Therapeutic interventions for bereavement: learning from Ugandan therapists

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Abstract

This paper contributes to the development of indigenous knowledge around therapeutic interventions for bereavement in non-western settings. Interventions are explored through 18 qualitative interviews with indigenous therapists in the Sub-Saharan African country of Uganda.

Aspects of the therapeutic process are examined along with clients' presenting problem and the ways in which clients make sense of their loss and express their grief.

Ugandan therapists identified contradictions between their indigenous practices and western assumptions embedded in bereavement counselling theory and practice. These indigenous accounts indicate ways in which existing therapeutic approaches might best be modified for use in non-western and pluralistic societies.

Key words: bereavement, Uganda, therapeutic, counselling, indigenous

Introduction

The international definition of social work emphasises the importance of indigenous knowledge in engaging people and structures to address life challenges and enhance wellbeing, yet there has been little indigenously stimulated social work research (Huang and Zhang, 2008). This paper explores indigenous accounts of therapeutic interventions for bereavement in a Sub-Saharan country, suggesting ways in which future therapeutic approaches to bereavement might be developed.

Historically, a core task of the social work profession has been the provision of both palliative care and psychological responses to loss (Paul, 2013). In the United Kingdom (UK), whilst the increase in managerialism has somewhat eroded the therapeutic functions of social work, the recent national end-of-life care programme (NEoLCP, 2010) has sought to strengthen the role of palliative care social work. Social workers also play a key role in providing culturally appropriate support for bereaved individuals (NEoLCP, 2010). In the United States (US), social workers practice as integral members of hospice teams, with a nationally recognized role (Lawson, 2007). Here, psychological interventions are frequently provided within culturally pluralistic settings. Reflection on social work provision in the resettlement of African refugees (Vongkhamphra et al., 2011; Wachter et al., 2016), has also highlighted the need to provide specialised responses to loss and grief. For example, by 2019 the US plans to resettle 50,000 refugees from the Democratic Republic of Congo, with social workers playing a pivotal role in the resettlement process (Wachter et al., 2016). The need for culturally sensitive interventions has been highlighted in social work research in other international contexts (Javadian 2007; Al-Krenawi and Graham, 1996), including Sub-Saharan Africa (Kasiram and Khosa, 2008; Van Breda, 2015).

Many societies, such as those in Sub-Saharan Africa, characterised by predominately collective identities, are seen to manage grief in ways that are different from predominantly individualistic societies, in which individual autonomy and self-actualisation is emphasised over identification with the group. Within Sub-Saharan African societies, the AIDS pandemic has altered formal and informal helping systems; with the numbers of dead, and the resulting economic and time constraints, making it impossible to maintain traditional rites around death and mourning (UNAIDS, 2010). Consequently, traditional mourning rituals with deeply embedded psychological benefits have been abridged or abandoned (Kilonzo and

Hogan, 1999). Alongside these changes, there has been an expansion of bereavement counselling in Sub-Saharan Africa. Individualistic westernised practices have been introduced, often by international agencies, into the pre-existing helping systems of local cultures (Kilonzo and Hogan, 1999; Lie and Biswalo, 1994). However, the western therapeutic frameworks which emphasise talk, intellectual insight, and personal relationships are seen to be too narrow, restrictive and ethnocentric for non-western clients (Arulmani, 2007; Rosenblatt, 2001). There is little known about therapeutic bereavement interventions in non-western settings (McLeod, 2009), with a call for further research in this area (Arulmani, 2007; West, 2007).

This study seeks to explore the provision of therapeutic interventions for bereavement in the Sub-Saharan African country of Uganda, through the eyes of Ugandan practitioners. This paper is part of a wider comparative study examining bereavement interventions in western and non-western settings. It will begin with a brief introduction to Uganda, followed by a summary of research methods and findings. The concluding discussion draws on the debate by Huang and Zhang (2008) around the indigenisation of social work knowledge, implications for social work are discussed in terms of how therapeutic approaches might best be modified for use in non-western and pluralistic societies.

Context

Uganda, a landlocked country in East Africa, is one of the world's poorest. Most (85%) of the population of 33.4 million live in rural communities existing predominantly on subsistence farming (U.S. Department of State [USDS], 2007). Despite recent economic growth, the majority of Uganda's population still live in poverty (IMF, 2000). It has a diverse culture, with 17 ethnic tribes, most of whom have their own mother tongue; English remains the official language.

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Although the country has enjoyed relative stability under the current presidency of Yoweri Museveni, who has been in power since 1986 (Oloka-Onyango, 2004), the US Department of State has highlighted serious human rights violations (USDS, 2013). The internal war between the Ugandan government and the rebel group, the Lord's Resistance Army (LRA), resulted in over 1.8 million deaths and abductions (Kiboneka et al., 2009). Uganda also faces the challenges brought by the AIDs pandemic, with an estimated 63,000 AIDS related deaths, 1,500,000 people living with AIDS, and one million AIDS orphans (UNAIDS, 2010).

Therapeutic approaches to grief in Uganda.

Traditionally in Uganda, support and advice have typically been provided within family structures. Often traditions of giving advice discriminate by age and gender (Seeley and Kajura, 1995), passed down through kinship groups and local communities (Senyonyi et al., 2012). When someone dies, the death is seen as the loss of a 'general asset' to the whole community (Nwoye, 2000), with death practices promoting the cohesion of the extended family, including continuity with ancestors. This is accompanied by a strong spiritual component, frequently embedded within syncretistic belief systems (Grant et al., 2011; Hodge and Roby, 2010). As part of this belief system, many individuals utilise the services of traditional healers, although the efficacy of this practice is much in question (Tseng, 1999).

Crucially, in this context, the expression of grief is strictly controlled by collectively-enforced social norms, prescribing rituals which are traditionally brief, intensive and collective. Several Ugandan studies emphasise the embargo on children expressing grief outside the mandatory grieving period (Atwine et al., 2005; Fjermestad et al., 2008). This picture of avoidance of grief, and normatively imposed silence is also found in studies of adult grief in East Africa, in which bereavement strategies were reinforced through community-based and religious beliefs (Nordanger, 2007).

Senyonyi et al. (2012) suggest that the development of counselling in Uganda has its roots in traditional guidance systems provided by families, and in school-based guidance and counselling. More recently, western counselling practices have been introduced within the structures of international AIDS organisations. These western forms of counselling are founded on Eurocentric values of independence, self-direction and assertiveness (Bracken, 2002). In contrast, African religions and belief systems require communal and family needs to take precedence over individual needs (Ugwuegbulam et al., 2009). There are conflicting arguments around the relative effectiveness of particular theoretical models offered within different settings (Dalal, 1997; Tseng, 1999). Tseng (1999) suggests that, because of colonial dominance, there are few indigenously-trained mental health professionals in Africa. Most mental-health professionals and counsellors are trained in settings where Western therapeutic models are used which are not contextualised to fit African cultures (Senyonyi et al., 2012).

Methodology

Interest in this research was stimulated when the first author transitioned from her home in Northern Ireland to live and work in Uganda, East Africa, for a five-year period. With a professional background in mental-health social work, she was based in a non-government organisation (NGO) providing mental health assessments and therapeutic interventions to both expatriate and indigenous communities. She observed that the Ugandan peers, with whom she worked, were trained in western therapeutic models and had become expert in applying bodies of theory generated in a different social setting to the one in which they and their clients were based. Exploration of their perceptions and experiences highlighted ways in which indigenous knowledge is developed, and can be utilsied (Huang and Zhang, 2008).

The research sought to explore indigenous practitioners' perception of therapeutic interventions for bereavement in Uganda. The study adopted a broad investigative strategy

since little prior research of this nature has been carried out. The research question asked 'What constitutes the practice of bereavement counselling in Uganda, as perceived by practitioners working in this setting? The term, 'bereavement counsellor', was broadly defined (Neimeyer, 2010). It included paraprofessional volunteers, and professionals from a range of disciplines, such as social work and nursing. In this study all the participants were employed as counsellors, and provided bereavement counselling as part of their job. Arguably, many of these therapeutic functions would be provided by social workers in western settings.

Cross-cultural research is vulnerable to the influences of researcher bias, in which the research findings depart from a 'true' finding (Gerstein et al., 2009). Since the research process is itself embedded in social relationships, the researcher is part of the data collection process, and will inevitably influence it. Although the principal researcher was living and working in Uganda for four years before the research began, she was not indigenous to this setting, raising the potential for researcher bias. Obvious and avoidable sources of bias were identified and challenged, as outlined below.

Participants were selected through the technique of purposive sampling (Bryman, 2004). Initial contact was made with the chair of the Ugandan Counsellors Association who identified individuals who might offer bereavement counselling as a distinct component of their job; 18 practitioners were identified. Fifteen were indigenous Ugandans. Twelve of these had trained and worked in Uganda and three had either trained or worked elsewhere. Three counsellors were western expatriates, who had made their long-term home in Uganda, and could potentially take a comparative view of their practice and its context.

Of the 18 participants interviewed in this study, all but two were female. Their mean age was 45 years. They represented a variety of sectors: NGOs, hospices, university counselling

departments, corporate organisations and private practice. Rural- and urban-based practitioners were included.

A semi-structured interview process was utilised as this corresponded to the predominantly narrative culture of Africa (Ugwuegbulam et al., 2009). Interviews were conducted in English, in the location of choice for the participant. A pilot interview was conducted and was included in the total data set. Interviews were fully transcribed, using a manual system.

Transcribed tapes were thematically analysed according to both data-driven and theory-driven readings of the transcribed data (Braun and Clarke, 2006). Additionally, in order to avoid misunderstanding the deeper assumptions on which respondents' answers were based, inter-rater reliability of findings was established through agreement with an indigenous researcher in Uganda, who independently categorised two interview transcripts. The use of desk research and participant observation sought to complement interview data.

Ethical approval was granted by the researchers' university ethics committee at the outset of this study. Whilst there were no organisational level processes for gaining ethical approval in Uganda, the same standards of ethical practice were applied. Written information was given to each participant during the first meeting which included information on confidentiality. A consent form was also utilised.

Limitations

A key concern of this study related to the issue of bias. However, as indicated in the methods, the research protocol sought to mediate against the introduction of culturally selective practices and to minimise bias throughout the stages of data gathering, analysis and reporting of findings.

This study adopted a broad investigative strategy since little prior research of this nature has been carried out. However, observations that are broad in scope belie the inevitable social, cultural and personal differences which exist (Huang and Zhang, 2008). The findings do not seek to present Ugandan therapists or their clients as a homogenous group, rather to highlight the dominant perceptions of the functions, practices and belief systems characteristic of bereavement interventions.

This study focuses on participants working in a bereavement counselling role, and not directly employed as social workers. In Uganda, counsellors appear to provide much of the therapeutic interventions following loss. The insights gained from this professional group should be applicable to social workers working in the area of loss and grief.

Furthermore, an in-depth, detailed analysis of counselling training per se has not been provided, and would have offered a useful context to the discussion. The effectiveness of therapeutic interventions was not a focus of the study, neither was a first-hand account of the client's experience, as the chosen emphasis was on practitioners' perceptions. Such limitations may be addressed in future studies.

Findings

Findings focused on participants' perceptions of the routines and activities which constitute bereavement counselling; the presenting problems brought by clients; and the therapeutic relationship. These will be addressed in turn, with analysis supported by selected participant quotations.

What constitutes therapeutic intervention?

Participants stated that the majority of clients were female, aged between 15 and 50 years. Clients were usually seen in the therapist office, with contact typically lasting between two

and six, hour-long sessions. Participants differentiated between pre-bereavement counselling, where the therapist sought to assist the client and their families to prepare for death, and bereavement counselling, offered to clients following the death of a loved one. Participants described a traditional talking therapy utilising specific strategies such as enabling clients to tell their stories, active listening, and developing supportive therapeutic relationships. Several participants also noted that clients had an expectation of financial or practical assistance, whilst some participants were proactive in advocating for resources or helping clients to manage their finances: 'I love it when I have a solution to their problems, but I have run away from only offering psychological support. I also want to support the client get a source of income'. Participant, NGO

Participants confirmed that therapeutic intervention was not seen as a one-to-one activity, but as one that should always involve others, and in particular, the extended family. A justification for including others was that the family, and not the practitioner, had ultimate responsibility for the client.

> 'Family support system - we always make sure that the client doesn't depend on us. We remove that dependency by making sure this client is linked more to the sisters, more to the friends, and for other organisations surrounding'. Participant, NGO

It is deemed necessary that decisions are made with the explicit involvement of other significant people in the life of the client.

> 'I say there's a context, a big wide context, you can't work with the individual alone. ... I'm dealing with a seventeen-year-old, like I was today, she has a mother, she has a father, these two are separated; that has an effect on her. She cannot, even if she is 18, cannot make up her own mind, you have to take in consideration all the people around

her and the influence that they have on her and you actually have to bring them into counselling.' Participant, Corporate agency

To a large extent participants did not identify any particular theoretical framework, although when pressed, they stated that they were most familiar was Worden's 'Tasks of Mourning', as this had been taught in their training. It appears that theoretical issues were not high on participants' list of priorities and allegiance to a narrowly-defined conceptual framework was not salient. However, practitioners did describe a belief in the concept of grief-work as the task facing the bereaved, and in the therapeutic value of the counsellor-client dyad. Only those participants, who had lived or trained outside Uganda identified concerns about utilising these western therapeutic frameworks. 'I realise that most of the models wouldn't apply so much to our context here. So I try to do what we think will be applicable and more culturally sensitive to our people'. Participant, Private practice

Presenting problems and interventions

Participants were asked to describe the typical concerns that clients presented with. These included spiritual, emotional, financial, and relational issues.

Financial issues: Many bereavement theories focus on emotional issues with limited focus on the secondary adjustments that need to be made following a loss (Hansson and Stroebe, 2007). In Uganda 'secondary losses', were commonly seen as the fundamental problem; of these, financial concerns were most prominent.

'In northern Uganda, grief counselling tends to focus on the financial problems, a child might say, "If my mother had been alive then I would have had my school fees" at other times the sadness can be the focus'. Participant, NGO

Relational issues: Clients' connection to their community was a central and prominent feature of the therapeutic focus, with a need to be accepted, and acceptable, within the community. Life is lived collectively in which a sense of belonging to one's community was of utmost importance.

> 'If you are to support a client you can't look at him or her in isolation of those other systems, cause they are very influential in helping this client cope with the grief, with the death, they are so important.' Participant, Private practice

Here, networks of interdependent relationships were explicitly acknowledged; the goal of Ugandan participants was to reintegrate clients into the collective order and uphold that order through a therapeutic process which was shared with others.

> 'When you counsel a child, or when a child does something wrong, it is the community's responsibility, when you prosper it is the community's joy, so by helping this individual, you will be helping the community'. Participant, Private practice

Emotional issues: A central theme in Ugandan bereavement studies is that the expression of emotion is prohibited outside the mandatory grieving period (Fjermestad et al., 2008). There was no place to express emotion outside restricted and time-limited rituals where intense public expression is promoted and then denied. Similarly, in this study bereaved individuals needed to be resilient following a death, and assume that they would learn to cope. 'Before coming for counselling, people will not have been listened to, allowed to be themselves, to express any emotion'. Participant, Private practice

One participant, who had lived outside Uganda, suggested that western therapeutic models do not fit Ugandan norms and mores because of the embargo on emotional expression. 'Grief is not easily expressed the way I think it is done in the West' Participant, Private practice

In spite of this cultural inhibition, the majority of participants suggested that bereavement counselling offered clients a unique opportunity to express emotion which was otherwise socially unacceptable. Whilst many clients did express emotion in the counselling session some did not feel they had the right to; they felt embarrassed by their grief and apologised for it. However, many clients conveyed relief in being allowed to express emotions. '"Already I feel a relief. I don't know why they stopped me from being myself, but now I can be myself"'. Participant quoting a client, Private practice

Whilst the positive therapeutic effects of emotional expression have been challenged (Stroebe et al., 2005), bereavement counselling is seen to facilitate the alteration of client's accounts of their loss into a discourse of feelings (Árnason et al., 2004). Ugandan participants in this study, perhaps drawing on a Western imported model of the psyche, encouraged their clients to express their individual feelings. Thus, the external repression of strong impulsive emotions appears to be temporarily reversed within the therapeutic process.

Spiritual issues-Making sense of the loss: Participants also identified their clients' need to find a reason for the death of their loved one. This was expressed within a spiritual framework, based on pre-established and socially sanctioned meaning. Other Ugandan studies tell us that death must always be somebody's fault and is often attributed to human malice (Seeley and Kajura, 1995). Most often, blame is associated with a belief in witchcraft where a neighbour or family member is said to have bewitched the deceased (Hooper, 1987). In this study, witchcraft was identified by the majority of participants. In the following

quotation the participant relates her work with an HIV-positive client who stopped taking medication because he believed that he had been 'bewitched':

> 'During that time of sickness when he was bedridden ... Then he started saying that, this time, it is not HIV, it is witchcraft. And you know, I visited this guy and he said "So and so is bewitching me", and he got off the drugs and started using herbs'.
>
> Participant, NGO

This is consistent with the findings of other Ugandan-based research in which bereaved children (Withell, 2009) and bereaved adults (Seeley and Kajura, 1995) knew that death resulted from an illness, understood in medical terms, but nonetheless suspected that the illness was initiated by the bewitching process. Participants also described their clients as having a core Christian belief, thus a syncretistic belief system was identified which integrated a belief in witchcraft and traditional religions, with Christianity.

The therapeutic relationship

Participants also discussed their therapeutic relationships focusing on the therapeutic alliance, confidentiality and the extent to which the counsellor directed the client.

The therapeutic relationship is seen to play a pivotal role in bereavement interventions (Beresford et al., 2008). In Uganda, the therapeutic relationship was identified as important; however, few participants described this as their first priority, perhaps reflecting the Ugandan counsellors' prioritising of guidance and direction. Ugandan participants seldom mentioned confidentiality, with one indigenous participant who had worked in America, suggesting that a significant difference in therapeutic interventions between America and Uganda was in the differential interpretations of confidentiality:

'You talk to one person at a time in America; in Uganda you can talk to several people at a go. Even here, when I am doing counselling, people come in and out and they don't even think about it. I am talking to someone, they are not supposed to be barging in like that, but that's Uganda'. Participant, Corporate agency

Differences in how the self is conceived may explain these attitudes to confidentiality (Van Dyk & Nefale, 2005). In Uganda, the concept of an individual self is limited and the locus of control is external; people tend to act and think alike, possessing a shared or collective consciousness. With a shared identity, there is arguably much less need for privacy and consequently less need to impose tight boundaries around engaging with one person at a time.

Several participants described their clients as being under a wide system of community control, for example in highlighting the authoritative role that the community elders take in response to an HIV diagnosis:

'Maybe social stigma, that also is a concern of our clients. "Maybe they will see me with a skin rash, they will see me losing weight. How am I going to take these drugs? Maybe my elders will question me. Why I am not breast-feeding this child?" All those concerns are there'. Participant, Private practice

Participants also referred to themselves as part of a system of accountability and control in which they did not have autonomy to make independent decisions about their clients. 'I still need to consult, I can't make my decision as, compared to the West, you work with that person, they know what they want, they make their own decision'. Participant, Corporate agency

However, perhaps in contradiction to this, participants at other times challenged their societal norms, for example, encouraging their clients to interpret sickness and death in scientific

terms. 'You are actually trying to help them to understand the facts surrounding the sickness, so that they outgrow that belief that it could be witchcraft. I think you can reach those levels and shake the belief'. Participant, Private practice

Parkes (1996) suggests that a key task of mourning is for bereaved individuals to adjust their 'assumptive models' in light of their loss. Participants identified a disruption of clients' assumptive world views, affecting fundamental belief systems. However, it appears that the assumptive world views of clients are not shared by counsellors. Ugandan counsellors, trained in western scientific models, appear to impose westernised, scientific assumptive models on their client's magico-mythical belief systems.

Discussion

This study utilised the perceptions of indigenous Ugandan practitioners who were trained in western practices. They had become expert in applying bodies of theory generated in a different social setting to the one in which they and their clients were based. Their insights can be used to contribute to the discussion around culturally sensitive practices for social workers, and other professionals, who are tasked with offering therapeutic interventions for bereavement in non-western and pluralistic settings.

Huang and Zhang (2008) reflect on the indigenisation of social work knowledge, suggesting that practitioners should analyse indigenous social and cultural structures and find effective ways to improve them, whilst also showing caution around the unquestioning acceptance of western values and principles. Arguably, the practitioners in this study did just that. They identified contradictions between their indigenous practices and western bereavement models. They dealt with these contradictions by adapting certain aspects of western models to

conform to their societal norms, and also by subverting their cultural practices in response to other aspects of western models.

Analysing the impact of western approaches in non-western settings requires some understanding of the underpinning philosophy of western models and theories. Granek (2010) in exploring the historical development of grief theory, suggests that Sigmund Freud provided a foundational understanding of the psychological processes of mourning and loss. Freud (1917) instituted the conceptualisation of the self in terms of intra-psychic forces; a perception of the task of the bereaved to undergo a journey of adjustment or reformulation of the self; and a belief in the therapeutic value of the alliance between counsellor and client. A review of post-Freudian theories suggests that Freud's conceptualisation of grieving has undergone transformative change (Hagman, 2001). However, Freud's influences remain strong, and many post-Freudian theories and models of grief, including those of Worden, are premised on a staged process of grief, and a conception of self which is deeply rooted in western notions of individualisation and reflexive introspection (Hagman, 2001).

However, Ugandan practitioners showed caution in the unconditional acceptance of these values of individualisation and reflection, rather they continued to view their clients as part of a close knit network of interdependent relationships. They encouraged a sense of communal allegiance, rather than individualised soul-searching. Ugandan clients were not regarded as free individuals en-route to self-actualisation, but as members of social networks, which had power to constrain how they might act. Consequently, although the routines of therapeutic practice were, in many ways, similar to those practices in the West, a key difference was that therapeutic interventions were not offered to clients individually, without also seeking to engage the family and the community in the process. Decisions relating to the client were

shared so that the loci of control lay not with clients or therapists but with all interested parties working towards the perceived good of the community.

Conversely, however, Ugandan practitioners also challenged some of their societal mores, seeking to improve the experiences of bereaved individuals in light of western principles. Participants acknowledged that in Ugandan culture, the appropriate behaviour for bereaved individuals is a brief, time-limited and collectively-managed period of very intensive mourning, after which he or she must not grieve. However, the Ugandan participants also urged their clients to express their individual feelings and emotions of sorrow. Many clients accepted this encouragement and felt relief in emotionally cathartic experiences.

Participants also sought to subvert indigenous belief systems in conceptualising sickness and death according to a western mind-set. Western counselling philosophy promotes a scientific rationale which is at variance with the traditional discourses identified in African settings, where sickness and death is often attributed to the consequences of witchcraft or ancestral interference. Drawing on this imported narrative, many Ugandan participants appeared to promote a scientific, medicalised rationale with which to explain death.

Challenging societal norms in this way faces clients with opposing western and African discourses around loss. Expressing emotions outside prescribed rituals may be unfamiliar territory for Ugandan clients; they may not have the means to process their feelings reflectively in nuanced ways, and doing so may contravene community-based and religious beliefs (Nordanger, 2007). Clients may also be unable to accept 'rational' and scientific assumptive models to explain loss. Within a society overwhelmed by HIV, Ugandans remain vulnerable; detached, 'rational' and causal explanations may be insufficient to meet their cognitive and emotional needs (Elias, 2001). The impact of aligning opposing western and

African discourses around loss is not yet understood. Bereaved individuals may return to settings which may be authoritarian and harsh, where group needs must take precedence over those of individuals, and where a strong collective belief system is in place.

Implications for Social Work

At the level of social work research and service provision, there is a crucial need to develop culturally appropriate models for therapeutic interventions for grief. Williams and Graham (2014) highlight the rapid development of the 'international' in social work, suggesting that the corresponding research agenda has not kept pace with these global changes. There is a need for social workers to respond to issues of loss and grief in the increasingly pluralistic societies in which they find themselves (Holloway, 2007). The ways in which indigenous practitioners, in this study, adapted these western models should inform both practice and research in this area. In particular, in keeping with the findings of other social work research (Javadian 2007; Kasiram and Khosa, 2008; Wachter et al., 2015), the importance of combining individual therapeutic practice with family and community interventions is emphasised. Additionally, looser boundaries around confidentiality and privacy might be anticipated. Existing therapeutic approaches for bereavement favour a focus on the emotional component of the loss; however, a focus on the practical aspects of the loss may need to predominate. In helping clients make sense of their loss, a collectively endorsed discourse in which illness and death may be understood within a framework incorporating magic and religious belief should be acknowledged. Finally, therapeutic interventions should accommodate the fact that emotional expression or repression may be managed through an externally-validated process.

Conclusion

Bereavement practitioners in Uganda, whilst ostensibly working within a westernised theoretical framework, adjusted their practice to deal with the reality of their clients' psychological dispositions and societal requirements. The ways in which they did so were informative. In keeping with the suggestions of Huang and Zhang (2008) concerning the indigenisation of social work, some aspects of the western therapeutic models were adapted to suit collective identities, whilst current traditional practises around belief systems and emotional expression were challenged, in light of these models. This raises questions around the impact on clients of practicing within both western and African discourses around loss. Identifying these core contradictions offers a valuable starting point in the provision of contextually appropriate and sensitive therapeutic practices.

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