UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

THE NEED FOR AN EMPLOYEE BEREAVEMENT SUPPORT PROGRAMME AT UMGENI HOSPITAL

BY

VANAGREE NAIDOO

Submitted in partial fulfillment of the requirements for the degree
MSW (EMPLOYEE ASSISTANCE PROGRAMME)

in the

DEPARTMENT OF SOCIAL WORK AND CRIMINOLOGY
FACULTY OF HUMANITIES
at the
UNIVERSITY OF PRETORIA

SUPERVISOR: PROFESSOR CSL DELPORT
FEBRUARY 2009

© University of Pretoria

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

ACKNOWLEDGEMENTS

I wish to express my sincere gratitiude and give recognition to the following persons for their unconditional assistance and support to me, in successfully completing this study:-

- Firstly, God for the guidance and strength given to me through this study.
- My parents for their continous love, support, encouragement and instilling in me the belief that I can achieve anything that I set out to do.
- My siblings and their spouses for their ever willing support and assistance.
- My nephew and niece for their care, joy and laughter through this stressful process.
- My supervisor, Professor C.S.L. Delport for her guidance, patience, support and encouragement through this study. My you be blessed with prosperity and the strength to achieve all that you desire.
- The University of Pretoria, Kwa-Zulu Natal Department of Health and the management of Umgeni Hospital for giving me permission to conduct the study and make available the necessary and required resources.
- All of my colleagues and friends for their professional guidance and support as well as motivation and encouragement at times when it was much needed.
- To all of the respondents who voluntarily participated in this study, my heartfelt thanks to you. I wish you well in all of your endeavours.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

ABSTRACT

THE NEED FOR AN EMPLOYEE BEREAVEMENT SUPPORT PROGRAMME AT UMGENI HOSPITAL

by

Vanagree Naidoo

Supervisor: Professor CSL Delport

DEPARTMENT OF SOCIAL WORK AND CRIMINOLOGY
DEGREE: MSW (EMPLOYEE ASSISTANCE PROGRAMME)

Bereavement and grief are life changing and universal experiences. People cope with loss of a loved one in many ways. For some the experience may lead to personal growth and for others it could lead to deterioration in their normal functioning. There is no right way of coping with death. The way a person grieves depends on the personality of that person and the relationship with the person that has died.

Grief and loss occurs both at work and at home. However, these days, most people spend more of their time at the workplace than at home. Therefore when a colleague dies or one is grieving a death or a loss, the impact on his or her co-workers can be tremendous. The death of an employee can bring the workplace activity to a halt. Anyone who knew the person will experience some degree of shock and anxiety.

However, how a person copes with grief is affected by the person's cultural and religious background, coping skills, mental history, support systems and the person's social and financial situation.

The workplace could therefore be a significant support system that could help a person to cope with the loss. The manner in which grief and loss are managed in the workplace could determine if the employees' experiences of this loss is dealt with either positively or negatively.

The researcher, through consultations with employees at Umgeni Hospital, has learnt that the employees have within a short time period experienced the loss of several colleagues through traumatic events. Some employees are also struggling to cope with losses in their personal lives.

The aim of this study was to investigate the need for an employee bereavement support programme at Umgeni Hospital.

The objectives of this study were:

- To conceptualize theoretically employee bereavement and its impact in the workplace as well as the support strategies for employees.
- To conduct an empirical investigation into the need for an employee bereavement support programme at Umgeni Hospital.
- To provide recommendations to the hospital management on the need for a bereavement support programme at Umgeni Hospital based on the information gained from this research.

A quantitative research approach was used to assist the researcher understand this need. Applied research focusses on problem solving in practice. In this study applied research was used as the findings of this exploratory study determined the recommendations to management on the need for an employee bereavement support programme at Umgeni Hospital.

The data collection method was hand delivered questionnaires. The population for the study was 422 employees. However, systematic sampling was used to chose a sample of 70 employees.

These questionnaires were pilot tested on 5 employees that did not form part of the actual study. The data was analysed using the SPSS statistical package, interpreted and displayed using table format and various graphical presentations.

The goal of the study was to investigate the need for an employee bereavement support programme at Umgeni Hospital. This goal was definitely achieved as the study determined not only that there is definitely a need for an employee bereavement support programme at Umgeni Hospital but also the exact or specific needs of the employees with regards to the programme itself. This study would therefore definitely add value to the hospital and its employees as it will assist hospital management in developing an appropriate bereavement support programme to assist their employees in the future.

Key concepts

Employee
Bereavement
Support
Bereavement support programme

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

OPSOMMING

DIE BEHOEFTE AAN 'N VERLIES-ONDERSTEUNINGSPROGRAM VIR WERKNEMERS BY UMGENI HOSPITAAL

deur

Vanagree Naidoo

Studieleier: Professor CSL Delport

DEPARTEMENT VAN MAATSKAPLIKE WERK EN KRIMINOLOGIE

GRAAD: MSW (WERKNEMERSHULPPROGRAM)

Verlies en verdriet is gewoonlik lewensveranderend en universele ervarings. Mense beleef die verlies van 'n geliefde op baie maniere. Vir sommige persone mag die ervaring na persoonlike ontwikkeling lei en vir ander kan dit aanleiding tot agteruitgang in hulle gewone lewens gee. Daar is nie 'n regte manier om die verlies van 'n geliefde te hanteer nie. Die manier waarop 'n persoon treur hang af van die persoonlikheid van daardie persoon en die verhouding met die persoon wat te sterwe gekom het.

Verlies en verdriet gebeur by die werk asook by die huis. Deesdae spandeer die meeste mense egter meer van hulle tyd by die werk as by die huis. Daarom as 'n kollega sterf óf as 'n mens treur oor 'n persoonlike verlies, kan die impak op jou medewerkers geweldig wees. Die dood van 'n werknemer kan alle aktiwiteite by die werkplek tot 'n stilstand bring. Enigiemand wat die persoon geken het, sal een of ander vorm van skok en angs ondervind.

Die manier waarop 'n persoon verlies ervaar, word deur die persoon se kulturele en godsdienstige agtergrond, vaardighede, emosionele geskiedenis, ondersteuningsstelsels en die persoon se sosiale en finansiele situasie beïnvloed.

Die werkplek kan 'n betekenisvolle ondersteuningssisteem wees wat 'n mens kan help om verlies positief te hanteer. Die manier waarop verdriet en verlies in die werkplek hanteer word, kan bepaal of die werknemers se ervaring van hierdie verlies 'n positiewe of negatiewe uitwerking het.

Die navorser het, deur beraadslaging met werknemers by die Umgeni Hospitaal, vasgestel dat die werkers binne 'n kort tydperk die verlies van talle kollegas deur tragiese insidente ervaar het. Sommige van die werkers sukkel ook om verliese in hulle persoonlike lewens te hanteer.

Die doel van hierdie studie was om die behoefte aan 'n verlies-ondersteuningsprogram vir werknemers by die Umgeni Hospitaal, te ondersoek. Die doelwitte van hierdie studie was:

- Om die verlies van werknemers en die invloed daarvan op die werkplek sowel as die ondersteuningsstrategieë vir werknemers, teoreties te konseptualiseer
- Om 'n empiriese ondersoek ten opsigte van die behoefte aan 'n verlies-ondersteuningsprogram by Umgeni Hospitaal uit te voer.
- Om aanbevelings aan die hospitaalbestuur ten opsigte van 'n verlies-ondersteuningsprogram by Umgeni Hospitaal, gebaseer op die inligting van hierdie navorsing, te maak

'n Kwantitatiewe studie, gebaseer op toegepaste navorsing, is uitgevoer.

Die data insamelingsmetode was handafgelewerde vraelyste. Die populasie vir die studie was 422 werknemers by Umgeni Hospitaal. Sistematiese steekproeftrekking was gebruik om 'n steekproef van 70 werknemers te selekteer.

Die vraelyste was deur ‘n voorafstudie op vyf (5) werknemers, wat nie deel van die hoofstudie uitgemaak het nie, getoets Die data is volgens die SPSS statistiese pakket geanaliseer, daarna geinterpreteer en toe grafies voorgestel.

Die doel van hierdie studie was om die behoefte aan ’n verlies-ondersteuningsprogram vir werknemers by die Umgeni Hospitaal, te ondersoek. Die doel van die studie was beslis bereik aangesien die studie nie alleen die behoefte aan ’n verlies-ondersteuningsprogram vir werknemers by Umgeni Hospitaal bevestig het nie, maar ook die spesifieke behoeftes ten opsigte van die inhoud van so ’n program is geidentifiseer. Hierdie studie sal daarom beslis waarde aan die hospitaal en sy werknemers toevoeg, aangesien dit die hospitaalbestuur sal help om ’n toepaslike verlies ondersteuningsprogram vir hulle werknemers in die toekoms te ontwikkel.

Sleutelwoorde

Werknemer
Verlies
Ondersteuning
Verliesondersteuningsprogram

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

TABLE OF CONTENTS PAGE

ACKNOWLEDGEMENTS i

ABSTRACT ii

OPSOMMING v

CHAPTER 1

GENERAL BACKGROUND

1.1 INTRODUCTION 1

1.2 PROBLEM FORMULATION 5

1.3 GOAL AND OBJECTIVES OF THE STUDY 6

1.3.1 Goal of the study 6

1.3.2 Objectives of the study 6

1.4 RESEARCH QUESTION 7

1.5 RESEARCH METHODOLOGY 7

1.6 ETHICAL ASPECTS AND ISSUES 10

1.6.1 Informed and voluntary consent 10

1.6.2 Confidentiality / Privacy / Anonymity 11

1.6.3 Avoidance of harm 12

1.6.4 Debriefing 12

1.6.5 Deception of respondents 13

1.6.6 Action and competence of the researcher 13

1.6.7 Release and publication of the findings 13

1.7 DEFINITION OF THE KEY CONCEPTS 14

1.8 LIMITATIONS OF THE STUDY 16

1.9 CONTENTS OF THE RESEARCH REPORT 17

CHAPTER 2

BEREAVEMENT IN THE WORKPLACE

2.1 INTRODUCTION 18
2.2 SIGNS AND SYMPTOMS OF GRIEF AND BEREAVEMENT 20
2.3 THEORIES OF GRIEF AND BEREAVEMENT AND THE GRIEF PROCESS 24
2.3.1 Freud 25
2.3.2 Lindemann 25
2.3.3 Bowlby 26
2.3.4 Elizabeth Kubler-Ross 28
2.3.5 Parkes 31
2.3.6 Worden 31
2.3.7 Stroebe and Schut 34
2.4 BEREAVEMENT AND GRIEF IN THE WORKPLACE 35
2.5 WORKPLACE BEREAVEMENT SUPPORT PROGRAMMES 43
2.6 SUMMARY 53

CHAPTER 3

EMPIRICAL RESEARCH FINDINGS OF THE STUDY

3.1 INTRODUCTION 55
3.2 RESEARCH METHODOLOGY 56
3.2.1 Research approach 56
3.2.2 Type of research 56
3.2.3 Research design 57
3.2.4 Data collection method 57
3.2.5 Data analysis 58
3.2.6 Pilot study 59

3.2.6.1 Testing of the data collection instrument 60
3.2.6.2 Feasibility of the study 60
3.2.7 Description of the research population, sample and sampling methods 61
3.2.7.1 Research population 61
3.2.7.2 Research sample 61
3.2.7.3 Sampling method 62
3.3 RESEARCH FINDINGS 63
3.3.1 Section A: Personal details 63
3.3.2 Section B: Experience of grief or bereavement 67
3.3.3 Section C: Impact of Event Scale-Revised (IES-R) 70
3.3.4 Section D: Bereavement support 77
3.4 SUMMARY 88

CHAPTER 4

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION 90
4.2 SUMMARY 91
4.2.1 Goal of the study 91
4.2.2 Objectives of the study 91
4.2.3 The research question 91
4.2.4 Contents of the research report 92
4.3 CONCLUSIONS 92
4.3.1 Literature Review 92
4.3.2 Empirical Data 94
4.4 RECOMMENDATIONS 97
4.5 ACCOMPLISHMENT OF THE GOAL AND OBJECTIVES OF THE STUDY 98
4.6 CONCLUDING REMARKS 99

LIST OF REFERENCES

APPENDICES

Appendix A : Permission from the Kwa-Zulu Natal Department of Health
Appendix B : Permission from Hospital Manager
Appendix C : Letter of ethical clearance
Appendix D : Respondents letter of informed consent
Appendix E : Cover page of data collection instrument
Appendix F : Data collection instrument (questionnaire)

LIST OF TABLES

Table 1 : The effects of grief and trauma 22
Table 2 : Structured workplace bereavement support programme 1 51
Table 3 : Structured workplace bereavement support programme 2 52
Table 4 : Intrusion subscale and gender of respondents 71
Table 5 : Avoidance subscale and gender of respondents 72
Table 6 : Intrusion subscale and age of respondents 72
Table 7 : Avoidance subscale and age of respondents 73
Table 8 : Intrusion subscale and causes of death 73
Table 9 : Avoidance subscale and causes of death 74
Table 10 : Effects of lack of support on work performance 78
Table 11 : Effect of support received 80
Table 12 : Accomplishment of the study objectives 97

LIST OF FIGURES

Figure 1 : Gender of respondents 63
Figure 2 : Age of respondents 64
Figure 3 : Marital Status of respondents 65
Figure 4 : Home language of respondents 66

Figure 5	: Hospital components	67
Figure 6	: Number of deceased acquaintances	68
Figure 7	: Relationship with the deceased	69
Figure 8	: Causes of death	70
Figure 9	: Intrusion Sub-Scale	75
Figure 10	: Avoidance Sub-Scale	75
Figure 11	: Hyper-Arousal Sub-Scale	76
Figure 12	: Support offered	77
Figure 13	: Support network	79
Figure 14	: Follow up services	81
Figure 15	: Further services required	82
Figure 16	: The need for an employee bereavement support programme	83
Figure 17	: Type of bereavement support programme	84
Figure 18	: Content of an employee bereavement support programme	85
Figure 19	: Length of the employee bereavement support programme	86
Figure 20	: Coordination of the employee bereavement support programme	87

CHAPTER 1

GENERAL BACKGROUND

1.1 INTRODUCTION

Bereavement is the period after a loss during which grief is experienced and mourning occurs (MedicineNet.com, 2007:1). It is an almost universal human experience and strikes practically all people several times during a life course. This is viewed as the most stressful life event that is often severely traumatic, effects all sides of a person's life and could last from weeks to years (Woof & Carter, 1997:443).

Lindstrom (1983:2) offers a similar understanding and states that bereavement is a vastly multi-faceted stressor that influences most parts of a person's life including psychological, physiological, sociological and existential-religious areas. It creates problems in areas where problems were hardly expected and to which the bereaved person might be unprepared. The terrible emotional turmoil and the behaviour evoked by bereavement is considered as basically normal, even when it includes manifestations which may appear as bizarre to non-mourners or persons from another culture. Grief, despite temporary ups and downs, normally fades over time, "normal life" is resumed, and sometimes improved. However, this course of events may go wrong, causing an impoverished state of life, or an activation or re-activation of psychiatric problems or conditions.

People cope with the loss of a loved one in many ways. For some, the experience may lead to personal growth, even though it is a difficult and trying time. There is no right way of coping with death. The way a person grieves

depends on the personality of the person and the relationship with the person who has died (MedicineNet.com, 2007:1).

However, according to the National Cancer Institute (2006:2) generally, people who are grieving often feel extremely tired because the process of grieving usually requires physical and emotional energy. The grief they are feeling is not just for the person who died, but also for the unfulfilled wishes and plans for the relationship with the person. Death often reminds people of past losses or separations and bereavement symptoms can be debiliating if left unattended.

The National Cancer Institute (2006:2) further states that the bereavement process may be described as having four phases:

Phase one: shock and numbness

This usually occurs in the beginning and lasting a brief period. People experience the feelings of numbness and being stunned. It is useful in helping people function through the initial funeral time period.

Phase two: yearning and searching

Survivors experience separation anxiety and cannot accept the reality of the loss. They try to find and bring back the lost person and feel ongoing frustration and disappointment when this is not possible.

Phase three: disorganization and despair

This is the period when the bereaved is easily distracted and might have difficulty concentrating, focusing or may feel restless. They find it difficult to plan for the future.

Phase four: reorganization

This occurs towards the end of the bereavement period when the person has begun to adjust to life without the loved one.

People, however, handle grief differently in the workplace than they do at home (HealthGate Data Corp, 2007:1). Many try not to cry or show emotions at work because they are under social pressure to act normally regardless of the crisis. People tend to view a show of emotions as a sign of weakness, but that is far from the truth. When a sense of loss is present in the workplace, everyone typically experiences a series of emotions that cycle through the grieving process. Those emotions are shock or denial, inward anger, outward anger, depression and acceptance. Some may not experience every emotional stage, while others will linger longer in one stage than another. One person may have intense feelings and another may even deny that any loss has occured.

Most people spend more of their waking hours at the workplace than they do at home, so the death of a co-worker or an employee's bereavement when a loved one dies, can profoundly affect the workplace in a variety of ways. It can be difficult to maintain productive relationships with someone who is angry, anxious, and depressed and interacting with traumatized people can make others feel traumatized as well (HealthGate Data Corp., 2007:1).

According to Personal Assistance Services (2007:1) a sudden death of co-workers has a shock value that often takes a long time to process. The loss felt by staff will seem bottomless, and each person in the organization will grieve in a different way and be at different places along the grieving process spectrum. However, just because everyone grieves differently does not mean that they should be ignored and pretend like nothing is different.

The researcher is employed as an Employee Assistance Programme Practitioner by the Department of Health at Umgeni Hospital. Umgeni Hospital is a specialized hospital situated in Howick, and provides for the care of persons with mental, physical and multiple disabilities. It is a long-term care facility so employees inevitably get attached to the patients at the hospital and in the event

of the death of one of the patients; the employees go through the bereavement process.

The researcher further, through personal interviews with other professionals and consultations with employees, has learnt that employees have, within a short period of time, experienced the loss of several co-workers or colleagues through unexpected and traumatic events which they have found, and some still continue to find, difficult to cope with. According to the clinical psychologist at Umgeni Hospital, Mrs. Andrea Zank (2007), and as was stated above, during the period of loss of co-workers, the employees at Umgeni Hospital, definitely experienced the phases or process of bereavement. The shock or denial, inward anger, outward anger, depression and eventually acceptance had a huge impact on the employees functioning and productivity at work. The employees experienced difficulty in coping with the loss, difficulty in concentrating, as well as confusion as they never expected the deaths. According to Zank (2007) the hospital also has no formal programme in place to assist employees with such situations.

The above information was confirmed by Mrs. N.B. Buthelezi (2007), the social worker at Umgeni Hospital. Buthelezi (2007) however not only stressed the impact of the loss of co-workers but also the loss of patients at Umgeni Hospital. As was stated earlier Umgeni Hospital is a long term psychiatric hospital, with some patients living at the hospital for 30 years or longer. The death of these long term patients inevitably affects the employees, especially those working at the hospital for a long time. According to Buthelezi (2007) these patients eventually become like your own children, so the impact of their deaths are like the loss of a loved one or family member.

Hence, the researcher recognized, and supported by the clinical psychologist and social worker, that there could be a need for a bereavement support programme for employees of the hospital.

The researcher is of the opinion that the research findings will not only benefit her in a professional capacity, but it will also benefit the Department of Health as an organization and specifically Umgeni Hospital and its employees. This research could add value to the hospital and its employees as it could determine the exact or specific needs of the employees with regards to bereavement support. This will in turn assist in developing an appropriate bereavement support programme to assist employees in the future.

1.2 PROBLEM FORMULATION

According to Morrell (2000:2), one of the major challenges of death in the workplace is that grieving is not well understood and managers and employees do not have enough information or awareness to respond appropriately. It is not business as usual when someone dies and ignoring the situation will not make it go away.

Death in the workplace can be a difficult challenge to deal with on both a personal and professional level. Death may be a natural part of life, but the death of a co-worker will make everyone feel anything but normal. People may be listless and unable to work. They may be prone to crying or sobbing. They may be sad or depressed, angry or resentful to that person for leaving so many projects undone. They may be in denial that anything bad really happened. All of these reactions are coping mechanisms that help people to get through the hard times (Personal Assistance Services, 2007:1).

The researcher is of the opinion that these reactions could ultimately, if not addressed appropriately, impact on the employee’ s work performance in terms of poor concentration, more workplace accidents, substance misuse, decreased motivation, increase in absenteeism and as stated earlier the influencing of co-worker’s performance and morale (SETA, [sa]:16).

Therefore due to the lack of a formal bereavement support programme and the lack of scientific evidence on the need for a bereavement support programme for employees of Umgeni Hospital the researcher is of the opinion that it is essential to determine scientifically the need for a bereavement support programme for employees of Umgeni Hospital, which is the focus of this research.

1.3 GOAL AND OBJECTIVES OF THE STUDY

1.3.1 Goal of the study

According to Fouché and De Vos (2005a:104), the purpose or goal of a study is the broader, more abstract conception of the end toward which effort or ambition is directed, while the objective denotes the more concrete, measurable and more speedily attainable conception of such end towards which effort or ambition is directed.

The purpose or goal is the dream that one wants to achieve or attain and the objective is the realistic steps one has to take, within a time span, in order to attain the dream (Fouché & De Vos, 2005a:104).

The goal of this study is to investigate the need for an employee bereavement support programme at Umgeni Hospital.

1.3.2 Objectives of the study

The objectives of this study are:

- To conceptualize theoretically employee bereavement and its impact in the workplace as well as the support strategies for employees.
- To conduct an empirical investigation into the need for an employee bereavement support programme at Umgeni Hospital.
- To provide recommendations to the hospital management on the need for a bereavement support programme at Umgeni Hospital based on the information gained from this research.

1.4 RESEARCH QUESTION

A research question is one that yields hard facts to help solve a problem, produce new research or add to theory (NetTOM, [sa]:21).

Palmquist ([sa]:10) states that a research question is a way for you to approach a particular topic from your own point of view.

Fouché and De Vos (2005a:100) state that the careful conceptualization and phrasing of the research question are critical because everything we do in the remainder of the research process will be aimed at answering that research question.

The researcher formulated the following question for the present study:

What is the need for an employee bereavement support programme at Umgeni Hospital?

1.5 RESEARCH METHODOLOGY

The present study utilized a quantitative research approach as it aimed to investigate objectively, through a questionnaire, the perceptions of employees at Umgeni Hospital regarding the need for an employee bereavement support programme.

Applied research was used as the study aimed to solve the problem of the employee's need for an employee bereavement support programme at Umgeni Hospital.

The researcher is of the opinion that little is known about the need for an employee bereavement support programme at Umgeni Hospital. Therefore, in

the broader context of applied research, exploratory research was used to achieve the study's goal and objectives.

The randomized cross-sectional survey design, which is commonly used with surveys like the needs assessment phase of research, was most suitable for this study as little is known about the need for an employee bereavement support programme at Umgeni Hospital. This research design therefore assisted to investigate this need, through the administration of questionnaires to respondents.

The researcher utilized the data collection method of questionnaires. As the respondents in this study consisted of the employees at Umgeni Hospital, the researcher is of the opinion that hand delivered questionnaires was the most appropriate data collection method. The researcher distributed each questionnaire together with an envelope and requested the respondents to complete and place the questionnaire, in the sealed envelope, in a box outside the EAP office. This procedure helped to ensure the confidentiality, privacy and anonymity of the respondents.

In data analysis the first step is to prepare the data. The researcher used coding and changed the information provided on the questionnaire into numerical format, for example, male and female was changed to numbers one and two respectively. The numerical codes that were written on the questionnaires were then entered into a computer in a format that could be used by a statistical computer package, that is, the SPSS programme. The data was then checked for errors and corrected if necessary.

The results were then processed, analyzed and interpreted using univariate analysis. The variable that was analyzed and interpreted was the employee's need for an employee bereavement support programme at Umgeni Hospital. The

data was then displayed and summarized using the frequency distribution of this variable which was displayed in table format and various graphical presentations.

The researcher conducted a pilot study with a group of five hospital personnel who was not a part of the main study. They were asked to complete the data collection instrument (questionnaire) independently and then they were asked to give feedback to the researcher. This enabled the researcher to ensure the validity and reliability of the instrument by identifying deficiencies in the instrument and correcting them. One deficiency that was identified was in Section C of the questionnaire. The headings of the Impact of Event Scale – Revised (IES-R) was not included on the pages where the scale continued, which made it difficult for the respondents to answer the questions on the scale as they had to go back to the beginning of the scale each time. These recommended changes from the pilot study made completion of the instrument in the main study much easier.

The researcher is of the opinion that the research was feasible as it was conducted within the researcher's area of operation. The researcher is the Employee Assistance Programme Practitioner at Umgeni Hospital, therefore respondents and resources was easily accessible and difficulties in terms of suitable venues, transport and other logistical arrangements was not experienced.

The researcher obtained written permission from the Department of Health, Kwa-Zulu Natal (Appendix A) as well as the Hospital Manager at Umgeni Hospital (Appendix B).

The universe of the present study was 55 237 Department of Health personnel in Kwa-Zulu Natal. The population was all the employees at Umgeni Hospital that is 422 personnel. The research sample comprised of 16% of the population, that is, 70 employees.

For the purpose of this research, probability sampling was used. In the context of probability sampling, systematic sampling was used. The motivation for the researcher using this sampling method was that it was possible to obtain a list of all personnel at Umgeni Hospital, from management to general assistants, who were then randomly chosen as respondents using a selected interval, that is, every fifth interval for this study, up to 70 respondents who were selected to represent the population.

1.6 ETHICAL ASPECTS / ISSUES

Ethics is a set of moral principles which is suggested by an individual or group is subsequently widely accepted, and which offers rules and behavioural expectations about the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students (Strydom, 2005:57).

Especially when working in the sensitive field of bereavement, researchers need to be more alert in considering a number of ethical issues. The following are the ethical issues that the researcher took note of in the present study:

1.6.1 Informed and Voluntary Consent

Babbie (2004:64) defines this ethical issue as a norm which subjects base their voluntary participation in research projects on a full understanding of the possible risks involved.

The researcher ensured that the research respondents received adequate information regarding the goal and procedures of the study. The respondents were informed that they could withdraw at any time if they wish and that the researcher would be available to answer any questions that they had. The

research respondents were further required to sign a letter of informed consent (Appendix D).

1.6.2 Confidentiality/ Privacy/ Anonymity

A research project guarantees confidentiality when the researcher can identify a given person's response but promises not to do so publicly (Babbie, 2004:66).

Neuman (2000:99) defines confidentiality as information that may have names attached to it but the researcher holds it in confidence or keeps it secret from public.

Clarke (2006:2) defines privacy as the interest an individual has in controlling or at least significantly influencing the handling of data about themselves.

Anonymity is the quality or state of being unknown or unacknowledged (*The American Heritage Dictionary of the English Language,* 2004:15).

The researcher explained to the respondents that confidentiality, privacy and anonymity would be maintained. The respondents were told how the data would be collected, recorded, stored and processed for release. They were informed that the researcher would distribute each questionnaire together with an envelope and requested them to complete and place the questionnaire, in the sealed envelope, in a box outside the EAP office. This procedure helped to ensure their confidentiality, privacy and anonymity.

The respondents were further assured that all means of maintaining their confidentiality, privacy and anonymity would be used, not only in the covering letters but verbally and by coding each questionnaire to protect their private information. Therefore all completed questionnaires were coded, stored in a secure lockable cabinet; the information will not be released in a way that permits

linking specific individuals to specific responses and will be publicly presented only in an aggregate form, such as percentages.

1.6.3 Avoidance of harm

According to Strydom (2005:58) subjects can be harmed in a physical and/or emotional manner. The researcher informed the respondents of any possible emotional or physical risks involved in disclosing information regarding the sensitive subject bereavement. The option of them withdrawing was then explained to them again. The researcher also explained to them that if they wished to continue and experienced emotional and physical harm, such as uncertainty or disclosure of their personal experiences and its associated stress, during or after the research process, the researcher, if she could not assist them herself, arranged in advance for relevant experts, such as the psychologist in the hospital, to assist. However, none of the respondents needed any professional assistance.

1.6.4 Debriefing

The National Trauma Committee of the South African Police Service (NTC) (1998:5) defines debriefing as a means of emotional unloading or ventilation of feelings in a controlled and safe environment. The symptoms and feelings the person experiences are normal reactions to an abnormal situation.

French and Harris (1999:2) define trauma debriefing as Traumatic Incident Reduction (TIR). The two authors view it as a powerful regressive, repetitive, desensitization procedure or effective tool for use in the rapid resolution of virtually all trauma relation conditions.

The researcher ensured in advance that debriefing be offered to respondents if required. However, none of the respondents needed any debriefing.

1.6.5 Deception of respondents

Neuman (2000:229) states that deception occurs when the researcher intentionally misleads subjects by way of written or verbal instructions, the actions of other people, or certain aspects of the setting.

The researcher helped alleviate this by informing the participants of all necessary information, whether this would make them want to withdraw from the research study or not. The researcher also undertook to give the respondents a true reflection of the data collected. The researcher avoided any form of deception.

1.6.6 Actions and competence of researcher

Researchers are ethically obliged to ensure that they are competent and adequately skilled to undertake the proposed investigation (Strydom, 2005:63).
The researcher is of the opinion that she was competent to do the research as it was done in her field of employment. She ensured objectivity as she is a professional and understands its importance in the research process. The researcher further understood the research process properly before undertaking the research and liaised with relevant experts when necessary.

1.6.7 Release or publication of the findings

Results of studies should be published with careful attention to the rights of respondents. Care should be taken to protect the identities of individuals and groups, especially if it was guaranteed in the consent agreement. Researchers should not falsify or fabricate data in their publications and should point out the limitations of their findings. Errors in publication should also be publicly acknowledged and recognized (Durrheim & Wassenaar, 2006:70).

The researcher wrote the research report as honestly, accurately and objectively as possible. The report is clear and contains all the necessary information. Confidentiality and anonymity of the respondents was maintained.

1.7 DEFINITION OF KEY CONCEPTS

NEEDS ASSESSMENT

A needs assessment is a process of looking at many kinds of information about a target group or community (Fallis, 1998: sn).

According to Bless and Higson-Smith (2000:46) needs assessment is a survey of all facets of the community in order to define the various concerns of all community members.

The researcher is of the opinion that a needs assessment is a survey in which information is gathered to determine a specific need to address a specific problem or issue. In the context of this study it refers to a survey in which information is gathered to determine the perceptions of employees at Umgeni Hospital regarding the need for an employee bereavement support programme.

BEREAVEMENT

A state of sadness, grief, and mourning after the loss of a loved one (National Cancer Institute, 2006:11)

The period after a loss during which grief is experienced and mourning occurs. The time spent in a period of bereavement depends on how attached the person was to the person who died, and how much time was spent anticipating the loss (Webster's New World Medical Dictionary, 2003:40).

The researcher is of the opinion that bereavement is the time when a person is attempting to deal with his or her feelings and sense of loss of someone or something close to them.

PROGRAMME

A list of the successive items of any entertainment, public ceremony, conference, course of study plus other relevant information (Cassell's English Dictionary, 2000: 986).

A resemblance of a project in that it is a set of objectives designed to facilitate the achievement of specific objectives but generally on a larger scale and over a longer time frame (Cusworth & Franks, 1993:1).

The researcher is of the opinion that a programme is an organized and well planned schedule or agenda aimed at achieving a particular goal or objective. In the context of this study a programme would be a well planned schedule to assist employees of Umgeni Hospital during their time of bereavement.

EMPLOYEE

A person who works for another in return for financial or other compensation (Dictionary of Business Terms, 2000: 90).

A person who is hired by another person or business for a wage or fixed payment in exchange for personal services and who does not provide the services as part of an independent business; any individual employed by an employer (The 'Lectric Law Library's Lexicon, 2007:1).

According to the researcher, an employee is any person performing a particular task for which he or she is reimbursed. In the context of this study an employee would be any person that is being paid by Umgeni Hospital for tasks that he or she is performing.

SUPPORT

To give aid or encouragement to a person or cause (The American Heritage Dictionary of the English Language, 2004: 190).

The activity of providing for or maintaining by supplying with money or necessities (Webster, [sa]:sn).

The researcher is of the opinion that support is the offering of assistance through varies means or methods. In this study support would be the assistance or activities offered through the bereavement support programme.

UMGENI HOSPITAL

A hospital is an institution where sick or injured are given medical or surgical care (Webster's New World Medical Dictionary, 2003:40).

Hospitals are health facilities where patients receive treatment (Webster, [sa]: sn).

According to the researcher, a hospital is an institution that offers medical and health care services.

Umgeni Hospital is a specialized hospital situated in Howick, and provides for the care of persons with mental, physical and multiple disabilities. The hospital caters for people of all races, from 3 years of age and serves the entire KwaZulu-Natal region.

1.8 LIMITATIONS OF THE STUDY

The researcher understands that in any research study there are limitations of the study. The limitations of the study provide potential shortfalls or weaknesses of the study. This simply means the difficulties or challenges experienced by the researcher while conducting the research study.

The researcher did not encounter major limitations during the study but did experience a problem in receiving questionnaires back punctually, due to employees of the hospital having different working hours or working different shifts. However after some follow-up attempts all questionnaires were received.

1.9 CONTENTS OF THE RESEARCH REPORT

The research report for the present study consists of the following four chapters.

CHAPTER 1: General background

CHAPTER 2: Theoretical conceptualization of employee bereavement and its impact in the workplace as well as a discussion on support strategies for employees.

CHAPTER 3: Empirical investigation into the need for an employee bereavement support programme at Umgeni Hospital, data analysis and interpretation.

CHAPTER 4: Chapter four focused on the conclusions and recommendations based on the research findings.

CHAPTER 2
BEREAVEMENT IN THE WORKPLACE

2.1 INTRODUCTION

The experience of bereavement is an important and widespread social phenomenon. Losing someone or something you love is very painful and it is something that almost everyone will experience at some point in their lives.

Bereavement is derived from a root word meaning ‘shorn off’ or ‘torn up’; indicating being stripped or suddenly deprived of something against a person’s will (DeSpelder & Strictland, 1999:224). According to the American Psychological Association (APA) (1994:684), in DSM IV, bereavement is, “the diagnostic category which can be used if the focus of clinical attention is a reaction to the death of a loved one”.

Bereavement is often used interchangeably with the word grief. This is as a result of both these words being used to describe the sense of loss felt when a loved one passes away. This sense of loss may contain a host of emotions such as sadness, anger, guilt, frustration and anxiety and the period immediately following the death is often referred to as the bereavement period (Facing Bereavement, 2007:1). The researcher would therefore in this study use the terms grief and bereavement interchangeably.

However, some literature defines grief and bereavement as different processes. Grief, according to the National Mental Health Foundation Centre ([Sa]: 1), is the normal response of sorrow, emotion and confusion that follows after losing someone or something important to you. It is a natural part of life and a typical reaction to death, divorce, job loss, move away from family and friends or loss of good health due to illness. According to DeSpelder and Strictland (1999:224) grief is a universal experience, a reaction to loss as an irreversible event, and

often thought of in negative terms such as distress, suffering, sorrow and anguish, as well as in terms of anger, relief and self-pity.

McMurray (2000: sn) however states that bereavement extends beyond grief to affect many aspects of physical, social, emotional and psychological health including loss of social support and function, physical symptoms, change of hopes and changes in financial status.

King and Tellioglu (2007:1) explain further that although people who are grieving continue to work and socialize, it inevitably affects their productivity at work and school. The researcher agrees with King and Tellioglu's (2007:1) point of view as, in her professional experience as an Employee Assistance Programme Practitioner and working with grieving employees, the effects of grief and bereavement on job performance and productivity can easily be identified. Due to the short length of allocated bereavement leave, employees are forced to return to work soon after the loss of a loved one and the following effects are identified in some employees:-

- poor concentration which results in slower production rates and poor performance
- employees isolating themselves from co-workers
- inability to control emotions and temper which affects co-workers and in turn productivity
- extreme tiredness which could result in workplace accidents
- unreliability

The above are just a few effects of grief and bereavement in the workplace that have been identified by the researcher.

The researcher will therefore in this chapter provide an overview of grief and bereavement, its signs and symptoms, theories on grief and bereavement and the grief process, grief and bereavement in the workplace and workplace bereavement support programmes.

2.2 SIGNS AND SYMPTOMS OF GRIEF AND BEREAVMENT

Grief and bereavement is a personal process. Different people may grieve in different ways and these may vary by families and culture. Some people may express their sorrow openly by crying whereas others believe certain aspects of grieving should remain private. According to King and Tellioglu (2007:1), the course of normal grief reactions is determined by a number of factors such as:-

- the pattern of previous losses;
- how these were handled;
- personal (ego) strengths;
- the closeness of the attachment;
- the mode of death;
- additional current problems;
- the nature of family and community support;
- Opportunity for new attachments that can give similar satisfaction.

However, although each person will grieve in their own way, there appears to be general or common patterns in terms of signs and symptoms in response to loss (King & Tellioglu, 2007:1).

Gadi (2006:1) states that the entire person, mind, body and spirit, reacts when responding to grief. Common normal reactions can include physical, emotional, behavioural or psychological, social and even spiritual changes.

Physical symptoms include fatigue, feelings of exhaustion, weakness, shortness of breath, tightness in the throat, palpitations, nausea, diarrhea, constipation, aches and pain (abdominal, stomach, back, headaches), lightheaded, trouble sleeping, change in appetite leading to increased or decreased weight, change in sex drive and substance abuse (Gadi, 2006:1).

Tousley (1991:1) provides the following emotional symptoms or reactions: shock, crying, sadness, anger, irritability, panic, anxiety, meaninglessness, apathy,

numbness, disbelief, denial, guilt, relief, fear, loneliness, longing, vulnerability, abandonment and helplessness.

Behavioural and/or psychological symptoms include wondering aimlessly, searching for the deceased, needing to retell the story of the deceased's death, avoiding to talk about loss so that others would not feel uncomfortable, appetite disturbances, forgetfulness, slowed thinking, difficulty concentrating, dreams of the deceased, hallucinations of the deceased, sleep disturbances, confusion, depression and sense of the deceased's presence (Horinek & Solove, 2002:1-5).

Grief Watch (2003: 1-2) provide the following social symptoms or reactions: overly sensitive, dependent, withdrawn, avoidance of others, lack of initiative, lack of interest, less productive, hyperactive, under active, relationship difficulties and lowered self esteem.

Spiritual symptoms or reactions include doubting belief systems, questioning spiritual values, spiritual injury, loss of faith, disappointment in religion, feelings of betrayal by God / Spiritual force, anger with God and preoccupation with own death (Gadi, 2006:2).

During the grieving period, the bereaved person experiences some or most of the above symptoms or reactions. Although these experiences are difficult, their purpose is to make a transition to life without the deceased. As this transition progresses, the intensity of grief subsides and it helps the bereaved person to accept the death and re-engage in their own lives (Shear, Sa: 2).

However, according to Gill, Smith and Segal (2007:4), grief tends to be mixed with trauma when a loss is sudden and unexpected, a fatal heart attack, suicide, an accident, a murder are perceived to be outside the normal cycle of life, as is the death of a child. For example, someone who nurses a sick spouse through a long illness will grieve when the spouse is gone, but the person who witnesses

the sudden death of a spouse in a car crash will likely be traumatized as well. While trauma always incorporates grief, the two states are very different in how you experience them and what effect this would have on you. Grief is a normal reaction to loss, with its symptoms diminishing over time. On the other hand, trauma is a disabling reaction that can block the grieving process, disrupt your life, and leave you psychologically vulnerable. If you are coping with a traumatic loss, you may want to think about turning to a counselor or other professionals for help.

In Table 1, Gill *et al.* (2007:5), provides the following differences on the effects of grief and trauma.

TABLE 1: THE EFFECTS OF GRIEF AND TRAUMA

The Effects of Grief	*The Effects of Trauma*
Sadness is the dominant emotion	Terror is the dominant emotion
Grief feels real	Trauma feels unreal
Pain is related to the loss	Pain involves not just loss, but terror, helplessness, and fear of danger
Talking about grief can help	Talking about trauma is difficult or impossible
Anger is nonviolent	Anger often involves violence towards yourself or others
Guilt involves unfinished emotional business with the deceased	Guilt includes self-blame for what happened or thoughts that it should have been you who was harmed
Your self-image and confidence generally remain intact	Your self-image and confidence are distorted and undermined
You dream about the person you lost	You dream about yourself in danger
Symptoms lessen naturally over time	Untreated symptoms may get worse

Shear (Sa: 2-3) explains traumatic grief and the symptoms as:-

- Preoccupation with the person who died
  - ❖ Recurrent intrusive thoughts, memories and images of the deceased
  - ❖ Intensive yearning for the deceased
  - ❖ Persistent searching for the deceased
- Intense painful emotions
  - ❖ Intense sadness
  - ❖ Irritability, bitterness or anger related to the death
  - ❖ Intense envy of others who have not lost someone
  - ❖ Persistent feelings of being stunned, dazed or shocked
- Social withdrawal
  - ❖ Purposelessness – feelings of futility about the future
  - ❖ Avoidance of activities that are reminders of the deceased
  - ❖ Avoidance of social gatherings
  - ❖ Avoidance of places related to the death

The researcher, based on the above information, is of the opinion that people experience grief and bereavement differently due to various influences such as culture, tradition, personality traits, relationship with the deceased and even societal expectations. Despite these influences, people experience common signs and symptoms of normal grief and bereavement which affect them physically, emotionally, behaviourally, psychologically, socially and spiritually, of which they are able to work through over a period of time as these signs and symptoms decrease. However, if the loss of a loved is unexpected, people may experience traumatic grief and may require professional assistance to help them deal with their grief. People further require varied time periods to deal with their grief but they are forced to return to work soon after the loss of a loved one because their bereavement leave is finished. This results on the grief and bereavement impacting on the workplace through their possible poor job performance and productivity at work.

In order to further understand grief and bereavement and its impact, it is important to explore theories of grief and bereavement and the bereavement process, which will now be discussed.

2.3 THEORIES ON GRIEF AND BEREAVEMENT AND THE GRIEF PROCESS

There is a lot to learn about grief and bereavement especially the necessity of grieving a loss. Some people do not allow themselves to grieve; they hold it in, only to have it negatively affect them for the rest of their lives. Some people tend to wallow in their grief too long, unable to adjust. Although the grieving process is difficult for each individual, it is imperative that grief be worked through so that you can re-adjust and go on living a healthy life (Nix, 2006:2).

The researcher chose to combine the grief process with the theories on grief and bereavement as most theories, that will be discussed, will explain the grief process in their respective contexts.

Sherer (2004:3) stated that it is important to note that the grief process is not linear, but is more often experienced in cycles. Grief is sometimes compared to climbing a spiral staircase where things can look and feel like you are just going in circles, yet you are actually making progress. Hence the explanations of the grief process in phases or stages.

King and Tellioglu (2007:1) add to this and state that some people go through the stages quickly or even skip some stages entirely. Other people seem to linger or return to certain stages after a period of feeling better, for example, during anniversaries and special days.

Several blueprints or theories about grief have been proposed. In this study the researcher has chosen to briefly discuss the following well known and common theories of seven theorists.

2.3.1 Freud

In 1917 Freud wrote an article on grief called "Trauer und Melancholi". This became crucial because he introduced two important concepts for understanding the nature of grief. He used the term "object loss" to describe losing something or someone to whom one is attached. The goal of the grief is to break the bond that exists between the griever (the subject) and the deceased (the object). This demands a heavy psychological input from the mourner, so Freud called this process "Grief Work" (Woof & Carter, 1997: 443-448).

2.3.2 Lindemann

Another classic contribution to the understanding of grief came from the American psychiatrist Eric Lindemann. Lindemann wrote a landmark study in 1944 titled " Symptomatology and management of acute grief", which observed and interviewed one hundred and one patients who were experiencing grief, due primarily to the Cocoanut Grove Fire in Boston, or relatives of members of the armed forces. This pioneer study in grief investigation focused on acute grief being a "normal reaction to a distressing situation" rather than a psychiatric or medical condition (Lindemann, 1944:141).

He was the first to describe the physical and mental symptomatology of acute grief, and demonstrate that people's reaction patterns, when the grief is released, are remarkably uniform. His work thus became the foundation for our being able to distinguish between normal and pathological grief reactions (Lindemann, 1944:141). The normal course of grief, according to Lindemann (1944:141), consists of the following three stages:-

- Stage 1: Relinquish the attachment

In the first stage the bereaved must relinquish the attachment he or she has to the deceased and develop a new relationship with the loved one based on the status which has been altered.

- Stage 2: Readjustment to the world

The second stage involves readjustment to the world without the deceased, where the person must adopt new skills and roles to accommodate the world he or she lives in now without their loved one, and to compensate for functions once performed by the deceased.

- Stage 3: Reinvest emotional energy

The final stage is when the bereaved is able to invest emotional energy into someone or something else. Preoccupation with the deceased is lessened and there is a gradual re-entry into both new relationships and daily life in general (Lindemann, 1944:143).

2.3.3 Bowlby

The 1950's and 1960's saw what is known as the emergence of the death and dying movement. One of the landmark theorists of the time was John Bowlby whose **Attachment Theory** is "the most impactful theory in the field of bereavement" (Stroebe & Schut, 1995:3).

Bowlby's theory is based on attachment and loss and stemmed from the belief that bereavement is an unconscious process in which childhood experiences of attachment are of great importance when experiencing later loss. Bowlby stresses that part of a child's behaviour is aimed at creating and retaining contact with the mother. It cries, seeks, calls, smiles, grips, holds on and so on. Part of a mourner's behaviour may be understood as an attempt to make contact with or in some more unconscious way to hold on to the deceased. Weeping may thus be a way of summoning the deceased, just as a baby cries to summon his mother (Stroebe & Schut, 1995:10).

Bowlby (1961:318) identifies the following seven themes in the process of mourning which he regards as normal.

Theme 1

His first theme in question form is, "What is the nature of the psychological process engaged in healthy mourning?" in which he explores the effects of withdrawing emotional attachment from a lost object and preparing for developing new relationships.

Theme 2

Bowlby's second theme explores why mourning is so painful.

Theme 3

The third theme explores the relationship between mourning and anxiety, from the view that anxiety is the response when the mother figure is temporarily absent, turning to mourning when she is permanently gone.

Theme 4

Questioning the motivations of mourning by exploring the expressions of weeping as an instinctive behaviour is Bowlby's fourth theme.

Theme 5

The fifth theme is mourning associated with anger and hatred with anger having two objectives; anger against anyone who seems to have contributed to / or been responsible for the loss, and secondly anger against those trying to prevent the reunion with the lost object.

Theme 6

Defining the line between pathological and healthy mourning was Bowlby's sixth theme.

Theme 7

Bowlby's final theme questions "at what stage of development and by what processes does the individual arrive at a state which enables him or her to respond to loss in a healthy manner?"

Bowlby's theory further contained **Four Phases of Mourning,** namely:-

Phase 1 - Numbness

The first phase is numbness where the bereaved is stunned, often denying the loss and not truly understanding it.

Phase 2 – Yearning and searching

The second phase is that of yearning and searching to reunite with the lost person that includes the expressions of weeping and anger.

Phase 3 – Despair and Disorganization

Despair and disorganization is the third phase in which the bereaved learns that reuniting with the lost person is not possible which leads to disorganization as there is no desire and ability to see meaning in life.

Phase 4 - Adjustment

The final phase is when the bereaved breaks attachments with the deceased, redefines his or her sense of identity and situation and begins to establish new bonds, relationships and acquires new skills (Bowlby, 1961: 334).

2.3.4 Elizabeth Kubler-Ross

Elizabeth Kubler-Ross did a great deal of work in the field of grief, and clarified five stages of grief in her **grief cycle model**. Each and every stage of grief must be passed through and experienced before you can heal. She later stated that these stages are not necessarily or usually experienced in order and one must be aware that even though you think you may have worked through a stage, you may suddenly find yourself back in it. It just means that there is something else that needs to be worked through. Kubler-Ross stated that it is important to remember that grieving is a process which must be emotionally worked through effectively at each stage (Nix, 2006:6-7).

Kubler-Ross (1969:39) identified the following five stages in the grief process:-

Stage 1 – Denial and isolation

The first stage of her theory is labeled denial and isolation. Denial is a conscious or unconscious refusal to accept facts, information and reality and therefore acts as a buffer after unexpected shocking news. It is a perfectly natural healthy reaction or coping mechanism to painful stimuli and most people used this as a temporary defense. Some people can become locked in this stage when dealing with a traumatic change that can be ignored. Death of course is not particularly easy to avoid or evade indefinitely (Kubler-Ross, 1969: 39).

Stage 2 - Anger

The second is the stage of anger. Anger can manifest in different ways therefore this stage is difficult to cope with, especially for family and colleagues, as the anger is displaced and projected onto people and the environment. Knowing this, it helps to remain detached and non-judgmental when experiencing the anger of someone who is very upset. It is also important to respect, understand and give time and attention to the bereaved person so that he or she still feels valued (Kubler-Ross, 1969:51).

Stage 3 - Bargaining

Bargaining is the third stage of the grief cycle model. During this phase individuals try to postpone the inevitable from happening by making deals or entering agreements. The bargain is usually always for an extension of life of the loved one and is finalized by the promise to not ask for more once this is granted. The bargains are usually kept secret and are often made with God which brings about feelings of guilt for actions such as not attending church regularly. Bargaining rarely provides a sustainable solution, especially if it is a matter of life or death (Kubler-Ross, 1969:84).

Stage 4 - Depression

Kubler-Ross' (1969:97) fourth stage is depression. This stage is also known as preparatory grieving. In a way it is the dress rehearsal or the practice run for the

aftermath although this stage means different things depending on whom it involves. It is sort of acceptance with emotional attachment. It is natural to feel sadness and regret, fear and uncertainty as it shows that the person has at least begun to accept the reality and begins to lose the numbness and anger. The losses are not only physical, but also include financial, psychological, job or role losses, spiritual and loss of independence (Chapman, 2006:4).

Stage 5 - Acceptance

The fifth stage of acceptance is finally reached once the previous four phases have been effectively worked through. Again this stage definitely varies according to the person's situation although broadly it is an indication that there is some emotional detachment and objectivity. People dying can enter this stage a long time before the people they leave behind, who must pass through their own individual stages of dealing with grief (Chapman, 2006:4).

Chapman (2006:1) notes that Kubler-Ross' five stage grief model is also transferable to personal change and emotional upset resulting from factors other than death and dying such as work redundancy, enforced relocation, crime and punishment, disability and injury, relationship break-up, financial despair and bankruptcy. This makes the model worthy of study and reference far outside of death and bereavement and could be regarded as a "change model" for helping to understand and deal with personal reaction to trauma. This is because trauma and emotional shock are relative in terms of effect on people. While death and dying are for many people the ultimate trauma, people can experience similar emotional upsets when dealing with many of life's challenges, especially if confronting something difficult for the first time and / or if the challenge happens to threaten an area of psychological weakness, which we all possess in different ways.

2.3.5 Parkes

In 1972 Collin M. Parkes published the book **"Bereavement: Studies of Grief in Adult Life"**, that was epoch-making for research into grief reactions. His work comes from a psychiatrist's point of view, indicating that, "part of the difficulty in fitting grief into existing descriptive disease categories derives from the fact that grief is a process and not a state" (Bowlby, 1972:21). In it he gathered his experience from an investigation into widows' grief reactions and gave a detailed description of the many constituent processes of which the normal grief work consists. What is particularly interesting about Parkes' writings is his close collaboration with Bowlby, who inspired him to take as his starting point, for a better understanding of the grief process, the attachment between the mourner and the deceased. As mentioned earlier, Bowlby stresses that part of the child's behaviour is aimed at creating and retaining contact with the mother. Bowlby and Parkes agree that part of the mourner's behaviour may be understood as an attempt to make contact with or in some more unconscious way to hold on to the deceased (Bowlby, 1972:8).

2.3.6 Worden

Another well known and recognized theorist is Worden whose theory comprise of the "**Four Tasks of Mourning**" rather than stages. According to Worden (1991:11) mourning is a process, not a state of mind, and as in any process, work is done so that the process can proceed to successful finalization.

Duff (2005:4-7) describes Worden's four tasks as follows:-

Task 1

The first task is **accepting the reality of the loss**. This task involves coming face to face with the reality that the person is dead and will not return. Often the bereaved refuse to face the reality of the loss, and may go through a process of not believing, and pretending that the person is not really dead. This denial can take several forms. Denying the facts of the loss, the bereaved may manifest

symptoms that range from slight reality distortions to full blown delusions. There may be attempts to keep the body in the house, retaining possessions ready for use when the deceased returns or keeping the room of the deceased untouched for years. Denying the meaning of the loss is another form, in an attempt to make the loss less significant than it actually is. The bereaved may express thoughts such as “we were not close” or “he was not a good person” or may remove all reminders of the deceased so as not to be reminded of his or her existence. A third form is denying that death is irreversible in an attempt to maintain the attachment. The bereaved may seek recourse to spiritualists. There may be incidents of selective forgetting, or blocking out memories of the deceased. Traditional rituals such as burials and cremations may help the bereaved accept the loss as the rituals force them to face the realty of death (Duff, 2005:4).

Task 2

The second task is to **work through the pain of grief**. The process of allowing oneself to feel the pain rather than suppressing the experience is thought to be beneficial in the normal resolution of mourning. In some social contexts the expression of grief may be encouraged, while in others a subtle message may be given that the mourner should stop grieving and get on with life. Hence, the expression of grief may be considered unhealthy and demoralizing, with the proper action of a friend being to distract the mourner from grief. People can hinder the mourning process by avoiding painful thoughts, using thought stopping strategies, or by entertaining only pleasant thoughts of the deceased, idealizing the dead, avoiding reminders of the dead and using alcohol and substances to desensitize (Duff, 2005:4).

Task 3

To adjust to an environment in which the deceased is missing is the third task. Following the death, the bereaved must take on new roles and adjust to the changed dynamics in his or her environment. Frequently the full extent of what this involves, and what has been lost, is not realized for some time after the loss

occurs. Many resent having to develop new skills and cope with the changed situation. In addition, survivors have to cope with their own sense of self, particularly if they have denied their own identity so as to care for others following the death. If attempts to fulfill the roles previously carried out by the deceased fail, a reduction in self-esteem can result. Alternatively the bereaved may promote their own helplessness by not using or developing the skills that they need to cope. In response, the bereaved person may withdraw from the world and not face the requirements of the situation (Duff, 2005: 4-5).

Task 4

The final task is to **withdraw emotional energy and re-invest** it in another relationship. Emotional relocation requires that the bereaved form an ongoing relationship with the memories associated with the deceased, in such a way that they are able to continue with their own lives after the loss. Holding on to the past attachment rather than allowing the evolution of a new relationship with the memories of the deceased can hinder this task (Duff, 2005: 5).
Nix (2006:5) builds on this final stage of Worden's theory and states that the support and encouragement of a loving family and good support group is necessary to move on with your life.

Worden (1991: 10) emphasizes the importance of completing all tasks, not necessarily in any specific order, as incomplete grief tasks can impair further growth and development. Mourning is considered to be complete when the person is able to experience pleasures, take on new roles, look forward to new events, and when memories of the deceased no longer evoke physical responses of sorrow and pain, although occasional feelings of sadness my remain.
The model of the grief process presented by Worden provides a comprehensive framework around which counseling and therapy can be structures to help individuals to resolve their grief in a satisfactory manner (Duff, 2005:7).

The researcher is of the opinion that Worden's four tasks, as explained by Duff (2005:4-7), is very similar to Lindemann's (1944:141) stages as they both discuss acceptance of the loss and working through the pain, adjusting to the environment and reinvesting of energy into new relationships.

2.3.7 Stroebe and Schut

Stroebe and Schut (1995: 20-21) proposed the **Dual Process Model**. This model explores the belief that one must confront the bereavement in order to experience coming to terms with the loss and avoid ill health due to grief. Two fundamental stressors are identified in this model, that is, loss-orientated stressors and restoration-orientated stressors. Loss-orientation refers to the "concentration on, dealing with, processing of some aspect of the loss experience itself, most particularly, with respect to the deceased person". The focus is on the bond shared, expressed by rumination about the life together, the person, and the circumstances of death. Loss orientation dominates early bereavement, however the authors point out that their model is "not a phasal model. We do not propose a sequence of stages but rather a waxing and waning, an ongoing flexibility, over time" (Stroebe & Schut, 1995: 20-21).

Restoration-orientation is the second type of bereavement stressor. This is a relatively new concept in grief literature and counseling programming. The focus is not on the result of the stress but on the secondary source of stress such as role changes and task mastery, changes of identity and relationships and "what needs to be dealt with", for example social loneliness, and" how it is dealt with", for example avoiding solitariness. The switching between loss-orientation and restoration-orientation coping is necessary for optimal adjustment, mental and physical health, as emphasized by this model.

From the researcher's point of view, although Stroebe and Schut do not talk about phases, stages or tasks, their two stressors can also be linked to Worden's tasks (Duff, 2005:4-7) and Lindemann's (1944:141) stages. The loss-oriented

stressors are similar to Worden's first two tasks (Duff, 2005:4-7) and Lindemann's (1944:141) first stage as they all focus on dealing with and processing of the loss of a loved one. The restoration-oriented stressors are similar to Worden's third and fourth tasks (Duff, 2005:4-7) and Lindemann's (1944:141) second and third stages as these all focus on aspects of the person's adjustment to their new situation and ways of coping without the deceased.

Grief Work, stages, phases, themes and tasks of the grief process! The researcher is of the opinion that these are all guide posts to help an individual deal with their grief. As stated numerously in the study, each individual deals differently with their grief so they might not follow these steps in the orders as stated, but may fluctuate between them depending on their needs and emotions at different points in the grief process. These theories however definitely makes understanding of the grief process much easier and will further assist in the understanding of grief and bereavement in the workplace.

2.4 BEREAVEMENT AND GRIEF IN THE WORKPLACE

These days, most people spend more of their waking hours at the workplace than at home. People who work together may become close like an extended family. Therefore when a colleague dies or one is grieving a death or a loss, the impact on his or her co-workers can be tremendous and can influence the workplace in a variety of ways. Productivity can be compromised and the dynamics of the workplace can change. When the death is unexpected, in a violent act or an accident, the grief response can be quite traumatic for the survivors, further impacting on work (Dyer, 2002:1).

Because employees spend a lot of time at the workplace, they often learn more about their colleague's personal life than they do about that individual's job. Then, suddenly, someone to whom they have said, "Good morning" to everyday is gone! The person with a communal workload has passed away; the friend with

whom personal stories have been shared is no longer there. The employees who remain can be distracted by emotions that range from confusion to chaotic pain, from dismay to devastation (Grief in the Workplace, 2000:1).

One of the difficult certainties of life is that at certain times it is touched very deeply by the human sense of loss. The death of a parent, sibling, family members, friends and working colleagues affects us in many different ways. Apart from the grief itself it can create a sense of instability, of worry, concern and unease. These emotions can express themselves in many different forms in the workplace and can have deeply personal and wider impacts. Death is an inevitable and normal part of life and work. It is a painful reality which all of us have to face at some point in our lives although most of us prefer not to have to deal with it. Death is challenging especially at work where it can be seen as a taboo topic which is best avoided or at least, dealt with privately (McGuinness, 2007:9).

After the death of a close relative or friend it is customary for the bereaved person to be allowed three days of compassionate leave from work. This is often not sufficient time for the funeral to be arranged or for the bereaved person to recover sufficiently emotionally. Some people find it very difficult to return to work whereas others find work diverts their mind away from grief. According to McGuiness (2007:9) the benefits of going back to work after bereavement are:

- Enables the worker to return to a known safe environment surrounded by workmates or colleagues.
- Encourages the worker to resume a regular daily routine again, such as getting up and having meals at certain times.
- Takes the mind away from grief and enables the worker to feel normal for a while.
- Successfully completed work may help the bereaved person feel more confident and raise their self esteem.

For others there could be difficulties of returning to the workplace. Returning to the workplace could be an overwhelming burden in addition to their grief and they may need extra time off. McGuiness (2007:9) further states that when back at work, some people are affected by reduced work performance which may be caused by:-

- Lack of concentration and memory.
- Tiredness from emotion and sleepless nights.
- Feelings of depression.
- Reduced patience and short temper.

The researcher agrees with McGuiness (2007:9) as through conversations with bereaved co-workers, they expressed feelings of exhaustion, lack of motivation to be at work, lack of concentration as they are preoccupied with thoughts about family at home and some even stated that they themselves have not dealt with their grief as yet, as they need to be strong for their family members.

Management and workers may not appreciate the difficulties that grief can cause and the worker may worry that they will lose their job from reduced work performance or because of extra time taken from work. Bereaved workers may also worry that they have developed a reputation for:-

- wasting time
- taking too much sick leave
- being bad tempered, unreliable, unstable
- receiving special treatment

The worker may be tempted to give up a job for fear of failure or to reduce the pressure on them (Grief reactions associated…, 2007).

Dyer (2002:1) states that grief and loss occurs both at work and home, but these two realms can be difficult to separate. Serious illness and death in the family commonly affect a person's workplace performance. Typically, the grief response results from a personal crisis – divorce, fire, work-related or auto accident,

sudden death, heart attack, stroke, suicide, accident, homicide, chronic or terminal health problems, or job termination, layoff or dismissal.

According to the Canadian Mental Health Association (2004:1) responses to grief may include mental lapses, decreased energy, difficulty in making decisions, anxiety, helplessness, an inability to concentrate and preoccupation. Other reactions may involve social withdrawal, crying or other seemingly inappropriate workplace behaviour. Employers often underestimate the effect of an illness or death on workers around the bereaved person. Employers may not understand or recognize the extent to which:-

- Employees' form emotional attachments with one another, in some cases friendships with co-workers can be more important than familial relationships.
- Problems associated with grief, for example, absenteeism or personal conflict may surface months after the loss.
- The grief process.

This is explained perfectly by Rajesh (2006:2) who states,

> "When we heard one fateful morning that our thoughtful and brave colleague had passed away in the dead of night to cancer, we felt the raw edge of grief in a way that left us totally baffled. Some of us found it impossible to concentrate on work for little more than short spans. A few realized that they could not make it to the office over the next two to three days. One immediate junior actually submitted her resignation, saying that she could not bear to stay in an environment which served as a daily reminder of her departed boss. Managing the anguish resulting from death is traumatic. It is an experience that diminishes our energy, disrupts productivity and even changes our ability to think clearly and rationally. But what pained us even more was the fact that our branch head who, in the best of

times is not very sensitive, behaved like an absolute brute. He sent memos, held a lunch time meeting and even announced on the PA system that life has to go on and if the agency's profitability dips as a result of the time spent in mourning, all of us will have to bear the brunt".

Rajesh (2006:2) emphasizes that sorrow in the workplace can claim many victims. Countless companies lose valuable employees, or find themselves watching helplessly as a bubbly, cheerful employee transforms into a depressed, unproductive individual. In today's society, erratic work times and the arrival of new opportunities has distanced one's own family, but also made individuals connect with colleagues in the workplace as a type of extended kin, which makes the loss of the colleague so devastating.

According to the Suicide Information and Education Centre (SIEC) (2000:1), suicide is a painful loss for surviving family and friends. However, the effects of a co-worker's suicide can be equally profound within the workplace. Co-worker's grief reactions are often the same as those of family or friends and can include:-

- Shock or disbelief at the death itself, and often at the cause of death.
  Shock may be expressed in many ways including violent outbursts, dazed withdrawal, and the inability to take in the reality of the death.
- Anger which may be directed at co-workers, management, health care providers, and even the deceased colleague. Co-workers may express anger that the colleague never confided in them about how desperate they felt. They may also be angry or experience a sense of personal rejection because they feel that they were not given the opportunity to help their colleague.
- Guilt over things which may or may not have been done or said. Some guilt may be related to regret about insufficient care and concern for their colleague.

People go to work expecting things to be business as usual. At the end of the day, they go home to their families. The last thing anyone expects is for a co-worker to die in the workplace, either from natural causes, or as a result of a tragic event. When a death occurs in the workplace, the normally orderly environment can quickly turn to one of chaos. If the death occurred as a result of an industrial incident, fire, murder or similar tragic incident, workers have to deal with additional concerns in addition to the shock, the death of a co-worker and the loss of safety in the work environment. Workers and management may become concerned about how and why the incident occurred and what sort of steps are being taken to ensure that another accident will not happen and / or the security is being increased to protect them from future acts of violence. Death in the workplace may result in feelings of anger, guilt, unease, fears of personal safety plus the pervasive need for someone or something to blame (Dyer, 2002:2).

The researcher can conquer with Dyer's (2002:2) statements. At the researcher's place of work, two employees died tragically within a space of two months. One employee was murdered by her spouse and the other was hijacked at his home. This affected majority of the employees as they found it difficult to accept that their co-workers and friends would not return. Some employees were in denial, some in shock, some were extremely angry and looked for people and circumstances to blame and some even felt guilty as they thought that they could have maybe helped in some way to prevent these losses. It took a long time for employees to accept the loss of their co-workers and some to date continue to find it difficult to cope without their co-workers and friends.

According to the Personal Assistance Services (PAS) (2007:1), in the case of death being preceded by a long illness, your anticipatory grief will not make the loss of the person any less painful. But it can give you time to get used to the idea of the person's death. A sudden death has a shock value that often takes a long time to process. In either case, the loss felt by management and employees

will seem bottomless. Each person in the organization will grieve in a different way and be at different places along the grieving process spectrum. However, just because everyone grieves differently does not mean that one should ignore how people feel and pretend that nothing is different. Ignoring the signs or grief will simply postpone the process; it will not go away itself. Death may be a natural part of life, but the death of a co-worker will make everyone feel anything but normal. Employees may be listless and unable to do their own work. They may be prone to crying and sobbing or may be sad or depressed. Some employees might be angry or resentful that the deceased has left so many projects undone. Management may be unable to think about hiring a replacement or having others do part of the deceased job. Other employees may be in denial that anything bad really happened. All these reactions are coping mechanisms that help people get through the hard times.

Dyer (2002:4-5), states that many times, significant life or work changes contain elements of loss that can be overwhelming and very devastating. Events specific to workplace include downsizing, reduction-in-force, layoffs, mergers and promotions; these can all potentially produce grief-like responses as workers adjust to the change. The lives of the survivors and the victims of work changes will be transformed. The victims of work changes must cope with social, interpersonal, and financial adjustments. Those who remain must deal with changes in supervision and reporting lines, loss of co-workers, additional or redesigned work, and uncertainty of their role and value to the company. All of these issues can heighten the sense of loss. Both groups have encountered changes that will forever change their lives, causing them to go through transitions. Workers often feel that the change “happened to them” rather than being their choice or something that was within their control. How people react frequently depends on the individual, their previous work and personal experiences along with their history of past losses. Most workers’ reactions to the workplace event will be more about the secondary associated losses than the actual change itself.

According to Dyer (2002:1) grief upsets workers and hampers the work environment. Unfortunately, most businesses cannot afford to halt production, sales or services to accommodate the grief response. Instead they continue on in the mode of "business as usual".

It is a fact that many workplaces are not enabled to handle an employee's loss and grief. Most human resource policies are woefully unprepared in terms of support for a bereaved or distress employee (Rajesh, 2006:2).

When an employee experiences a loss or an illness their ability to deal with the grieving process can become even more prolonged if the person does not feel aided by his or her manager, supervisor or employer. Those who feel cared for and supported are more likely to have improved recovery (Dyer, 2002:1).

The American Hospice Foundation (2007:1), states that it is well known that depression reduces productivity due to absenteeism, mistakes, turnover and increased use of health benefits, but it is less well known that grief has similar effects. In 2002 the annual cost of death-related grief to American Business in lost productivity was estimated to exceed $37.6 billion. For employees who serve as caregivers at home, the associated burdens generate their own costs. A 2006 MetLife Caregiving Cost Study estimated that the annual cost to American business of full-time employees providing care giving is $33.6 billion, including costs associated with absenteeism, workday interruptions, crises in care, supervision, unpaid leave and increased turnover.

Carbasho (2005:1) confirmed the above by stating that the Grief Recovery Institute Educational Foundation, a non profit corporation with 25 years of experience in studying people's reaction to grief and loss, used the September 11 terrorist attacks as a catalyst to prepare the, "Hidden Annual Costs of Grief in America's Workplace". The outcomes of the report showed that the death of a

loved one tops the list as the grief incident that costs employers the most money, an estimated $37.5 billion per year. Coming in second is divorce at $11 billion, followed by family crisis at 9 billion, pet loss at $2.4 billion and other losses at $1.2 billion.

These figures could easily be equivalent if not much higher in South Africa considering the excessively high rates of crime and violence in the country that would inevitably contribute to employee grief and bereavement.

The above information proves that grief and bereavement in the workplace has vast consequences ranging from tiredness and lack of concentration of employees to increased employee absenteeism and decreased productivity and organizational profits. Grief and bereavement in the workplace occur not only as a result of the death of employee's loved ones but also from significant life and work changes of employees such as retrenchments, downsizing and closure of companies, which are very realistic considering our country's current economy. The support given to bereaved employees can however minimize these effects of grief and bereavement in the workplace. Workplace bereavement support programmes is a method of support for bereaved employees and can be valuable resources for organizations.

2.5 WORKPLACE BEREAVEMENT SUPPORT PROGRAMMES

Loss is a fact of life. We experience it from the moment we are born and leave our mother's womb and then from that moment on we fight to not only understand losses in our life but then better learn how to cope with it. We fight anger, depression and then miraculously we are supposed to accept it. Well, what if you never learn how? How can we best be of help to ourselves as well as others in the workplace? (Dutmer, [sa]:1).

According to Gould (2004: 1), how a company treats its grieving employees strongly affects how employees perceive the company. Without proper training, managers and colleagues may end up mismanaging the situation in a variety of ways. An employee may receive a poor performance rating instead of needed help. Inappropriate comments such as, "It's God's will," or, "Isn't it time you got over this?" can have such a negative impact that a valued employee may end up resigning. However, if managed well, it could be of benefit to the company. Vincent (2004:1) provides an excellent example of workplace support and its benefits.

> "One April afternoon my daughter Maya was declared brain dead after a fall from a horse. My supervisor and another middle manager came to the hospital. I will always remember their courage and their support. They sat with my stunned family and asked: 'What can we do? How can we help?' Five days later the same manager and dozens of my co-workers from the company attended Maya's memorial service. They donated money to support programmes at the church in her memory. The CEO of the company sent me a personal note. The compassionate response of the managers of the company was crucial to my recovery from a devastating loss. For two years after Maya's death it was all I could do to survive, let alone function productively. My managers responded with flexibility and support, offering me extended bereavement leave, employee assistance counseling and flexible hours. Now, seven years later, I realize how fortunate I was. All too frequently, grief stricken employees are expected back on the job in three days and there is little understanding of how much time and struggle are involved in recovering from loss" (Vincent, 2004:1).

Vincent (2004:2-3) goes on to state that job performance and morale can suffer if managers are not educated about grief and prepared to respond. The key is for supervisors to balance the emotional needs of grief-stricken employees with the work demands of their organization. Employees who experience a compassionate response to their situation often become intensely loyal. And co-workers who observe supervisors providing a well-informed, flexible response to grief can be positively affect as well. Some specific actions that supervisors can take are:-

- Purchase a sympathy card, write a personal message, and pass it around the office.
- Hold a meeting with the entire workgroup to brainstorm ways to help.
- Talk with the employee before he or she returns to work to help ease the reentry.
- Become familiar with the stages of grief and help educate employees by providing access to brochures or materials from your Employee Assistance Programme.
- Work with the bereaved employee to renegotiate work expectations and set up regular times to check in on progress.
- If possible allow flexible working hours or a leave of absence.
- Encourage employees to get support through counseling, bereavement support programmes or from clergy members.

According to Smith (Sa: 1-2), deaths occur at work, people often receive the news of a relative's death while at work, and employees often have to remain on the job after they learn of a colleague's death. Unfortunately, we also live in a society that does not really understand nor feel comfortable with the grief process. Consequently, if an employee's grief is responded to at all, it is often in awkward and unsure ways. Employees do not expect management or human resource personnel to fix their grief, but they do expect them to respond to and respect their loss. According to Smith (Sa: 1-2), the following information may be of benefit to managers who are confronted with employees coping with a loss:-

- **Recognizing the grief**: Recognition can be as simple as a letter of condolence from a supervisor, or flowers sent to the funeral or mention of the employee's loss in a newsletter. Few things hurt and offend more than to experience a loss and have no one acknowledge it.
- **Responding to the grief**: If employees witness a death (or even a near death) of a colleague at work, this is considered a Critical Incident. The Employee Assistance Programme (EAP) can link managers with a resource who can educate and debrief employees to minimize the emotional impact. This intervention is known as Critical Incident Stress Debriefing (CISD) and is best provided within a 24-72 hour time period. If colleagues learn of a death in their co-workers family, EAP can provide managers with a resource to facilitate an awareness session on grief and loss. Employees learn tips on what to say, how to support and welcome their colleagues back to work. Having printed materials available on grief and loss can also be of benefit. As employees react to grief, their productivity, attendance, health and relationships with colleagues and customers may suffer. Some turn to alcohol and drugs to cope with the pain. Managers educated on the signs and symptoms of an employee not coping with their loss are better prepared to approach and refer employees to EAP and other appropriate resources for help in a timely manner.
- **Respecting the grief:** Respecting an employee's loss is an important way to demonstrate respect for that person as an individual. It also enhances morale when staff realizes that what happens in their lives matters to their managers as well. Respect develops when managers implement such actions as outlined above. It shows employees the sincerity of concern when assisting them in times of loss.

Adding to the above mentioned SIEC (2000:2) provides advice on additional support that employers can give to their bereaved staff including:-

- **Offering concrete and specific help.** Often the newly bereaved are too overwhelmed to know what they need. They may require information on bereavement leave, benefit entitlements, paperwork associated with final pay cheques, medical claims or life insurance policies.
- **Being flexible about time-off** especially in the first year after bereavement. Some employees will require more leave than the company policy allows.
- **Redistributing** those parts of the bereaved employee's job which must be done. Eliminating the pressure to perform is one way of demonstrating support for a grieving employee. At the same time, the employer must be aware of the additional strain this can create for other staff who temporarily or permanently take on new duties.
- **Recognizing** that some employees may return to work too quickly to avoid dealing with their grief. In the long-term, this method of coping is counterproductive as it can lead to complicated grief reactions.

Lynn (2001:926), states that both structured and unstructured bereavement programmes should be available, of which the above means of support could be provided in. Unstructured programmes include an increased awareness of the bereavement process and stages, and addressing issues as they arise. Structured programmes focus on specific issues and include formal organizations with the goal of helping the bereaved to achieve satisfactory closure.

All of the above information on appropriate responses of management to bereaved staff could be regarded as unstructured support programmes in the workplace, as according to Lynn (2001: 926-927), unstructured programmes include:-

- ➢ Acknowledgement of the death.
- ➢ Acquiring knowledge about the stages of bereavement.
- ➢ Providing appropriate information.
- ➢ Being a partner in the process by showing support.

- Follow-up through a personal phone call, follow-up card or letter and attendance at the funeral or memorial service.
- Pastoral support services.

Structured programmes, according to Lynn (2001:928), are most effective when they are tailored to the participant's individual needs and could include:-

- **Written Handouts**

Written handouts about death and bereavement can help the bereaved, family members and co-workers**.** The amount and type of information given to the bereaved, family members and co-workers must be adjusted to meet their needs. Handouts raise awareness of feelings and fears that the bereaved, family members and co-workers often experience about dying and grieving process. Adequate time to discuss issues raised in written materials is important. According to King and Tellioglu (2007:2), the most important aspect for grieving people is learning to cope with their loss and the following information could be included in written handouts. People who are grieving may need to keep certain coping tips in mind, including:-

- Avoiding isolation. It is important for grieving people to talk to others and explain how they are feeling. They must not be afraid to ask for support.
- Taking care of physical health. People who are grieving still need to see a physician when feeling unwell. Most physical complications of grief can be eased by eating properly, exercising and getting plenty of rest.
- Postponing major decisions when possible. Grief may interfere with judgment.

Individuals can take certain steps to help others cope with grief, including:-

- Listening – people who are grieving need to share their thoughts and feelings with others.
- Not offering false comfort. Comments such as "he's in a better place now", "at least she is not suffering anymore" often do not help and may make the grieving person feel even worse.

- Offering practical help. Grieving individuals may benefit from assistance with household chores and errands.

- **Availability of professional psychological support**

Pilgrims Hospice (2008:1) states that bereavement and grief are complex psychological processes that may not be clearly and fully recognized by the bereaved, family members and co-workers. Social workers, psychologists and psychiatrists are helpful in understanding bereavement and grief. Grief is a healthy and necessary process. It is not healthy to avoid grief or to deny loss for a long period of time. Avoidance of grief may lead to serious physiological and emotional problems later in life. Most grieving people do not need psychological or psychiatric treatment. Typical medications, such as antidepressants, are required only when grief has progressed into major depression. However, when professional help is sought, grief counseling and debriefing are types of bereavement services that are rendered. These services can be done either individually or in a group setting. A timely debriefing can assist in getting the workplace stabilized and ensure that anyone needing specific grief support gets the assistance they need. Debriefings allow those involved to explore the impact of the loss while dispelling rumors, identifying ways to assist family and friends of the deceased and, where desired, putting company policies and procedures in place to assist when the need arises.

According to Pilgrims Hospice (2008:1), grief counseling helps mourners with normal grief reactions to work through the tasks of grieving. The goals of grief counseling therefore include:-

- Helping the bereaved to accept the loss by helping him or her to talk about the loss.
- Helping the bereaved to identify and express feelings related to the loss (for example, anger, guilt, anxiety, helplessness and sadness).

- Helping the bereaved to live without the person who died and to make decisions alone.
- Helping the bereaved to separate emotionally from the person who died and to begin new relationships.
- Provide support and time to focus on grieving at important times such as birthdays and anniversaries.
- Describing normal grieving and the differences in grieving among individuals.
- Providing continuous support.
- Helping the bereaved to understand his or her methods of coping.
- Identifying coping problems the bereaved may have and making recommendations for professional grief therapy.

- **Support groups**

Formal bereavement support groups help the bereaved and family members reach closure. Individuals with experience, specialized education and knowledge about grieving usually lead support groups. Within support groups, grieving individuals receive support from other group members. Support groups can help grieving people, especially those who wish to receive specialized support, such as parents who have lost a child. Support groups have various activities, some being, an annual "remembrance" event or "memorial service," when those who have passed away during the year are remembered (Lynn, 2001:928).

In Table 2, Jonathan Hartley (Sa: 1-2) provides an example of a structured formal workplace bereavement support programme.

TABLE 2: STRUCTURED WORKPLACE BEREAVEMENT SUPPORT PROGRAMME 1

9:30	Setting the scene (Expectations, learning objectives for the day, housekeeping, self care)
9:45	Taking the sting out (Addressing personal fears and phobias around death, dying and loss)
10:00	Bereavement and loss (Facts, figures and costs: value to organizations of addressing the impact of bereavement and benefits of a supported workforce. Theories and models of bereavement support)
10:30	Manifestations of grief in the workplace (What are the signs to look out for? The do's and don'ts of a helpful response)
11:15	Coffee
11:30	Case studies / scenarios (Enhance skills – listening and communication)
12:30	Lunch
1:30	Taking the sting out (Appropriate use of humour when dealing with sensitive issues)
2:00	Grief and the workplace (Practical steps to creating a supportive environment and developing a long term workplace strategy)
2:45	Death in the workplace (Responding to loss and trauma inside the workplace)
3:30	Sharing the learning (How to use the information practically in the workplace. Building confidence through self and peer support. Debriefing and good-byes)
4:00	End

Table 3 includes another example of a workplace bereavement support programme, provided by Machin ([Sa: 2).

TABLE 3: STRUCTURED WORKPLACE BEREAVEMENT SUPPORT PROGRAMME 2

9:30	Introduction
9:45	Hopes and fears of the day
10:00	Exploring the spectrum of loss experience
10:30	Group exercise: loss and the personal meanings we bring to our work
11:00	Coffee
11:15	Theoretical frameworks which increase our understanding of people's grief reactions ➢ Traditional theories of loss ➢ Contemporary theories of grief ➢ Theories of crisis intervention, stress and trauma Group discussion
12:30	Lunch
13:30	Helping models ➢ Counseling and case work models ➢ Systematic models (example, families and groups)
14:00	Exploring case examples brought by participants and identifying practitioner skills ➢ Assessment ➢ Intervention ➢ Endings ➢ Support and Supervision
15:15	'A good ending' – group exercise
16:00	End / Refreshment

Various forms of support can be offered to grieving employees in the workplace. The appropriateness of the support however could be determined by the sources of the grief of employees, the needs of the employees, the willingness of the organization to provide support and the availability and affordability of support resources to organizations. However, lack of support or inappropriate support could have extremely negative consequences. Offering workplace bereavement support programmes will not only benefit grieving employees but also the organization through increased loyalty, morale and job performance of employees which will ultimately result in increase organizational profits.

2.6 Summary

Generally speaking, bereavement and grief are emotional responses to the death of a loved one. Very often grief is equated to sadness, though it is not always so simple. Instead, grief often involves a progression of different emotions and reactions that include shock, and / or numbness, anxiety, anger, sadness and many more as discussed in this chapter. Some people never experience all of these emotions and this is perfectly normal. As explained through the various theories and stages or phases of grief, it may take days, weeks or even years for someone who is grieving to complete all the stages of the grief cycle depending on the source of the bereavement or grief. There is no set itinerary for grief, though if there is a distinct lack of emotional response, or an emotional response so overwhelming that it affects in great degrees a persons employment, education or personal relationships, professional assistance is required (Facing bereavement, 2007:1)

There are many benefits to the provision of bereavement care, especially in the workplace. It has been shown that support through a bereavement support programme can enhance a survivor's coping ability, teach and identify interpersonal coping strategies, and allow opportunity for those grieving to tell their story and express their feelings. If addressed effectively in the workplace it

can impact positively on productivity, staff morale and employee retention but if mismanaged it could have devastating consequences (Lev & McCorkle, 1998:147).

CHAPTER 3

EMPIRICAL RESEARCH FINDINGS

3.1 INTRODUCTION

This chapter focuses on the empirical findings of the study. The research goal, objectives, question and methodology is described, followed by the discussion of the empirical findings, which are presented according to the sections of the questionnaire.

The goal of this study was to investigate the need for an employee bereavement support programme at Umgeni Hospital.

In order to obtain the goal of the study the following objectives were formulated:

- To conceptualize theoretically employee bereavement and its impact in the workplace as well as the support strategies for employees.
- To conduct an empirical investigation into the need for an employee bereavement support programme at Umgeni Hospital.
- To provide recommendations to the hospital management on the need for a bereavement support programme at Umgeni Hospital based on the information gained from this research.

Against this background the following research question was formulated:

What is the need for an employee bereavement support programme at Umgeni Hospital?

3.2 RESEARCH METHODOLOGY

3.2.1 Research approach

According to Creswell (1994:1-2), the main aims of a quantitative research approach is to objectively measure the social world, to test hypotheses and to predict and control human behaviour. A quantitative study may, therefore, be defined as an inquiry into a social or human problem, based on testing a theory composed of variables, measured with numbers and analyzed with statistical procedures in order to determine whether the predictive generalizations of the theory hold true.

Therefore, in the context of quantitative research, the researcher is of the opinion that in the present study a quantitative research approach was most applicable, as the study aimed to investigate objectively, through a questionnaire, the need for an employee bereavement support programme at Umgeni Hospital.

3.2.2 Type of research

Applied research aims to contribute towards practical issues of problem-solving, decision making, policy analysis and community development (Terre Blanche & Durrheim, 2006:40-41).

The researcher is of the opinion that in the present study applied research was most applicable as the study aimed to contribute towards solving the problem of the need for an employee bereavement support programme at Umgeni Hospital.

Terre Blanche and Durrheim (2006: 43) pointed out that the goal of exploratory studies is to make preliminary investigations into relatively unknown areas of research and attempt to look for new insights into phenomenon.

Little is known about the need for an employee bereavement support programme at Umgeni Hospital; therefore, in the broader context of applied research, exploratory research was used to achieve the study's goal and objectives.

3.2.3 Research design

The main focus of a research design is to explain how you will find answers to your research questions. The research design sets out the logic of your inquiry and should include the following: the study design per se and the logistical arrangements that you propose to undertake, the measurement procedures, the sampling strategy, the frame of analysis and the time-frame (Kumar, 2005:20-22).

Fouché and De Vos (2005b:137) state that Quantitative-descriptive (survey) designs are of a more quantitative nature, requiring questionnaires as a data collection method. They further noted that the randomized cross-sectional survey is one of two Quantitative-descriptive (survey) designs that are commonly used with surveys like the needs assessment phase of research.

The researcher is therefore of the opinion that as little is known about the need for an employee bereavement support programme at Umgeni Hospital, the above mentioned research design assisted to investigate this need, through the administration of questionnaires to respondents.

3.2.4 Data collection method

The researcher utilized the data collection method of questionnaires.

A questionnaire is a document containing questions and other types of items designed to solicit information appropriate for analysis. Questionnaires are used primarily in survey research but also in experiments, field research and other modes of observation (Babbie, 2004:244).

According to Delport (2005:169), some questionnaires are delivered by hand, so that respondents can complete them in their own time and then it can be collected later. Questionnaires delivered by hand has the advantage of saving time, raising response rates because of the personal contact, the researcher merely distributes the questionnaires and does not bother the respondents at an inconvenient time and if the respondents experience some difficulties with the questionnaires, they can clarify the matter with the researcher on his or her return.

A self-constructed hand-delivered questionnaire was used as a data collection instrument (Appendix F). The aim of the research as well as the requirements from the respondents was emphasized on the cover page of the questionnaire (Appendix E). The researcher distributed each questionnaire together with an envelope and requested the respondents to complete and place the questionnaire, in the sealed envelope, in a box outside the EAP office. This procedure helped to ensure the confidentiality, privacy and anonymity of the respondents.

3.2.5 Data analysis

According to Durrheim (2006:47), the aim of data analysis is to transform information (data) into an answer to the original research question.
Durrheim (2006:98) further states that data analysis requires the following steps.

The first step is to prepare the data. Data are raw materials of research and in quantitative research it is lists of numbers that represent scores or variables. This step requires the data to be coded, entered and cleaned.

Coding involves applying a set of rules to the data to transform information from one form to the other.

In the present study the researcher changed the information provided on the questionnaire into numerical format, for example, male and female was changed to numbers one and two respectively. The numerical codes that were written on the questionnaires were then entered into a computer in a format that could be used by a statistical computer package, that is, the SPSS programme.

While coding and entering the data, errors could occur, therefore, it is necessary to clean the data before using it for statistical analysis. This simply means checking of the data for errors and then correcting these errors.

The next step is to process, analyze and interpret the results.
According to Kruger et al. (2005:222) the simplest form of data analysis is univariate analysis, which means that the variable is analyzed, mainly with a view to describing that variable. Basically this means that all the data gathered on that variable needs to be summarized for easy comprehension and utilization. In the context of this study, the variable was the employee's need for an employee bereavement support programme at Umgeni Hospital.

The data was then displayed and summarized using the frequency distribution of this variable which was displayed in table format and various graphical presentations.

3.2.6 Pilot study

Fouché and Delport (2005:82), describe a pilot study as the dress rehearsal for the main investigation – a small-scale implementation of the planned investigation in an attempt to bring possible deficiencies to the fore timeously.

Neuman and Kreuger (2003:179-180) suggests that conducting a pilot study is one method to increase the reliability of the data collection instrument.

Babbie (2004:143) states that the validity of the data collection instrument is determined by the extent to which the instrument accurately reflects the concept it is intended to measure.

3.2.6.1 Testing of the data collection method

According to Strydom (2005:210), in order to test the data collection method and for the pilot study to be effective, the pilot study must be executed in the same manner as is planned for the main investigation.

For the present study, to test the data collection instrument and as far as possible test its reliability and validity, the researcher conducted a pilot study with a group of five hospital personnel who was not a part of the main study. They were asked to complete the data collection instrument (questionnaire) independently and then they were asked to give feedback to the researcher. This enabled the researcher to identify deficiencies in the instrument and correct them. One deficiency that was identified was in Section C of the questionnaire. The headings of the Impact of Event Scale – Revised (IES-R) was not included on the pages where the scale continued, which made it difficult for the respondents to answer the questions on the scale as they had to go back to the beginning of the scale each time. These recommended changes from the pilot study made completion of the instrument in the main study much easier.

3.2.6.2 Feasibility of the study

Strydom (2005:208) describes the feasibility of a study as an overview of the actual, practical situation where the prospective investigation will be executed. He further states that the feasibility of a study is especially important with a view to the practical planning of the research project, such as, transport, finance and time factors. Other factors that need to be considered are the venue and the accessibility of the respondents.

The researcher is of the opinion that the research was feasible as it was conducted within the researcher's area of operation. The researcher is the Employee Assistance Programme Practitioner at Umgeni Hospital, therefore respondents and resources was easily accessible and difficulties in terms of suitable venues, transport and other logistical arrangements was not experienced.

The researcher obtained written permission from the Department of Health, Kwa-Zulu Natal (Appendix A) as well as the Hospital Manager at Umgeni Hospital (Appendix B).

3.2.7 Description of the research population, sample and sampling methods

3.2.7.1 Research population

Gravetter and Forzano as quoted by Strydom (2005:193) states that the term sample always implies the simultaneous existence of a population or universe of which the sample is a smaller section or set of individuals selected from a population.

However, Arkava and Lane as quoted by Strydom (2005:193), draw a distinction between the terms universe and population. Universe refers to all potential subjects who posses the attributes in which the researcher is interested, which was 55 237 Department of Health personnel in Kwa-Zulu Natal. Population is a term that sets boundaries on the study units. The population for this study was all the employees at Umgeni Hospital that is 422 personnel.

3.2.7.2 Research sample

As stated above, the research sample is a smaller section or a set of individuals selected from a population.

However, Sarantakos (2000:139) states that the major reason for sampling is feasibility. This is so because a complete coverage of the total population is seldom possible and all the members of a population of interest cannot possibly be reached.

A sample of 70 employees was used in this study.

3.2.7.3 Sampling method

Van Vuuren (1999:274) describes sampling as the process used to select cases for inclusion in a research study. Doing sampling means that the researcher will not be able to tell with certainty that the findings are true for the whole population but rather, it would probably be true.

For the purpose of this research, probability sampling would be used. Gravetter and Forzano (2003:118) state that in probability sampling the odds of selecting a particular individual are known and can be calculated and the selection of persons from the population is based on some form of random procedure.

In the context of probability sampling, systematic sampling was used in this study. According to Strydom (2005:200) in systematic sampling only the first case is selected randomly, preferably from a random table. All subsequent cases are selected according to a particular interval.

The motivation for the researcher using this sampling method was that it was possible to obtain a list of all personnel at Umgeni Hospital, from management to general assistants, who were then randomly chosen as respondents using a selected interval, that is, every fifth interval for this study, up to 70 respondents who were selected to represent the population.

3.3 RESEARCH FINDINGS

The questionnaire was divided into four sections and the research findings are, therefore, presented as such.

3.3.1 Section A: Personal Details of Respondents

GENDER

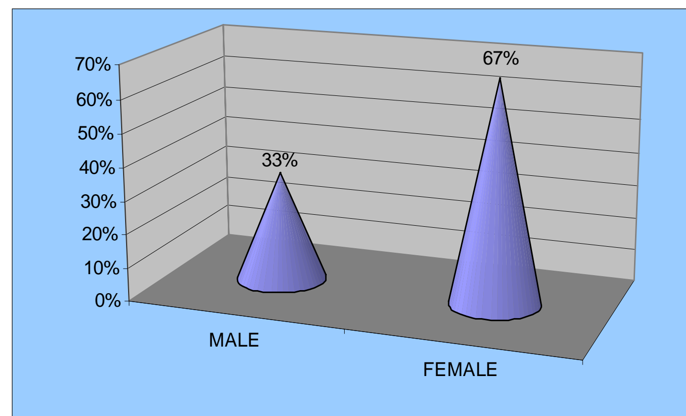


FIGURE 1: Gender of respondents

Figure 1 illustrates that the gender distribution of the respondents who participated in the study was 23 (33%) males and 47 (67%) females. The researcher expected more participation from females due to the fact that the percentage of female employees at Umgeni Hospital is much higher than male employees. However, the response rate from both genders was very good and there was no huge disparity in the research findings between the genders.

AGE

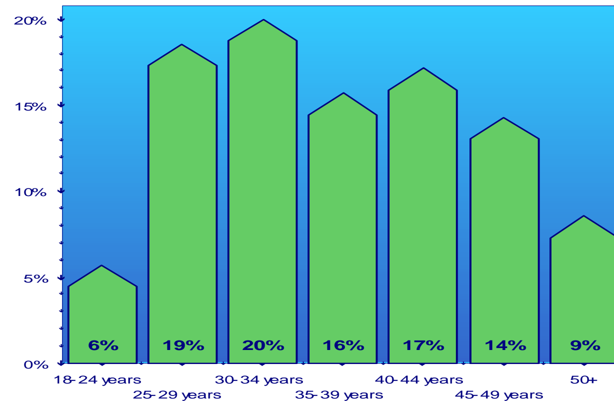


FIGURE 2: Age of respondents

Figure 2 indicates that 4(6%) of the respondents were between the ages of 18-24 years, 13(19%) between the ages 25-29 years, 14(20%) between the ages 30-34 years, 11(16%) between the ages 35-39 years, 12(17%) between the ages 40-44 years, 10(14%) between the ages 45-49 years and 6(9%) were 50 years and older. The findings suggest that most of the respondents ranged between 25-49 years.

MARITAL STATUS

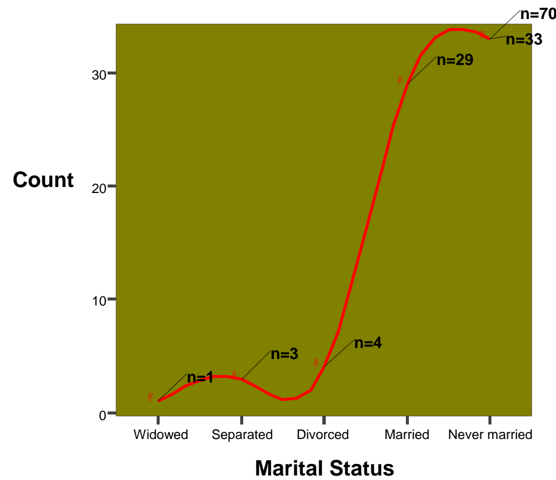


FIGURE 3: Marital status of respondents

Majority of the respondents (33), as illustrated in Figure 3, were never married, which constitutes almost 50% of the respondents and 29 respondents were married. The remainder of the respondents constituted a small number with 4 being divorced, 3 separated and 1 widowed. The fact that the number of respondents that were never married was the highest followed by those that are married, these figures correspond with the age categories stated earlier. Majority of the respondents are aged between 25 and 40 years form a big part of the labour market and could possibly be focusing on their career development or on providing for their family.

HOME LANGUAGE

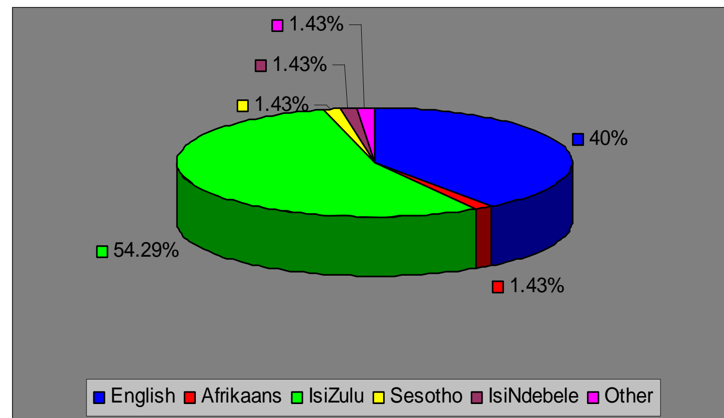


Figure 4: Home Language of respondents

Figure 4 indicates that IsiZulu was the most dominant home language with 54.29% (38), followed by 40% (28) respondents having English as their home language and Afrikaans, Sesotho, IsiNdebele and other languages having 1.43% or 1 respondent each.

The researcher found it important to note that despite IsiZulu being the dominant home language, English is the preferred language of communication when employees approach the EAP for services. This trend could be attributed to the high educational level of employees as well as the fact that English is being used more often in the institution to ensure that all employees have a common understanding.

HOSPITAL COMPONENTS

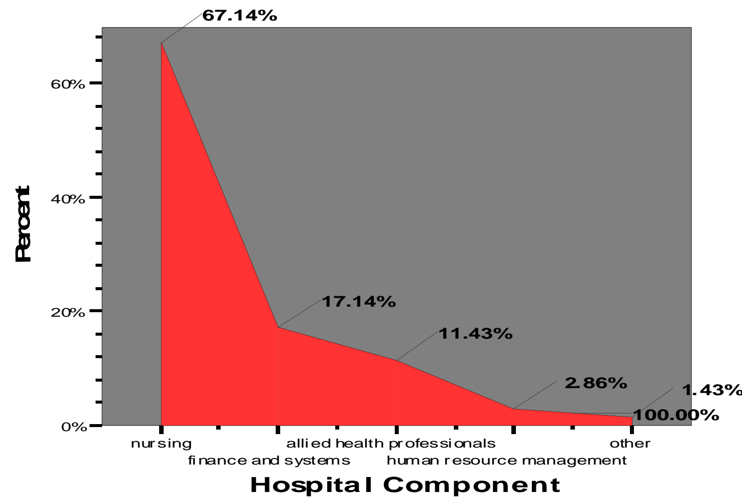


Figure 5: Hospital Components of respondents

Majority of the respondents, 67.14%, as indicated in Figure 5, were from the nursing component of Umgeni Hospital, 17.14% from finance and systems, 11.43% from the allied health professionals, 2.86% from human resource management and 1.43% from other hospital components.

These statistics were definitely expected as nursing is the largest component and this is a good representation of the distribution of employees at Umgeni Hospital. This further confirms the statement mentioned earlier that English could be more commonly used at Umgeni Hospital due to the high educational levels of employees as majority of the employees in these hospital components are required to have a Grade 12 qualification and relevant diplomas or degrees.

3.3.2 Section B: Experience of grief or bereavement

In this section the researcher established the respondents' experiences of grief or bereavement. This information was vital in order to understand the respondents' responses later on in the questionnaire.

NUMBER OF DECEASED ACQUAINTANCES

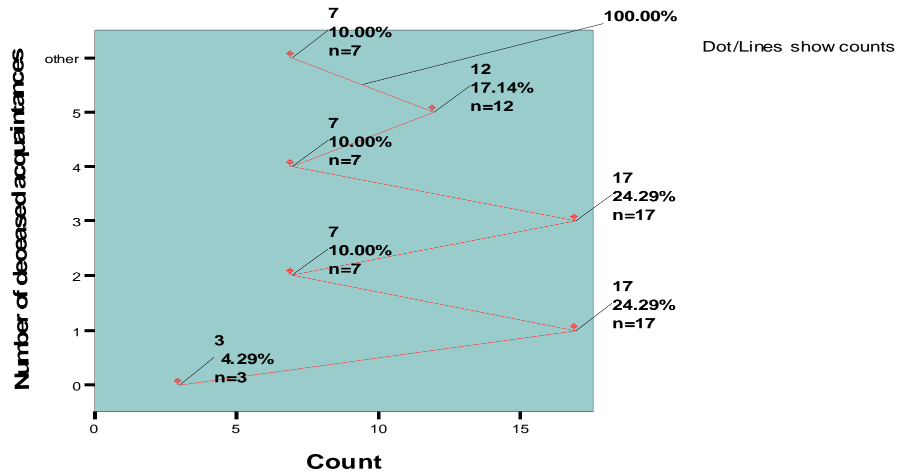


Figure 6: Number of deceased acquaintances

Figure 6 indicated the number of deceased acquaintances known to the respondents in the past three years. It revealed that only 3 (4.29%) of respondents did not know anyone that has been deceased, 17 (24.29%) knew one person, 7 (10%) knew two people, a further 17 (24.29%) knew 3 deceased acquaintances, followed by 7 (10%) that knew at least 4 deceased acquaintances, 12 (17.14%) knowing five and 7 (10%) knowing more than five deceased acquaintances in the past three years.

These statistics indicate that more than 50% of the respondents knew 3 or more people that have died in the past three years.

RELATIONSHIP WITH THE DECEASED

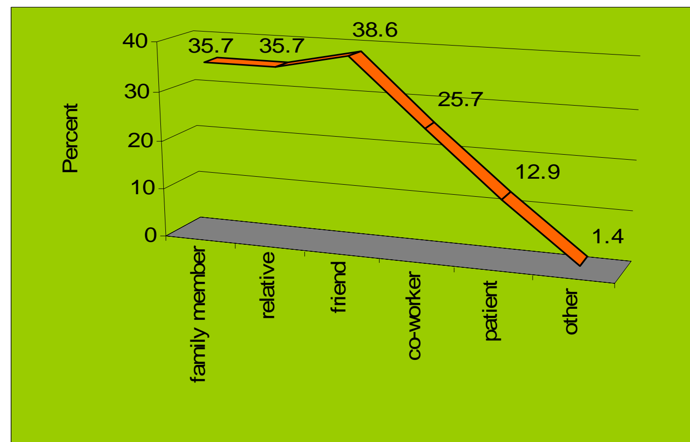


Figure 7: Relationship with the deceased

An equal percentage (35.7%) of respondents, as illustrated in Figure 7, showed relationships with the deceased being a family member or a relative, 38.6% a friend, 25.7% co-worker, 12.9% a patient and 1.4% with persons from other categories. According to King and Tellioglu (2007:1), the course of normal grief reactions is determined by a number of factors, one being the closeness of the attachment or relationship with the deceased. From the above information, it can noted that majority of the respondents had lost family, relatives and friends, people that were very closed to them which has a significant impact on the grieving process and the support required.

CAUSES OF DEATH

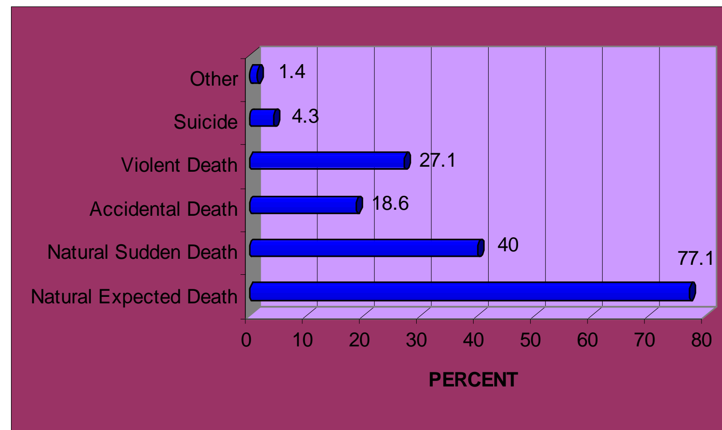


Figure 8: Causes of death

Figure 8 clearly indicates that 77.1 % of the causes of death were natural and expected, 40 % was natural but sudden, 18.6% was accidental, 27.1% was violent, 4.3% was suicide and 1.4% was as a result of other causes. According to Gill, Smith and Segal (2007:4), grief tends to be mixed with trauma when a loss is sudden and unexpected such as a fatal heart attack, suicide, an accident and murder. Grief is a normal reaction to loss, with its symptoms diminishing over time but trauma is a disabling reaction that can block the grieving process, disrupt your life, and leave you psychologically vulnerable. If you are coping with a traumatic loss, the assistance of a counselor or other professionals is recommended. The researcher noticed that the percentage of the natural sudden deaths, accidental deaths and violent deaths was quite high which could therefore have impacted on the respondents responses on the need for an employee bereavement support programme.

3.3.3 Section C: Impact of Event Scale-Revised (IES-R)

The Impact of Event Scale–Revised (IES-R) is a 22-item self report measure that assesses subjective distress caused by traumatic events. Respondents are asked to identify a specific stressful life event, which in this study is the death of someone close to the respondent, and then indicate how much they were

distressed or bothered through answering the 22 questions. The IES-R yields a total score and subscale scores for intrusion, avoidance and hyper-arousal (Weiss & Marmar, 1996:1). The hyper-arousal subscale has a good predictive validity with regard to trauma, while the intrusion and avoidance subscales detect relevant differences in the clinical response to traumatic events of varying severity (Christianson & Marren, 2008:1). The researcher in this study wanted to investigate any relevant differences in the responses of respondents to the death of people close to them, of which in turn might assist in determining the need for an employee bereavement support programme. The researcher will therefore focus on the results of the intrusion and avoidance subscales, using Analysis of Variance (ANOVA) between the intrusion and avoidance subscales and the respondents' responses on the causes of the deaths of people close to them. A brief summary will be provided on the results of the hyper-arousal sub-scale.

ANOVA RESULTS OF INTRUSION SUBSCALE AND GENDER OF RESPONDENTS

TABLE 4: Intrusion subscale and gender of respondents

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	5.506	22	.250	1.184	.306
Within Groups	9.936	47	.211		
Total	15.443	69			

According to Rosnow and Rosenthal (1996:285-286), if the F ratio is approximately 1 it is said that the null hypothesis is true, which means that there is no relation between the gender of the respondents and the intrusion impact. If the significance is smaller than 0.05 level, it is considered statistically significant and if the significance is smaller than 0.01 level then it is considered very statistically significant. The above results indicate that there was no significant difference between the genders of the respondents in terms of the Intrusion impact as well.

ANOVA RESULTS OF AVOIDANCE SUBSCALE AND GENDER OF RESPONDENTS

TABLE 5: Avoidance subscale and gender of employees

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	6.010	25	.240	1.121	.361
Within Groups	9.433	44	.214		
Total	15.443	69			

Due to the F ratio in Table 5 being 1.121, it proves that the null hypothesis is once again true and that there is no relation between the genders of the respondents in terms of avoidance. With the significance also not being smaller than 0.05 or 0.01 levels, the results show no significant difference between the genders of the respondents in terms of avoidance.

ANOVA RESULTS OF INTRUSION SUBSCALE AND AGE OF RESPONDENTS

TABLE 6: Intrusion subscale and age of employees

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	51.767	22	2.353	.708	.808
Within Groups	156.176	47	3.323		
Total	207.943	69			

As indicated in Table 6, there was no significant difference between the age of the respondents and the intrusion aspect due to the F ratio being .708 and the significance being .808.

ANOVA RESULTS OF AVOIDANCE SUBSCALE AND AGE OF RESPONDENTS

TABLE 7: Avoidance subscale and age of employees

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	72.176	25	2.887	.936	.561
Within Groups	135.767	44	3.086		
Total	207.943	69			

Results of Table 7 also indicate that there was no significant difference between the age of the respondents and the avoidance aspect with the F ration being .936 and the significance being .561.

ANOVA RESULTS OF INTRUSION SUBSCALE AND CAUSES OF DEATH

TABLE 8: Intrusion subscale and causes of death

		Sum of Squares	df	Mean Square	F	Sig.
Natural expected death	Between Groups	4.640	22	.211	1.287	.230
	Within Groups	7.703	47	.164		
	Total	12.343	69			
Natural sudden death	Between Groups	4.789	22	.218	.852	.651
	Within Groups	12.011	47	.256		
	Total	16.800	69			
Accidental death	Between Groups	2.899	22	.132	.806	.703
	Within Groups	7.686	47	.164		
	Total	10.586	69			
Violent	Between Groups	3.394	22	.154	.694	.822
	Within Groups	10.448	47	.222		
	Total	13.843	69			
Suicide	Between Groups	.821	22	.037	.856	.646
	Within Groups	2.050	47	.044		
	Total	2.871	69			
Cause of death - other	Between Groups	.186	22	.008	.496	.962
	Within Groups	.800	47	.017		
	Total	.986	69			

The above results indicate that there was no significant difference between the causes of death in terms of the Intrusion aspect as all of the significance scores were over 0.05.

ANOVA RESULTS OF AVOIDANCE SUBSCALE AND CAUSES OF DEATH

TABLE 9: Avoidance subscale and causes of death

		Sum of Squares	df	Mean Square	F	Sig.
Natural expected death	Between Groups	4.110	25	.164	.878	.629
	Within Groups	8.233	44	.187		
	Total	12.343	69			
Natural sudden death	Between Groups	6.350	25	.254	1.069	.412
	Within Groups	10.450	44	.238		
	Total	16.800	69			
Accidental death	Between Groups	2.702	25	.108	.603	.911
	Within Groups	7.883	44	.179		
	Total	10.586	69			
Violent	Between Groups	5.043	25	.202	1.009	.477
	Within Groups	8.800	44	.200		
	Total	13.843	69			
Suicide	Between Groups	.738	25	.030	.609	.907
	Within Groups	2.133	44	.048		
	Total	2.871	69			
Cause of death - other	Between Groups	.486	25	.019	1.710	.059
	Within Groups	.500	44	.011		
	Total	.986	69			

Due to the significance in Table 9 also not being smaller than 0.05 or 0.01 levels, the results show no significant difference between the causes of death in terms of avoidance.

INTRUSION SUB-SCALE

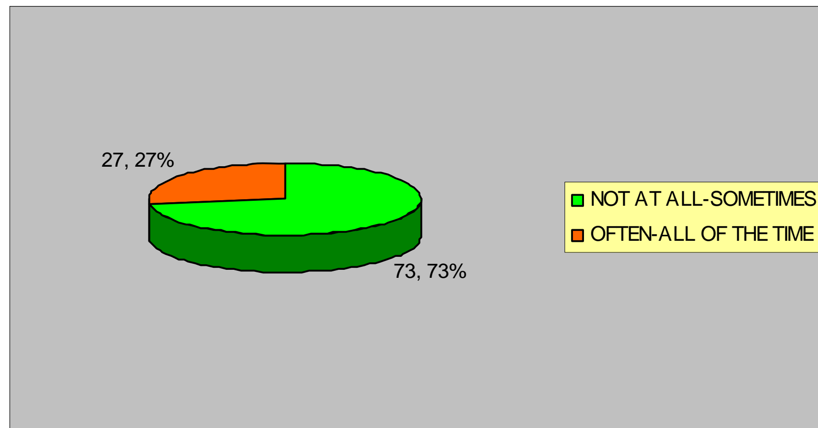


Figure 9: Intrusion Sub-Scale

Figure 9 illustrates that 73.73% of the respondents did not or sometimes felt some form of intrusion after the death of the loved one and 27.27% of the respondents indicated that they felt some form of intrusion often or all of the time. This could be as a result of the time period between the respondents' experiences of the death of loved ones and the completion of the IES-R.

AVOIDANCE SUB-SCALE

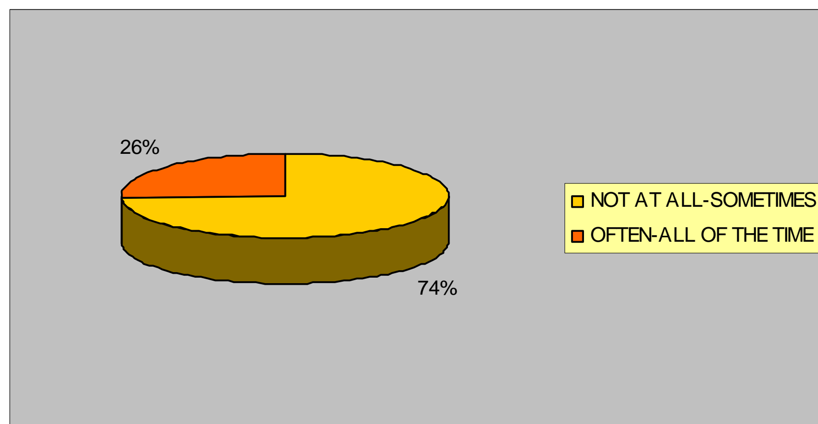


Figure 10: Avoidance Sub-Scale

In Figure 10 it can be seen that 74% of the respondents did not or sometimes felt some avoidance of the death of a loved one and 26% felt some avoidance often

or all of the time. Although majority of the respondents did not experience avoidance to great extents, as stated in Figure 10, with the respondents that did experience avoidance often or all of the time, the avoidance could be as a result of the time period between the respondents' experiences of the death of loved ones and the completion of the IES-R.

HYPER-AROUSAL SUB-SCALE

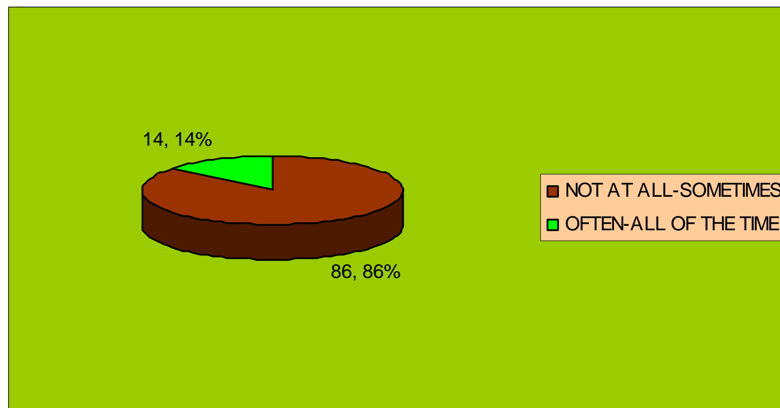


Figure 11: Hyper-Arousal Sub-Scale

Figure 11 illustrates that 86.86% of the respondents did not or sometimes felt some sort of hyper-arousal after the death of a loved one and only 14.14% felt some sort of hyper-arousal often or all of the time. As stated by Christianson and Marren (2008:1), the hyper-arousal subscale has a good predictive validity with regard to trauma. These responses could have therefore resulted from various factors such as the causes of the death or the time period between the death and completion of the IES-R.

All of the above results indicate that, although the respondents would have experienced some impact in terms of intrusion and avoidance, there was no significant difference between the respondent's gender, age and the causes of death on the intrusion and avoidance sub-scales. The hyper-arousal sub-scale results indicated that only a small percentage of the respondents experienced hyper-arousal often or all of the time. The researcher is of the opinion that these

results could be due to the varying time frames of the experiences of bereavement of the respondents. Weiss and Marmar (1996:1) state that this scale is most effective within seven days of bereavement. This is so because the symptoms of intrusion, avoidance and bereavement on the whole diminish over time, which could have impacted in the above results.

3.3.4 Section D: Bereavement Support

SUPPORT OFFERED

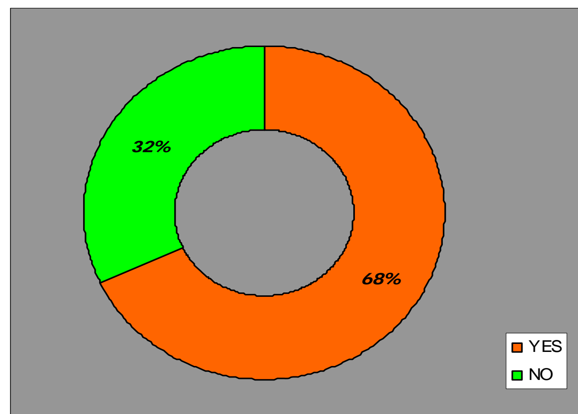


Figure 12: Support offered

Figure 12 indicates that 68% of respondents did receive some sort of support after their loss and 32% did not. DeSpelder and Strictland (1999:256) state that the experience of grief varies according to the amount of social support available. The researcher therefore found these statistics to be very positive as it indicates that the respondents have some support network already.

EFFECTS OF LACK OF SUPPORT ON WORK PERFORMANCE

Table 10: Effects of lack of support on work performance

NUMBER OF RESPONDENTS THAT DID NOT RECEIVE ANY SUPPORT	EFFECT ON WORK PERFORMANCE	NUMBER OF RESPONDENTS AFFECTED
8	Difficulty Concentrating	8
9	Extremely emotional	9
3	Affected my attendance	3
3	Affected my motivation	3
0	Affected my relationship with my colleagues	0
2	Did not affect my work performance	2
1	Other effects	1

According to King and Tellioglu (2007:1) some effects of grief and bereavement on employees are poor concentration which results in slower production rates and poor performance, employees isolating themselves from co-workers, inability to control emotions and temper which affects co-workers and in turn productivity, extreme tiredness which could result in workplace accidents and unreliability. Table 10 indicates that 26 respondents who did not receive any support during their grief and bereavement experienced some of the effects, as stated by King and Tellioglu (2007:1), such as difficulty concentrating, being extremely emotional, their attendance, motivation and relationships with their colleagues were affected. The researcher is of the opinion that these statistics emphasis the importance of a bereavement support programme.

SUPPORT NETWORK

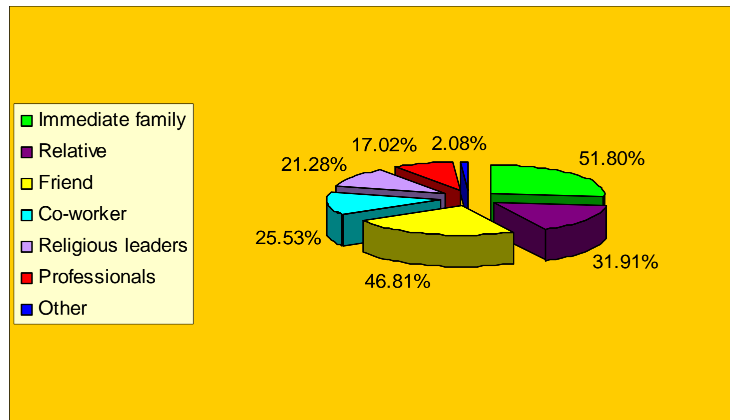


Figure 13: Support network

Figure 13 clearly illustrates that majority of the respondents have some sort of a support network. Some respondents received support from more that one of the above categories. The researcher has however noticed that 51.80% of the respondents received support from their immediate family, 31.91% from relatives, 46.81% received support from friends and only 17.02% from professionals. These statistics were expected as most people turn to family and friends for support during bereavement as they are more easily accessible as compared to professionals. According to DeSpelder and Strictland (1999:257), family support can be a key factor in determining whether the bereaved feels supported and encouraged to deal successfully not only with grief per se, but also with the myriad practical issues that follow bereavement. The researcher would however like to note that almost 90% of the respondents, as illustrated in figure 8, lost loved ones unexpectedly or through ways that are extremely traumatic and in these circumstances, professional assistance is very beneficial.

EFFECT OF SUPPORT

Table 11: Effect of support received

EFFECT OF SUPPORT	NUMBER OF RESPONSES
Less stressed	14
Emotionally stronger	13
Better coping strategies	8
More relaxed	5
Able to deal with grief and move on	26
Other	1
	TOTAL= 67

Of the 68% of respondents that have received support, as indicated in Figure 12, statistics in Table 11 indicate that 67 responses were received from them stating that they benefited from the support they have received in one or more of the above categories. The researcher is of the opinion that the fact that 26 (37%) of the respondents were able to deal with their grief and move on, is very positive as it indicates that the support that they received was beneficial in that regard. There is recognition that sharing the grief does not take it away, yet it can assist the bereaved with their grief. The expression of grief and bereavement forms part of the mourning rituals that help the bereaved feel cared for and supported and this support is essential (DeSpelder & Strictland, 1999: 562). Although the respondents benefited in other ways as well, the researcher is of the opinion that there could be more emphasis place on those aspects like dealing with emotions, providing relaxation techniques and coping strategies, if there is a need for an employee bereavement support programme at Umgeni Hospital.

FOLLOW UP SERVICES

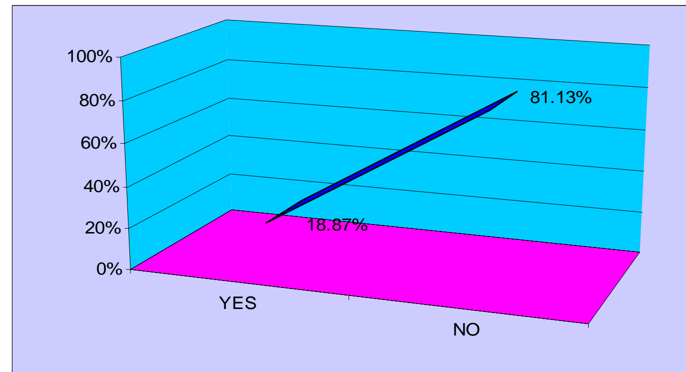


Figure 14: Follow up services

The researcher found the statistics that are indicated in Figure 14 very crucial as the researcher is of the opinion that follow up services are very important for the bereavement services to be effective. This corresponds with Faulkner's ([Sa]:sn) statement that follow up programmes can assist the bereaved to continue relationships with the deceased after death, assist and promote openness within families, and offer empowerment with the view to liberate and educate the bereaved to find coping strategies in order to deal with their grief. Figure 14 indicates that only 18.87% of the respondents actually received follow up services while 81.13% of the respondents did not receive follow-up services. The researcher is therefore of the opinion that this is another crucial aspect that can be considered if there is a need for an employee bereavement support programme.

FURTHER SERVICES REQUIRED

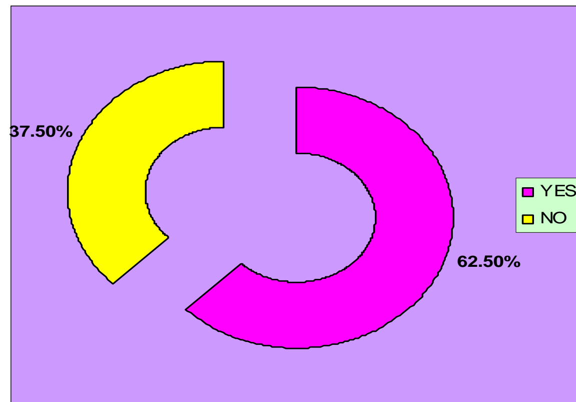


Figure 15: Further services required

Figure 15 indicates that the majority namely 62.50% of respondents would have liked to have received further support services. The researcher believes that the availability of further bereavement services is necessary as each person deals with grief and bereavement at their own pace. Jackson (1996:2-11) highlights another benefit and states that most substantial is the extensive documentation that demonstrates that follow up or further bereavement support results in increased health status of the bereaved. Studies have found that a perceived lack of support after bereavement raises the risk of health consequences from less that twenty percent to almost eighty six percent. The bereaved with follow up support have shown fewer symptoms of distress physically and psychologically, fewer visits to the doctors and have higher health status scores. Therefore, if there is a need for an employee bereavement support programme at Umgeni Hospital, the availability of further bereavement or follow up services must be considered.

THE NEED FOR AN EMPLOYEE BEREAVEMENT SUPPORT PROGRAMME

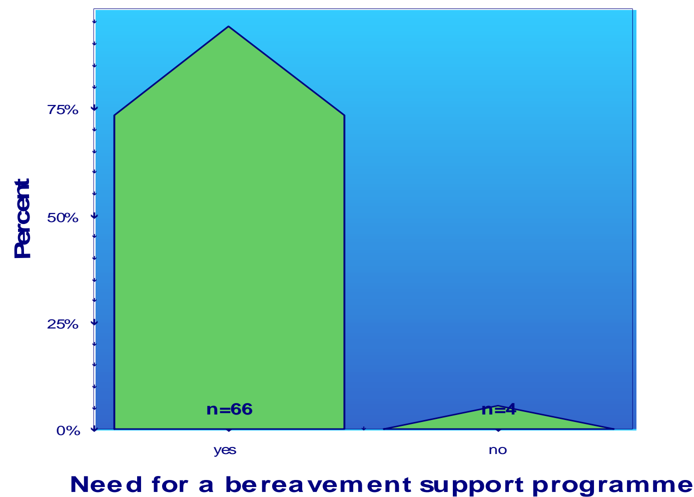


Figure 16: The need for an employee bereavement support programme

Despite majority of the respondents receiving some sort of bereavement services, as indicated in Figure 12, and 95% of the respondents benefiting from the support received, as indicated in Table 11, 66 (94%) of the respondents felt that there is definitely a need for an employee bereavement support programme at Umgeni Hospital and only 4 (5.7%) felt that there is no need for the programme. This could be due to 81.13% of respondents, as indicated in Figure 14, not receiving follow up services, 62.50% of respondents, as indicated in Figure 15, requiring further services and that an employee bereavement support programme at Umgeni Hospital could be more easily accessible as well as provide a range of bereavement services. These statistics further correspond with the literature, as explained in Chapter 2, that a bereavement support programme in a workplace is necessary and can be extremely beneficial for employees. Based on these statistics the researcher can answer the research question, that is, **what is the need for an employee bereavement support programme at Umgeni Hospital?** These statistics indicate that the employees of Umgeni Hospital definitely feel that there is a need for a bereavement support programme.

TYPE OF BEREAVEMENT SUPPORT PROGRAMME

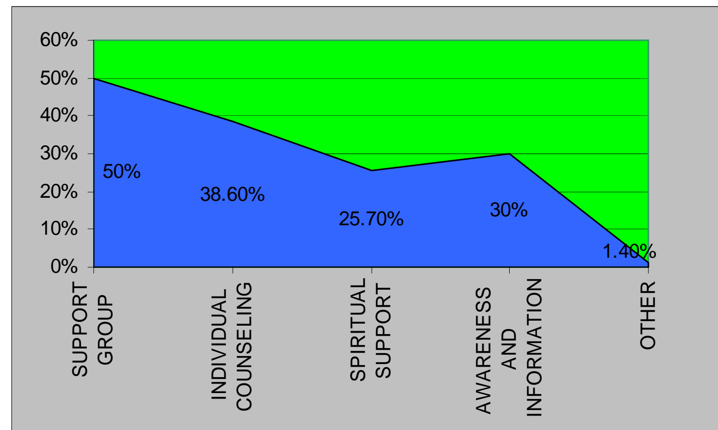


Figure 17: Type of employee bereavement support programme

Figure 17 indicates the type of bereavement support programmes that the respondents would prefer. A support group was definitely the most preferred type of programme by 50% of the respondents, 38.60% of respondents preferred individual counseling, 25.70% prefer spiritual support, 30% prefer awareness and information and 1.40% wanted other types of programmes. DeSpelder and Strictland (1999:258) mentioned that the type of group or programme chosen is an individual or personal decision. These statistics correspond with literature as, "Recent decades have seen an increased emphasis on counseling and therapy following bereavement" (DeSpelder & Strictland, 1999: 547). The researcher is of the opinion, based on the above statistics and literature, that the employee bereavement support programme can include a combination of the above services to be very effective and meet the needs of majority of the employees or the type of programme rendered could also depend on the need of the employees at particular times.

CONTENT OF AN EMPLOYEE BEREAVEMENT SUPPORT PROGRAMME

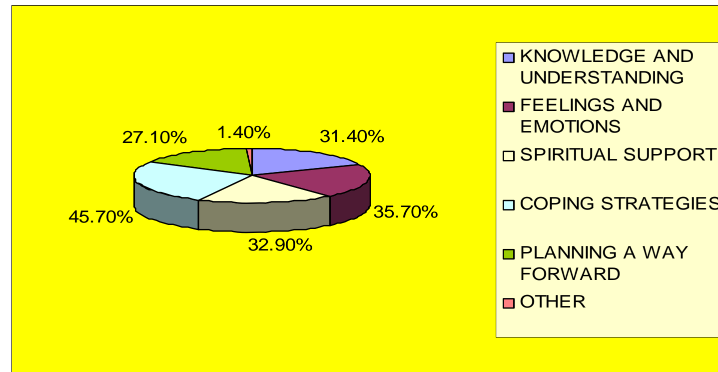


Figure 18: Content of an employee bereavement support programme

The researcher is of the opinion that the content of any bereavement support programme is crucial and must be carefully planned and prepared for in order to address the needs of the respondents. Figure 18 illustrates that 45.70% of the respondents would like the inclusion of coping strategies in the programme, 35.70% want to discuss feelings and emotions in relation to bereavement, 32.90% would like spiritual support, 31.40% want more knowledge and understanding of bereavement, 27.10% would like to now how to plan a way forward without their loved one and 1.40% would like other content included.

According to Pilgrims Hospice (2008:1), grief counseling or support helps mourners with normal grief reactions to work through the tasks of grieving. The goals of grief counseling and support therefore includes:-

- ❖ Helping the bereaved to accept the loss by helping him or her to talk about the loss.
- ❖ Helping the bereaved to identify and express feelings related to the loss (for example, anger, guilt, anxiety, helplessness and sadness).
- ❖ Helping the bereaved to live without the person who died and to make decisions alone.
- ❖ Helping the bereaved to separate emotionally from the person who died and to begin new relationships.

- ❖ Provide support and time to focus on grieving at important times such as birthdays and anniversaries.
- ❖ Describing normal grieving and the differences in grieving among individuals.
- ❖ Providing continuous support.
- ❖ Helping the bereaved to understand his or her methods of coping.
- ❖ Identifying coping problems the bereaved may have and making recommendations for professional grief therapy.

The researcher supports Pilgrims Hospice (2008:1) view and therefore believes that the content of the employee bereavement support programme should include a combination of the categories as stated in Figure 18 or the programme be adjusted to meet the needs of the employees if necessary.

LENGTH OF THE EMPLOYEE BEREAVEMENT SUPPORT PROGRAMME

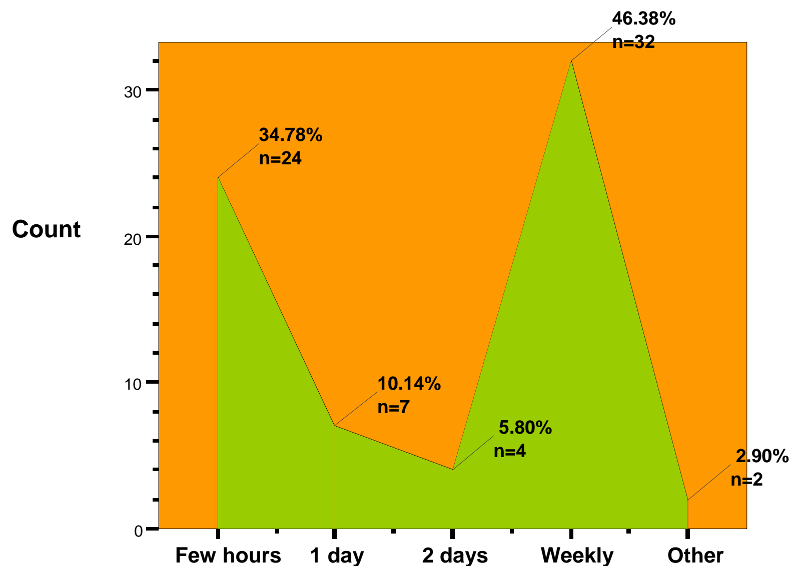


Figure 19: Length of the employee bereavement support programme

Figure 19 indicates that 46.38% of the respondents would like a weekly bereavement support programme while 34.78% would like a programme that is only a few hours and only 18.84% of the respondents would like either a 1or 2 day or another length programme. As was stated by Facing Bereavement

(2007:1), and as explained through the various theories and stages or phases of grief, it may take days, weeks or even years for someone who is grieving to complete all the stages of the grief cycle depending on the source of the bereavement or grief. The researcher therefore is of the opinion that although the statistics in Figure 19 can be used as a guideline, the person/s coordinating the employee bereavement support programme must use their discretion, depending on the source of the grief of the employees, to determine the length of the bereavement support programme.

COORDINATION OF THE EMPLOYEE BEREAVEMENT SUPPORT PROGRAMME

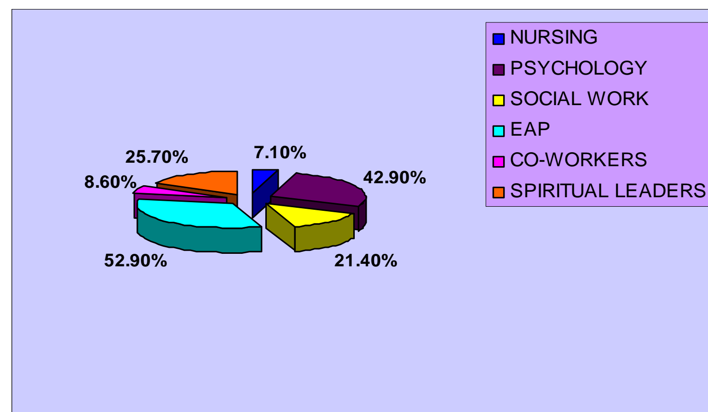


Figure 20: Coordination of the employee bereavement support programme

Pilgrims Hospice (2008:1) states that bereavement and grief are complex psychological processes that may not be clearly and fully recognized by the bereaved, family members and co-workers. Social workers, psychologists and psychiatrists are helpful in understanding bereavement and grief. The researcher agrees with the statement of Pilgrims Hospice (2008:1) as professionals like social workers, psychologists and psychiatrists, due to their professional training, experience and code of ethics, will be more effective in rendering bereavement services. This corresponds with the statistics of Figure 20 of which 52.90% of the respondents prefer the EAP to coordinate the employee bereavement support

group, 42.90% prefer the psychologist and 21.40% would like the social workers to coordinate the programme. The researcher noticed that 25.70% of the respondents would like spiritual leaders to coordinate the programme and this can be considered when the programme is going to be implemented at the hospital. A small percentage of respondents would have liked their co-workers to coordinate the programme and from the 7.10% of respondents that wanted others to coordinate, some respondents wanted the above professionals and components to work together in coordination of the employee bereavement support programme, which could also be considered.

3.4 SUMMARY

The researcher used a self-constructed questionnaire as a way of collecting the data. The data was presented and analyzed in this chapter, using table and graphs, to highlight the research findings. The data was analyzed in four sections, according to the data collection instrument, which included the respondents' personal details, the respondents' experience of grief or bereavement, the Impact of Event Scale-Revised (IES-R) and the respondents' need for bereavement support.

The research findings indicate that despite the fact that each respondent would have grieved and experienced grief differently there were very clear findings as to the need for an employee bereavement support programme at Umgeni Hospital. Although the IES-R did not reveal very significant results, this could have been due to the differences in time frames of the respondents' experiences of bereavement. However, an overwhelming percentage of respondents, although having received support during the time of bereavement and found this support to be beneficial in some ways, still believe that there is a need for an employee bereavement support programme at Umgeni Hospital. The researcher is of the opinion that although the respondents indicated their preference regarding the type, content, length and coordination of the programme, these

aspects need to be properly planned and prepared ensuring the needs of the employees are met.

The following chapter will provide the conclusions and recommendations for this research study.

CHAPTER 4

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

Bereavement and grief are life changing and universal experiences. People cope with loss of a loved one in many ways. For some the experience may lead to personal growth and for others it could lead to deterioration in their normal functioning. There is no right way of coping with death.

Grief and loss occurs both at work and at home. However, these days, most people spend more of their time at the workplace than at home.
However, how a person copes with grief is affected by the person's cultural and religious background, coping skills, mental history, support systems and the person's social and financial situation.

The workplace could be a significant support system that could help a person to cope with the loss. The manner in which grief and loss are managed in the workplace could determine if the employees' experiences of this loss is dealt with either positively or negatively. A workplace bereavement support programme could therefore be a valuable resource in assisting employees with their grief, loss and bereavement.

In this chapter, the most information drawn from the literature and the empirical data will be briefly discussed. The summary is outlined, followed by the conclusions and recommendations which are based on the research findings.

4.2 SUMMARY

This section provides a summary of the entire study. The goal and objectives of the study as well as the research question are restated together with the contents of the research report.

4.2.1 Goal of the study

The goal of this study was to investigate the need for an employee bereavement support programme at Umgeni Hospital.

4.2.2 Objectives of the study

The objectives of this study were:

- To conceptualize theoretically employee bereavement and its impact in the workplace as well as the support strategies for employees.
- To conduct an empirical investigation into the need for an employee bereavement support programme at Umgeni Hospital.
- To provide recommendations to the hospital management on the need for a bereavement support programme at Umgeni Hospital based on the information gained from this research.

4.2.3 Research question

The researcher formulated the following research question for the present study:

What is the need for an employee bereavement support programme at Umgeni Hospital?

The research questioned was proved or answered by the findings of this research study and supported by the literature review.

4.2.4 Contents of the research report

This research report comprises of four chapters:-

Chapter 1: General background

This chapter focused on the conceptualization of the study. That included the background and rationale for the study, the goal, objectives and research question of the study and a brief description of the research methodology.

Chapter 2: **Bereavement in the workplace**

Chapter 2 provided a theoretical conceptualization based on an in-depth literature review of employee bereavement and its impact in the workplace as well as the support strategies for employees.

Chapter 3: Empirical findings of the study

This chapter focused on the empirical investigation into the need for an employee bereavement support programme at Umgeni Hospital, the data analysis and interpretation.

Chapter 4: **Summary, conclusions and recommendations**

Chapter 4 presents the summary of the research process, the conclusions and recommendations based on the research findings.

4.3 CONCLUSIONS

4.3.1 The **literature review** of this study provided core information on grief and bereavement. The following conclusions are important:

- The experience of bereavement is an important and widespread social phenomenon. Losing someone or something you love is very painful and it is something that almost everyone will experience at some point in their

lives. Bereavement is often used interchangeably with the word grief; however some believe that bereavement extends beyond grief to affect many aspects of physical, social, emotional and psychological health including loss of social support and function, physical symptoms, change of hopes and changes in financial status.

- People experience grief and bereavement differently due to various influences such as culture, tradition, personality traits, relationship with the deceased and even societal expectations. Despite these influences, people experience common signs and symptoms of normal grief and bereavement which affect them physically, emotionally, behaviourally, psychologically, socially and spiritually, of which they are able to work through over a period of time as these signs and symptoms decrease. However, if the loss of a loved is unexpected, people may experience traumatic grief and may require professional assistance to help them deal with their grief. People further require varied time periods to deal with their grief but they are forced to return to work soon after the loss of a loved one because their bereavement leave is finished. This results on the grief and bereavement impacting on the workplace through their possible poor job performance and productivity at work.

- Several blueprints or theories about grief have been proposed by Freud, Lindemann, Bowlby, Elizabeth Kubler-Ross, Parkes, Worden and Stroebe and Schut. They described grief through grief work, stages, phases, themes and tasks of the grief process. These theories are all guide posts to help an individual deal with their grief. However, each individual deals differently with their grief so they might not follow these steps in the orders as stated, but may fluctuate between them depending on their needs and emotions at different points in the grief process. These theories, however, definitely makes understanding of the grief process much easier and

further assist in the understanding of grief and bereavement in the workplace.

- ❖ Grief and bereavement in the workplace has vast consequences ranging from tiredness and lack of concentration of employees to increased employee absenteeism and decreased productivity and organizational profits. Grief and bereavement in the workplace occur not only as a result of the death of employee's loved ones but also from significant life and work changes of employees such as retrenchments, downsizing and closure of companies, which are very realistic considering our country's current economy. The support given to bereaved employees can however minimize these effects of grief and bereavement in the workplace. Workplace bereavement support programmes is a method of support for bereaved employees and can be valuable resources for organizations.

- ❖ Various forms of support can be offered to grieving employees in the workplace. The appropriateness of the support however could be determined by the sources of the grief of employees, the needs of the employees, the willingness of the organization to provide support and the availability and affordability of support resources to organizations. However, lack of support or inappropriate support could have extremely negative consequences. Offering workplace bereavement support programmes will not only benefit grieving employees but also the organization through increased loyalty, morale and job performance of employees which will ultimately result in increase organizational profits.

4.3.2 The **empirical data** revealed the following information:

- ❖ There was more female than male respondents. Most of the respondents ranged between 25-49 years. Almost 50% of the respondents were never

married followed by those that were married. The respondents that were divorced, separated and widowed constituted a small number.

- IsiZulu was the most dominant home language followed by respondents having English as their home language with very few respondents having other home languages.

- The largest number of respondents was from the hospital's nursing component, with a fair number from finance and systems and the allied health professionals and smaller numbers from other hospital components.

- The respondents experiences of grief indicates that more than 50% of the respondents knew three or more people that have died in the past three years with majority of the respondents having lost family, relatives and friends, people that were very closed to them which has a significant impact on the grieving process and the support required. More than half of the causes of death were natural and expected. However, the percentage of the natural sudden deaths, accidental deaths and violent deaths was quite high.

- The results of the Impact of Event Scale – Revised (IES-R) indicated that, although the respondents would have experienced some impact in terms of intrusion and avoidance, there was no significant difference between the respondents' gender, age and the causes of death on the intrusion and avoidance sub-scales.

- The bereavement support findings revealed that almost three quarters of the respondents did receive some sort of support and only twenty four respondents who did not receive any support during their grief and bereavement experienced some of effects on their work performance.

Majority of the respondents received support from their immediate family, relatives, friends and only a small number from professionals. Sixty seven responses were received from them stating that they benefited from that support.

- Interesting results were revealed regarding follow up and further services. Only thirteen respondents actually received follow up services and forty four respondents would have liked to have received further services apart from the support that they had already received.
- **Sixty six of the seventy respondents felt that there is definitely a need for an employee bereavement support programme at Umgeni Hospital.**
- A support group was definitely the most preferred type of bereavement programme followed by the preference of individual counseling with smaller numbers indicating other types of programmes.
- Findings regarding the content of the programme indicated that a combination of the various categories, that is, knowledge and understanding, feelings and emotions, spiritual support, coping strategies, and planning a way forward, will be suitable as the preference of these categories ranging between 25% and 45%.
- Majority of the respondents (46.38%) would like a weekly bereavement support programme while 34.78% would like a programme that is only a few hours.
- The EAP was the most preferred (52.90%) component to coordinate the bereavement programme followed by 42.90% of respondents' who prefer the psychology department. A smaller percentage requested other components and 21.40% preferred the social worker department to coordinate the programme.
- The researcher is of the opinion that although the respondents indicated their preference regarding the type, content, length and coordination of the programme, these aspects need to be properly planned and prepared for ensuring the needs of the employees are met. If the employees require

the combination of various types and contents of the programme as well as changing time frames and combining various departments to coordinate, then this must be considered.

4.4 RECOMMENDATIONS

Based on the goals, objectives and findings of the research study as stated above, the researcher recommends the following:-

- Management of Umgeni Hospital form a bereavement committee comprising of relevant role players or hospital components such as the EAP practitioner, the psychologist, social workers, relevant nursing staff and spiritual leaders.
- A future study can be done together with the bereavement committee on the actual development and implementation of an employee bereavement support programme.
- The bereavement support programme must be made available to all employees of the hospital.
- The bereavement programme that will be implemented is suitable to the needs of the employees such as the type, content and length of the programme.
- Follow up or further bereavement services be rendered to employees if it is necessary.
- It is important that future studies involve evaluating the employee bereavement support programme after the programme has been developed and implemented.

4.5 ACCOMPLISHMENT OF GOALS AND OBJECTIVES OF THE STUDY

Goal of the study: To investigate the need for an employee bereavement support programme at Umgeni Hospital.

Table 12 focuses on how the goal and resulting objectives of the study were accomplished.

Table 12: Accomplishment of the study objectives

Objectives	Objective Achievement
To conceptualize theoretically employee bereavement and its impact in the workplace as well as the support strategies for employees.	The objective was achieved as reflected in the discussion presented in Chapter 2.
To conduct an empirical investigation into the need for an employee bereavement support programme at Umgeni Hospital.	The objective was accomplished successfully through a detailed discussion in Chapter 3 on the quantitative findings on the need for an employee bereavement support programme at Umgeni Hospital.
To provide recommendations to the hospital management on the need for a bereavement support programme at Umgeni Hospital based on the information gained from this research.	The objective was achieved through a presentation of recommendations in Chapter 4.

4.6 CONCLUDING REMARKS

Grief and bereavement are an important and widespread social phenomenon and it is something that almost everyone will experience at some point in their lives. People cope with the loss of a loved one in many ways. However, how a person copes with grief is affected by the person's cultural and religious background, coping skills, mental history, support systems and the person's social and financial situation.

Grief and loss occurs both at work and at home and the workplace could therefore be a significant support system that could help a person to cope with the loss.

This research would definitely add value to the hospital and its employees as it determined not only that there is definitely a need for an employee bereavement support programme at Umgeni Hospital but also the exact or specific needs of the employees with regards to the programme itself. This will in turn assist hospital management in developing an appropriate bereavement support programme to assist their employees in the future.

LIST OF REFERENCES

American Hospice Foundation. 2007. *Workplace Issues*. USA: American Hospice Foundation.

American Psychological Association. 1994. *Psychology Matters*. Washington D.C: APA.

Babbie, E. 2004.*The practice of social research.*10th ed. Belmont: Wadsworth/Thomson Learning.

Bless, C. & Higson-Smith, C. 2000. *Fundamentals of Social Research Methods: An African Perspective*. 3rd ed. Creda Communications: Cape Town.

Bowlby, J. 1961. Process of Mourning. *International Journal of Psychoanalysis*, 42: 317-340.

Bowlby, J. (1972). Forward. In Parkes, C.M. *Bereavement: studies of grief in adult life*. Middelsex: Penguin.

Buthelezi, N.B. 2007. Interview with Social Worker, Umgeni Hospital. [Transcript]. 13 November. Howick.

Cassell's English Dictionary. 2000. Great Britain: Mackays.

Canadian Mental Health Association. 2004. *Bereavement* in the Workplace. Canada: Centre for Suicide Prevention.

Carbasho, T. 2005. *Workplace programs aim to help employees deal with grief and loss*. USA: Pittsburgh Business Times.

Chapman, A. 2006. *Interpretation of Elizabeth Kubler-Ross' Grief Cycle Model.* [o]. Available:
http://www.elizabethkubler-rossgriefcyclemodel.html
Accessed on 2008/02/27

Christianson, S. & Marren, J. 2008. The Impact of Event Scale – Revised (IES-R). *Best practices in nursing care to older adults*, 19:1-2.

Clarke, R. 2006. *Introduction to Dataveillance and Information Privacy, and Definition of Terms.* Canberra: Xamax Consultancy.

Creswell, J.W. 1994. *Research design: qualitative and quantitative approaches*. Thousand Oaks: Sage.

Cusworth, J.W. & Franks, T.R. 1993. *Managing Projects in Developing Countries.* [S1: sn].

Delport, C.S.L. 2005. Quantitative data-collection methods. In De Vos, A.S. (Editor), Strydom, H., Fouché, C.B. & Delport, C. S.L. *Research at Grass Roots for the social sciences and human science professions*. Pretoria: Van Schaik Publishers.

DeSpelder, L.A. & Strictland, A.L. 1999. *The last dance*. 5th ed. California: Mayfield Publishing Company.

Dictionary of Business Terms. 2000. [S1]: Barron's Educational Series, Inc.

Duff, J. 2005. *Grief.* USA: Behavioural Neurotherapy Clinic.

Durrheim, K. 2006. Research design. In Terre Blanche, M. & Durrheim, K. *Research in Practice: Applied Methods for the Social Sciences.* Cape Town: University of Cape Town Press (PTY) Ltd.

Durrheim, K. & Wassenaar, D. 2006. Putting design into practice: writing and evaluating research proposals. In Terre Blanche, M. & Durrheim, K. *Research in Practice: Applied Methods for the Social Sciences.* Cape Town: University of Cape Town Press (PTY) Ltd.

Dutmer, J.W. [Sa]. *Grief in the workplace*. [S1: sn].

Dyer, K.A. 2002. *How to Cope with Loss, Grief, Death & Dying – Professionally & Personally*. USA: California State University.

Facing bereavement. 2007. How grief affects your relationships.
[o]. Available:
http://www.facingbereavement.html
Accessed on 2008/01/25

Fallis, B. 1998. *Proposal Writing*. [S1: sn].

Faulkner, A. [Sa]. Development in bereavement services. *The future for palliative care: issues of policy and practice*, 68-79.

Fouché, C.B. & Delport, C.S.L. 2005. Introduction to the research process. . In De Vos, A.S. (Editor), Strydom, H., Fouché, C.B. & Delport, C. S.L. *Research at Grass Roots for the social sciences and human science professions*. Pretoria: Van Schaik Publishers.

Fouché, C.B. & De Vos, A.S. 2005a. Problem Formulation. In De Vos, A.S. (Editor), Strydom, H., Fouché, C.B. & Delport, C. S.L. *Research at Grass Roots*

for the social sciences and human science professions. Pretoria: Van Schaik Publishers.

Fouché, C.B. & De Vos, A.S. 2005b. Quantitative research designs. In De Vos, A.S. (Editor), Strydom, H., Fouché, C.B. & Delport, C. S.L. *Research at Grass Roots for the social sciences and human science professions*. Pretoria: Van Schaik Publishers.

French, H. & Harris, G. 1999. Dealing with Trauma. In Herman, J. *Life alter trauma: A workbook for healing.* Guildford Press, New York.

Gadi, V.K. 2006. *Symptoms of Grief*.
[o]. Available:
http://www.symptomsofgrief.mht
Accessed on 2008/01/25

Gill, E.J., Smith, M. & Segal, J. 2007. Coping with Grief and Loss: Guide to grieving and bereavement.
[o]. Available:
http://www.copingwithgriefandloss.html
Accessed on 2008/02/27

Gould, M. 2004. *Handling bereavement: mourning death in the workplace.* New Jersey: Princeton Group.

Gravette, F.J. & Forzano, L.B. 2003. *Research methods for the behavioural sciences*. Belmont: Wadsworth/Thomson Learning.

Grief in the Workplace. 2000. Eckert: Bereavement Publications, Inc.

Grief Reactions Associated with the Workplace. 2007.
[o]. Available:
http://www.workplace.html
Accessed on 2007/08/07

Grief Watch. 2003. *Symptoms of Grief.*
[o]. Available:
http://www.griefwatch.com/
Accessed on 2008/01/25

Hartley, J. [Sa]. *Grief in the workplace*. United Kingdom: Talking Life Seminars.

HealthGate Data Corp. 2007.*Communities prepared: Grief in the workplace.* USA: University of Pittsburg Medical Centre.

Horinek, K. & Solove, T. 2002. *Understanding grief: assessment and treatment planning.* [S1: sn].

Jackson, I. 1996. Critical care nurses' perceptions of a bereavement follow up service. *Intensive and Critical Care Nursing*, 12: 2-11.

King, S.A. & Tellioglu, T. 2007. *Grief.*
[o]. Available:
http://www.Grief1.mht
Accessed on 2008/02/27

Kruger, D.J., De Vos, A.S., Fouché, C.B. & Venter,L. 2005. Quantitative data analysis and interpretation. In De Vos, A.S. (Editor), Strydom, H., Fouché, C.B. & Delport, C. S.L. *Research at Grass Roots for the social sciences and human science professions*. Pretoria: Van Schaik Publishers.

Kubler-Ross, E. 1969. *On Death and Dying*. New York: Macmillan.

Kumar, R. 2005. *Research Methodology: A step-by-step guide for beginners*. 2nd ed. Thousand Oaks: Sage.

Lev, E.L. & McCorkle, R. 1998. Loss, Grief and Bereavement in family members of cancer patients. *Seminars in Oncology Nursing*, 14(2):145-151.

Lindemann, E. 1944. The symptamotology and management of acute grief. *American Journal of Psychology*, 101: 141-148.

Lynn, J. 2001. Serving patients who may die soon and their families. *JAMA*, 285: 925-932.

Lindstrom, T.C. 1983. *Good Grief: Adapting to bereavement.* Norway: University of Bergen.

Machin, L. [Sa]. *Bereavement and Loss in Social Care & Bereavement in Healthcare*. United Kingdom: Talking Life Seminars.

McGuinness, B. 2007. *Grief at Work: Developing a Bereavement Policy*. Ireland: Irish Hospice Foundation.

McMurray, A. 2000. Bereavement. In Oliver, D., Borasio, G.D. & Walsh, D. (Eds).Palliative *Care in Amyotrophic Lateral Sclerosis (Motor Neuron Disease).* Oxford: Oxford University Press.

MedicineNet.com. 2007. *Bereavement.*
[O]. Available:
http://bereavement-Mental Health Disorders on MedicineNet_com
Accessed on 2007/08/13

Morrell, S.L. 2000.*Grief in the workplace.* British Collumbia: Westwood Dynamics.

National Cancer Institute. 2006. *Loss, Grief and Bereavement.*
[O]. Available:
http://cancer.gov/cancertopics/pdq/supportivecare.bereavement
Accessed on 2007/08/07

National Mental Health Foundation Centre. [Sa]. *How to deal with grief*. USA: SAMHSA.

National Trauma Committee of the South African Police Service. 1998. *National Instruction 18/1998*. Pretoria: SAPS.

NetTOM. [Sa]. *Introduction to research methods*. Malawi: The Malawi College of Accounting.

Neuman, W.L. 2000. *Social research methods: qualitative and quantitative approaches*. 4th ed. Boston: Allyn & Bacon.

Neuman, W.L. & Kreuger, L.W. 2003. *Social research methods: qualitative and quantitative approaches*. Boston: Allyn & Bacon.

Nix, L.S. 2006. *Grief and Loss.* USA: [sn].

Palmquist, M. [Sa]. *The Bedford Researcher*. USA: Colorado State University.

Personal Assistance Services (PAS). 2007. *Grief in the Workplace*. Durham: Duke University.

Personal Assistance Services. 2007. *Grief in the workplace.*
[O]. Available:
http://DukeUniversityPAS.mht.
Accessed on 2007/08/07

Pilgrims Hospice. 2008. Bereavement Support: Workplace Debriefings.
[o]. Available:
http://www.XanadaHelps.org
Accessed on 2008/02/07

Rajesh, S. 2006. *Does your workplace allow for personal grief?* India: The Hindu group of publications.

Rosnow, R.L. & Rosenthal, R. 1996. *Beginning Behavioural Research: A conceptual primer*. (2nd ed). New Jersey: Prentice Hall, Inc.

Sarantakos, S. 2000. *Social Research*. Sydney: Macmillan.

Services Sector Education and Training Authority (SETA). [Sa]. *Recognising loss and trauma in the workplace.* Johannesburg: [sn].

Shear, K. [Sa]. *Traumatic Grief*. Pittsburgh: University of Pittsburgh Press (PTY) Ltd.

Sherer, K. 2004. *Life after loss: Dealing with Grief*. USA: University of Texas at Austin Press (PTY) Ltd.

Smith, J. [Sa]. *Bereavement in the Workplace: How to recognize it, respond to it and respect it*. Nova Scotia: HR Links.

Stroebe, M. & Schut, H. 1995. *The Dual Process Model of Coping with Bereavement: rationale and description*. Washington D.C: Oxford University Press.

Strydom, H. 2005a. The Pilot Study. In De Vos, A.S. (Editor), Strydom, H., Fouché, C.B. & Delport, C. S.L. *Research at Grass Roots for the social sciences and human science professions*. Pretoria: Van Schaik Publishers.

Strydom, H. 2005b. Sampling and Sampling Methods. In De Vos, A.S. (Editor), Strydom, H., Fouché, C.B. & Delport, C. S.L. *Research at Grass Roots for the social sciences and human science professions*. Pretoria: Van Schaik Publishers.

Strydom, H. 2005c. Ethical aspects of research in the social sciences and human service professions. In De Vos, A.S. (Editor), Strydom, H., Fouché, C.B. & Delport, C. S.L. *Research at Grass Roots for the social sciences and human science professions*. Pretoria: Van Schaik Publishers.

Suicide Information & Education Centre (SIEC). 2000. *Reactions to a colleague's suicide.* Canada: Canadian Mental Health Association.

Suicide Information & Education Centre (SIEC). 2000. *Bereavement in the workplace.* Canada: Canadian Mental Health Association.

Terre Blanche, M. & Durrheim, K. 2006. *Research in Practice: Applied Methods for the Social Sciences*. Cape Town: University of Cape Town Press (PTY) Ltd.

The American Dictionary of the English Language. 2004. 4th ed. USA: Houghton Mifflin Company.

The 'Lectric Law Library's Lexicon. 2007. [S1: sn].

Tousley, M.M. 1999. *Emotional Reactions to Loss.*

[o]. Available:
http://www.emotionalreactionstoloss.mht
Accessed on 2008/02/27

Van Vuuren, D. 2006. Survey Methods in market and media research. In Terre Blanche, M. & Durrheim, K. *Research in Practice: Applied Methods for the Social Sciences.* Cape Town: University of Cape Town Press (PTY) Ltd.

Vincent, E. 2004. *When an employee is grieving*. USA: LifescapeSolutions.

Webster, M. [Sa]. *Collegiate Dictionary.* [S1: sn].

Webster's New World Medical Dictionary. 2003. 2nd ed. [S1: sn].

Weiss, D.S. & Marmar, C. R. 1996. The Impact of Event Scale – Revised. In Wilson, J. & Keane, T.M. *Assessing psychological trauma and PTSD*. New York: Guilford.

Woof, W.R. & Carter, Y.H. 1997. The grieving adult and the general practitioner: A literature review in two parts (part 1). *British Journal of General Practice*, 47: 443-448.

Worden, J.W. 1991. *Grief Counselling and Grief Therapy: A Handbook for Mental Health Practitioners*. 2nd Ed. London: Springer.

Zank, A. 2007. Interview with Psychologist, Umgeni Hospital. [Transcript]. 9 November. Howick.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

APPENDIX A

JUN.23.2008 11:17 0333943782 HEALTH SERVICE DELIVERY #4732 P.001 /001

HEALTH
KwaZulu-Natal

Health Research & Knowledge Management sub-component
10 – 103 Natalia Building, 330 Langalibalele Street
Private Bag x9051
Pietermaritzburg
3200
Tel.: 033 – 395 2944
Fax.: 033 – 394 3782
Email.: xolani.xaba@kznhealth.gov.za
www.kznhealth.gov.za

Reference : HRKM040/08
Enquiries : Mr X. Xaba
Telephone : 033 – 395 2805

17 June 2008

Dear MS V. Naidoo

Subject: Approval of a Research Proposal

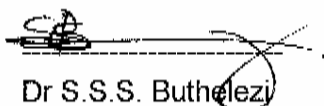
1. The research proposal titled **'The need for an employee bereavement support programme at Umgeni Hospital"** was reviewed by the KwaZulu-Natal Department of Health. The proposal is hereby **approved** for research to be undertaken at Umgeni Hospital.

2. You are requested to undertake the following:
   a. Make the necessary arrangement with identified facilities before commencing with your research project.
   b. Provide an interim progress report and final report (electronic and hard copies) when your research is complete.

3. Your final report must be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT, 10-102, PRIVATE BAG X9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to xolani.xaba@kznhealth.gov.za

For any additional information please contact Mr X. Xaba on 033-395 2805.

Yours Sincerely



Dr S.S.S. Buthelezi
Chairperson: Provincial Health Research Committee.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

DEPARTMENT OF HEALTH

PROVINCE OF KWAZULU-NATAL

UMGENI HOSPITAL

Main Road Howick
Private Bag X23, HOWICK, 3290
Tel.: 033 330 6146, Fax.: 033 330 5564
Email.:h993780@dohho.kzntl.gov.za

Reference : **EAP**
Enquiries : **Miss.Naidoo**
Date : **2June 2008**

The Acting Hospital Manager
Umgeni Hospital
HOWICK

Cc: **The Provincial Health Research Committee**
Department of Health
Pietermaritzburg
Kwa-Zulu Natal

Dear Sir,

PERMISSION TO CONDUCT RESEARCH AT UMGENI HOSPITAL

1. Permission is requested to conduct research with employees at Umgeni Hospital.
2. I would like to conduct research on the need for a bereavement support programme for employees at this hospital.
3. The reason for this choice of topic is that Umgeni Hospital is a long term psychiatric institution were employees inevitably form bonds with patients, and with the loss of patients, a need arises for support of employees.
4. Through consultation with employees, I have further noted that employees experienced loss of colleagues as well which impacted on their work performance.
5. I therefore, feel that research on the need for a bereavement support programme could provide valuable information on how to effectively manage similar situations at the hospital in the future.
6. I believe that there could be several benefits of this research, such as:
   - Identifying critical needs of employees with regards bereavements and support in this regard.
   - Showing employees that management does care about them and their needs.
   - Recommendations to management on how employees can be supported through the bereavement process, such as the need for a standardized bereavement support programme that could benefit all employees

- Recommendations that can help build a more healthier and effective workforce.

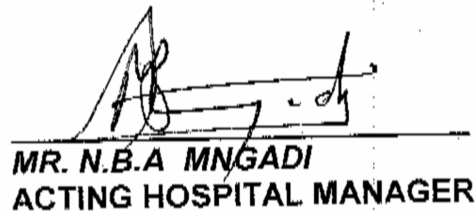
7. I am a registered student for a Master's Degree in Employee Assistance Programme (MSD-EAP) at the University of Pretoria (Faculty of Humanities – Department of Social Work and Criminology). This research study will therefore also serve as partial fulfillment of the Degree in 2008.

I hope that this request is met favourably.

Yours faithfully

MISS. VANAGREE NAIDOO
EAP PRACITITONER
(033-3306146 X248)

PERMISSION GRANTED / ~~PERMISSION NOT GRANTED~~



MR. N.B.A MNGADI
ACTING HOSPITAL MANAGER

04/06/2008
DATE

- KINDLY RETURN ALL DOCUMENTATION WHEN REPLYING

APPENDIX C

100
1908 - 2008

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Proposal and Ethics Committee

28 May 2008

Dear Prof. Delport,

Project:	**The need for an employee bereavement support programme at Umgeni Hospital**
Researcher:	**Naidoo, V**
Supervisor:	**Prof. CSL Delport**
Department:	**Social Work and Criminology**
Reference number:	**26432448**

Thank you for your response to the Committee's letter of 10 March 2008.

I have pleasure in informing you that the Research Proposal and Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 27 May 2008. The approval is subject to the candidate abiding by the principles and parameters set out in her application and research proposal in the actual execution of the research.

The Committee requests you to convey this approval to Ms Naidoo.

We wish you success with the project.

Sincerely

Brenda Louw

Prof. Brenda Louw
Chair: Research Proposal and Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: brenda.louw@up.ac.za

Research Proposal and Ethics Committee Members: Prof P Chiroro; Dr M-H Coetzee; Prof C Delport; Dr JEH Grobler; Prof KL Harris; Ms H Klopper; Prof E Krüger; Prof B Louw (Chair); Prof A Mlambo; Prof G Prinsloo; Mr C Puttergill; Prof H Stander; Prof E Taljard; Dr J van Dyk; Prof C Walton; Mr FG Wolmarans

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

APPENDIX D

WRITTEN CONSENT FORM FOR A RESEARCH PROJECT

________________________________ __________________

PARTICIPANT'S NAME **DATE**

PRINCIPAL RESEARCHER

Miss. Vanagree Naidoo
Employee Assistance Programme Practitioner
Umgeni Hospital
Private Bag X23
HOWICK
3290

Telephone number (033) 3306146 (ext 248)

The researcher is also a Master's student at the:

University of Pretoria
Faculty of Humanities
Department of Social Work and Criminology
Pretoria
0002

TITLE OF THE STUDY
The Need for an Employee Bereavement Support Programme at Umgeni Hospital.

PURPOSE OF THE STUDY
To investigate the need for an employee bereavement support programme at Umgeni Hospital.

PROCEDURES
The questionnaires will be delivered and collected by hand by the researcher. I will be asked to complete a questionnaire. I will be informed of the findings. The questionnaire will be completed at my convenience.

RISKS
I understand that my participation in this research will not contain any foreseeable risks to me. However if I feel the need for any assistance, I will contact the researcher.

BENEFITS

I understand that there are no immediate benefits for me from participating in this research. However, the information I supply would assist in determining the need for an employee bereavement support programme at Umgeni Hospital.

FINANCIAL COMPENSATION

I will not be reimbursed for participating in this research.

PARTICIPANT'S RIGHTS

I may withdraw from participating in the research at any time and without any negative consequences.

CONFIDENTIALITY

Information that I supply will be treated confidentially. Anonymity is assured and the data I supply will be destroyed should I choose to withdraw from the research. The researcher will respect my choice to disclose or not disclose any information about myself. I understand that the research may be published as a dissertation.

If I have any questions or concerns, I am free to contact the researcher at (033) 3306146 ext. 248, at any time during the day.

I understand my rights as a research subject and I voluntarily consent to participating in this research. I understand what the research is about and my requirements in completing the questionnaire.
I will receive a signed copy of the consent form.

____________________	____________________	______________
PARTICIPANT'S SIGNATURE	**PLACE**	**DATE**

____________________	____________________	______________
RESEARCHER'S SIGNATURE	**PLACE**	**DATE**

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

APPENDIX E

TO ALL RESPONDENTS

Dear Sir / Madam

You are requested to complete the questionnaire. The questionnaire is designed for research purposes. The purpose of the research is to investigate the need for an employee bereavement support programme at Umgeni Hospital. The results may help management to determine if there is a need for an employee bereavement support programme at Umgeni Hospital.

Every response will be treated with confidentiality. Anonymity is guaranteed. There is no right or wrong responses. Please indicate your response by putting an "X" in the appropriate boxes. In other questions you will be asked to motivate your responses.

Before completing the questionnaire, let me explain what bereavement is. Bereavement is the period after a loss during which grief is experienced and mourning occurs. It is an almost universal human experience and strikes practically all people several times during a life course. This is viewed as the most stressful life event that is often severely traumatic, effects all sides of a person's life

Your participation in this research study will be appreciated and the results will be made available to interested respondents.

Thank you,

____

Miss. Vanagree Naidoo
Employee Assistance Programme Practitioner
Umgeni Hospital
Private Bag X23
HOWICK
3290

Telephone number (033) 3306146 (ext 248)

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

APPENDIX F

QUESTIONNAIRE: THE NEED FOR AN EMPLOYEE BEREAVEMENT SUPPORT PROGRAMME AT UMGENI HOSPITAL

Respondent

This questionnaire is aimed at exploring the need for an employee bereavement support programme at Umgeni Hospital.
*You are requested to answer **ALL** questions and reflect your true reaction when doing so.* ***Indicate your choice by marking the appropriate shaded block with an* "X" and elaborate where and if necessary.**

For example:

Male	1
Female	~~2~~ (X)

The questionnaire is completed anonymously and will take approximately 20 minutes of your time. Thank you for your cooperation.

SECTION A: PERSONAL DETAILS

1. WHAT IS YOUR GENDER?

Male	**1**
Female	**2**

2. WHAT IS YOUR AGE?

18-24 years	**1**
25-29 years	**2**
30-34 years	**3**
35-39 years	**4**
40-44 years	**5**
45-49 years	**6**
50+	**7**

3. WHAT IS YOUR MARITAL STATUS?

Married	**1**
Divorced	**2**
Widowed	**3**
Separated	**4**
Never married	**5**

4. WHAT IS YOUR RACE?

African	**1**
Asian	**2**
Coloured	**3**
White	**4**
Other (please specify)	**5**

5. WHAT IS YOUR HOME LANGUAGE?

English	**1**
Afrikaans	**2**
IsiZulu	**3**
IsiXhosa	**4**
SeSotho	**5**
Setswana	**6**
Tshivenda	**7**
Xitsonga	**8**
Sepedi	**9**
Steswati	**10**
IsiNdebele	**11**
Other (please specify)	**12**

6. WHAT IS YOUR HIGHEST LEVEL OF EDUCATION THAT YOU HAVE SUCCESSFULLY COMPLETED?

Grade 8	**1**
Grade 9	**2**
Grade 10	**3**
Grade 11	**4**
Grade 12	**5**
N3	**6**
Certificate	**7**
Diploma	**8**
Undergraduate Degree	**9**
Honors Degree	**10**
Master's Degree	**11**
Doctoral Degree	**12**
Other (Please specify)	**13**

7. IN WHICH COMPONENT ARE YOU EMPLOYED AT UMGENI HOSPITAL?

Nursing	**1**
Finance and Systems	**2**
Allied Health Professions	**3**
Human Resource Management	**4**
Integrated Clinical Services	**5**
Quality Assurance and Accreditation	**6**
Other (please specify)	**7**

8. INDICATE YOUR YEARS OF EMPLOYMENT AT UMGENI HOSPITAL?

Less than 1 year	**1**
1-2 years	**2**
3-4 years	**3**
5-9 years	**4**
10-14 years	**5**
15-19 years	**6**
20 years+	**7**

SECTION B : EXPERIENCE OF GRIEF OR BEREAVEMENT

1. HOW MANY PEOPLE WHOM YOU KNEW PERSONALLY HAVE DIED IN THE PAST 3 YEARS?

0	**1**
1	**2**
2	**3**
3	**4**
4	**5**
5	**6**
Other (please specify)	**7**

2. WHAT WAS YOUR RELATIONSHIP/S WITH THE DECEASED?

Immediate family member	**1**
Relative	**2**
Friend	**3**
Co-worker	**4**
Patient	**5**
Other (please specify)	**6**

3. HOW LONG DID YOU KNOW THE DECEASED PRIOR TO HIS / HER DEATH?

1-5 years	**1**
6-10 years	**2**
11-15 years	**3**
16-20 years	**4**
20 +	**5**
Other (please specify)	**6**

4. WHAT WAS THE CAUSE/S OF DEATH?

Natural, expected causes (such as terminal or long term illness)	**1**
Natural, sudden causes (such as heart attack)	**2**
Accidental cause (such as car accident)	**3**
Violent death (such as murder)	**4**
Suicide	**5**
Other (please specify)	**6**

5. HOW LONG AGO DID THE PERSON/S DIE?

1-2 years	**1**
3-4 years	**2**
5-6 years	**3**
7-8 years	**4**
9-10	**5**
11 +	**6**
Other (please specify)	**7**

SECTION C: THE IMPACT OF EVENT SCALE

Below is a list of difficulties people sometimes have after stressful life events. Please read each item and then indicate how distressing each difficulty has been for you DURING THE FIRST MONTH, with respect to the deceased?

	COMMENT	NOT AT ALL 0	A LITTLE BIT 1	SOMETIMES 2	OFTEN 3	ALL THE TIME 4
1	Any reminder brought back feelings about it					
2	I had trouble staying asleep					
3	Other things kept making me think about it					
4	I felt irritable and angry					
5	I avoided letting myself get upset when I thought about it or was reminded of it					
6	I thought about it when I didn't mean to					
7	I felt as if it hadn't happened or wasn't real					

	COMMENT	NOT AT ALL 0	A LITTLE BIT 1	SOMETIMES 2	OFTEN 3	ALL THE TIME 4
8	I stayed away from reminders about it					
9	Pictures about it popped into my mind					
10	I was jumpy and easily startled					
11	I tried not to think about it					
12	I was aware that I still had a lot of feelings about it, but I didn't deal with them					
13	My feelings about it were kind of numb					
14	I found myself acting or feeling as though I was back at that time					
15	I had trouble falling asleep					
16	I had waves of strong feelings about it					
17	I tried to remove it from my memory					
18	I had trouble concentrating					
19	Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart					
20	I had dreams about it					
21	I felt watchful or on-guard					
22	I tried not to talk about it					

SECTION D: BEREAVEMENT SUPPORT

1. WERE YOU OFFERED OR RECEIVED ANY SUPPORT DURING YOUR TIME OF BEREAVEMENT?

Yes	**1**
No	**2**

2. IF YOU ANSWERED "NO" IN THE PREVIOUS QUESTION, HOW DID IT AFFECT YOUR WORK PERFORMANCE?

Difficulty concentrating	**1**
Extremely emotional	**2**
Affected my attendance at work	**3**
Affected my motivation for work	**4**
Affected my relationship with my colleagues	**5**
Did not affect my work performance	**6**
Other (please specify)	**7**

3. IF YOU ANSWERED "YES" TO QUESTION 1, FROM WHOM DID YOU RECEIVE SUPPORT?

Immediate family member	**1**
Relative	**2**
Friend	**3**
Co-worker	**4**
Religious leaders	**5**
Professionals	**6**
Other (please specify)	**7**

4. WAS THIS SUPPORT BENEFICIAL?

Yes	**1**
No	**2**

5. IF YOUR ANSWER TO THE PREVIOUS QUESTION WAS "YES", IN WHAT WAY WAS THIS SUPPORT HELPFUL?

Less stressed	**1**
Emotionally stronger	**2**
Learnt better coping strategies	**3**
More relaxed	**4**
Was able deal with my grief and move on	**5**
Other (please specify)	**6**

6. DID YOU RECEIVE ANY FOLLOW UP SERVICES?

Yes	**1**
No	**2**

7. WOULD YOU HAVE LIKED FURTHER SERVICES?

Yes	**1**
No	**2**

8. IF YOUR ANSWER TO THE PREVIOUS QUESTION WAS "YES", WHAT FURTHER SERVICES WOULD YOU HAVE LIKED?

More individual counselling	**1**
Group support	**2**
More information on bereavement	**3**
More coping strategies	**4**
Other (please specify)	**5**

9. DO YOU FEEL THAT THERE IS A NEED FOR A BEREAVEMENT SUPPORT PROGRAMME AT UMGENI HOSPITAL?

Yes	**1**
No	**2**

10. IF A BEREAVEMENT SUPPORT PROGRAMME WAS TO BE IMPLEMENTED AT UMGENI HOSPITAL, WHAT TYPE OF PROGRAMME WOULD YOU PREFER IT TO BE?

Support group	**1**
Individual counselling	**2**
Spiritual support	**3**
Awareness and information giving	**4**
Other (please specify)	**5**

11. WHAT CONTENT WOULD YOU LIKE TO BE INCLUDED IN THE BEREAVEMENT SUPPORT PROGRAMME, IF IT IS IMPLEMENTED?

Knowledge/understanding of bereavement	**1**
Feelings/emotions associated with bereavement	**2**
Spiritual support	**3**
Coping strategies/techniques/skills	**4**
Planning the way forward	**5**
Other (please specify)	**6**

12. HOW LONG SHOULD THE PROGRAMME BE?

Few hours	**1**
1 Day	**2**
2 Days	**3**
Weekly	**4**
Other (please specify)	**5**

13. WHO SHOULD COORDINATE THE PROGRAMME?

Nursing department	**1**
Psychology department	**2**
Social work department	**3**
Employee Assistance Programme	**4**
Co-workers	**5**
Spiritual leaders	**6**
Other (please specify)	**7**

~~~THANK YOU FOR TAKING THE TIME TO COMPLETE THIS~~~ QUESTIONNAIRE