  $p=0.038$ ).

Association between perceived level of closeness with deceased mother and CG

Respondents were asked to rate their level of closeness/close relationship with their deceased mother at three levels: not close, a bit close, and not close at all. The

descriptive statistics of mean ICG scores by participants' perception of the level of closeness with the deceased mother are displayed in Table 4.16.

*Table 4.16: Perceived Closeness with Deceased Mother and CG*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Not close at all	30	29.40	9.59	1.75	25.82	32.98	10.00	47.00
A bit close	23	32.49	6.76	1.41	29.55	35.40	18.00	44.00
Very close	54	34.20	7.99	1.09	32.02	36.39	13.00	57.00
Total	107	32.49	8.42	.81354	30.87	34.09	10.00	57.00

Out of the total respondents who had lost their mother, those who were very close to their deceased mothers (n=107) demonstrated high grief scores, 32.49 (SD=6.76); as compared to those who were not close at all to their mother, whose score was 29.40 (SD=9.59). In general, mothers are the primary caregivers to children right from birth. In most cases, the mother is also the first attachment figure that the child starts to relate with after birth. As such, children who have lost their mothers would have more grief. The higher the level of closeness to a loved one, the more intense the grieving process is likely to be. A Pearson correlation was done to determine the statistical significance of the difference in means. The outcome was as shown in Table 4.17.

*Table 4.17: Perceived Level of Closeness with Deceased Mother and CG (Correlation)*

Correlations		ICG total score at baseline	How close were you with your mother? (if mother is dead)
Pearson Correlation	ICG total score at baseline	1.000	.241
	How close were you with your mother? (if mother is dead)	.241	1.000
Sig. (1-tailed)	ICG total score at baseline	.	.006
	How close were you with your mother? (if mother is dead)	.006	.
N	ICG total score at baseline	107	107

How close were you with your mother? (if mother is dead)	107	107
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As per the results (Table 4.17), a moderate positive correlation between the level of closeness with the deceased mother and the level of grief was established: this relationship was statistically significant ( $r=0.241$ ,  $p=0.006$ ). This reveals a potential link between very close relationship to the deceased mother and relatively high mean ICG scores. The factors: age, gender, and perceived level of closeness with deceased father, cause of death, and cultural factors did not show any significant influence on levels of CG.

#### Association between age and CG

Via descriptive statistics, the mean grief scores for the different age groups were described. Table 4.18 shows the outcome.

*Table 4.18: Grief Mean Scores by Age Category (Descriptive Statistics)*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
10-11(preteen)	95	32.34	10.04	1.03	30.29	34.38	10.00	57.00
12-13(early teen)	85	32.19	6.54	.709	30.78	33.59	16.00	51.00
14-15(mid teen)	61	31.46	6.76	.865	29.73	33.18	11.00	46.00
Total	241	32.06	8.12	.523	31.03	33.09	10.00	57.00

As seen in Table 4.18, the mean grief score for all the respondents was 32.06. In the comparison of means, the younger age groups, that is 10-11 years (preteens) showed slightly higher CG scores 32.34 (SD=10.04), while the eldest respondents, that is, those in the age group of 14-15 years had the least grief scores with a mean of 31.46 (SD=6.76).

The correlation between age and CG at baseline was as depicted in Table 4.19.

*Table 4.19: Correlation between Age and CG at Baseline*

Correlations
--------------

		ICG total score at baseline		Age Group
Pearson Correlation	ICG total score at baseline	1.000		-.041
	Age Group	-.041		1.000
Sig. (1-tailed)	ICG total score at baseline	.		.265
	Age Group	.265		.
N	ICG total score at baseline	241		241
	Age Group	241		241

Although there was a slight difference in grief scores among the age groups, the results from the linear regression (Table 4.19) did not evidence a significant difference in means ( $p=0.265$ ). The implication here is that even though the younger participants showed higher grief means compared to the older ones, no linear relationship was established between the age of the participant and CG, an indication that age alone cannot be associated with the development of grief. The results could also be attributed to the fact that the participants were more or less within the same age group, hence there may be little differences in their experiences when it comes to experiencing CG.

#### Association between gender and CG

The scores presented in Table 4.20 show the descriptive statistics of mean ICG scores by gender for all the participants.

*Table 4.20: Descriptive Statistics for Mean Grief Scores by Gender*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Male	118	31.51	8.12	.75	30.03	32.99	13.00	48.00
Female	123	32.59	8.12	.73	31.14	34.04	10.00	57.00
Total	241	32.06	8.12	.52	31.03	33.09	10.00	57.00

There was minimal difference in the mean grief scores for males, and female participants, with the male participants' mean grief scores of 31.51 (SD=8.12) and females recording grief mean scores of 32.59 (SD=8.12) (see Table 4.20).

A Chi-Square test was done to test for association between gender and CG.

The results are presented in Table 4.21.

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*Table 4.21: Association between Gender and CG (Chi-Square Test)*

	Value	df	Asymp. Sig. (2-Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	1.399 <sup>a</sup>	1	0.237	
Continuity Correction <sup>b</sup>	1.019	1	0.313	
Likelihood Ratio	1.402	1	0.236	
Fisher's Exact Test			0.299	0.156
Linear-by-Linear Association	1.393	1	0.238	
N of Valid Cases	241			

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 19.59.

b. Computed only for a 2x2 table

As depicted in Table 4.21, Chi-square test for association between gender and incidence of CG showed that there was no significant association between gender and grief among the participants,  $0.05, \chi^2 (1, N=241)=1.399, P=0.237$ . This implies that CG was not dependent on whether an orphan was male or female, leading to the inference that gender by itself was not a distinct determinant in the development of grief.

#### Association between perceived level of closeness with deceased father and CG

Respondents were asked to rate their level of relationship with the deceased father in three levels: not close, a bit close, and not close at all. The descriptive statistics of grief mean scores in the level of closeness the participant had with their deceased father were as portrayed in Table 4.22.

*Table 4.22: Perceived Closeness with Deceased Father and CG*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Not close at all	72	31.69	9.12	1.07	29.55	33.83	10.00	47.00
A bit close	27	30.29	8.40	1.61	26.97	33.62	16.00	46.00
Very close	84	32.62	7.01	.765	31.09	34.14	13.00	55.00
Total	183	31.91	8.09	.59	30.73	33.09	10.00	55.00

The scores presented in Table 4.22 reveal relatively high grief scores for the respondents who stated that they very were close to their deceased fathers at 32.62 (SD=7.01), in comparison to those who indicated ‘just a bit close’ relationship at 30.29 (SD=8.40).

A Pierson’s correlation test was done to test for relationship between perceived level of closeness with deceased father and CG. The result is displayed in Table 4.23.

*Table 4.23: Perceived Level of Closeness with Deceased Father and CG (Correlation)*

Correlations		ICG total score at baseline	How close were you with your father?)if father is dead)
Pearson Correlation	ICG total score at baseline	1.000	.055
	How close were you with your father?) if father is dead)	.055	1.000
Sig. (1-tailed)	ICG total score at baseline	.	.229
	How close were you with your father?) if father is dead)	.229	.
N	ICG total score at baseline	183	183
	How close were you with your father?) if father is dead)	183	183

As shown in Table 4.23, there was no statistically significant correlation between the level of closeness with the deceased father and CG (r=0.055, p=0.229), implying that the level of closeness with the deceased father had no relationship with CG. The explanation here could be that unlike mothers who are the first point of attachment for children, many of the fathers may not be taking as much caregiving responsibilities as the mothers. In general, the bereaved child still experienced high grief levels, but these levels were not associated with the level of closeness to deceased father.

Association between the cause of death and CG

The cause of death was computed to assess if there was any difference in grief mean scores among the respondents. The feedback is presented in Table 4.24.

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*Table 4.24: Descriptive Statistics of ICG Score by the Nature of the Death*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Sickness	179	31.75	8.15	.61	30.55	32.95	10.00	57.00
Accident	33	34.61	9.38	1.63	31.28	37.93	11.00	55.00
I dont know	29	31.10	5.79	1.08	28.90	33.31	15.00	40.00
Total	241	32.06	8.12	.52	31.03	33.09	10.00	57.00

The descriptive statistics results show that sickness was the main cause of death. As seen in Table 4.24, respondents whose parents had died through an accident had slightly elevated mean grief scores of 34.61 (SD=9.38), compared to the mean of 31.74 (SD=8.15) for those whose parents had died from sickness.

Table 4.25 gives the ANOVA results for the association between the nature of death and CG.

*Table 4.25: Nature of Death and CG (Tests of Between-Subjects Association)*

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	257.811 <sup>a</sup>	2	128.905	1.970	.142	.016
Intercept	134968.911	1	134968.911	2062.545	.000	.897
b14_cause_of_death	257.811	2	128.905	1.970	.142	.016
Error	15574.256	238	65.438			
Total	263577.000	241				
Corrected Total	15832.066	240				

a. R Squared = .016 (Adjusted R Squared = .008)

As seen in Table 4.25, the ANOVA results demonstrate that these differences in mean were not statistically significant  $F(2, 238) = 1.970, p = 0.142$ .

Association between the availability of school-based guidance and counseling and CG

To assess the availability of school-based support/counseling for grief, respondents were asked whether they had received any counseling when they resumed school after the burial of their parents. The results are presented in Table 4.26.

*Table 4.26: Availability of Guidance and Counselling in School and Mean Grief Scores*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
No	200	32.05	8.14	.58	30.91	33.18	10.00	57.00
Yes	41	32.15	8.12	1.27	29.58	34.70	17.00	51.00
Total	241	32.06	8.12	.523	31.03	33.09	10.00	57.00

Only 17% of the respondents (n=41) indicated that they had received school-based guidance and counseling after the death of their parents. The CG scores for those who reported having received counseling in school seemed to be marginally higher (M=32.15; SD=8.14), than for those who did not receive any counseling at school (M=32.05; SD=8.14) (see Table 4.26). These results put to question the quality of counseling given to orphaned children with a possibility that because it is not skilled grief counseling, it could worsen the situation and consequently increase the risk for developing CG.

*Table 4.27: Availability of Counseling in School and Mean Grief Scores (Correlation)*  
Correlations

		ICG total score at baseline	Did you receive any guidance and counseling in school when you returned back to school after the burial?
Pearson Correlation	ICG total score at baseline	1.000	.005
	Did you receive any guidance and counseling in school when you returned back to school after the burial?	.005	1.000
Sig. (1-tailed)	ICG total score at baseline	.	.471
	Did you receive any guidance and counseling in school when you returned back to school after the burial?	.471	.
N	ICG total score at baseline	241	241
	Did you receive any guidance and counseling in school when you returned back to school after the burial?	241	241

As seen in Table 4.27, the correlation tests reveal that there was no significant correlation between the availability of counseling in school and CG ( $r=0.05$   $p=0.427$ ). These results bring to question the nature of counseling given in school. With many schools not having trained counselors, there is a possibility that the unprofessional counseling offered in schools could explain the lack of difference between those who receive counselling in school and those and those who do not.

#### Association between cultural death/burial rituals and CG

Specific items on SDQ inquired on the cultural burial rites associated with the Luo culture such as viewing of the body, the coffin with body placed in the house on the eve of the burial, wailing and screaming, eating and celebrations, dancing, and sharing of deceased personal belongings after the burial. Table 4.28 captures the results relating to the association between the Luo cultural burial rites and CG.

*Table 4.28: Frequencies of Luo Cultural Burial Practices Experienced by Participants*

		N	% of Total N
Did you view the body in the coffin?	No	62	25.7%
	Yes	179	74.3%
Did screams/wails and cries bother you?	No	54	22.7%
	Yes	184	77.3%
Did many people in your home, cooking and eating bother you?	No	211	88.7%
	Yes	27	11.3%
Did the night dancing/music bother you?	No	205	86.1%
	Yes	33	13.9%
Did having the body in the house bother you?	No	127	53.4%
	Yes	111	46.6%
Did viewing the body bother you?	No	139	58.4%
	Yes	99	41.6%
After the burial, did night dancing bother you?	No	184	77.0%
	Yes	55	23.0%

After the burial, did the empty compound bother you?	No	123	51.9%
	Yes	114	48.1%
Did relatives coming to share your parents' belongings bother you?	No	177	74.7%
	Yes	60	25.3%

The participants to a large extent, experienced several cultural practices associated with Luo burial ceremonies. According to the results, 53.4% (n=127) of the participants were not bothered by the fact that the body was in the house overnight on the eve of the burial, while 46.6% (n=111) indicated that this bothered them. A majority of the participants 74.3% (n=179), viewed the body of the deceased parent in the coffin, while 25.7% (n=62) did not. However, a higher percentage, 58.4% (n=139) stated that they were not bothered by the viewing of the body, compared to 41.6% (n=99) who mentioned that this bothered them. Most of the participants, at 77.3% (n=184) admitted to being bothered by the screams and wails, while only 22.7% (n=54) said that this did not bother them.

The cooking and night dancing associated with Luo burial ceremonies did not seem to bother the participants. The majority of them reported that they were not bothered by the cooking and eating; night dancing during the burial preparations; and night dancing after the burial: 88.7% (n= 211); 86.1% (n=205; and 77% (n=184) respectively. Similarly, the participants indicated that they were not bothered by the empty compound after the death of their parent and even when relatives came to share the belongings of the parents after the burial ceremony: 51.9% (n=123 and 74.9% (n=177) respectively.

The results presented in Table 4.28 generally indicate that most of the participants participated or observed the cultural practices associated with burial ceremonies but were not bothered by the practices. The fact that there is no significant

risk when exposed to these cultural practices could only mean that the bereaved have accepted the practices as a cultural norm or expectations and have adapted to them; hence no psychological harm is experienced.

Binomial logistic regression was used to predict CG from cultural factors. The choice of this test was based on the binomial (dichotomous) nature of the dependent variable (incidence of CG), that is, respondents either met the cut off for CG (1) or did not (0). Similarly, the independent variables were categorical in nature with either yes (1) or no (0) responses for each cultural factor. The results were as depicted in Table 4.29.

*Table 4.29: Predicting CG Based on Specific Cultural Factors*

Variables (Cultural factors)	B	S.E.	Wald	df	Sig.	Exp(B)
c24_view_body	-.044	.432	.011	1	.918	.957
c25a_screams_wails	.422	.595	.503	1	.478	1.526
c25b_cooking_eating	.932	.657	2.012	1	.156	2.539
c25c_preburial_night_dancing	.210	.698	.091	1	.763	1.234
c25d_body_in_house	.196	.631	.097	1	.756	1.217
c25e_view_body_bother	.402	.610	.433	1	.510	1.494
c26a_postburial_dancing	.572	.816	.491	1	.483	1.772
c26b_empty_compound	.003	.820	.000	1	.997	1.003
c26c_sharing_belongings	-.300	.856	.123	1	.726	.741

As per the results (see table 4.29), none of the cultural factors had a significant influence on CG ( $p > 0.05$ ). As explained above, there is a possibility that the cultural practices have been largely accepted in the community and are therefore not considered traumatizing by the participants, therefore no significant indicators of development of CG.

To determine if the individual factors combined would bring any significant risks in the development of grief, a composite index of cultural factors was computed from all the binary (Yes/No) questions pertaining to the cultural practices surrounding

the death of a parent. A bivariate correlation was then computed between the cultural factors index and the grief scores at baseline to determine if there were any linear relationships between the two variables. See Table 4.30.

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*Table 4.30: Correlations between Cultural Factors and ICG Score at Baseline*

Correlations		Cultural factors Index	ICG total score at baseline
Cultural factors Index	Pearson Correlation	1	.011
	Sig. (2-tailed)		.867
	N	241	241
ICG total score at baseline	Pearson Correlation	.011	1
	Sig. (2-tailed)	.867	
	N	241	241

The results captured in Table 4.30 did not reveal any statistical significance in the correlation between cultural factors even when the factors were combined as a composite index ( $r=0.011$ ,  $p =0.867$ ). These results further demonstrate that even when participants were subjected to the majority of the cultural practices, there was no risk of developing CG since no relationship was established between the factors and CG.

#### 4.2.7 Perception on academic performance and CG

Respondents were asked to assess their academic performance based on whether they perceived that the same had dropped after the death of their parents. The feedback was as displayed in Table 4.31.

*Table 4.31: Perceived Drop in Academic Performance Following Parent's Death*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
No	62	32.56	7.75	.98	30.59	34.53	10.00	47.00
Yes	179	31.88	8.26	.61	30.67	33.11	11.00	57.00
Total	241	32.06	8.12	.52	31.03	33.09	10.00	57.00

According to the results (Table 4.31), 179 participants (74.2%) felt that their performance in school had dropped since the death of their parents. The difference in means between those who said their performance had dropped were very minimal. These results show that the majority of the orphans thought that their academic

performance had reduced compared to when their deceased parent was alive. Nevertheless, other variables that could lead to poor academic performance could not be controlled for, and the variations in the schools' association between grief and actual academic performance could also not be assessed.

Correlation to determine if there is any relationship between perception on changes in academic performance following the death of a parent was tested. The outcome was as shown in Table 4.32.

*Table 4.32: Perception of Academic Performance after Death of Parent and CG Correlations*

		ICG total score at baseline	Do you feel your performance in school has reduced
Pearson Correlation	CG total score at baseline	1.000	-.036
	Do you feel your performance in school has reduced	-.036	1.000
Sig. (1-tailed)	CG total score at baseline	.	.287
	Do you feel your performance in school has reduced	.287	.
N	CG total score at baseline	241	241
	Do you feel your performance in school has reduced	241	241

There was no significant correlation between perception of academic performance and level of CG ( $r = 0.036$   $p=0.287$ ). (see Table 4.32).

#### 4.2.8 Effectiveness of MCGT in reducing symptoms of CG

To find out if MCGT was effective in treating CG, a paired samples T-Test was used. This test makes it possible to test for the difference in means between two variables. In this case, the variables to compare were ICG scores at baseline, midline, and endline. Table 4.33 shows the summaries of means at baseline, midline, and endline.

*Table 4.33: Mean Grief Scores for CG at Baseline*

Grouping		N	Mean	Std. Deviation	Std. Error Mean
Experimental	CG score at baseline	123	32.77	7.55	.68
	CG total score at midline	123	16.02	9.89	.89
	CG total score at endline	123	17.29	9.04	.82
Control	CG total score at baseline	118	31.32	8.64	.79
	CG total score at midline	118	30.52	12.12	1.11
	CG total score at endline	118	30.87	10.99	1.01

At baseline, the experimental group’s mean grief score was 32.77, while for the control group it was 31.22 (see Table 4.33). These results indicate that the average mean scores for the two groups were not that different.

Table 4.34 shows results of paired-sample t-test statistics, after comparison of the means at baseline and midline for both groups.

*Table 4.34: Mean Difference of ICG Scores at Midline (Paired Samples Test)*

Paired Samples Test		Mean	Std. Deviation	Std. Error Mean	Paired Differences 95% Confidence Interval of the Difference		t	Df	Sig. (2-tailed)
Grouping					Lower	Upper			
Exp	Pair 1 CG ML- CG BL	-16.75	11.76	1.06	-18.85	-14.65	-15.79	122	.000
Ctr	Pair 1 CG ML- CG BL	-.797	12.15	1.12	-3.011	1.418	-.712	117	.478

As seen in Table 4.34, in the experimental group, there was a notable reduction in the mean grief scores at midline, and this shows that the intervention was effective in treating CG  $t(122) = -15.79, p=0.00$ . There CG scores reduced by an average of 16.75 points after administering MCGT treatment in the experimental group. This could not be said for the control group as there was minimal reduction of -0.79 points in mean CG scores at midline as compared to the means at baseline  $t(117) = -0.712, p=0.478$ . This implies that without treatment, there was no significant change in CG between the baseline and the midline stages (see Table 4.34). A

calculation of the effect size of the intervention results showed that the intervention has a relatively large effect size ( $d=1.424$ ;  $>0.8$ ).

$$\text{Cohens } d = (M2 - M1) / SD$$

$$d = (16.75) / 11.76 = 1.424$$

In addition, to assess how long the treatment results would last after intervention was withdrawn, mean scores at midline and at endline were assessed. The results are shown in Table 4.35.

*Table 4.35: Mean Difference of ICG Scores at Endline (Paired Samples Test)*

Paired Samples Test			Mean	Std. Deviation	Std. Error	Paired Differences		t	df	Sig. (2-tailed)
Grouping						Lower	Upper			
Exp	Pair 1	CG EL – CG ML	1.27	9.07	.82	-.35	2.88	1.55	122	.124
Ctr	Pair 1	CG EL – CG ML	.35	12.78	1.18	-1.98	2.68	.29	117	.768

The treatment outcomes remained even after the intervention was withdrawn. Among the control group, there was a marginal increase of 1.27 in the CG score between the midline and endline assessments, but the increase was not statistically significant  $t(122)=1.550$ ,  $p=0.124$ . A comparison with the control group results indicated that there was no significant change in the ICG scores  $t(117)=0.295$ ,  $p=0.768$  (see Table 4.35). The implication here is that without treatment, the grief scores of the control group remained largely the same.

#### MCGT's efficacy by age

A paired sample t-test was also done to determine the effectiveness of the MCGT treatment when age was put into consideration. The results are shown in Table 4.36.

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*Table 4.36: Mean ICG Scores by Age at Baseline and Endline (Paired Samples Test)*

Paired Samples Test			Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
Grouping	Age Group	Paired Differences				Lower	Upper			
Exp	10-11 (preteen)	CG EL - CG BL	-19.63	13.33	2.16	-24.01	-15.25	-9.07	37	.000
	12-13 (early teen)	CG EL - CG BL	-16.11	10.31	1.67	-19.49	-12.72	-9.63	37	.000
	14-15 (mid-teen)	CG EL - CG BL	-14.97	10.04	1.80	-18.65	-11.28	-8.29	30	.000
Ctr	10-11 (preteen)	CG EL - CG BL	-6.09	9.634	1.65	-9.45	-2.73	-3.69	33	.001
	12-13 (early teen)	CG EL - CG BL	2.03	11.47	1.91	-1.85	5.91	1.061	35	.296
	14-15 (mid-teen)	CG EL - CG BL	.00	9.33	1.91	-3.94	3.94	.000	23	1.000

The intervention was relatively effective across all the age groups with all the groups in the experimental group showing statistically significant reduction of grief scores. For the age group 10-11 years, mean reduction was of -19.63; for the 12-13 years, the mean reduction was -16.10; while in the age group of 14-15 years, the reduction was -14.97. (see Table 4.36).

The above was not true for the participants in the control group, as their mean scores remained above 25, thus indicating they were still having CG. From the mean reductions in the CG scores by age groups, it was observed that for participants in all age groups who went through the MCGT treatment, the CG scores significantly reduced by the end of the treatment.

#### MCGT's efficacy by gender

Table 4.37 presents the results for the paired sample test of changes in mean ICG scores by gender.

*Table 4.37: Mean Difference of ICG Scores by Gender at Baseline and Endline (Paired Samples Test)*

Paired Samples Test			Mean	Std. Deviation	Std. Error	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
Group	Gender	Lower				Upper				
Exp	Male	CG EL - CG BL	-16.06	12.26	1.73	-19.54	-12.58	-9.26	49	.000
	Female	CG EL - CG BL	-17.88	10.77	1.43	-20.74	-15.01	-12.53	56	.000
Ctr	Male	CG EL - CG BL	.044	10.99	1.64	-3.26	3.34	.027	44	.978
	Female	CG EL - CG BL	-2.77	10.59	1.51	-5.82	.26	-1.833	48	.073

The ICG scores of the male participants reduced significantly by -16.06 at  $t(49)=-9.26$ ,  $p=0.000$ , and the scores for the female respondents reduced by -17.88 at  $t(56)=-12.53$ ,  $p=0.000$  - as captured in Table 4.37. The results reveal that regardless of gender, the ICG scores of the respondents who undertook the MCGT intervention reduced CG symptoms significantly during the duration of the study and the respondents no longer showed signs of the same at the end of the therapy.

Regarding the control group's participants, no statistically significant changes in the mean ICG scores for both genders were observed:  $p$  values of  $p=0.978$  and  $p=0.073$  for males and females respectively (see Table 4.37).

#### MCGT's efficacy by gender of deceased parent

Lastly, the study tested the effectiveness of the MCGT treatment depending on the gender of the deceased parent. A paired samples  $t$ -test was done, and the outcome was as portrayed in Table 4.38.

*Table 4.38: Mean Difference of ICG Scores by Gender of the Parent Who Died (at Baseline and Endline)*

Group	If YES above, which parent did you lose through death?	Mean	Std. Deviation	Paired Differences Std. Error Mean	95% Confidence Interval of the Difference		t	df	Sig. (2-tailed)
					Lower	Upper			
Exp	Both parents	-17.13	11.02	2.29	-21.89	-12.36	-7.45	22	.000
	Mother	-19.63	11.68	2.13	-23.99	-15.27	-9.21	29	.000
	Father	-15.53	11.49	1.56	-18.67	-12.40	-9.94	53	.000
Ctr	Both parents	-.11	12.89	3.12	-6.75	6.51	-.038	16	.970
	Mother	1.56	11.61	2.73	-4.22	7.33	.568	17	.577
	Father	-2.71	9.86	1.28	-5.28	-.14	-2.11	58	.449

The results (see Table 4.38) show that for the respondents who had lost both parents, the ICG scores reduced by -17.13 at  $t(22)=-7.454$ ,  $p=0.000$ , while for those who had lost a mother, the scores reduced by -19.63 at  $t(29)=-9.206$ ,  $p=0.000$ . In relation to those who had lost a father, the ICG scores reduced by -15.53 at  $t(53)=-9.937$ ,  $p=0.000$ . In the case of the control group, the grief scores remained largely the same for participants who had lost both, mother only, and father only ( $p>0.05$ ). This, therefore, demonstrates that the MCGT treatment led to a statistically significant reduction in the ICG scores for respondents independent of the gender of the parent who died.

The results, in relation to “the effectiveness of MCGT in reducing the symptoms of CG”, therefore demonstrate not only the overall effectiveness of the tool in treating CG but also that the tool was effective in addressing the same independent of the participant’s gender, age, nature of the death of the parent, and the gender of the deceased parent.

### 4.3 Summary of Key Findings

The following were some of the key findings from this study:

1. Results on parental death showed that over half, at 56.5% (n=136), of the participants were paternal orphans (had lost a father); 24.1% (n=58) had lost only a mother; and 19.5% (n=47) had lost both parents.
2. The major cause of parental deaths in Siaya County was sickness, as cited by 74.2% (n=179) of the participants. Only 13.6% (n=33) cited accidents as the cause of their parent/s' death, while 12.2% (n=29) did not know what had caused the parents' death.
3. The prevalence of CG was found to be 66% among orphaned children in the selected schools, with a mean grief score of 31.6 (SD=9.52).
4. Most of the participants, 75.6% (n=182), experienced multiple losses; with almost half of them, 48.9% (n=89), indicating they had lost siblings, while 48.3% (n=88) had lost a close relative such as aunty/uncle/grandparents.
5. Sibling separation following parental death was associated with higher levels of CG, with participants who indicated that they were not living together with their siblings recording higher grief scores ( $r=-0.036$ ,  $p=0.038$ ).
6. High level of closeness to deceased mother before the death showed high levels of CG among orphaned children ( $r=0.241$ ,  $p=0.006$ ), while the level of closeness to deceased father did not show any significant association with levels of grief scores ( $r=0.055$ ,  $p=0.229$ ).
7. Grandparents are taking over the burden of caregiving for orphaned children following the death of the child's parent. Most of the participants were living with a relative 44.8% (n=108) while only 2.1% (n=5) were living in a

children's home. Specifically, it was observed that most 65.5% (n=79) of the participants were living with a grandparent. while 7.4% (n=9) were living with older siblings.

8. The MCGT was efficacious in the reduction of CG symptoms, with a statistically significant reduction seen in the treatment group after receiving the MCGT treatment. The mean difference between the grief scores at the termination of the intervention and the baseline was 16.75, with an average reduction of 1.29 per week.

#### 4.4 Summary

This chapter has captured the findings from the participants, as indicated in the data collection instruments. Different aspects from the data collection instruments have been presented and analyzed appropriately. Analysis of data helped the researcher to derive pertinent themes and other useful information regarding the study. The following chapter focuses on discussions of the findings, conclusions, and recommendations of the study.

## CHAPTER FIVE: DISCUSSIONS, CONCLUSIONS, AND RECOMMENDATIONS

### 5.1 Introduction

This chapter presents discussions of the findings concerning the objectives of the study. It also provides the conclusions and recommendations of the study, and finally suggestions for further studies.

### 5.2 Discussions

The study noted that the orphaned children were at an increased risk of developing CG, and this was exacerbated by specific sociodemographic factors. For example, the majority of the orphans were found to be paternal orphans, were living with their grandparents, had experienced other losses, had lost their parents through sickness, and were separated from their siblings following the death of their parent/s. It was also noted that factors such as separation from siblings, level of closeness to deceased mother, and number of siblings were associated with higher chances of developing CG. On the other hand, factors such as age, gender, and level of closeness to deceased father were not associated with CG. The study also determined that MCGT was effective in treating CG among orphaned children. The subsequent sections are a detailed discussion of the findings by each of the objectives.

#### 5.2.1 Sociodemographic characteristics of orphaned children

The first objective of this study was to document the distribution and sociodemographic characteristics of orphaned children in selected public primary schools in Siaya County. Based on the schools' records, there was a total population of 4989 children enrolled in the selected primary schools. The enrollment by gender

was 2592 males and 2572 females. These results showed that the enrollment in the schools by gender was 51.5% for boys and 49.5% for girls, an indication that there was an almost even distribution of boys and girls enrolled in the 12 public primary schools sampled for this study.

These results are in line with Kenya's MoE 2016 basic education statistics which showed that the total number of children enrolled in classes 3 to 7 was 163,680, comprising 50.2% (n=82,272) boys, and 49.7% (n= 81408) girls. This shows a parity of only 0.6% when enrollment by gender was observed (RoK, MoE, 2016). These results indicate that the enrollment numbers for girls and boys are largely equal for public primary schools in Siaya County.

In terms of the age and gender distribution of the respondents, the study found more orphans in the lower age groups of 10-14 years, as compared to those in higher age groups. Regarding parental death, 56.5% (n=136) of the respondents had lost only a father, 24.1% (n=58) had lost only a mother, and 19.5% (n=47) had lost both parents. These results showed that over half of the participants were paternal orphans. This can be related to the 2018 Kenya HIV estimates report's record that the mortality for male adults has consistently been higher in comparison to that of females, with adult HIV deaths for males being 55.6% (n=13,289), and female adult deaths being 44.4% (n= 0,074) (NACC, 2018)

The participants' living situation after the death of a parent was also assessed. Participants were asked to state whom they were currently living with. The majority of the participants were living with a relative 44.8% (n=108), while only 2.1% (n=5) were living in a children's home. These results are evident that the majority of the participants were under the care of relatives, as opposed to institutionalization.

Correspondingly, a study conducted in Busia County in 2015, which aimed to understand the kinship care/alternative care concluded that in Kenya, “communities have historically and traditionally cared for and protected orphaned, abandoned, and vulnerable children within the extended family.” (Save the Children, 2015, p.13).

Concerning the respondents who live with their relatives (other than their surviving parent), the nature of relationships to the relative was also assessed. It was observed that for most 65.5% (n=79) participants who were living with relatives as their caregivers, that relative was a grandparent, while 7.4% (n=9) were living with older siblings. These results communicate that grandparents took over the burden of caregiving for orphaned children following parental death. This aligns with Kagendo’s (2017) finding that as of 2017, the burden of care for orphans largely remained with grandparents who were expected to assume full parental care of orphaned or abandoned children.

In relation to the nature or cause of their parent’s death, the majority, 74.2% (n=179) of the participants cited sickness, while only 13.6% (n=33) cited accident. Those who indicated that they did not know the cause of their parent’s death were 12.2% (n=29). This finding points out that the major cause of parental deaths was sickness. It can hence be deduced that HIV is a major cause of orphanhood in Siaya County. According to a 2016 report by NACC, counties in Western Kenya recorded the highest prevalence of HIV cases, with Siaya coming third at a prevalence rate of 24.8%. The same report showed that in Siaya County, HIV infections were four times higher than the total Kenya’s national prevalence at 21% with at least 2645 deaths recorded in the county in the year 2015 (NACC, 2016). Siaya County recorded the

second highest number of orphaned children at 12.7% after Migori County, which recorded 18% (KNBS, 2018).

Out of the participants who reported that their parents had been sick, over half of them at 53.2% (n=123) indicated that they had taken care of their sick parents before they (the parents) died. The implication here is that more of the participants were taking up caregiving roles of ailing parents. Similarly, Akerman and Statham (2014) and Kiambi and Mugambi (2017) determined that in the African set-up, there were higher possibilities of orphaned children caring for ailing parents which could lead to irregular school attendance and further exposure of the children to the suffering of the sick parents. Limo and Kibowen (2017) likewise observed that due to poverty levels, families cannot afford proper care in hospitals or home-based care, and therefore, caregiving is left to the family members.

The majority of the participants at 75.6% (n=182) experienced multiple losses with almost half of them indicating that they had lost siblings 48.9% (n=89), and 48.3% (n=88) having lost a close relative such as aunty/uncle/grandparents. These numerous losses could be attributed to the high number of HIV deaths that were registered in Siaya County. The county's HIV prevalence, as reported by NACC (2016), stood at 24%

### 5.2.2 The prevalence of CG among orphaned children

The second objective of this study was to determine the prevalence of CG among orphaned children in selected public primary schools in Siaya County. As per the findings, the prevalence of CG was estimated at 66% among orphaned children. This high prevalence could be associated with the facts and findings from other studies that have shown that parental death was a very devastating and traumatic

event for children (Heeke, 2018). In the general population, the prevalence of grief has been estimated at 10-20% (Kersting et al., 2011; Shear et al., 2011)

Similarly, although a general prevalence of CG has been approximated at 10%, the prevalence of grief was found to increase to highs of 78% in the high-risk population, as a result of traumatic deaths and prolonged sicknesses (Enez, 2018). In this study, it was confirmed that more participants indicated that their parents were sick and also that they were present at the time their parent died 58.7% (n=141). These results justify the high prevalence and further prove that most of the sick and dying parents suffer at home as their children watch the suffering leading to risks of developing CG.

The results echo those by Heeke (2018) and Lee et al. (2014) that the exposure to the suffering of a parent can further predispose the child to grief complications when the parent eventually dies. Finally, the high prevalence could be related to the fact that most of the orphans in the current study reported that their parents had died as a result of sickness, with the majority confirming that they had taken up caregiving roles during the prolonged illnesses, and others indicating that they had seen their parent die.

The prevalence of CG among orphaned children can also be related to the arguments furthered in REBT. The REBT theory was considered in this study specifically to assess cognition and emotional disorders associated with CG. Similarly, since the CGT model was developed from CBT and given an attachment approach, Shear and Shair (2005) still believed that the cognitions that the bereaved person establishes after realizing that the attachment figure is gone influences whether the person will resolve the grief or not.

### 5.2.3 Risk factors for CG among orphaned children

In its third objective, this study determined the effect of specific risk factors associated with CG among orphaned children enrolled in selected public primary schools in the county of Siaya. Concerning the determinants of CG, risk factors, namely number of siblings, separation from siblings, and level of closeness with the deceased mother before the latter's death were significantly correlated with increased means scores on the inventory for grief tool; while age gender, and closeness with deceased father - prior to the latter's death - were not associated with high levels of grief.

Participants with a higher number of siblings presented with lower grief mean scores ( $M=30.79$ ), compared to those who said they had one sibling ( $M=34.10$ ), with a weak negative correlation ( $r=-0.068$ ,  $p=0.047$ ). Those who did not live with their siblings had higher grief scores. Although the statistics confirmed that the association was significant, the relationship was a weak negative correlation between sibling separation and CG ( $r=-0.036$ ,  $p=0.038$ ).

Relatedly, Gong et al. (2009) investigated the psychological impact of sibling separation among orphans in rural China. Although the study focused on psychological effects in general and not CG, the findings were that orphans who get separated from the siblings are at risk of presenting with increased psychological distress in comparison to those who remained with their siblings after the death of the parent (Gong et al., 2009). The results of the current study also indicated that the care arrangement should focus on accommodating the siblings in none home instead of spreading them across many relatives, as in the Siaya County case.

In regard to level of closeness with deceased parents, according to the results, the level of closeness to deceased mother showed significantly higher grief scores with significantly moderate positive correlation ( $r=0.241$ ,  $p=0.006$ ). On the other hand, the level of closeness to deceased father did not show any significant effect on the grief scores ( $r=0.055$ ,  $p=0.229$ ). According to the results, even though the participants still presented with elevated grief scores when the deceased parent was a father, these levels were not associated with the perceived level of closeness with the deceased father.

Results from other studies have also shown that mothers are the primary attachment figures for children. The theory of loss and attachment by John Bowlby postulates that the loss of an attachment figure through death leads to disorientation on the bereaved child and may interfere with the ability to rebuild new attachment relationships (Aleem, 2018; Stroebe, Schut, & Boerner et al., 2010). The results under this objective also revealed the foundations of the loss and attachment as a risk factor for the inability to resolve grief and increase chances of psychosocial disorganizations and impairment.

According to John Bowlby, a child always desires to be in proximity with the loved one. Orphaned children are denied this proximity when their parents die, leaving them psychologically vulnerable (Aleem, 2018). As a result, when this bond is broken through death, the child goes through four stages of mourning. This incapacitation to reestablish security and new relationships are associated with CG. In addition, studies that have focused on the relationship between closeness to the deceased and level of grief have found that the level of closeness is associated with

higher or prolonged grieving, beginning from the inability to accept the death of the loved one and yearning for their return (Kübler-Ross, 1978; Stroebe et al., 2010).

The age of participants in this study did not show statistically significant differences in grief scores. The descriptive statistics of the variation of ICG scores among different age groups showed that respondents in the younger age groups, 10-11 years (preteens) had slightly higher CG scores 32.34, in comparison to their older counterparts. The weak positive correlation between the level of closeness with the deceased father and CG was not statistically significant ( $r=0.055$ ,  $p=0.229$ ). The results from this study are contrary to research findings that have established age as a determinant of CG with higher grief symptoms seen in elderly bereaved persons (Miller, 2012; Shear et al., 2013).

The fact that the respondents in this study were all within the same age bracket could explain why there may have been no significant difference seen in their mean grief scores against their specific ages. The studies that have shown significant effect of age on grief have compared grief symptoms between different age sets, such as comparing grief between adolescents and the elderly and discussing manifestation of grief in different age groups.

Finally, although the results showed that grief scores were slightly higher among females, the difference was statistically insignificant ( $p=0.301$ ). The mean difference in grief scores across gender was not statistically significant. Resultantly, gender was not considered a determinant of CG. These results could compare to the findings by Wing et al. (2001) who concluded that when it comes to gender and grief, the presentation and expression of the grief is the biggest difference. Females may present as having more grief, since they present with intuitive grief. Such grief is

characterized by more feeling than thinking, open displays of intense affect (Zonnebelt-Smeenge & DeVries, 2003), waves of emotional reactions (Wing et al., 2001), and desire to express the feelings and seek support. On the other hand, males were found to present instrumental grief which engages a lot of thinking rather than feeling. There is less display of emotions, and a lot of camouflaging of emotions and grief is expressed cognitively (Shear & Shair, 2005).

Concerning the nature of death and CG, the results showed that sickness was the main cause of death. It was also noted that respondents whose parents died from sudden death showed higher mean ICG scores at 34.61 against 31.74 for those whose parents had died from sickness. The literature on the nature of death and the development of CG has shown that prolonged sickness and traumatic/sudden death could increase the chances of a bereaved person developing CG. The predisposition to CG is explained in that, in traumatic deaths and especially those that are sudden, the bereaved person had no time to prepare for the loss (Shear et al., 2013).

According to Shear et al. (2013), when a loved one dies after a difficult and prolonged illness as seen in terminal patients, the bereaved family members are at risk of developing CG. Witnessing the suffering of an ailing parent is traumatizing for the child, and the stress and worry in anticipation of the death of the parent predisposes the child to a complicated grieving process when the parent eventually dies (Akerman & Statham, 2014; Limo & Kibowen, 2017). In the case of the participants in this study, the majority of their parents had died as a result of prolonged illness, hence the reason for the higher grief scores. The lack of statistically significant difference in means between those whose parents died from illness and those whose parents died from accidents could be explained by the fact that there was a high number of

participants whose parents had died through sickness, as compared to those who died through accidents. Similarly, considering that sickness and accidents are rated as the highest risks in the development of CG, the participants in this research were likely to show high grief scores, and therefore, comparisons would show minimal differences.

To assess the availability of school-based support/counseling for grief, the participants were asked whether they had received any counseling when they resumed school after the burial of their parents. Only 17% (n=41) received school-based guidance and counseling after the death of their parents. The ICG score for those who reported having received counseling in school was marginally higher than that for those who did not receive such counseling. These results are contrary to other findings that have indicated that grief counseling helps bereaved persons to get over the grief. For example, grief work has been described as interventions geared at helping participants resolve significant loss and resume functionality (Spuij et al., 2015; Stroebe & Schut, 1999).

Emotional, cognitive, and behavioral models of psychological intervention have proven to be effective in the management of grief as they focus on its core components (emotions and cognition/thought). Based on this study's findings, it is clear that the structure, quality, and expertise of grief work is crucial in the treatment of grief symptoms. The study established that the kind of counseling available in school is not done by professionals or trained counselors. In assessing the situation of guidance and counseling in Kenyan schools, Wambu and Fisher (2015) discovered that 'guidance and counseling' teachers in Kenyan schools are teachers to begin with and have no professional training in counseling.

The schools were found to have no comprehensive and organized counseling services to address the needs of students within the school. Without proper training, there are higher chances of malpractices that may damage the bereaved rather than treat grief. In this study, the researcher argued that with no expertise in counseling and/or grief work, the bereaved children who receive counseling are more likely to not receive any help or their symptoms could get worse. The results from this study, therefore, bring to question the quality of counseling offered in the schools.

The Luo burial rites have been known for structured, intense, and extensive mourning processes. The participants, to a large extent, experienced several cultural practices associated with Luo burial ceremonies such as screams and wails, having the body in the house overnight, cooking and dancing celebrations, body viewing, and the dancing ceremony after the burial. These results agreed with Olela (2014) who systematically observed and explained the Luo cultural burial rites. The results confirm that across the whole region, the Luo burial rituals and practices have been upheld and continue to be practiced.

Interestingly, these activities did not seem to bother the participants in this study, with the majority of them reporting that they were not bothered by the cooking and eating 88.7%(n=211), and night dancing during the burial preparations 86.1%(n=205), and even the night dancing after the burial 77%(n=184). This implies that the majority of the participants participated or observed the cultural practices associated with burial ceremonies.

To determine if these burial/cultural rites within the Luo culture increased chances of CG for the orphans, a bivariate correlation was computed between the cultural factors index and the ICG scores at baseline. The results showed that

activities such as viewing of the body, having the body with coffin put in the house, wailing and screaming, eating and celebrations, dancing, and sharing of deceased personal belongings after the burial, did not show any significant effect on the mean grief scores ( $r=0.011$ ,  $p=0.867$ ). These results are in line with findings that have shown that some of the cultural practices in the African traditions help in mourning and grieving processes, hence can prevent the development of pathological grief. In the African context, the mode of mourning is culturally based, and the duration of mourning is predetermined by specific cultural practices and rituals (Drenth et al., 2013; Nwoye, 2005).

In 2005, Nwoye took issue with the westernized approach of pathological grief patterns when dealing with African clients. Nwoye argued that the very rituals and experiences that accompany the mourning process help in healing the clients and that intervention for grief in the African context should be seen within this spectrum and not through clinical settings (Nwoye, 2005). Perhaps of most importance is the understanding of grief as presented by Nwoye (2005) in which the mourning and burial rights becomes a pattern and a series of predetermined activities that lead to the healing of psychological wounds. Nwoye's arguments are also supported in this study since the majority of the participants admitted to having viewed the body and participated in most of the rituals, yet when correlation of participating in these activities and CG was done, there was no statistically significant difference between those who participated in the practices and those who did not.

#### 5.2.4 Perception on academic performance and CG

As its fourth objective, this study tested the relationship between CG and academic performance among orphaned children enrolled in selected public primary

schools in Siaya County. Respondents were asked to assess their academic performance based on whether they perceived that the same had dropped after the death of their parents. At least 74.2% felt that their performance in school had dropped since the death of their parents. The difference in means between those who said their performance had reduced and those who thought their performance had remained the same was minimal.

This study was only able to assess the perceptions of participants on academic performance but not actual examination scores. Nonetheless, the finding that the majority of the participants perceived that their performance had dropped support the findings of other studies that have qualitatively also concluded that CG has a detrimental effect on academic performance in children. Grief has generally been found to lead to emotional instabilities, causing a significant reduction in cognitive functioning. In a study conducted in Kenya, Limo and Kibowen (2017) determined that in the case of orphans, reduced cognitive functioning is evidenced in low academic performance, and that the situation is worse for many orphaned girls who in the African setting, are forced to take up caregiving roles and therefore drop out of school (Akerman & Statham, 2014).

#### 5.2.5 Effectiveness of MCGT in the treatment of CG

In the fifth objective, this study evaluated the effectiveness of the MCGT in treating CG symptoms among orphaned children enrolled in the public primary schools in the county of Siaya. Modification to the CGT was done by reducing the number of sessions from 16 to 12 sessions. A paired sample t-test was done to test the effectiveness of the MCGT in reducing clinical symptoms of CG. The paired samples T-Test compared the means at baseline and endline. Findings showed that there was a

statistically significant reduction, at  $-15.48$ ,  $t(122) = -14.664$ ,  $p=0.000$ , of the mean grief scores when scores at baseline and endline were evaluated. Further, to examine the effect size of the intervention, a *Cohen's d* was calculated, and the results showed a statistically significant large effect size ( $d=1.321$ ;  $>0.8$ ). The results also showed that on average, the weekly reduction of grief scores was 1.29 points.

These efficacy results are in line with findings from studies that have shown that CGT is generally an effective treatment of CGT. For example, in comparing the effectiveness of CGT and IPT interventions in grief management, Wetherell (2012) conducted pilot studies in a randomized group of 83 adults who exhibited symptoms of CG. Participants who were subjected to the 16 sessions of the CGT showed better improvement at 51% as compared to those who were treated using the IPT (Wetherell, 2012). Clinical trials in Japan were done in 2011 to determine the effectiveness of a modified version of CGT. Asukai et al. (2011) modified the CGT to suit the Japanese cultural setup and tested the modified version on bereaved women who had lost loved ones through violent death (Asukai et al., 2011). The aim of the Japanese study was to restructure CGT to ensure its suitability for the population in Japan and also to test the effectiveness of the modified version as a treatment for traumatic grief and the sample comprised 13 women with symptoms of PTSD relating to traumatic grief. The participants attended a total of 12-16 sessions of the modified CGT and at assessment using Jacobson's reliable change index, the results showed that at least 46% of the participants recorded progress (Asukai et al., 2011).

In another study conducted in 2014 in New York, CGT was found to be effective in treating CG among an elderly bereaved sample of 151 participants (Shear et al., 2014). The study compared CGT and IPT's efficacies in grief treatment. At

baseline, the mean grief score of the sample was 30 grief points. Participants were assessed at baseline and then subsequent tests done at week eight, twelve, sixteen, and finally at week twenty. The findings showed that CGT had better efficacy with an average reduction of 1.05 grief scores on a weekly basis [ $t_{633}=3.85$ ;  $P < 001$ ] (Shear et al., 2014).

According to this current study's results, the MCGT tested for orphaned children in the county of Siaya was similarly effective with a weekly average reduction of 1.29 grief scores. These findings, therefore, confirm that the MCGT tested by this researcher performed better among orphaned children compared to the effectiveness results of the current CGT conducted in the New York sample of elderly participants. This researcher did not find any studies that have tested CGT in Kenya, nor was there any particular study that found that examined the effectiveness of CGT specifically on orphaned children.

The foundations of CGT interventions are drawn from the theoretical framework of 'attachment' and 'REBT' theories. This study was anchored on these two theories with the aim of (1). understanding attachment between parent and child and the psychological disorganization that occur to the child when the attachment figure is no longer present; and (2). understanding the manner in which children interpret death as a temporary separation that leaves the child longing for the return of the attachment figure. It is this longing that interferes with the child's ability to re-establish new relationships hence complicating the grieving process. Further, understanding of the theoretical frameworks of REBT was critical in relating how techniques from REBT and IPT were combined in the CGT intervention in treatment of CG.

The techniques within the CGT intervention are geared towards supporting the bereaved person to have closure on the relationship with the deceased person, accept that the deceased person will not be coming back, and begin to reestablish new relationships for support and eventual healing from the CG. It is also understood that treating CG does not mean that the bereaved forgets the deceased person, but that to a certain degree, the bereaved person is able to retain memories of the deceased but still continue to function normally. Memory work contained in the CGT intervention are informed by the REBT techniques which involve revisiting, guided imagery, and cognitive reframing to look at situations from a different perspective.

In the researcher's view, the modifications that may have worked well for this intervention would entail the use of trained teachers to offer the school-based intervention because teachers are trained to interact with the children and to ensure engagement of the child. The interactive sessions at the end of each session worked well for this intervention for they rejuvenated the participants and helped them to look forward to the intervention sessions.

### 5.3 Conclusion

This study sought to determine the efficacy of MCGT in the treatment of CG among orphaned children enrolled in public primary schools in Siaya County. Specifically, the study sought to establish the prevalence of CG among the children; determine the effect of specific risk factors associated with CG; and test the relationship between CG and academic performance among the children. The focus was on orphaned children aged 10-15 years, who were enrolled in the selected 12 public primary schools in the county.

The study found a high prevalence, at 66%, of CG among the respondents and concluded that orphaned children are a high-risk population for the development of CG. The high prevalence established in this study could be explained by the findings that most of these participants had lost their parents through sickness, the majority of them had taken up caregiving roles during the prolonged illness of their parents, and others were present when their parent died. These factors may have predisposed the children to the development of CG symptoms.

According to the study findings, sociorelational factors such as a higher level of closeness to deceased mother, separation from siblings, and lower number of siblings were associated with high grief scores. On the other hand, biological factors such as age and gender were not found to influence the level of CG. This means that orphaned children regardless of their age and gender have equal chances of developing CG, but their sociorelational situations before and after the death of the parent may predispose them to grief.

In terms of cultural factors and CG, the bereaved children may have adapted to the Luo death and burial rituals, and this does not predispose them to the development

of CG. Although participants admitted to having participated and observed the intense activities involved in the extensive mourning processes associated with the Luo burial rituals, these activities did not show any association with higher levels of grief. Particularly, the results showed that activities such as viewing of the body, body with coffin put in the house, wailing and screaming, eating and celebrations, dancing and sharing of deceased personal belongings after the burial, did not show any significant association with grief scores; hence, do not pose any increased risk to development of CG in children.

Unskilled counseling and lack of expertise in grief management among teachers or school counselors could worsen the situation and increase the risk of developing CG among orphaned children. In this study, it was discovered that schools had no designated counselors and that some schools had specific teachers doubling as the counselors to the pupils. Unfortunately, the CG scores among those who reported having received counseling in school were marginally higher than for those who did not receive such counseling. This raises a question on the quality of counseling given to orphaned children.

The study concluded that MCGT is an effective intervention in the management of CG among orphaned children. MCGT is an effective school-based grief treatment model that reduces symptoms of CG significantly within 12 weeks. Reducing the sessions from 16 to 12 did not affect the effectiveness of the intervention. MCGT can reduce the treatment gap and increase access to free grief care in schools.

#### 5.4 Recommendations

This study determined that orphaned children are a high-risk population in the development of CG. With this in mind, psychological support becomes very critical, especially for children who are living with ailing parents. Orphaned children are vulnerable, and the counseling support offered to the ailing parent could also be extended to other family members, including the children.

Humanitarian organizations, such as UNICEF, and home-based care service providers could adopt psychological support and the MCGT manual as a component of all psychosocial services and programs implemented in Kenya. This would help to minimize the risks of orphaned children developing CG.

Separation from siblings following parental death was found to be a key risk factor in the development of CG. In most situations, orphaned children are split up, and caregiving is taken up by different relatives. The orphaned children interpret this as another loss, and they have no familiar faces around to assist them in negotiating the grief. It is recommended that siblings be taken care of within one setup or taken to relatives who live close by allowing the siblings to at least see each other frequently. It is also recommended that all the siblings be within one children's home in cases where caregiving has to be in an institutionalized center.

The department of child services; and humanitarian organizations supporting the CT-OVC could consider modifying the program to include psychosocial support for the OVCs who receive these cash transfers. Similarly, increasing or having additional incentives for families taking up the orphaned child together with the siblings would encourage more families to assume caregiving roles without having to separate the orphaned child from her siblings.

This study ascertained the effectiveness of a school-based grief intervention. The MCGT was found to be effective in reducing symptoms of CG among orphaned children. Unfortunately, it was also observed that there were no skilled school counselors and that there was a lack of expertise in grief management among teachers. This was found to increase the risks of high grief scores among orphaned children. It is therefore recommended that the ministry of education, ministry of health, and department of child services ensure the full implementation of the directive requiring that all schools have a trained counselor.

It is recommended that stakeholders in the education department also consider including MCGT in curriculums for designated 'guidance and counseling' teachers to ensure that the teachers have basic knowledge of grief care during their training.

In addition, government, policymakers, and humanitarian organizations could consider adding MCGT as an integral pillar in OVC care to ensure support and care for OVCs, including their psychological wellbeing as a basic need. Lastly, MCGT could be used as a capacity-building program for psychologists and counselors, to increase their grief management skills and competences.

### 5.5 Recommendations for Further Research

Based on the findings from this study, no significant relationship was established between CG and age of the orphaned child. The researcher argues that this could have been the case because the participants involved in this study were largely within a small age bracket (10-15 years). Due to this, the influence of age on grief may have not been distinguished significantly. It is recommended that a study be done to determine the relationship between age and CG using wider age

differences/brackets, for example, comparing children, adolescents, adults, and/or the elderly.

Secondly, the scope of this study was limited in terms of geographical coverage. Specifically, the study location was selected purposively based on reports that Siaya County had a high prevalence of orphanhood and that this increased the chances of getting the desired sample size of orphaned children. To validate and generalize the findings from this study, it is recommended that further studies testing MCGT be done using randomized representative sample of orphaned children from different regions in Kenya. Similarly, Siaya County was chosen based on the high prevalence of HIV cases and a high prevalence of orphanhood; and although this study confirmed that the majority of the orphanhood was occasioned by illness, it could not be concluded that these orphaned children were indeed AIDs orphans. A qualitative research, specifically targeting AIDs orphans to determine their predisposition to CG, is hence recommended.

Although this study inquired on the availability of counseling, it was limited in terms of qualitatively assessing the quality of counseling services. The conclusions on the lack of skilled counseling was based on the observation that none of the schools had a qualified counselor on site. There is, therefore, a need for a study to assess the quality of counseling offered in primary schools to determine its effectiveness in not only in managing emotional and behavioral issues among the students, but also its ability to manage grief among bereaved children.

Further, this study was not able to quantitatively measure the influence of CG on academic performance. It is, therefore recommended that further quantitative studies be done to determine the relationship between CG and academic performance.

Additionally, the language by which this study was conducted was English, and one of the requirements for participation was the ability of the child to understand the tools used in the screening, diagnosis, and intervention. Due to this, many of the orphaned children, especially those in lower classes could not be included in the study. The researcher thus proposes the need for studies to test the reliability and validity of a translated Luo and Kiswahili versions of ICG to curb the language barriers experienced and hence make it possible to cover a larger number of orphaned children in need of grief intervention.

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## APPENDICES

## Appendix A: Introduction Letter (For the Participants)

Dear Respondent,

My name is Maureen Onyango Ngesa; I am a PhD student in Clinical Psychology at Daystar University. I am carrying out a research titled Modified Complicated Grief Therapy in treatment of complex bereavement among orphaned children in selected primary schools in Siaya County, Kenya. In this study, I would want to know how you have been coping at home and in school since you lost your parent and the difficulties you have been facing. With the help of my team we are going to do counseling on you to try to help you cope better with the grief of losing your parents. The Study is going to take almost 6 months and you will meet with my team members every week for about 3 months. Please if you do not understand anything you can always ask me or any member of my team.

I would also want to tell you that your participation in this research is voluntary. You can decide not to participate, or you can change your mind at any time during the time that we will be doing this study. Nobody will punish you or force you to be in the research or to reveal any information that you are not willing to reveal. However, to make this study a success, I urge you to be as open and as truthful as possible to me and my team when you are responding to our questions. Although there may be no money related benefits for you to participate in my study, your participation will be good for you to be able to deal with challenges you are facing and also help the school and in future the government to develop policies that can be beneficial to all orphans in the country.

All the information you give us will be kept secret and confidential only me and my team will be able to see the information. I will not use your name and I will give you special numbers so that nobody knows it is you. If you need to ask me anything you can call or ask your teacher to call me on 0722618797

Thank you for agreeing to participate in my study.

-----  
Maureen Onyango Ngesa

## Appendix B: Informed Assent (Treatment group)

I am aware that Maureen Onyango Ngesa is a PhD student in Clinical Psychology at Daystar University and that she is carrying out a study on Modified Complicated Grief Therapy in treatment of complex bereavement among orphaned children in selected primary schools in Siaya County, Kenya. I have been given full information about my involvement in this research and have been assured that all the information I give in this study will be kept confidential, and that my name will be hidden to hide my identity. I agree to be truthful and open when answering to the questions that I will be asked.

I understand that I will be required to be actively involved in a group therapy for a period of three months and that the whole study will take a period of 6 months. I have also been told that my participation is voluntary and that I cannot be forced to be in the study. I have also been informed that I can decide to stop participating in the study any time if I want and that nobody will punish me if I do so. I understand that I will not receive any payments in terms of money or gifts, but my participation will benefit me and also help the school to be able to support orphans in the country. I am also aware that my academic progress will also be monitored during this study

I have read and understood the information provided by the researcher in this study and that any questions or issues regarding the research have been clarified to my satisfaction. I therefore agree to participate in this research.

\_\_\_\_\_  
Participant signature

\_\_\_\_\_  
Date

I confirm that I have fully briefed, the above participant on my identity and the purpose of the research and their rights as participants in accordance with human research ethics.

\_\_\_\_\_  
Principal Researcher

\_\_\_\_\_  
Date

## Appendix C: Informed Assent (Control group)

I am aware that Maureen Onyango Ngesa is a PhD student in Clinical Psychology at Daystar University and that she is carrying out a study on Modified Complicated Grief Therapy in treatment of complex bereavement among orphaned children in selected primary schools in Siaya County, Kenya. I have been given full information about my involvement in this research and have been assured that all the information I give in this study will be kept confidential, and that my name will be hidden to hide my identity. I agree to be truthful and open when answering to the questions that I will be asked.

I understand that I am in this study voluntarily and that the researcher will be coming to check on my symptoms every three months and after that I will be engaged in a group therapy. I have also been told that my participation is voluntary and that I cannot be forced to be in the study. I have also been informed that I can decide to stop participating in the study any time if I want and that nobody will punish me if I do so. I understand that I will not receive any payments in terms of money or gifts, but my participation will benefit me and also help the school to be able to support orphans in the country. I am also aware that my academic progress will also be monitored during this study

I have read and understood the information provided by the researcher in this study and that any questions or issues regarding the research have been clarified to my satisfaction. I therefore agree to participate in this research.

\_\_\_\_\_  
Participant signature

\_\_\_\_\_  
Date

I confirm that I have fully briefed, the above participant on my identity and the purpose of the research and their rights as participants in accordance with human research ethics.

\_\_\_\_\_  
Principal Researcher

\_\_\_\_\_  
Date

## Appendix D: Informed Consent (Guardians)

My name is Maureen Onyango Ngesa; I am a PhD student in Clinical Psychology at Daystar University. I am carrying out a research titled *Modified Complicated Grief Therapy in treatment of complex bereavement among orphaned children in selected primary schools in Siaya County, Kenya*.

I am asking for your permission to allow your child to participate voluntarily in my research. Please read the following information about the study.

Your child has been selected to be in the study because he/she has lost one or both parents. In this study I would want to know how the child have been coping at home and in school since they lost a parent and the difficulties they have been facing. With the help of my team we are going to do counseling to try to help the child cope better with the grief of losing your parents. The Study is going to take almost 6 months

I would also want to participation in this research is voluntary. Nobody will force your child to be in the study. All the information we get from the child will be kept secret and confidential only me and my team will be able to see the information. If you would wish your child to be part of this study, kindly sign below.

*I have read and understood the information provided by the researcher in this study and that any questions or issues regarding the research have been clarified to my satisfaction. I therefore agree to participate in this research.*

\_\_\_\_\_  
Guardian Signature Date

Name of the Child: \_\_\_\_\_ Class \_\_\_\_\_

*I confirm that I have fully briefed, the guardian on my identity and the purpose of the research and the rights of their children as participants in accordance with human research ethics.*

\_\_\_\_\_

## Appendix E: Informed Consent (School headteachers)

### MODIFIED COMPLICATED GRIEF THERAPY IN TREATMENT OF COMPLEX BEREAVEMENT AMONG ORPHANED CHILDREN IN SELECTED PRIMARY SCHOOLS IN SIAYA COUNTY, KENYA.

Maureen Onyango Ngesa, PhD student in Clinical psychology

School of Human and Social Sciences, Daystar University, Nairobi Kenya

Tel. 0722-618797; Email: adhi3maureen@gmail.com

#### Introduction

This is a request to conduct research in your school. It is important for you to understand what this study will involve. Please read the information below and feel free to ask for any clarification from the above- named researcher.

#### Purpose of the study

The purpose of this study is to implement a modified complicated grief therapy on bereaved orphaned children who present with symptoms of complicated grief. The aim is to test its efficacy in management of grief and improve academic performance among orphans enrolled in primary schools in Siaya county, Kenya

#### Study Procedures

Upon receipt of all necessary approvals from relevant institutions, the teachers will be briefed on the study to help them understand its importance. The students will also be briefed, and participants will be briefed on the study and informed consent and assent sought from the participants. The participants will be subjected to MCGT intervention for 12 weeks. A midline survey to measure grief will be done followed by an evaluation of their academic performance. A window period of three months will be allowed before a final assessment based on grief assessment and academic evaluation is done.

#### Ethical Considerations

The researcher will ensure that privacy and confidentiality is observed and that no participant will be victimized or humiliated. All data will be safely stored by the researcher and no personal names will be used in the responses to hide identity of the participants. Participants will also benefit from the psychological treatment with hope to help them resolve their grief and improve their academic performance. The report submitted to the school will not contain any confidential results but will be based on the general outcome of the study. Your School's participation in this study is voluntary and you are free to withdraw at any time without any repercussions. As the participants are minors, your signature acts as a consent and approval for researcher to interview the participants.

### Contact Information

Should you have any concern or question about this research, please contact the principal researcher using the contacts given above. Should there be need for further consultation or reporting you can contact the Institutional Review Board at Daystar University, Kenya through the supervisors of this study: and using the Daystar University office - Nairobi campus. Address: P. O. Box 44400-00100 Nairobi, Kenya; Phone: 0709 972 000 | 0724 256 408 | 0724 256 409.

I have read and understood the information provided by the researcher this study and that any questions or issues regarding the research have been clarified to my satisfaction. I therefore give consent for my students to participate in this research.

\_\_\_\_\_  
School Head teacher

\_\_\_\_\_  
Date

I confirm that I have fully briefed, the above participant on my identity and the purpose of the research and their rights as participants in accordance with human research ethics.

\_\_\_\_\_  
Principal Researcher

\_\_\_\_\_  
Date

Appendix F: Brief Grief Questionnaire

Brief Grief Questionnaire\_

*Katherine Shear M.D. and Susan Essock Ph.D*

	<i>Not at All</i>	<i>Somewhat</i>	<i>A lot</i>
1. How much are you having trouble accepting the death of _____?			
2. How much does your grief still interfere with your life?			
3. How much are you having images or thoughts of _____ when s/he died or other thoughts about the death that really bother you?			
4. Are there things you used to do when _____ was alive that you do not feel comfortable doing anymore, that you avoid? Like going somewhere, you went with him/her, or doing things you used to enjoy together? Or avoiding looking at pictures or talking about _____? How much are you avoiding these things?			
5. How much are you feeling cut off or distant from other people since _____ died, even people you used to be close to like family or friends?			
<b><i>TOTAL TICKS</i></b>			
	<b><i>x0</i></b>	<b><i>x1</i></b>	<b><i>x2</i></b>
<b><i>TOTAL SCORE</i></b>			

A score of 5 or more may be suggestive of the presence of the syndrome of Complicated Grief

Appendix G: Sociodemographic Questionnaire

**SOCIODEMOGRAPHIC QUESTIONNAIRE ON COMPLICATED GRIEF AMONG ORPHANED CHILDREN IN PRIMARY SCHOOLS IN SIAYA COUNTY, KENYA**

DATE: \_\_\_\_\_ CODE: \_\_\_\_\_

My name is Maureen Onyango Ngesa, a PhD student in Clinical Psychology at Daystar University. This study aims to understand the prevalence of grief and to support in managing the consequences of grief among orphans in primary schools in Kenya. This information is confidential and will help in determining if you may be having problems coping with the loss of your parent(s). Please read carefully and tick (√) where applicable or write the response as required.

INTERVIEWER: \_\_\_\_\_

**Part A: BIODATA**

1. Name \_\_\_\_\_ of \_\_\_\_\_ School \_\_\_\_\_

2. Gender:  
 Male  Female

3. Age (years)  
 10  11  12  13  14  15

4. Religion  
 Catholic  Anglican  Pentecostal  Dentist  Muslim  
 Other \_\_\_\_\_

5. I am in class  
 Class 3  Class 4  Class 5  Class 6  Class 7

6. How many siblings do you have?  
 One  Two  Three  Four and above

**PART B: NATURE OF ORPHANHOOD /OTHER LOSSES/NATURE OF DEATH**

The following questions will ask you more about the death of your parent, more

information about how they died, and if you have lost any other loved one

7. Have you lost a parent through death?

YES  NO

8. If YES in 7, which parent did you lose through death?

Both Parents  Mother  Father

9. In which year did your mother die?

2018  2017  2016  2015  2014  1 below  
Alive

10. In which year did your father die?

2018  2017  2016  2015  2014  1 below  
Alive

11. How close was your relationship with your mother? ( if mother dead)

Not close  A bit close  Very close

12. How close was your relationship with your father (if father is dead)?

Not close  Somewhat close  Very close

13. How close are you with the surviving parent?

Not close  Somewhat close  Very close  Both dead

14. How did your parent die?

Sickness  Accident/Sudden  I do not Know  Old age

15. Was your parent sick before they died?

YES  NO

16. Did you take care of your parent when they were sick?

YES  NO

17. Were you with your parent when he/she died?

YES  NO

18. Where did your parent die?

at home	in the hospital	I do not Know	Other
---------	-----------------	---------------	-------

19. Apart from your parent, have you ever lost another loved one?

YES  NO

20. If YES in 19 above, which other loved one have you lost?

Sibling  Friend  Another close relative

---

**PART C: AVAILABILITY OF CAREGIVER/**

---

This section seeks to find out who you are currently living with and the nature of relationship with the current care giver

21. Whom are you currently living with?

Mother (relative)  Father  Relative  Children's  Guardian (not relative)

22. Do you currently live with any of your brothers or sisters?

YES  NO

23. If not living with your other siblings. How often do you see your sisters/brothers?

Never  Frequently (daily/weekly)  Rarely (yearly)  Few times (monthly)

24. If you are living with a family member/relative, what is the relationship between you and your caregiver?

Aunty/Uncle  Grandparent  Older Sibling

25. If living with a Guardian who is not a relative, who are they?

Neighbour  Teacher  Pastor  Friend to parent

26. If living in a children's home, who took you there

Relative  Teacher/School  Relative  Pastor  Guardian

(not relative)

#### PART D: CULTURE AND DEATH

This section seeks to understand some of the cultural practices surrounding death and how they affected you

27. Did anybody tell you that your parent had died?

YES

NO

28. If YES in 27 above, who informed you about the death of your mother/father

Surviving Parent  
Pastor

Sibling

Other  Relative

Teacher

29. If NO in 27 above, how did you know about the death?

I was there when he/she died

I saw/heard people crying over the death

30. Did you attend the burial of your parent?

YES

NO

31. Did anyone tell/ask you to view the body in the coffin?

YES

NO

32. Did you view the body in the coffin?

YES

NO

33. During the preparation for burial, which of the following activities bothered you most (Tick at least TWO)

Screams/Wails and Cries

Many people in your home cooking and eating

The night dancing/music

Having the body in the house all night on the day before the burial

Viewing the body

34. After the burial which of the following activities bothered you most (Tick as appropriate)

<input type="checkbox"/> The night dancing/music <input type="checkbox"/> Empty compound in the next days <input type="checkbox"/> Relatives coming to share out your parent's belongings
<b>PART E: PSYCHOSOCIAL SUPPORT</b>
<p>This section seeks to find out if you received any emotional support at the time of death, burial and after burial of your parent</p> <p>35. Did anyone talk/comfort you on how you were feeling about the death of your parent?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>36. Did you receive any counseling/talk about meaning of death?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>37. If YES in 36 above, from whom did you receive this talk?</p> <p><input type="checkbox"/> Relative <input type="checkbox"/> Pastor <input type="checkbox"/> Teacher</p> <p>38. Did you receive any guidance and counseling in school when you returned back to school after the burial?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>39. When you feel sad in school do you have someone you can talk to?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>
<b>PART F: THOUGHTS/BELIEFS</b>
<p>The following questions seek to understand what your thoughts in relation to the death of your parent</p> <p>40. Do you still think your parent will come back?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>41. Since your parent died, have you had thoughts that your loved one did not have to die?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p>

42. Since your parent died, have you had thoughts that life is unbearable without them?

YES

NO

43. Since your parent died, have you had thoughts that the only thing that can really help you is to have this person back?

YES

NO

44. Since your parent died, have you had thoughts that you could have done something to stop the death?

YES

NO

45. Since your parent died, have you had thoughts that relatives/doctors did not do enough to stop the death?

YES

NO

46. Since your parent died, have you had thoughts that you have no one to turn now that your loved one is gone?

YES

NO

47. Since your parent died, have you had thoughts that something is wrong with you because you are grieving so much? You should be over this by now?

YES

NO

#### PART I: ACADEMIC PERFORMANCE/SCHOOL ATTENDANCE

The next questions will ask you about your school life in terms of school attendance and academic performance

48. Did any of your teachers attend the burial of your parent?

YES

NO

49. After the burial how long did you stay without going to school?

Less than two weeks

More than a month

A whole term

More than one term

50. Since your parent died have you had to miss school?

YES  NO

51. If YES, why did you miss school

Lack of school fee

Lack of school items (uniform, books, pencils).

Chores at home

Sickness

Discipline issues

Others

52. Compared to the time before your parent died do you feel your performance in school has reduced?

YES  NO

53. If yes above, what is causing the reduction in performance?

I am not able to concentrate in class or to read

I am worried about my future and/or that of my siblings

I have no interest in reading anymore

54. Which of these factors could also contribute to your drop in performance?

I am absent from school a number of times

At home I have no time to read due to house chores

I lack school items such as books, stationeries

THE END: THANKYOU FOR PARTICIPATING

MAUREEN A NGESA- PRINCIPAL RESEARCHER

Email: [maureenaNgesa@daystar.ac.ke](mailto:maureenaNgesa@daystar.ac.ke); Cellphone: 0722618797

Appendix H: Inventory for Complicated Grief (ICG)

(Prigerson et al., 1995)

For each item, describe how you feel right now using one of these five terms:	Never	Rarely	Sometimes	Often	Always
1. I think about this person so much that it is hard for me to do the things I normally do					
2. Memories of the person who died upset me...					
3. I feel I cannot accept the death of the person who died...					
4. I feel myself longing for the person who died...					
5. I feel drawn to places and things associated with the person who died...					
6. I cannot help feeling angry about his/her death...					
7. I feel disbelief over what happened...					
8. I feel stunned or dazed over what happened...					
9. Ever since s/he died, it is hard for me to trust people...					
10. Ever since s/he died, I feel like I have lost the ability to care about other people					
11. I have pain in the same area of my body or have some of the same symptoms as the person who died					
12. I go out of my way to avoid reminders of the person who died...					
13. I feel that life is empty without the person who died...					
14. I hear the voice of the person who died speak to me...					
15. I see the person who died stand before me...					
16. I feel that it is unfair that I should live when this person died...					
17. I feel bitter over this person's death...					
18. I feel envious of others who have not lost someone close...					
19. I feel lonely a great deal of the time ever since s/he died...					
Number of Ticks					
	x 0	x 1	x 2	x 3	x 4
Scores					
Interpretation of Scores <25 = Normal Grief 26-30 = Symptoms of complicated grief ≥31 = Definite complicated grief	Total Scores <span style="background-color: black; color: black;">██████████</span>				

Appendix I: Proposed MCGT Manual

**A Modified 12 Session  
Manual for Treatment of Complicated  
Grief**

DAYSTAR UNIVERSITY

## Acknowledgement

This manual is based on the 2015 CGT manual by Shear Katherine. This manual was created as part of a doctoral research in the field of clinical psychology. The sole objective of the modification was to test if a shorter, less stringent manual could be used to train teachers on grief management and that the teachers use the same manual to offer grief counselling to primary school children in a rural setting. The main objective of the doctoral research was to determine the effectiveness of a shortened and less stringent version of CGT (modified complicated grief therapy) would be effective as a school based program for grief management.

*Maureen Onyango Ngesa*

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*Photo Credit: Mindhine Primary School*

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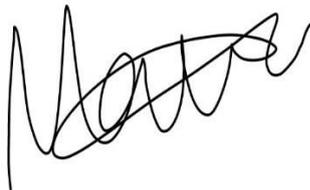
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## Foreword

This proposed 12 session manual is to be used as a therapy guide for counsellors dealing with grieving children. It is a modification and a shortened version of the original Complicated Grief Therapy (CGT) developed by (Shear, 2015). This modified version addresses the need to have a shorter manual that is trainable and adoptable for use in regions especially in Africa, where there is minimal access to mental health services, mental health workers and exhibit low mental health literacy. As with the original manual, this therapy is only recommended upon confirmation that participant is unable to resolve grief and as a result developing grief complications as exhibited in emotional, cognitive, and social impairment. Some of the tools and questionnaires used in the intervention are borrowed from the original CGT therapy.

The first efficacy test for this manual will be among orphaned children in rural Kenya. Specifically, the participants will be drawn from 12 public primary schools in Siaya County, Kenya.

Maureen Ngesa



DAYSTAR UNIVERSITY

### Overview of Complicated Grief

All grief is normal, but the severity and duration of grief is what determines the type of abnormal grief a child could be going through. Complicated grief also referred to as Persistent Complex Bereavement Disorder (PCBD) is a grieving process marred with difficulties and interfered with by other symptoms that are not related to the grief itself and that may hinder the bereaved person from recovering from the grief (Simon, 2010).

Such symptoms may manifest themselves in form of other mental disorders and the focus would be then to deal with these symptoms first to allow for normal grieving to happen (Simon et al., 2011). PCBD can be diagnosed only if the symptoms have been there for at least 12 months in adults and 6 months in children since death of an attachment figure. Young children may experience the loss of a primary caregiver as traumatic, given the disorganizing effects the caregiver's absence can have on a child's coping response.

It has been estimated that about 10% of bereaved population will experience complicated grief (Enez, 2018) Unfortunately, the prevalence is much higher at 20%, 50%, and as high as 78% in prolonged illnesses of loved ones and violent deaths (Papa, Rummel, Garrison-Diehn, & Sewell, 2013). In complicated bereavement, the process of adapting and accepting the finality of the death of a loved one is slowed and complicated in the sense that the individual is unable to readjust back to normal functioning (Simon, 2013). During the grieving process the individual is expected to redefine their goals, and restore a meaningful life that is satisfying without the deceased (Koon & Neo, 2016).

## Symptoms of Complicated Grief

## PERSISTENT COMPLEX BEREAVEMENT DISORDER DSM V

A. The individual experienced the death of someone with whom he or she had a close relationship

B. Since the death, at least one of the following symptoms is experienced on more days than not and to a clinically significant degree and has persisted for at least 12 months after the death in the case of bereaved adults and 6 months for bereaved children.

Persistent yearning/longing for the deceased. In young children, yearning may be expressed in play and behaviour, including behaviours that reflect being separated from, and reuniting with, a caregiver or other attachment figure.

Intense sorrow and emotional pain in response to the death.

Preoccupation with the deceased.

Preoccupation with the circumstances of the death.

In children, this preoccupation with the deceased may be expressed through the themes of play and behaviour and may extend to preoccupation with possible death of others close to them.

C. Since the death, at least six of the following symptoms are experienced on more days than not and to a clinically significant degree, and have persisted for at least 12 months for bereaved adults and 6 months for bereaved children:

Marked difficulty accepting the death. In children, this is dependent on the child's capacity to comprehend the meaning and permanence of death.

Experiencing disbelief or emotional numbness over the loss.

Difficulty with positive reminiscing about the deceased.

Bitterness or anger related to the loss.

Maladaptive appraisals about oneself in relation to the deceased or the death (e.g., self-blame).

Excessive avoidance of reminders of the loss (avoidance of individuals, places, or situations in children, avoidance of thoughts and feelings regarding the deceased).

D. Social/identity disruption

A desire to die in order to be with the deceased.

Difficulty trusting other individuals since the death.

Feeling alone or detached from other individuals since the death.

Feeling that life is meaningless or empty without the deceased, or the belief that one cannot function without the deceased.

Confusion about one's role in life, or a diminished sense of one's identity (e.g., feeling that a part of oneself died with the deceased).

Difficulty or reluctance to pursue interests since the loss or to plan for the future (e.g., friendships, activities).

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

F. The bereavement reaction is out of proportion to or inconsistent with cultural, religious, or age-appropriate norms.

Source: American Psychiatric Association, (2013)

Modified Complicated Grief Therapy

The MCGT manual proposed by the researcher will be a 12 session program that can be administered as a group intervention. The effectiveness of MCGT as a school-based intervention will be tested. In deciding the sessions and techniques to remove, the researcher only considers techniques that can be implemented in a group session and also techniques that do not require intense expertise or training to administer. The reliability and validity of the MCGT will be established.

A major limitation in the existing CGT manual is the prolonged sessions and the need for intensive training. Therefore, and as already discussed, the proposed

MCGT is a targeted intervention that can be trainable and implementable by the school counsellors or persons with minimal counselling skills. The order of sessions, number of sessions and specific content will be simplified to make it more targeted to the population of the study. The specific modification proposed between the current and the proposed MCGT treatment are presented below.

#### Differences between Current CGT and Proposed MCGT

Description	Current CGT	Proposed MCGT
Total number of sessions	16	12
Introductory Phase	3 sessions Session 1-3 History taking, Overview of CGT, Grief monitoring	2 sessions: Session 1-2  History taking  Psychoeducation on grief  Training on Grief monitoring
Intermediate Phase	7sessions:  Sessions 4-10  Restoration work  Imaginal	6 sessions:  Sessions 3 – 8  Narrative of the death story  Narrative of memories with the deceased

	<p>revisiting</p> <p>Imaginal conversation</p> <p>Memory work</p> <p>Progress evaluation</p>	<p>Life changes after the death</p> <p>Grief monitoring of thoughts/beliefs</p> <p>Grief monitoring of emotions</p> <p>Grief monitoring of behaviours</p> <p>Psychoeducation on relationship between thoughts, emotions and behaviours</p>
Final Phase	<p>6 sessions:</p> <p>Session 11-16</p> <p>Restoration work</p> <p>Imaginal revisiting</p> <p>Imaginal conversation</p> <p>Memory work</p> <p>Progress evaluation</p> <p>Preparation for termination</p>	<p>4 sessions: Sessions 9-12</p> <p>Progress evaluation of thoughts, emotions and behaviour</p> <p>Saying goodbye: imaginal conversation with deceased for closure</p> <p>Rebuilding new relationships</p> <p>Adaptive coping skills</p> <p>Preparation for terminations</p> <p>Evaluation of grief symptoms</p> <p>Review of participants after 3 months</p>

## Tools used in the 12 session MCGT

The original CGT uses specific forms and tools in the intervention. In this version, more conversational interaction is preferred since the intervention will be a group intervention. Therefore, only two tools were adopted from the original CGT. The first tool is the screening tools and the original CGT also recommends screening using the brief grief questionnaire and this was also adopted in this trial. Secondly, the inventory for Complicated Grief, was borrowed from the original CGT by Shear et al (2015); and is purely for quantitative analysis of grief scores at baseline, midline and endline. The ICG is a 19-item rating of grief symptoms

When going for sessions, the therapist must ensure they have

MCGT manual

Therapy progress notes form

Blank papers for participants

Pencils for the participants

### Introductory Phase (Session 1 and 2)

CGT is a semi-structured treatment. We use structure to provide a framework for the treatment, to allocate time in the session, to assist in both gathering and providing information, and to plan for the interval between sessions. Structural elements provide useful framework for the treatment, though this does not mean you should use them rigidly. There is a lot to cover in each session and it is easier to get it all done if you set an agenda and follow it through. People with CG feel lost and out-

of-control and find predictability reassuring. At the same time, participants vary in their willingness and ability to accept and use an agenda, complete questionnaires, read handouts or follow interval plans. One of the challenges in learning a new treatment approach is that prior beliefs about how best to work may not be the best guide to decision making.

It may be difficult to effectively encourage participants to work with an agenda if you have not done structured treatments before and you might find it awkward at first. It is best to follow the treatment as closely as possible, at least until you are comfortable working this way.

Each session begins by setting an agenda that divides the session in three parts.

Intro - a brief introduction to discuss the plan for the session and review the past week

Middle - a longer period of time in which you implement the main session content

Ending - a brief ending of the session in which you summarize and get feedback from the participant, and plan for the upcoming week.

CGT sessions can be very intense and emotional. You need to track participants empathically and it is easy to lose track of time. You may want to set a timer to remind you when to shift the focus.

Session One: Rapport Building & History Taking

Duration: 60 minutes

The main goal of this session is to welcome the participant and to know as much as possible about the participant and the loss they experienced. In a group sessions, each of the participant gets a chance to introduce themselves, their families, and the loss they experienced. The group session will consist of maximum of 6 participants. The specific areas of queries are as follows.

Introduce yourself, your name, how many siblings you have, something about what you were like when you were in primary school, something that happened when in primary school. This helps to bring the therapist back to the level of the children and enhance rapport.

History of early family relationships, siblings (Allow the participants 2 minutes to say their name, how many siblings they have and who they are currently living with (use the spin the bottle game to give each child a random chance to introduce themselves).

Introduce the fact that they are in the group because they have lost a parent. Introduce the deceased person – who died? Have they lost another loved one?

Discuss participant's current life situation, what are some of the stresses and sufferings that the stressors

How have they been coping? (coping resources). In simple language ask them what they do when they are feeling sad and stressed

Provide a very brief introduction to the rationale and processes involved in CGT. Explain that the sessions are mainly to help them with this sadness and grief and support them through it.

Session Two: Monitor and Assess Grief

Duration: 60 minutes

The main goal of this session is to introduce grief monitoring and discuss complicated grief and how this relates to what the participant is going through. Remind the participant the importance of the therapy and the need to be honest and open. In case resistant can still be felt from one of the participants, the PI should be informed immediately.

Resistance is a process of avoiding or blocking the self-disclosing communication requested by the interviewer because it makes the interviewee uncomfortable or anxious. It can be seen through overreaction, noncompliance, lack of motivation, limits the amount of information communicated to the counsellor, silence, and minimal talk

Understand that there is a reason the client is resistant. It could be related to the stages of grief, i.e. the client could still be in denial, angry and is yet to start the processing of the grief.

Review of the week - grief monitoring will be done at the beginning of each subsequent sessions as it is a main source of understanding participants emotional state. Basically, ask the client to discuss some of the low moments they had in the week, things/events that may have triggered memories of the deceased

Discuss triggers that the clients feel make the grief worse. It could be what someone does, said, or just reminders.

Discuss times when grief was/ is relatively manageable. When does the client seem not to think about the deceased parent? Can you identify some patterns?

Encouraging the participant to think about personal aspirations, activities that have the potential for reawakening the capacity for joy and meaning in life. What would they love to be in future? Can the client describe a future?

### Intermediate Phase (Session 3 - 9)

#### Overview

This phase includes focused work on loss and restoration that is designed to revitalize the natural healing process. The main goal of revisiting exercises is to encourage the participant to reflect on the death. We seek to help participants to come to terms with the death in a way that integrates participant and the deceased.

The goal is to restore an effective transition between confrontation with painful information related to the loss and relief from that pain. The goal of the loss focus is for the participant to fully acknowledge the finality and consequences of the death and to integrate this knowledge into cognitive and emotional memory systems that contain models of self, others, and the world at large.

The goal of the restoration focus is for the participant to restore her capacity to envision a future, and to participate in life in a way that allows her to find joy and satisfaction even without the person who died. Several strategies are used to achieve loss-focused goals. They include

Decrease the emotional impact of the story of the death and help the participant comprehend the painful reality

Introduce and discuss the concepts of acceptance and faith

Reflect on the troubling aspects of the death and come to terms with the finality of the loss

- Reduce behavioural and experiential avoidance of reminders of the loss
- Facilitate the process of integration of memories with the reality of the death
- Help identify and begin to incorporate long-term aspirations and plans
- Encourage re-engagement in ongoing daily life and relationships
- Facilitate the experience of genuine positive emotions

### Session Three: Processing the Death

Duration: 60 minutes

The main goal of this session is to help the participant come to terms with the death of the loved one by helping the participant process the death at both emotional and cognitive level and integrate these processes. This is an emotionally intense session and must be handled with care.

Imaginal Revisiting is a method for helping people honour the death of a loved one and grapple with the painful reality (Shear et al 2015).

If the participant's reactions are too intense the session should be halted, and the participant given time to process. If in group session, the individual participant can be given extra time or given a follow up individual session. The session also acts as the debriefing session.

Imaginal revisiting simply makes the client relive these painful moments again, so this can start to become a reality to the client. For clients who are yet to accept the death, the emotional reaction may be intense, and this should be halted. For resistant clients, they may not be forthcoming with these disclosure and further probing and encouragement to make the client comfortable.

Introduce Imaginal revisiting - allow the participant 3-5 minutes to visualize and tell the story of when they learnt about the death- where were they? Who told them? How was the news broken to them? Were they there? Debrief and allow them to narrate what they did.

Help the participant to process the loss at an emotional level what did they feel at that point? Help participant to process at cognitive level- what did they think? What did they know about death then?

Reward participant – A reward is given for doing the hard, painful work of revisiting the painful memories.

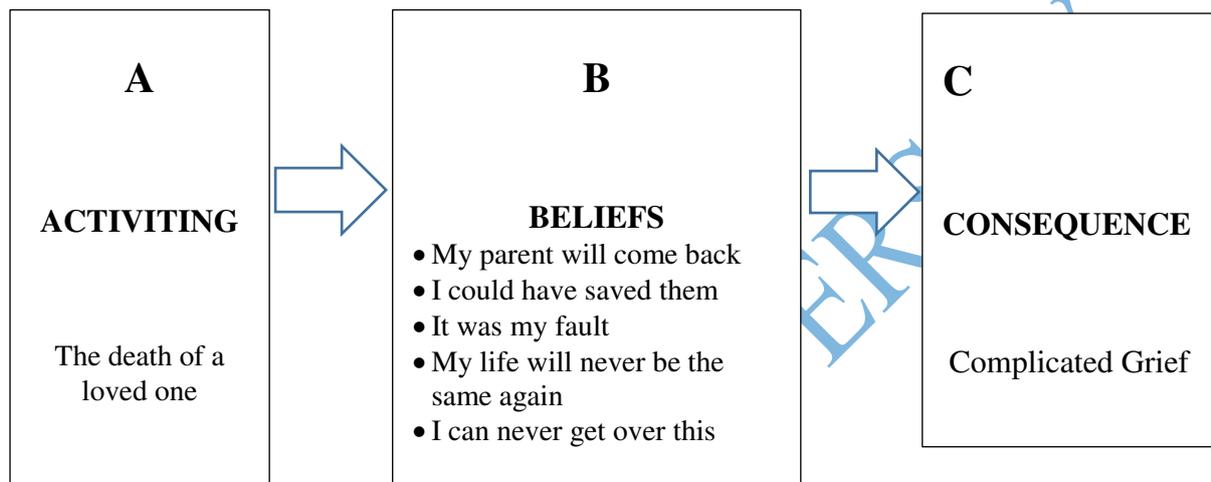
#### Session Four: Assessing Thoughts and Beliefs

Duration: 60 minutes

The main goal of this session is to introduce restoration work by assessing thoughts and beliefs that may be leading to complicated grief. Sometimes the irrational beliefs and distorted thoughts on death could be the reason the participant is still stuck in the grief.

One of Albert Ellis's profound statements was that people disturb themselves not by the events that happen to them but by the way they interpret these events (Mkangi 2010). Based on the ABC framework, activating events do not lead to emotional disturbance (Corey, 2009). That is to say for instance that death of a loved one (A= activating event) does not cause complicated grief (C= consequence). but

irrational beliefs (B) about the death can cause complicated grief. Therefore, focusing on how the participant interprets death helps to dispute some of the thoughts and replace them with more rational beliefs.



Review the week – weekly grief monitoring

Psychoeducation on ABC model and how maladaptive thinking can lead to grief complications.

Brief psychoeducation on common maladaptive thoughts and beliefs that complicate grief

Allow the client to discuss thoughts emotions and behaviour. Can clients tell when their thoughts are causing them to get stressed and think more about the deceased.

Encourage positive thinking to stop the negative thoughts?

#### THOUGHTS AND BELIEFS

1. Do you still think your parent will come back?

2. Since your parent died, have you had thoughts that your loved one did not have to die?
3. Since your parent died, have you had thoughts that life is unbearable without them?
4. Since your parent died, have you had thoughts that the only thing that can really help you is to have this person back?
5. Since your parent died, have you had thoughts that you could have done something to stop the death?
6. Since your parent died, have you had thoughts that relatives/doctors did not do enough to stop the death?
7. Since your parent died, have you had thoughts that you have no one to turn now that your loved one is gone?
8. Since your parent died, have you had thoughts that something is wrong with you because you are grieving so much? You should be over this by now?

#### Session Five: Revisiting Relationships

Duration: 60 minutes

The main goal of this session is to revisit the relationship the bereaved had with the deceased loved one. Participant revisits memories of life when the deceased was still alive and the changes in their current life.

Introduce relationship revisiting – the participant talks about the deceased and the relationship

Research assistant and participants engage in discussing memories shared with the deceased.

## POSITIVE MEMORIES

*List the most enjoyable times you had*

*What did you love most about them?*

## NEGATIVE MEMORIES

*What are some of the things you did not like about them?*

*List the worst moments you had with the deceased*

Introduce situational revisiting - the participant identifies activities or places they previously did or visited together. Situational revisiting of reminders of the loss.

What specific aspects of life can the participant pick out as been different since the death of the loved one.

The participant is encouraged to engage in a situational revisiting activity every day.

Engage in session break activities to enhance relaxation

## Session Six: Facing Difficult Times

Duration: 60 minutes

This session aims to address difficult times that the participant seems to feel more intense grief. Such include specific events of calendar dates that tend to trigger these intense feelings. By pointing them out then the research assistant and participant can discuss how to cope better during these periods.

Review the week

Difficult times - Participant identifies Calendar dates/months that are difficult or remind them of deceased –

Participant identifies the activities and places that have been avoided because they trigger grief or serve as reminders of the loved one.

How has the participant been coping?

Psychoeducate on stress management: Breathing exercises, relaxation techniques

The participant is encouraged to practice the skills learned on a daily basis

### Session Seven: Restoration Work

Duration: 60 minutes

The main goal of session seven is restoration work. The participant and research assistant review the grief diaries, and the situational revisits to see the progress made by the participant. Memory work continues with introduction of both positive and negative memories

Review the week- how was the week for the participant after the last session of revisiting relationship and situational exercises

Participant writes a paragraph describing her best moments with deceased

Participant writes a paragraph describing her worst moments with the deceased

How does the participant feel about the sessions so far? Allow participant to be as expressive as possible

Affirm and acknowledge the progress and discuss reward

### Session Eight: Rebuilding Relationships

Duration: 60 minutes

Specific to this session is discussing alternative significant other that participant can start to rebuild relationships with, this can be an adult relative, caregiver, older sibling ,church member/pastor, teacher etc.

Weekly review

Who is the participant currently close to? – why? How accessible is the person  
Rebuilding attachment?

Social interactions and relationships – friendships and interactions, allow them to talk about their friends and what they do together

New Social support – has the participants met or established new support

Emerging stressors and triggers – have there been new events or occurrences that have brought in new stress. Are there things that used not to bother them but now do?

Participant asked to go home and imagine they could get a final chance to talk to their loved one before they died. They should think of what they would like to tell the deceased loved one in the next session. They can also write a direct letter to the deceased. The participant will read out the letter in the next session.

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### Session Nine: Imaginal Conversation

The goal of this session is to allow the participant to address the deceased loved one through imaginal conversation and role playing. This exercise will help the participant have a closure and be rid of any negative feelings of guilt or anger that he or she may be going through. Engaging in imaginal conversation and giving participant a chance to say goodbye to the loved one. The participant imagines that the loved one has just died but is able to hear and speak. The participant plays both the role of the self and also of the loved one.

### Weekly review

Saying goodbye – telling the deceased that their death though painful has been accepted and discussing how they plan to cope. Participant can even ask the deceased to allow him/her to move on with life under the care of the new attachment figure. Session ends with research assistant recapping the achievements so far and introducing the news that the sessions are also drawing to the end now that participant has said goodbye.

### Final Phase (Session 10 – 12)

This session mainly seeks to say goodbye to the loved one and also marks the beginning of termination. The strategy for discussing termination is to begin by inviting the participant to think about termination. It is expected people will feel freer

to engage in their ongoing life in a way that has the potential for joy and satisfaction. Ask the participant if she has had any thoughts about the treatment ending. Depending upon what the participant says, you will explore these thoughts and feelings and encourage continued reflection on these. Preparation for termination includes reviewing with the participant what they have learned in the treatment and discussing progress on loss-related and restoration-related issues. The research assistant also helps the participant identify and deal with any feelings, both positive and negative, about ending the treatment and about her future prospects.

Plans for using and managing these feelings are discussed. Plans are also discussed for continued work on personal goals and on any other component of the treatment that is not fully completed. Termination can sometimes evoke feelings of loss that can trigger some of the participant's grief. This usually emerges on the Grief Monitoring. If grief intensity rises in the last few sessions in relation to termination of the treatment, this becomes an opportunity to illustrate how different loss experiences may trigger grief about her lost loved one.

Termination is also an opportunity for the research assistant to summarize and comment on her view of the treatment and the progress the participant has made. It is useful to summarize again the CGT model and the individual formulation and to discuss how the participant has or has not yet come to see things a little differently. It is important to summarize her strengths.

A second evaluation on the grief symptoms based on CGT is done at this stage.

## Session Ten: Role Transition

Duration 60 minutes

In this session the participant and the research assistant discuss the participants current situation with the knowledge that the sessions are coming to an end. The focus is to equip the participant with coping skills and help the participant to understand that the sessions are coming to an end. The outline of role transition work in the case of transition out of therapy is discussed below.

the ways in which the therapy has been supportive and helpful and feelings about losing this helpful support

the parts of the therapy that have been difficult, including things like the time it requires and travel and other inconveniences, ways that the therapy has been difficult and time consuming, other things that may have been distressing or problematic,

problems the person foresees in the future, including managing difficult times and other problems that the participant may anticipate. This may include issues the person feels are not yet resolved and might not be resolved by the end of the treatment,

opportunities and positive aspects of ending the treatment, including having more time, having the opportunity to test new learning and develop a sense of confidence in having assimilated something new that remains even when the meetings with the research assistant are over. A range of positive aspects of the future

### Session Eleven: Retelling the story and Coping Skills

Duration: 60 minutes

This session aims to give the participant a chance to retell the story. Specifically, the research assistant should be able to gauge how the participant is fairing by now. The participant talks about her current life situation in the past few weeks of therapy. It also prepares participant for termination.

Weekly review- how has the week been emotionally?

Participant does their own self-evaluation; How does the participant feel about their progress?

Overview of stress management skills; relaxations techniques and positive self-talk

Where and in what ways is the participant still stuck?

Revert to the personal goals and aspiration from session two; How can they be implemented even after the session

## Session Twelve : Termination

Duration: 60 minutes

This is the last session of therapy and the goal is for the participant to feel ready to be on their own and be stable enough to continue with their lives without the deceased.

Weekly review

Research assistant affirmation on the progress participant has made

Some participants may feel as if this is another loss, but research assistant empathetically explains that they believe the participant can make it through with the skills they have learned in therapy

Final reward for participants on work well done: Stationery is provided

Close of therapy

Grief evaluation

In this section please give a brief report on difficulties and specific challenges you faced while implementing the MCGT intervention.

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## Appendix J: Training on Grief Symptoms and Grief Management

This manual is to be used together with the MCGT manual to train on grief symptoms and grief management

### EXERCISE 1: The adjective introduction game/Memory exercise

Sit/Stand in a circle

Each participant chooses an adjective that best describes them

The adjective becomes their new first name i.e. Orderly Maureen

So, the 1<sup>st</sup> participant introduces themselves as. I am Orderly Maureen.

The second participant will introduce themselves and then introduce the 1<sup>st</sup> participant for example, I am analytical Francis, and she is orderly Maureen

The 3<sup>rd</sup> participant introduces herself and then continues to introduce those before him/her.

This goes on for two rounds to ensure that all participants have mastered the names of the members of the group

### EXERCISE 2: Presenting our history /self-disclosure

Self-disclosure in therapy entails a therapist sharing about his/her own personal views or experiences with a client with the purpose of improving the client's emotional or mental state during the therapy. It is also an important part in preparation and supervision of new therapists where therapists share their experiences with one another.

### Benefits of Self Disclosure

Self-disclosure can help to reduce the power differential between you and the client.

Self-disclosure can increase trust in the counselling relationship.

The client/therapist may feel less alone, knowing the helper has the same issue.

The client may feel more understood, knowing the therapist has similar experience.

Self-disclosure to the clients in this case could be limited to sharing of one's own experience with death and grief. Or other traumatic experiences that the person may have experienced during their primary school life (age of the respondents in the study). To avoid over disclosure, therapists can choose to disclose a single event and also use the guide to remain focused.

GUIDE FOR SELF DISCLOSURE ( 5 minutes per trainee)

*Briefly fill the following and present to the group*

Tell us more about your family?
Have you ever experienced death of a loved one?
How old were you when it happened?
Can you recall a predominant feeling you had during that time of grief?
Try to recall your life as a primary school child. What are some of the best memories you have?
What is the worst memory you have of your life in primary?
How did you cope/stabilize from the above?

## COUNSELLING MICROSKILLS

For effective therapy, a counsellor must first have

Enthusiasm,

Confidence

Belief in the patient's ability to change.

The following are the basic skills required of an effective counsellor

Listening.

*Attending* - full, undivided attention and that you care. Eye contact; not moving around or being distracted, encouraging verbalizations

*Listening/observing* - capturing and understanding the verbal and nonverbal information communicated

**CONTENT** - what is specifically said. Listen carefully to **WHAT** a person says and **HOW** they are saying it.

**PROCESS** - all nonverbal phenomena, including how content is conveyed, themes, body language, interactions, etc. Smiling

### EXERCISE 3: The Broken Telephone

Stand in a straight line

One person on one end whispers a statement on the year of the next person,

The person then whispers what they heard to the next

The last person on the line says aloud what they have heard

The first person confirms if that was the original statement

If not the group tracks where the 'telephone broke' so each member says aloud what they heard

Repeat one more time

Empathize do not sympathize – Feel with the clients. Let the clients feel like you truly understand.

Genuineness - Agreement between outer words/behaviors and feelings; being unpretentious. If you cannot handle a case refer to another therapist. For example, if the helper claims that they are comfortable helping a client explore a drug or sexual issue, but their behavior (verbally and nonverbally) shows signs of discomfort with the topic then they should refer the case.

Unconditional positive regard - an expression of care and nurturance as well as acceptance. Do not judge do not show surprise or shocked by information given

Respect - ability to communicate to the client have a sincere belief that every person possesses the inherent strength and capacity to make it in life,

Open Questions-- A questioning process to assist the client in clarifying or exploring thoughts or feelings. Counsellor is not requesting

specific information and not purposively limiting the nature of the response to only a yes or no.

Counsellor Self-Disclosure The counsellor shares personal feelings, experiences, or reactions to the client.

Interpretation counsellor is providing new meaning, reason, or explanation for behaviors, thoughts, or feelings so that client can see problems in a new way.

Information Giving and Removing Obstacles to Change Supplying data, opinions, facts, resources, or answers to questions. Explore with client possible problems which may delay or prevent their change process. In collaboration with the client identify possible solutions and alternatives.

Note taking – take clear and short notes that relate to what was covered in that session and a general opinion of the progress of the clients. If there are challenges or resistant shown by the clients be sure to mention

Therapy Progress Notes

School Name \_\_\_\_\_ Session Number: \_\_\_\_\_

Date \_\_\_\_\_

*Give a brief record of how the session was and If there were challenges with specific participants*

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**ANGER:** Anger is a necessary stage of the healing process. Be willing to feel your anger, even though it may seem endless. The more you truly feel it, the more it will begin to dissipate and the more you will heal. Anger is strength and it can be an anchor, giving temporary structure to the nothingness of loss.

**BARGAINING:** Before a loss, it seems like you will do anything if only your loved one would be spared. "What if..." statements. We want life returned to what it was; we want our loved one restored. We want to go back in time:

**DEPRESSION:** After bargaining, our attention moves squarely into the present. Empty feelings present themselves, and grief enters our lives on a deeper level, deeper than we ever imagined. This depressive stage feels as though it will last forever. It is important to understand that this depression is not a sign of mental illness. It is the appropriate response to a great loss. We withdraw from life, left in a fog of intense sadness, wondering, perhaps, if there is any point in going on alone?

**ACCEPTANCE:** Acceptance is often confused with the notion of being "all right" or "OK" with what has happened. This is not the case. Most people do not ever feel OK or all right about the loss of a loved one. This stage is about accepting the reality that our loved one is physically gone and recognizing that this new reality is the permanent reality. We will never like this reality or make it OK, but eventually we accept it.

N/B COMPLICATED GRIEF, MCGT, SESSION TRAININGS –  
REFER TO THE MANUAL

EXERCISE 4; 123 count

Stand and ensure you have some space around you

Lift your left hand and shake your wrist as you count one to 10; then lift your right hand and do the same

Lift your left foot and shake your ankles as you count you count up to 10. Do the same with the other foot.

Repeat the same process reducing the counts by one each time. I.e. do 9 counts then 8 all the way until you reach to 1.

When done do a good stretch

EXERCISE 5: Relaxation techniques

Muscle Relaxation

Stand straight

Hang your hands on the side until you start to feel their weight

Start to tense up all your muscles

Make an angry face to ensure all your facial muscles are tensed up

Raise your feet from the ground as you tense your muscles to maximum

Slowly release as you bring your feet back on the ground

Lift your hands and stretch

Breathing and Guided Imagery (3 minutes)

Sit on the floor feet crossed or straight. Relax

Take long, slow, deep breaths (also known as abdominal or belly breathing).

As you breathe, you gently disengage your mind from distracting thoughts and sensations.

Think up soothing scenes, places, or experiences in your mind to help you relax and focus.

Just make sure to choose imagery you find soothing and that has personal significance.

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## Appendix K: Ethical Clearance



Athi River Campus  
P. O. Box 17 90145  
Daystar University, Kenya  
Tel: 045 6622601 (2) (3)  
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Fax: 020 2728338  
Email: admissions@daystar.ac.ke

[www.daystar.ac.ke](http://www.daystar.ac.ke)

**Daystar University Ethics Review Board**

Our Ref. DU-ERB/02/04/ 2019 /00268

Date: 02-04-2019

**Maureen Adhiambo Onyango**

Dear Maureen,

**MODIFIED COMPLICATED GRIEF THERAPY IN TREATMENT OF COMPLEX  
BEREAVEMENT AMONG ORPHANED CHILDREN IN SELECTED PUBLIC  
PRIMARY SCHOOLS IN SIAAYA COUNTY, KENYA**

Reference is made to your request dated 27-02-2019 for ethical approval of your proposal by Daystar University Ethics Review Board.

We are pleased to inform you that ethical review has been done and approval granted. In line with the research projects policy, you will be required to submit a copy of the final research findings to the Board for records.

This approval is valid for a year from 02-04-2019

This approval does not exempt you from obtaining a research permit from the National Commission for Science, Technology and Innovation (NACOSTI).

Yours sincerely,

**Mrs. Purity Kiambi,  
Secretary, Daystar University Ethics Review Board**

"...until the day dawn and the daystar  
arise in your hearts"  
**2 Peter 1.19 KJV**

## Appendix L: NACOSTI Research Permit

**NATIONAL COMMISSION FOR SCIENCE,  
TECHNOLOGY AND INNOVATION**

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2241349,3310571,2219420  
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When replying please quote

NACOSTI, Upper Kabete  
Off Waiyaki Way  
P.O. Box 30623-00100  
NAIROBI-KENYA

Ref. No. **NACOSTI/P/19/33996/29451**

Date: **24<sup>th</sup> April, 2019**

Maureen Adhiambo Onyango  
Daystar University,  
P.O. Box 44400 – 00100,  
**NAIROBI.**

**RE: RESEARCH AUTHORIZATION**

Following your application for authority to carry out research on “*Modified complicated grief therapy in treatment of complex bereavement among orphaned children in selected Public Primary Schools in Siaya County, Kenya*” I am pleased to inform you that you have been authorized to undertake research in **Siaya County** for the period ending **23<sup>rd</sup> April, 2020.**

You are advised to report to **the County Commissioner and the County Director of Education, Siaya County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit **a copy** of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.

  
**GODFREY P. KALERWA MSc., MBA, MKIM**  
**FOR: DIRECTOR-GENERAL/CEO**

Copy to:

The County Commissioner  
Siaya County.

The County Directors of Education  
Siaya County.

*National Commission for Science, Technology and Innovation is ISO9001:2008 Certified*

**THIS IS TO CERTIFY THAT:  
 MS. MAUREEN ADHIAMBO ONYANGO  
 of DAYSTAR UNIVERISTY, 101011-101  
 NAIROBI, has been permitted to conduct  
 research in Siaya County**

**Permit No : NACOSTI/P/19/33996/29451  
 Date Of Issue : 24th April,2019  
 Fee Received :Ksh 2000**

**on the topic: MODIFIED COMPLICATED  
 GRIEF THERAPY IN TREATMENT OF  
 COMPLEX BEREAVEMENT AMONG  
 ORPHANED CHILDREN IN SELECTED  
 PUBLIC PRIMARY SCHOOLS IN SIAYA  
 COUNTY, KENYA**



**for the period ending:  
 23rd April,2020**

*[Handwritten Signature]*  
 Applicant's  
 Signature

*[Handwritten Signature]*  
 Director General  
 National Commission for Science,  
 Technology & Innovation

*[Large Blue TNY Stamp]*

**THE SCIENCE, TECHNOLOGY AND  
 INNOVATION ACT, 2013**

The Grant of Research Licenses is guided by the Science,  
 Technology and Innovation (Research Licensing) Regulations, 2014.

**CONDITIONS**

1. The License is valid for the proposed research, location and specified period.
2. The License and any rights thereunder are non-transferable.
3. The Licensee shall inform the County Governor before commencement of the research.
4. Excavation, filming and collection of specimens are subject to further necessary clearance from relevant Government Agencies.
5. The License does not give authority to transfer research materials.
6. NACOSTI may monitor and evaluate the licensed research project.
7. The Licensee shall submit one hard copy and upload a soft copy of their final report within one year of completion of the research.
8. NACOSTI reserves the right to modify the conditions of the License including cancellation without prior notice.



REPUBLIC OF KENYA



National Commission for Science,  
 Technology and Innovation

RESEARCH LICENSE

National Commission for Science, Technology and Innovation  
 P.O. Box 30623 - 00100, Nairobi, Kenya  
 TEL: 020 400 7000, 0713 788787, 0735 404245  
 Email: [reg@naci.go.ke](mailto:reg@naci.go.ke), [registry@naci.go.ke](mailto:registry@naci.go.ke)  
 Website: [www.nacosti.go.ke](http://www.nacosti.go.ke)

Serial No.A 24243

CONDITIONS: see back page

## Appendix M: Ministry of Education Research Authorization



REPUBLIC OF KENYA

MINISTRY OF EDUCATION

State Department for Early Learning and of Basic Education

COUNTY DIRECTOR OF EDUCATION  
SIAYA COUNTY  
P.O. BOX 564  
SIAYA

E-mail: cdesiaya2016@gmail.com

When replying please quote

CDE/SYA/URA/10/VOL.1/114

Monday, May 6, 2019

TO WHOM IT MAY CONCERN

**RESEARCH AUTHORIZATION – MAUREEN ADHIAMBO ONYANGO**

The above named person has been mandated to carry out research in Siaya County vide an authorization letter from National Commission for Science and Technology and Innovation Ref. No. NACOSTI/P/19/33996/29451 dated 24<sup>th</sup> April, 2019. This research study ends on 20<sup>th</sup> April, 2020.

The research title is “*Modified complicated grief therapy in treatment of complex bereavement among orphaned children in selected Public Primary Schools in Siaya County, Kenya*”.

Please accord him the necessary assistance in this County as he may require.

JOSEPH K. WAMBOCHO  
COUNTY DIRECTOR OF EDUCATION  
SIAYA COUNTY



## Appendix N: Research Approval - Siaya County

**THE PRESIDENCY**

MINISTRY OF INTERIOR AND COORDINATION OF NATIONAL GOVERNMENT

**Fax No.****Tel:** 0776 391011**Email:** cc.siaya@yahoo.comTHE COUNTY COMMISSIONER  
SIAYA COUNTY  
P.O. BOX 83- 40600  
**SIAYA**

CC/SC/A.31 VOL.III/20

6<sup>TH</sup> MAY, 2019All Deputy County Commissioners  
**SIAYA COUNTY****RE: RESEARCH AUTHORIZATION – MAUREEN ADHIAMBO  
ONYANGO**

The person referred to above from Daystar University has been authorized by the Director General/CEO, National Commission for Science, Technology and Innovation vide letter Ref. No. NACOSTI/P/19/33996/29451 dated 24<sup>th</sup> April 2019 to carry out research on "**Modified Complicated Grief Therapy in Treatment of Complex Bereavement among Orphaned Children in Selected Public Primary Schools in Siaya County.**"

The purpose of this letter therefore is to ask that you accord him the necessary support as she carries out research in your Sub County.

DENNIS OBIERO  
For: COUNTY COMMISSIONER  
**SIAYA COUNTY**Copy to Maureen A. Onyango  
Daystar University  
P.O. Box 44400- 00100  
**NAIROBI**County Director of Education  
**SIAYA**

Appendix O: Curriculum Vitae



# MAUREEN ONYANGO NGESA

COMMUNICATIONS SPECIALIST/PSYCHOSOCIAL RESEARCHER

### PROFILE

I am a communications expert with 12 years of experience in diverse communication platforms ranging from corporate communication, publication production, broadcast production, research and report writing. I have additional expertise in psychology with specific interest in psychosocial research to increase mental health literacy. My goal is to transfer my skills from both industries through research and knowledge management and dissemination.

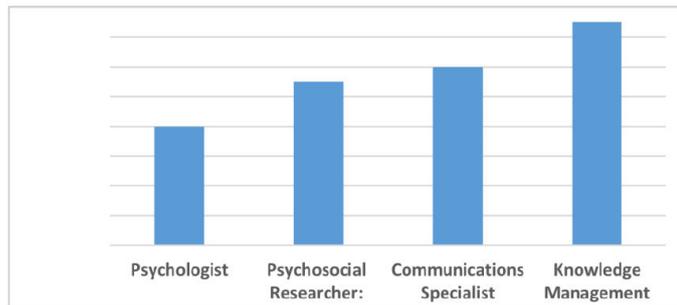
### EDUCATION

**PhD Clinical Psychologist –Student:**  
Daystar University (2017- to date)

**M.A Counselling Psychology,**  
Daystar University, (2012-2014)

**B.A Communication and Literature,** University of Nairobi (2004-2008)

### KEY EXPERTISE



- **Knowledge Management;** desk reviews, assessments, project reports, close out reports, position papers, working papers, action plans training modules
- **Communication Specialist** - publication development, broadcast production, editing, design and layout
- **Psychosocial researcher:** concepts, data collection tools, data entry, analysis and interpretation , report writing
- **Psychologist:** assessment, diagnosis, psychotherapy. psychoeducation, training and coaching

### REFEREES

Pauline Mundia Program  
Manager, Biovision Africa Trust  
+254722313291  
[pmundia@biovisionafrica.org](mailto:pmundia@biovisionafrica.org)

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[simon.kiragu@wpowerhub.org](mailto:simon.kiragu@wpowerhub.org)

Stella Nyagwencha, PhD  
Psychology Lecturer, Daystar  
University +254722 860485  
[snyagwencha@daystar.ac.ke](mailto:snyagwencha@daystar.ac.ke)

### SUMMARY WORK HISTORY

- Communication Specialist | USAID/KEA Mission Support JS2R program November 2019 (Current)
- Research/Communication Specialist | USAID/AFYA PWANI project- May - June 2019. (Consultancy)
- Research Communication Consultant | USAID/ EMIRGE project, 2018
- Research Communication Consultant | Biovision Africa Trust, 2018
- Lead Research Consultant - GeoPsy Multidisciplinary Consultancy, 2017
- Technical Editor | wPOWER project: 2018 (Consultancy)
- Communication Expert | Intercontinental Publishers 2011 – 2017
- Newspaper writer | Nation Media Group Daily Nation 2008 – 2011

### CONTACTS:

**MOBILE: +254722618797**

**EMAIL:** [adhi3maureen@gmail.com](mailto:adhi3maureen@gmail.com)

## Appendix P: Anti-plagiarism Report

## Maureen O. Ngesa dissertation - 17-08-2020

## ORIGINALITY REPORT

<b>17%</b>	<b>9%</b>	<b>8%</b>	<b>11%</b>
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

## PRIMARY SOURCES

<b>1</b>	Maureen O. Ngesa, Sylvia Tuikong, Kennedy Ongaro. "Treating Complicated Grief among Orphaned Children in Kenya: Effectiveness of Complicated Grief Therapy", Open Journal of Social Sciences, 2020 Publication	<b>3%</b>
<b>2</b>	link.springer.com Internet Source	<b>1%</b>
<b>3</b>	Submitted to Mount Kenya University Student Paper	<b>1%</b>
<b>4</b>	www.ncbi.nlm.nih.gov Internet Source	<b>1%</b>
<b>5</b>	Submitted to University of Queensland Student Paper	<b>&lt;1%</b>
<b>6</b>	Submitted to Kenyatta University Student Paper	<b>&lt;1%</b>
<b>7</b>	Submitted to Middle East Technical University Student Paper	<b>&lt;1%</b>

Submitted to Daystar University