Evaluating the Efficacy of Complicated Grief Therapy on Psychological Outcomes among Widows in Kenya: A Quasi-Experimental Study in Faith-Based Urban Communities

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DOI: https://doi.org/10.47772/IJRISS.2026.100500821

Received: 13 May 2026; Accepted: 18 May 2026; Published: 15 June 2026

ABSTRACT

Complicated grief is a persistent and impairing psychological condition that affects widows' emotional and functional wellbeing, particularly in contexts where bereavement is compounded by social and spiritual stressors. This study evaluated the effectiveness of Complicated Grief Therapy (CGT) in reducing symptoms of complicated grief among widows in selected churches in Nairobi County, Kenya. A quantitative, quasi-experimental design grounded in the post-positivist paradigm was employed. The study used a non-equivalent groups design involving an experimental group that received CGT and a control group that received no structured intervention. Data were collected using the Inventory of Complicated Grief (ICG), Beck Depression Inventory-II (BDI-II), and Harvard Trauma Questionnaire (HTQ-5) at baseline, midline, and endline. A total of 122 widows participated, selected through purposive sampling. Results indicated significant reductions in complicated grief symptoms in the experimental group compared to the control group across all assessment points ($p < .001$). Effect sizes were large, and MANOVA results confirmed a strong multivariate intervention effect (Pillai's Trace = .875). The intervention also showed consistent improvements across depression and PTSD symptoms. The study concludes that CGT is an effective, culturally relevant intervention for reducing complicated grief among widows in faith-based settings. It is recommended that CGT be integrated into church-based and community mental health programs.

Keywords: Complicated grief, CGT, widows, quasi-experimental design, Kenya, mental health.

INTRODUCTION AND LITERATURE REVIEW

Bereavement is a profound human experience that often disrupts emotional, social, and functional stability. While most individuals gradually adjust to loss over time, a subset develops persistent and impairing grief reactions that extend beyond culturally expected mourning periods. This condition, referred to as Complicated Grief (CG), is increasingly recognized as a clinically significant mental health disorder characterized by enduring yearning for the deceased, intense emotional pain, and difficulty re-engaging with life following loss. Epidemiological estimates suggest that CG affects approximately 7–10% of bereaved individuals and about 2–3% of the general population (Kersting et al., 2011). Unlike normative grief responses, which tend to diminish naturally, CG persists and interferes with reintegration into daily functioning and psychosocial recovery (Shear, 2015).

Clinical descriptions consistently highlight that individuals experiencing CG struggle with acceptance of the death, persistent preoccupation with the deceased, and difficulty restoring a sense of meaning in life. These symptoms are not only emotionally distressing but also functionally impairing, often affecting interpersonal relationships, occupational performance, and general wellbeing. Evidence further suggests that only a minority of bereaved individuals fall within this chronic trajectory. Population-based studies indicate that while nearly half of bereaved persons show adaptive recovery patterns, approximately 7–10% develop persistent grief that does not resolve without clinical intervention (Szuhany et al., 2021; Eisma & Boelen, 2023). This subgroup

represents the primary target for structured psychological interventions such as Complicated Grief Therapy (CGT).

Complicated Grief as a Clinical and Functional Disorder

The clinical significance of CG is further amplified by its strong association with comorbid psychiatric conditions. Research consistently demonstrates that CG rarely occurs in isolation. Instead, it is frequently accompanied by depression, anxiety disorders, post-traumatic stress disorder (PTSD), and somatoform symptoms (Morina et al., 2010; Rueger et al., 2024). Meta-analytic findings indicate that up to 63% of individuals with severe CG present with depressive symptoms, while nearly half exhibit PTSD symptomatology (Janshen & Eisma, 2024). These comorbidities not only intensify suffering but also complicate recovery trajectories, resulting in poorer psychosocial outcomes. In addition, CG has been linked to maladaptive behaviours such as insomnia, increased substance use, and elevated psychological distress, further reinforcing its status as a multidimensional clinical condition (Aoyama et al., 2020).

The relationship between CG and other mental health disorders appears to be bidirectional. While bereavement may trigger depressive or trauma-related symptoms, pre-existing psychological vulnerabilities can also hinder adaptive grief processing. This interaction contributes to prolonged and complicated mourning responses, particularly among individuals exposed to traumatic or unexpected loss events (Djelantik et al., 2018; Wen et al., 2023). Such findings underscore the need for targeted interventions that address both grief-specific symptoms and their broader psychological correlates rather than relying on general supportive counselling approaches alone.

Widowhood represents one of the most vulnerable contexts for the development of CG. The loss of a spouse not only signifies emotional separation but also entails profound shifts in identity, economic stability, and social functioning. Studies have shown that widowed populations exhibit elevated rates of CG compared to the general bereaved population, with approximately 9% of widowed women and 7% of widowed men meeting criteria for CG in some contexts (Simon, 2013). This vulnerability is further shaped by risk factors such as low social support, emotional regulation difficulties, sudden or traumatic death, and insecure attachment patterns, all of which are common in bereaved spouse populations.

Cross-cultural research demonstrates that CG is a global phenomenon, though prevalence rates vary across contexts. Studies report rates of 2.4% in parts of Asia, between 3.7% and 4.8% in several European countries, and approximately 3.7% in pooled African samples including Kenya, Nigeria, and Ghana (Fujisawa et al., 2010; Ben-Ezra et al., 2020). Notably, higher rates have been observed among populations exposed to migration stressors or traumatic loss experiences, suggesting that cultural and contextual factors significantly shape grief trajectories (Kokou-Kpolou et al., 2017). In Kenya, evidence remains limited in adult populations, although studies among orphaned children have reported markedly high levels of complicated grief, indicating substantial vulnerability within the broader population (Ngesa et al., 2020).

Theoretical perspectives on grief have evolved significantly over time. Early stage-based models, most notably Kübler-Ross' five-stage framework, proposed a linear progression through denial, anger, bargaining, depression, and acceptance. However, this model has been widely critiqued for its lack of empirical support and oversimplification of grief processes (O'Connor, 2019). Contemporary research instead emphasizes heterogeneous grief trajectories, with individuals exhibiting adaptive, delayed, or chronic patterns of response. Attachment theory provides a more robust explanatory framework, positing that grief intensity is closely linked to the strength of emotional bonds and that disruptions in attachment systems underlie persistent grief responses (Bowlby; Lenferink et al., 2023). Within this framework, CG is understood as a failure to integrate the loss into existing cognitive and emotional structures.

Widowhood, Cultural Contexts, and Vulnerability to Prolonged Grief

Cultural context further shapes the experience and expression of grief. In many African and Afro-Christian settings, death is not viewed as a final termination but as a transition within a continuing spiritual reality. Beliefs

in ancestral presence and ongoing relational bonds with the deceased contribute to communal and prolonged mourning practices (Brunsdon, 2019; Baloyi, 2014). While these cultural frameworks can provide meaning and continuity, they may also extend grief duration and complicate psychological adjustment in some individuals. Within Christian communities, churches often serve as primary sources of emotional and spiritual support through pastoral care, prayer, and fellowship. However, such support structures are not always sufficient to address clinically significant grief reactions, particularly when individuals experience spiritual distress or social isolation following loss (Kathomi et al., 2022).

Given the clinical burden and complexity of CG, several therapeutic approaches have been developed, including cognitive-behavioural therapy, interpersonal therapy, pharmacological treatment, and pastoral counselling. However, these approaches vary in their specificity to grief-related psychopathology. Evidence suggests that general interventions often produce partial or inconsistent outcomes, particularly in cases of severe or prolonged grief (LaPlante et al., 2024). This limitation has led to the development of Complicated Grief Therapy (CGT), a structured, evidence-based intervention specifically designed to address CG symptoms.

CGT integrates principles from attachment theory, cognitive-behavioural therapy, and interpersonal psychotherapy to target both the emotional and cognitive processes that maintain grief. It focuses on helping individuals accept the reality of loss, reduce maladaptive avoidance, restructure distorted cognitions such as guilt or self-blame, and re-engage with meaningful life activities. At the same time, it emphasizes restoration of interpersonal functioning and re-establishment of social roles, reflecting the relational nature of bereavement recovery. Randomized controlled trials have demonstrated that CGT produces faster and more robust symptom reduction compared to interpersonal therapy and treatment-as-usual, with significantly higher clinical improvement rates (Shear et al., 2005; Wetherell, 2012).

Meta-analytic evidence further supports the effectiveness of CGT and grief-focused cognitive-behavioural interventions, with moderate to large effects on grief severity and related depressive symptoms ($g \approx 0.65$ and $g \approx 0.53$ respectively) (O'Connor et al., 2024). Large-scale randomized trials have shown that a majority of participants receiving CGT achieve substantial clinical improvement within structured treatment periods, alongside reductions in functional impairment and maladaptive beliefs (Makunda et al., 2022). Importantly, these effects have been shown to persist over time, indicating durable therapeutic benefits.

Despite this strong evidence base, most CGT research has been conducted in Western clinical settings, limiting its generalizability to non-Western populations. In African contexts, particularly among widowed populations, empirical evidence remains scarce. Kenya, despite having an estimated 895,000 widows, has limited studies evaluating structured grief interventions (KNBS, 2016). Existing research suggests that bereavement counselling alone may not be sufficient to reduce complicated grief symptoms, highlighting the need for more structured therapeutic models (Ndetei et al., 2004). Preliminary evidence from school-based interventions among orphaned children indicates that CGT can be adapted effectively in low-resource settings, but similar studies among adult widows are lacking (Ngesa et al., 2020).

This gap is particularly significant in faith-based contexts, where many widows rely primarily on pastoral care and church-based support systems. While such systems provide emotional and spiritual comfort, they do not consistently offer structured clinical intervention for persistent grief symptoms. As a result, widows experiencing CG may remain underserved despite regular engagement with religious communities. The absence of empirically tested CG-specific interventions within these settings underscores the need for contextually grounded research evaluating the effectiveness of CGT among widowed populations in Kenya.

METHODOLOGY

Study Design

This study was grounded in the post-positivist paradigm, which assumes that reality exists independently but can only be understood imperfectly through empirical observation and measurement. Guided by this worldview, the study adopted a quantitative quasi-experimental design to evaluate the effectiveness of Complicated Grief

Therapy (CGT) in reducing symptoms of complicated grief, depression, and post-traumatic stress disorder (PTSD) among widows. A non-equivalent groups design was used because participants could not be randomly assigned to conditions. Pre-existing church-based groups were allocated to either the experimental or control condition. The experimental group received the CGT intervention, while the control group received no structured psychological intervention during the study period. Both groups were assessed at baseline (pre-test) and three months post-intervention (post-test), enabling comparison of changes over time and between groups.

Study Site

The study was conducted in Nairobi County, Kenya, an urban and cosmopolitan setting with diverse Christian congregations. Four churches were purposively selected: All Saints Cathedral, PCEA St. Andrews Church, CITAM Valley Road, and Nairobi Baptist Church. These churches were selected due to their established widows' fellowships, structured pastoral care systems, and active community support programs. Despite denominational differences, all sites shared similar organizational structures, including prayer groups, counselling services, and fellowship programs, making them suitable for comparative analysis of bereavement outcomes within relatively comparable psychosocial environments.

Participants and Sample Size

The target population comprised Christian widows residing in Nairobi County, drawn from approximately 260 widows across the four selected churches. The broader population of widows in Kenya is estimated at 895,000. Sample size determination was conducted using the Casagrande et al. (1978) formula for comparing two independent proportions. The calculation was based on a 95% confidence level, 80% statistical power, and a significance level of 0.05. Prevalence estimates of complicated grief were set at 8.5% (global estimate) and 4% (Kenyan estimate). The minimum required sample size was 111 participants, which was adjusted to 122 to account for potential attrition. A total of 280 participants were initially screened, and 122 eligible widows formed the final analytic sample, with 61 assigned to the experimental group and 61 to the control group.

Inclusion and Exclusion Criteria

Participants were included if they were adult widows, active members of the selected churches, and had experienced spousal bereavement at least six months prior to the study. Only individuals exhibiting relevant grief-related symptoms and willing to provide informed consent were enrolled. Exclusion criteria included non-widows, individuals below 18 years, non-members of the selected churches, and widows whose bereavement occurred less than six months prior to data collection. These criteria ensured that participants had sufficient exposure to grief processes while maintaining homogeneity within the study sample.

Sampling Procedure

A purposive sampling technique was used to select participants based on accessibility and relevance to the study objectives. Church-based widow fellowship groups served as the primary recruitment sites, with a minimum target of approximately 31 widows per church. Participants from All Saints Cathedral and PCEA St. Andrews Church were assigned to the experimental group, while those from CITAM Valley Road and Nairobi Baptist Church formed the control group. This allocation was based on natural group clustering rather than random assignment, consistent with the quasi-experimental design.

Intervention Process

The experimental group received a structured Complicated Grief Therapy (CGT) intervention delivered over 12 weeks in weekly sessions. The intervention was grounded in Worden's grief framework and integrated principles from cognitive-behavioural, interpersonal, and attachment-based therapies. The intervention was delivered in four phases:

- Phase 1 (Sessions 1–3): Rapport building, psychoeducation on grief, and initial assessment

- Phase 2 (Sessions 4–9): Core therapeutic work involving loss processing and restoration-oriented activities
- Phase 3 (Session 10): Midcourse evaluation and consolidation of progress
- Phase 4 (Sessions 11–12): Termination, review of gains, and preparation for post-therapy adjustment

The control group continued receiving routine pastoral and community support but did not receive structured psychotherapy during the study period. Ethical considerations ensured that they were later offered access to the intervention after completion of data collection.

Instruments Used

Data were collected using standardized psychometric instruments and a researcher-designed socio-demographic questionnaire. The socio-demographic questionnaire captured age, education level, employment status, economic condition, duration of widowhood, and religious engagement. The Inventory of Complicated Grief (ICG) measured grief severity using 19 items on a 5-point Likert scale, with scores ≥25 indicating clinically significant grief. The Beck Depression Inventory-II (BDI-II) assessed depressive symptoms across cognitive and somatic dimensions using 21 items, with scores ranging from 0 to 63. The Harvard Trauma Questionnaire–Revised DSM-5 (HTQ-5) measured PTSD symptoms using a 4-point scale, with mean scores ≥2.5 indicating significant trauma-related distress. All instruments demonstrated strong psychometric properties, including high internal consistency and established validity in previous studies.

Data Collection Procedure

Data were collected at three time points: baseline (pre-intervention), midline (three months after intervention commencement), and follow-up (three months post-midline). Both experimental and control groups completed identical assessments at each stage. The CGT intervention was delivered by the principal researcher with assistance from trained research assistants. Sessions were standardized using a structured manual to ensure consistency. Research assistants were trained in ethical procedures, instrument administration, and psychological support protocols. Data collection adhered to strict ethical standards, including informed consent, confidentiality, voluntary participation, and the right to withdraw. COVID-19 safety protocols such as distancing, sanitization, and mask use were also observed where applicable.

To ensure intervention fidelity and consistency in delivery, the CGT programme was implemented using a structured treatment manual outlining session objectives, therapeutic activities, and expected outcomes for each phase. The principal researcher and research assistants underwent prior orientation and training on the intervention protocol to promote standardised delivery. Session adherence was monitored through structured session checklists documenting completion of planned therapeutic activities. Regular supervisory reviews were conducted to assess implementation consistency, address procedural challenges, and minimise therapist drift. Attendance registers and session summaries were maintained throughout the intervention period to monitor participant engagement and intervention exposure. These measures strengthened treatment integrity and enhanced the reliability of the intervention outcomes.

Data Analysis

Data were analyzed using IBM SPSS. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize participant characteristics and baseline variables. Inferential statistics were applied to test study hypotheses. Independent samples t-tests were used to compare group differences, while Multivariate Analysis of Variance (MANOVA) assessed the combined effect of the intervention on grief, depression, and PTSD outcomes. Additional analyses included regression and chi-square tests where appropriate. A significance level of $p < 0.05$ was adopted for all statistical tests.

Ethical Considerations

Ethical approval was obtained from the Daystar University Ethics Review Board (DU-ERB) and the National Commission for Science, Technology and Innovation (NACOSTI). Permission was also granted by the leadership of the participating churches. Informed consent was obtained from all participants prior to enrollment. Confidentiality was maintained through anonymized coding and secure data storage. Participation was voluntary, and participants could withdraw at any stage without penalty. Psychological risks associated with grief recall were mitigated through on-site support and referral pathways. Control group participants were debriefed and offered access to CGT after study completion to ensure ethical fairness. Data were securely stored for five years before planned destruction.

sociodemographic characteristics across study groups

As shown in Table 1, the distribution of sociodemographic characteristics indicates that the experimental and control groups were generally comparable at baseline. Most variables did not show statistically significant differences between groups, including participant age ($\chi^2 = 5.476$, df = 4, p = .242), education level ($\chi^2 = 4.798$, df = 5, p = .441), family economic status ($\chi^2 = 0.297$, df = 2, p = .862), and employment status ($\chi^2 = 4.801$, df = 3, p = .187), suggesting adequate group equivalence. However, statistically significant differences were observed in years of marriage ($\chi^2 = 10.739$, df = 4, p = .030) and period of widowhood ($\chi^2 = 4.008$, df = 1, p = .045), indicating some variation in marital duration and bereavement exposure between groups. Overall, the majority of participants were aged 61–70 years, had secondary or tertiary education, and were predominantly in moderate economic status. These findings suggest that while the groups were largely similar, key life-course variables related to marital history and widowhood duration differed slightly across study conditions.

Table 1 Distribution of sociodemographic characteristics across study groups

Variables	Total %		Research Groups				Chi-square test		
			Experimental		Control		χ^2	df	Sig.
Participant's age									
30-40 years	8	8.6%	4	8.0%	4	9.3%	5.476	4	.242
41-50 years	23	24.7%	15	30.0%	8	18.6%			
51-60 years	14	15.1%	8	16.0%	6	14.0%			
61-70 years	45	48.4%	20	40.0%	25	58.1%			
71-80 years	3	3.2%	3	6.0%	0	0.0%			
Total	93	100%	50	100%	43	100%			
Participant's years of marriage									
< 5 years	5	5.4%	2	4.0%	3	7.0%	10.739	4	.030
< 10 years	5	5.4%	4	8.0%	1	2.3%			
11-20 years	33	35.5%	23	46.0%	10	23.3%			
21-30 years	48	51.6%	19	38.0%	29	67.4%			
31-50 years	2	2.2%	2	4.0%	0	0.0%			
Total	93	100%	50	100%	43	100%			
Participant's period of widowhood									
< 10 years	85	91.4%	43	86.0%	42	97.7%	4.008	1	.045
> 11 years	8	8.6%	7	14.0%	1	2.3%			
Total	93	100%	50	100%	43	100%			
Participant's levels of education									
KCE/KCSE	1	1.1%	1	2.0%	0	0.0%	4.798	5	.441
Certificate	16	17.2%	9	18.0%	7	16.3%			
Diploma	51	54.8%	29	58.0%	22	51.2%			
Bachelor	23	24.7%	9	18.0%	14	32.6%			
PGD	1	1.1%	1	2.0%	0	0.0%			
Master's	1	1.1%	1	2.0%	0	0.0%			

Total	93	100%	50	100%	43	100%			
Participant's family economic status									
Poor	15	16.1%	9	18.0%	6	14.0%	.297	2	.862
Moderate	72	77.4%	38	76.0%	34	79.1%			
Affluent	6	6.5%	3	6.0%	3	7.0%			
Total	93	100%	50	100%	43	100%			
Participant's employment status									
Self-employed	23	24.7%	11	22.0%	12	27.9%	4.801	3	.187
Employed	35	37.6%	16	32.0%	19	44.2%			
No job yet	32	34.4%	20	40.0%	12	27.9%			
Retired	3	3.2%	3	6.0%	0	0.0%			
Total	93	100%	50	100%	43	100%			

As presented in Table 2, the majority of participants in both study groups met the criteria for complicated grief, with 91 out of 93 participants (97.8%) classified as having complicated grief based on the Inventory of Complicated Grief (ICG). Only 2 participants (2.2%) fell within the uncomplicated grief category, both of whom were in the experimental group. Within the experimental group, 48 participants (52.7%) were classified as having complicated grief, compared to 43 participants (47.3%) in the control group. However, the distribution of complicated grief between the two groups was not statistically significant ($\chi^2 = 1.758$, df = 1, p = .185), indicating that baseline levels of complicated grief were comparable across groups. Overall, these findings confirm a high prevalence of complicated grief within the study sample, supporting the appropriateness of the population for evaluating the effectiveness of Complicated Grief Therapy.

Table 2 Inventory of Complicated Grief Scores Across Study Groups

	Total		Classification of complicated grief				Chi-square test		
			Uncomplicated		Complicated				
Variables	N	%	N	%	N	%	χ^2	df	Sig.
Experimental	50	53.8%	2	100.0%	48	52.7%	1.758	1	.185
Control	43	46.2%	0	0.0%	43	47.3			
Total	93	100%	2	100%	91	100%			

Across the study period, a clear downward pattern in Inventory of Complicated Grief (ICG) scores was observed from baseline through midline to endline, as presented in Appendix 1. This reduction was consistent across all socio-demographic categories, indicating a general improvement in grief symptoms over time. Age showed a statistically significant linear association with change in ICG scores ($F = 12.403$, $p < .001$), with variations in the magnitude of reduction across age groups. Similarly, significant differences were observed in relation to years of marriage ($F = 4.891$, $p = .030$) and period of widowhood ($F = 6.424$, $p = .013$), suggesting that both marital duration and time since loss shaped response trajectories. By contrast, education level ($p = .086$), economic status ($p = .159$), and employment status ($p = .311$) did not significantly influence the pattern of score reduction. Overall, the results point to a steady decline in complicated grief severity, with select demographic factors moderating the rate of change.

A clear divergence in the trajectory of complicated grief scores emerges between the two study groups, as shown in Table 3. At baseline, both the experimental ($M = 37.20$, $SD = 9.823$) and control groups ($M = 35.81$, $SD = 7.035$) recorded comparable levels of complicated grief, indicating initial group equivalence. Over time, however, the experimental group exhibited a marked and steady decline in ICG scores, reducing to 23.66 ($SD = 6.530$) at midline and further to 13.20 ($SD = 5.768$) at endline. In contrast, the control group showed only a gradual reduction, from 30.72 ($SD = 6.061$) at midline to 26.33 ($SD = 7.665$) at endline, remaining substantially higher than the intervention group at study completion. The grand mean also reflects this downward trend across time points. Bartlett's test of sphericity was significant ($p < .001$), indicating that the data were suitable for factor

analysis and supporting the robustness of the observed structure. Overall, the findings demonstrate a stronger and more sustained reduction in complicated grief among participants who received the intervention.

Table 3 Factor analysis of ICG Scores from Baseline to Endline

		Baseline		Midline		Endline		Bartlett's test
Grouping	N	Mean	Std.dev	Mean	Std.dev	Mean	Std.dev	
Experimental	50	37.20	9.823	23.66	6.530	13.20	5.768	< .001
Control	43	35.81	7.035	30.72	6.061	26.33	7.665	< .001
Grand total	93	36.56	8.629	26.92	7.211	19.27	9.372	

The comparison of mean Inventory of Complicated Grief (ICG) scores between the experimental and control groups across the three assessment points, as presented in Table 4, reveals a clear intervention effect over time. At baseline, there was no statistically significant difference between the groups ($t = 0.771$, $df = 91$, $p = .443$), indicating initial equivalence prior to intervention. However, significant group differences emerged at midline ($t = -5.374$, $p < .001$) and became more pronounced at endline ($t = -9.405$, $p < .001$), with progressively larger mean differences favouring the experimental group. The negative t-values and widening confidence intervals indicate substantially lower ICG scores among participants who received Complicated Grief Therapy compared to the control group. Levene's test indicated homogeneity of variance at midline and endline ($p > .05$), supporting the validity of the t-test assumptions for those time points. Overall, the results demonstrate that the intervention had a statistically significant effect in reducing complicated grief symptoms over time.

Table 4 Independent Sample t-test for Equality of Means in the Research Groups

Inventory of Complicated Grief (ICG)	Levene's test for equality of variance		t-test for equality of means				95% CI difference	
Assessment period	F	Sig.	T	Df	Sig.	Mean difference	Lower	Upper
Baseline	11.257	.001	.771	91	.443	1.386	-2.187	4.959
Midline	.695	.407	-.5374	91	< .001	-7.0609	-9.67086	-4.45100
Endline	3.475	.066	-9.405	91	< .001	-13.1256	-15.89775	-10.35341

The magnitude of the intervention effect, as indicated by Cohen's d in Table 5, shows a progressively strengthening impact of Complicated Grief Therapy over time. At baseline, the effect size was negligible ($d = 0.160$, 95% CI: -0.248 to 0.568), confirming minimal difference between the experimental and control groups prior to intervention. By midline, a large negative effect emerged ($d = -1.118$, 95% CI: -1.554 to -0.676), indicating a substantial reduction in complicated grief scores in the experimental group relative to the control group. This effect further intensified at endline ($d = -1.956$, 95% CI: -2.449 to -1.456), reflecting a very large treatment effect. The widening magnitude of effect sizes across assessment points demonstrates a strong and increasing intervention impact over time, with the Complicated Grief Therapy producing clinically and statistically meaningful reductions in grief severity compared to the control condition.

The multivariate analysis of variance (MANOVA) results indicate a statistically significant overall effect of the intervention on the combined dependent variables. All four multivariate test statistics—Pillai's Trace (.875), Wilks' Lambda (.125), Hotelling's Trace (6.980), and Roy's Largest Root (6.980)—converge on the same inference, with a highly significant model effect ($F = 64.370$, $df = 9, 83$, $p < .001$). The consistency across these tests strengthens confidence in the robustness of the findings, as each statistic assesses group differences from a slightly different multivariate perspective. The observed partial eta squared value of .875 suggests an exceptionally large effect size, indicating that approximately 87.5% of the variance in the combined outcome variables is attributable to group membership. Overall, the results provide strong evidence of a substantial multivariate difference between the experimental and control groups across the study outcomes.

Table 5 Multivariate Analysis of Variance (MANOVA) Test Results

	Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Pillai's trace	.875	64.370[a]	9.000	83.000	.000	.875
Wilks' lambda	.125	64.370[a]	9.000	83.000	.000	.875
Hotelling's trace	6.980	64.370[a]	9.000	83.000	.000	.875
Roy's largest root	6.980	64.370[a]	9.000	83.000	.000	.875
a. Exact statistic						

Across the analyses presented in this chapter, a consistent pattern of findings emerged regarding the impact of the Complicated Grief Therapy intervention. Baseline assessments indicated that the experimental and control groups were largely comparable on key demographic and clinical variables, with only minor differences that were not sufficient to threaten group equivalence. Over time, however, marked divergences between the two groups became evident. Participants in the experimental group demonstrated a steady and statistically significant reduction in complicated grief symptoms, alongside improvements across related psychological outcomes, compared to the control group. These changes were supported by both inferential tests and effect size estimates, which consistently indicated strong and progressively increasing intervention effects. The multivariate analysis further confirmed a robust overall treatment impact across combined outcome measures. Taken together, the results provide compelling statistical evidence that the intervention was associated with meaningful improvements in grief-related outcomes among the study participants.

DISCUSSION

The findings of this study provide strong evidence for the efficacy of Complicated Grief Therapy (CGT) in reducing symptoms of complicated grief among widows. Statistically significant differences emerged between the experimental and control groups at both midline and endline assessments, with the magnitude of improvement increasing over time. The large effect sizes observed further indicate that the intervention produced not only statistically significant changes but also clinically meaningful reductions in grief severity. These findings are consistent with established evidence demonstrating CGT as an effective intervention for prolonged grief disorder across clinical and community populations (Shear et al., 2016; Iglewicz et al., 2020). Overall, the results reinforce the conclusion that structured, targeted grief interventions can produce sustained therapeutic benefits in bereaved populations.

These outcomes align with a growing body of empirical literature supporting the efficacy of CGT in diverse settings. Prior research has shown that CGT yields superior outcomes compared to other evidence-based therapies, particularly in reducing persistent grief symptoms and improving psychological functioning. For instance, Shear et al. (2016) and Bettina and Maaten (2016) demonstrated that CGT was more effective than cognitive-behavioural therapy and interpersonal therapy in alleviating grief-related distress. Similarly, Iglewicz et al. (2020) highlighted CGT's role in reducing avoidance behaviours, enhancing emotional processing, and facilitating meaning reconstruction following loss. Within the Kenyan context, Ngesa et al. (2020) also reported significant reductions in grief severity following CGT-based interventions among bereaved children, suggesting cross-population applicability. The convergence of these findings with the current study strengthens the external validity and cross-cultural relevance of CGT as an intervention for complicated grief.

From a contextual standpoint, the effectiveness observed in this study can be understood through the interaction between CGT's therapeutic mechanisms and the psychosocial realities of widows in faith-based communities. CGT directly targets maladaptive grief processes such as avoidance, intrusive rumination, and difficulty accepting the permanence of loss, which are central features of prolonged grief disorder. In the Kenyan church setting, where widows often navigate grief within strong cultural and religious expectations of resilience, the structured nature of CGT provided a psychologically safe space for emotional expression and cognitive restructuring. This facilitated exposure to painful memories in a controlled therapeutic environment, promoting desensitisation and adaptive reappraisal of the loss experience (Shear et al., 2016; Iglewicz et al., 2020).

The group-based format of the intervention further enhanced therapeutic outcomes by introducing a collective dimension to grief processing. Participants benefited from shared narratives, emotional validation, and peer modelling of adaptive coping strategies, which are consistent with communal African frameworks of healing and social support. This relational component likely reduced feelings of isolation while strengthening engagement with the therapeutic process. In addition, the integration of spirituality within the intervention context appears to have amplified its effectiveness. Participants reported increased emotional relief alongside enhanced spiritual meaning-making, suggesting that CGT operated not only as a psychological intervention but also as a spiritually congruent process within Christian settings. This dual pathway of psychological and spiritual healing may explain the depth and sustainability of the observed outcomes (Ngesa et al., 2020; Iglewicz et al., 2020).

In conclusion, the results affirm that Complicated Grief Therapy is both an effective and contextually appropriate intervention for widows experiencing prolonged grief. Its structured, relational, and meaning-focused approach aligns well with the psychosocial and spiritual realities of bereaved women in faith-based environments. The robust statistical and clinical effects observed in this study, supported by converging evidence from prior research, underscore its potential for wider implementation in both clinical and community mental health settings. These findings support the integration of CGT into church-based counselling and public mental health frameworks, particularly in contexts where access to formal psychological services remains limited. Ultimately, CGT presents a viable and scalable intervention for enhancing psychological recovery, restoring functioning, and promoting long-term resilience among bereaved populations.

CONCLUSION

This study set out to evaluate the effectiveness of Complicated Grief Therapy (CGT) in reducing symptoms of complicated grief among widows in selected churches in Nairobi County. The findings provide strong empirical evidence that CGT is an effective intervention for addressing prolonged grief, with participants in the experimental group demonstrating significantly greater reductions in grief severity compared to the control group across all post-intervention assessments. The progressive decline in scores from baseline to endline, supported by large effect sizes and robust multivariate results, confirms both the statistical and clinical significance of the intervention. Beyond symptom reduction, the study demonstrates that structured grief-focused psychotherapy can produce sustained emotional and functional improvements within a real-world, faith-based context. The integration of CGT within church environments further highlights its contextual relevance, particularly in settings where widows rely heavily on communal and spiritual support systems. Overall, the findings affirm that CGT is not only effective in controlled clinical settings but also adaptable to community-based and culturally embedded populations.

RECOMMENDATIONS

Based on the findings, several recommendations are proposed for practice, policy, and future research.

First, there is a need to integrate Complicated Grief Therapy into community and church-based counselling programs. Faith-based institutions play a central role in providing psychosocial support to widows; therefore, equipping pastors, lay counsellors, and church welfare leaders with basic CGT-informed skills could significantly improve early identification and management of complicated grief. Structured training programs and supervision frameworks should be developed to support this integration.

Second, mental health systems in Kenya and similar contexts should consider adopting CGT as part of standard bereavement care within primary mental health services. Given the shortage of specialised mental health professionals, task-shifting approaches that involve trained non-specialists delivering structured grief interventions may improve access and reduce the treatment gap for bereaved populations.

Third, policymakers and stakeholders in the health and social sectors should support the development of culturally adapted grief intervention models that incorporate both psychological and spiritual dimensions. The findings suggest that interventions delivered within faith-based settings are not only acceptable but also highly

effective, underscoring the importance of collaboration between mental health professionals and religious institutions.

Finally, future research should explore the long-term sustainability of CGT outcomes beyond the follow-up period, as well as its applicability in other populations experiencing prolonged grief, such as parents who have lost children or survivors of traumatic loss. Comparative studies involving different therapeutic models may also help refine best-practice approaches for grief interventions in low-resource and culturally diverse settings.

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APPENDIX

Appendix 1

Mean Reduction Analysis of ICG Scores from Baseline to Endline

		Dimension of ICG scores reduction			Linearity test	
Variables	N	Baseline	Midline	End-line	F	Sig.
Participant's age						
30-40 years	8	29.88(SD:8.374)	24.00(SD:9.827)	17.88(SD:9.219)	12.403	<.001
41-50 years	23	34.30(SD:7.400)	24.78(SD:6.353)	16.87(SD:7.875)		
51-60 years	14	34.07(SD:9.950)	26.79(SD:9.183)	19.64(SD:11.80)		
61-70 years	45	39.60(SD:7.901)	28.51(SD:6.444)	21.00(SD:9.405)		
71-80 years	3	37.67(SD:8.386)	28.00(SD:1.732)	13.67(SD:4.509)		
Participant's years of marriage						
< 5 years	5.	33.80(SD:6.611)	27.00(SD:9.028)	22.00(SD:7.810)	4.891	.030
< 10 years	5	32.80(SD:7.791)	24.00(SD:4.123)	13.20(SD:4.025)		
11-20 years	33	34.24(SD:9.209)	23.97(SD:7.020)	16.24(SD:8.170)		
21-30 years	48	38.90(SD:8.080)	29.19(SD:6.884)	21.94(SD:9.960)		
31-50 years	2	35.00(SD:9.899)	28.50(SD:2.121)	13.50(SD.6.364)		
Participant's period of widowhood						
< 10 years	85	37.24(SD:8.455)	27.56(SD:6.992)	20.18(SD:9.264)	6.424	.013
> 11 years	8	29.38(SD:7.501)	20.13(SD:6.244)	9.63(SD:2.875)		
Participant's levels of education						
KEC/KCSE	1	46.00	27.00	7.00	3.017	.086
Certificate	16	32.87(SD:5.596	25.81(SD:5.879)	18.06(SD:8.67)		
Diploma	51	36.49(SD:8.033)	26.24(SD:7.273)	17.98(SD:9.129)		
Bachelor's	23	38.35(SD:11.09)	29.09(SD:8.146)	23.43(SD:9.816)		
degree	1	43.00	27.00	22.00		
PGD	1	42.00	30.00	18.00		
Master's						
degree						
Participant's family economic status						
Poor	15	38.80(SD:9.104)	27.47(SD:6.334)	20.73(SD:12.26)	2.017	.159
Moderate	72	36.39(SD:8.393)	26.93(SD:7.148)	19.14(SD:8.720)		
Affluent	6	33.00(SD:10.35)	25.50(SD:10.75)	17.17(SD:10.17)		
Participant's employment status						
Self-	23	36.48(SD:8.893)	27.13(SD:7.344)	19.30(SD:9.772)	1.040	.311
employment	35	34.40(SD:7.566)	27.60(SD:7.030)	20.60(SD.9.172)		
Employed	32	39.28(SD:9.145)	26.16(SD:7.759)	18.56(SD:9.541)		
Not yet	3	33.33(SD:8.386)	25.67(SD:2.309)	11.00(SD:2.646)		
employed.						
Retired						