

Original article

Morbid grief I: Are close relatives of the "redterror" victims of Addis Ababa still suffering from a morbid grief and other complications of bereavement?

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Abstract: To assess whether close relatives of the "red-terror" victims of the Ethiopian revolution of late 1970's are still suffering from a morbid grief and other complications of bereavement, a study was carried out in Addis Ababa, Ethiopia, between February and May 1995. Ninety one close relatives (sample I) have rated themselves with the Texas Inventory of Grief 18 years after bereavement and 89(97.8%) of them were found to have a profound grief reaction. Compared to 87 non-bereaving control group (sample II), they have scored significantly higher ($P < 0.001$) on the General Health Questionnaire-30 items version (GHQ-30), Beck Depression Inventory (BDI) and State Anxiety Inventory (SAI). The correlation ($r = +0.843$, $P < 0.001$) between the brief (BTIG) and the expanded (ETIG) forms of Texas Inventory of Grief has indicated that the two forms are equally reliable and useful in measuring grief reaction. All the rating scales are self-rating, Amharic translated with acceptable face validity, but they are not yet concurrently validated with their corresponding English versions. BTIG was recommended as a useful paper-and-pencil screening instrument with an arbitrary cut-off point of 16.24 (i.e. - 1.96 Z- score) for this particular group and it was suggested that respondents scoring 16.24 and above which amounts to 89(97.8%) be considered as probable cases of morbid grief and as candidates for bereavement counselling. [*Ethiop. J. Health Dev.* 1997;11(3):241-249]

Introduction

Grief is the usual response to the loss of a loved one. In an adult it follows uniform pattern that is partially modified by the bereaved premorbid personality, the importance and abruptness of the loss, and the presence of other recurrent stress (1). Freud (2) stated that mourning is a grave departure from the normal attitude of life, but he neither regarded it as a pathological condition nor referred it for a medical treatment. He felt that normal grief was self-limiting, was resolved by reality, and that interference with it was useless and may even be harmful. Lindemann (3) considered uncomplicated grief to be a definite syndrome with pathognomonic symptoms and a predictable course.

Clayton (4), in a study of normal bereavement had stated that there are only three symptoms: depressed mood, sleep disturbance and crying that more than one-half of the subjects experience. Three other symptoms: difficulty of concentrating, loss of interest in TV and news, and anorexia and/or weight loss occur frequently, but still in less than half the subjects interviewed. He concluded that as 98% of those studied did not seek psychiatric assistance during the bereavement period, bereavement is a psychological reaction rarely handled by the psychiatrist.

Normal grief commences within a 2 week time frame after a major loss of a significant attachment figure. The bereaved individual demonstrates phasic response that involves a general, but not fixed

¹ From the Department of Psychiatry, Addis Ababa University, P.O.Box 9086, Addis Ababa, Ethiopia and ²Amanuel Hospital, P.O.Box 1971, Addis Ababa, Ethiopia. bereaved person can then recall the deceased person without subjective pain and feels that he or she has grieved and has accepted the loss (5).

In the normal course of events the intensity, frequency and duration of grief reaction diminish

progression of phenomena. This is followed by a recovery progressively over the first year. The

with time. This period of time of normal grief varies but rarely is more than six months according to the western cultures. Grief beyond six months is arbitrarily considered to be prolonged (1). However, as each relationship is different, each grief is also different and it is not possible to adopt a rigid time frame for bereavement (6).

Anniversaries of the loss and significant holidays are critical points in time : there may be a transient exacerbation of symptoms that last few days and sometimes this recurrent pattern is misconstrued as cyclical bipolar disease (5). Double (multiple) loss seems to have an accumulated effect and this is referred as ‘bereavement overload’ (7). The complications of bereavement are (1,8):-

1. Pathological (morbid) grief which includes delayed, absent, severe and chronic grief,
2. Depression,
3. Anxiety disorders,
4. Alcohol or drug abuse, and
5. Mania- reported in persons with history of Mood Disorder.

The descriptive approach is generally not sufficient or satisfactory to differentiate normal from pathologic bereavements as some of the characteristics are found in both forms of bereavement. The relationship between the two forms is more of a continuous and the pathology is more related to the intensity of a reaction or the duration of a reaction rather than to the simple presence or absence of a specific behaviour (8).

Instruments have been developed to measure the intensity of symptoms of grief and bereavement (9,10,11,12). These instruments help to identify cases of unresolved (morbid) grief and allow reliable and valid description of the grief process. Concerning the duration of the grief process, pathological grief as long as 10,15 and even 25 years was reported in some communities and it was further stated that some aspects of ‘grief work’ may never end for a significant proportion of bereaved individuals (10).

Numerous studies have identified risk factors for developing complications of bereavement (1,4,11,13). We believe that our subjects who are close relatives¹ of victims of the so-called ‘redterror’ of the Ethiopian revolution of late 1970's have encountered many of the risk-factors that could complicate this bereavement process. Our day-to-day experience in the community and especially in the psychiatric OPDs reminds us that the loss of loved ones in the ‘red-terror’ was the most commonly mentioned event by the bereaved who were left with painful response on recalling the deceased. So far no effort was made to assess the magnitude of complication of bereavement among the close relatives of ‘red-terror’ victims. The purpose of this study was to find out whether close relatives of the ‘red-terror’ victims suffer from complications of bereavement in general and in particular, to :

1. measure the intensity of their pathologic (morbid) grief;
2. find out whether they could be identified as probable cases (i.e. non-psychotic) with the GHQ30 and score significantly higher than the control group on the GHQ-30, on the depression and the anxiety inventories.

¹ A close relative includes here a first degree relative (i.e. father or mother, brother or sister, husband or wife, son or daughter) or anybody with whom a respondent has lived for years and considered to be a family member.

The hypothesis proposed was that our subjects still suffer from a morbid grief and would score significantly higher than the control groups on GHQ-30, a depression inventory and an anxiety inventory.

Based on this study a proposal will be submitted to set up a separate bereavement counselling services in Addis Ababa and other cities for those who still suffer from the morbid grief. Close relatives of the victims have already formed associations in Addis Ababa and other cities to look after their psychosocial problems.

The design of this study also enabled us to elucidate two separate issues:

1. The phenomenology of pathologic grief processes among our subjects and the relationship of the morbid grief scores, as measured by the BTIG, to other psychological constructs such as GHQ-30, BDI and SAI scores. This is dealt with in paper II (21).
2. The influence of variables on the degree of grief reaction, depression and anxiety among our subjects and this is dealt with in paper III (22).

Methods

Selection of Samples: Sample I (i.e. close relatives of ‘red-terror’ victims) was drawn randomly from the list of families who suffered a loss or losses during the ‘red-terror’. The list was obtained from the Addis Ababa branch of Human Rights League for the Victims of Red-Terror which has a representative from all the 28 ‘Woredas’ (constituencies).

Sample II (i.e. control group) also was drawn randomly from among volunteers from each ‘woreda’. To minimize the bias, which could be a source of weakness, each ‘Woreda’ representative had first registered a number of volunteers (controls) who could match each of the candidates in sample I (cases). Then, one control was selected for each case by drawing a name from a hat.

At least five subjects were expected to join each sample from each ‘woreda’ to make a total of 140 subjects in each sample. As much as possible, the control group from each ‘woreda’ was matched with respect to variables like age, sex, occupation; etc. before the selection.

Excluded from the study, were those known to be psychiatric cases, drug addicts or suffering from a severe physical illness or having current social, legal or economic crises. Among sample II, subjects who lost a close relative in the last two years were also excluded.

All representatives of the ‘woredas’ have attended briefing sessions and panel discussions on the study and given instructions about obtaining random samples specifically about drawing numbers from a hat, about selecting matched control sample and about the time-table for distribution of the self-report questionnaires. The authors are aware of the shortcomings of these and other self-report questionnaires: they introduce reporting bias if the subject is too disturbed to complete the task; can not read or understand the intent of the questions; or is motivated in some way to falsify or exaggerate his responses. But they have clear advantage in saving professional time and expense. They are also more sensitive in evaluation of subjective distress in subjects who are not very disturbed. For those who can not read and write, a literate relative was permitted to read questions for the subject and fill the questionnaires appropriately.

Both samples have filled first the demographic data sheet about themselves and sample I (cases) have filled an additional data sheet about relatives lost in the ‘red-terror’. *Test materials and statistical analyses:*

1. Expanded Texas Inventory of Grief (ETIG) and Brief Texas Inventory of Grief (BTIG)(9,10,11): ETIG is a 34-item scale which also includes all the seven items of BTIG. Both are self-rated and each item is scored on scale of 1-5, with five being assigned to a response seemingly most indicative of unresolved grief. The ETIG generates a score between 34 and 170 and the BTIG between 7 and 35. Both are valid and reliable, ETIG being suitable as a tool for assessing the outcome of the grief as ‘good’ or ‘bad’ and BTIG as a paper-and-pencil screening tool. Only sample I has completed ETIG. Distribution of ETIG score of the group, mean score of the group on each of the 34 items of ETIG and the percentage of positive endorsement of each item was calculated. To test the correlation between the two forms of Texas Inventory of Grief scatter diagram was drawn, correlation coefficient (r) was calculated and the regression line was drawn.

In similar manner, correlation between BTIG and GHQ-30, BTIG and BDI and BTIG and SAI was tested. Also correlation between GHQ-30 and BDI, GHQ-30 and SAI and BDI and SAI was tested. The results of these correlation tests and the phenomenological analyses of the positively endorsed items of ETIG will be dealt with in paper II (21).

To know what variables of the bereaved and of the victims among sample I could influence the degree of grief reaction, depression and anxiety, t-tests or Z-tests were applied to detect significant differences in ETIG, BDI and SAI mean scores between the different variables. The result will be discussed in paper III (22).

2. General Health Questionnaire (GHQ-30 item version) (14,15): The GHQ-30 is a self-rated questionnaire which discriminates accurately between probable 'cases' and 'non-cases', but it is not intended to detect psychoses. It has a cut-off point of 4/5 and generates a score between 0 and 30 by the standard GHQ scoring method. The mean GHQ-30 scores of sample I (cases) and Sample II (controls) were tested with Z-test for a significant difference. The proportions above the cut-off point were also tested for a significant difference by X^2 test.
3. Beck Depression Inventory (BDI) (16): This is also a self-rated inventory with 21 items and each item is rated (0-3). It generates a score between 0 and 63. It is a valid and a reliable inventory which measures the depth of a depression.

The mean scores of sample I (cases) and Sample II (controls) on BDI were tested for a difference of significance with Z-test.

4. The State Anxiety Inventory (SAI) (17):

This inventory too is self-rated and has 20 items and each item is rated (1-4). It generates a score between 20 and 80. It is a valid, reliable and sensitive indicator of changes in the level of anxiety.

The mean scores of sample I and sample II on SAI were tested for a difference of significance with Z-test.

All test materials mentioned above were carefully translated into Amharic: first, English-Amharic dictionary (Oxford University Press) was used for a consistent translation of key words of each question and statement that indicate the different degrees of severity of symptoms. Then, the overall sense of each question and statement was examined to make sure that it has identical meaning with that of the English version. Finally, after further consultations with colleagues, the authors were convinced that the Amharic versions of the questionnaires have acceptable face validity and can measure satisfactorily what they are supposed to measure. As these Amharic versions are not yet statistically validated in our setting, the authors believe that separate researches have to be carried out to assess their concurrent validity and this will be a step forward towards standardization of these versions. All statistical tests reported were two-tailed.

Results

Ninety eight sets of forms have been distributed to sample I (cases) and 91(92.86%) have returned the completed forms. To sample II (controls), 93 sets of forms (ETIG excluded) have been distributed and 87 (93.54%) have returned the completed forms. The rest were returned incomplete or empty.

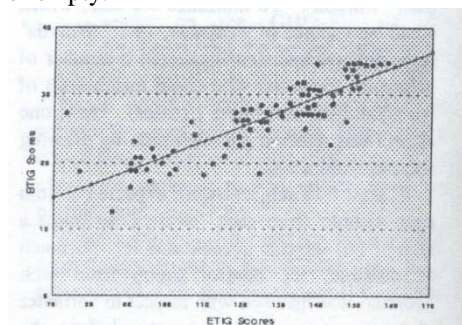


Figure 1: Scatter diagram of relation in 91 bereaved cases between ETIG and BTIG, Addis Ababa, 1996.

Table 1 shows the demographic variables of the two samples. It is evident from the table that there is a preponderance of younger, male, single, educated and the employed among respondents of sample II (controls). Therefore, the two samples can not be taken to be alike for the purpose of comparison. However, a stratified sample is created in almost all variables. As a solution to this problem, the authors decided to compare the whole sample at each stratum for a significant difference, at least on BDI mean scores. The results of these analyses are incorporated for convenience into Table 1 and will be dealt with in the discussion.

Table 1: Demographic variables of sample I (cases) and sample II (controls) (with their mean scores on BDI and significance levels incorporated for convenience), Addis Ababa, 1996.

Variables	Sample I (N=91)	(cases) Mean score	Sample II (N=87)	(controls) Mean score	Significance*	P<
	N(%)		N(%)			
Age distribution:						
20-29	16(17.58)	18.63	44(50.57)	11.95	<0.02	
30-39	20(21.98)	22.15	22(25.25)	16.68	NS	
40-49	9(9.89)	24.11	8(9.20)	14.38	NS	
50-59	13(14.29)	23.77	7(8.05)	10.57	<0.05	
60-69	20(21.98)	24.95	4(4.60)	20.5	NS	
70-79	12(13.19)	26.88	1(1.15)	(24)	-	
unspec	1(1.1)	(34)	1(1.15)	(27)	-	
Sex:						
Male	49(53.85)	23.78	61(70.11)	13.34	<0.001	
Female	42(46.15)	22.52	26(29.89)	14.35	<0.02	
Religion:						
Christ.	80(87.91)	24.13	79(90.80)	13.84	<0.001	
Muslim	11(12.09)	19.64	5(5.75)	18.6	NS	
Unspec.	0(0.0)	--	3(3.45)	13.0	-	
Marital status:						
Single	23(25.27)	19.30	46(52.87)	13.22	<0.05	
Married	40(43.96)	24.28	28(32.18)	14.18	<0.01	
Divorced	3(3.3)	41.33	3(3.45)	16.00	<0.05	
Separated	3(3.3)	31.00	4(4.6)	10.00	NS	
Widow/er	21(23.08)	21.00	6(6.9)	23.33	NS	
Unspec.	1(1.1)	(8)	0(0.01)	--	-	
Educational level:						
Illitr.	5(5.49)	27.8	0(0.0)	--	-	
Primary	40(43.96)	23.1	16(18.39)	17.94	NS	
Second.	22(24.18)	22.09	38(43.68)	14.39	<0.01	
Tertiary	3(3.3)	23.00	11(12.64)	12.25	NS	
Vocational	14(15.38)	18.29	22(25.29)	11.23	<0.01	
Unspec.	7(7.69)	31.00	0(0.0)	--	-	
Employment Status						
Employed	22(24.18)	17.59	46(52.87)	11.65	<0.05	
Pensioned	31(34.07)	21.94	8(9.2)	13.5	<0.02	
Dependent	29(31.87)	27.10	27(31.03)	17.0	<0.01	
S-employed	5(5.49)	40.00	1(1.15)	(9)	-	

Unspec.	4(4.4)	20.75	5(5.75)	18.6	NS
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NS = Not significant

Unspec. = Unspecified

S.employed = self employed

* z- Table 2 shows distribution of only ETIG scores of sample I (cases). Their mean ETIG score was test or t- test was performed depending on the number of respondents at each stratum.

126.36 (range 74 to 158, SD=21.42) and on BTIG their mean was 26.88 (range 13 to 35, SD=5.43).

Table 3 shows the 34 items of ETIG and the mean scores of each item. The seven items of BTIG are marked by asterisk (*). The overall mean score for all items of ETIG was 3.72 (range 1.71 to 4.81, SD=0.88) and that of BTIG was 3.84 (range 2.44 to 4.64, SD= 0.77). No significant difference between these two overall severity mean scores ($P > 0.5$, $t = 0.3349$, $DF = 39$).

When the results of ETIG and BTIG of individual respondents were plotted out (Fig 1), they correlated fairly well with one another ($r = +0.843$, $P < 0.001$) and indeed the correlation is strongly positive and very highly significant.

Table 4 indicates the mean scores of the two samples on GHQ-30, BDI and SAI. On all scales the mean scores of sample I are higher than the corresponding mean scores of sample II ($P < 0.001$ in all) and, indeed, these differences are very highly significant.

Further more, in GHQ-30 the proportion above the 4/5 cut-off point of probable 'caseness' in sample I (62 or 68.13%) is higher than in sample II (controls) (42 or 48.28%) and this difference too is highly significant ($P < 0.01$).

Discussion

The random selection of sample I respondents resulted in a reasonably fair distribution of different age and sex groups and other variables. But among respondents of sample II, there is a preponderance of younger, male, single, educated and employed as mentioned earlier. The solution to the bias thus created by sample selection will be mentioned towards the end of the discussion.

Despite the long duration (18 years) between the loss of a close relative in the 'red-terror' and the completion of the questionnaires, almost all respondents of sample I felt strongly affected by the loss. The mean score of 126.36 on ETIG and 26.88 on BTIG and the overall mean score for all items on ETIG (3.72) and on BTIG (3.84) indicate that the degree of their grief reaction is quite high. Theoretically, it is expected that the magnitude of grief will diminish as a function of time from death (9), but it remained high among those who lost a close relative in the 'red-terror'. There are several factors that could contribute to the 'poor' outcome of the individual grief reaction, but as a group the circumstances surrounding the loss were painful, horrifying and mismanaged. The victims were young (83 or

91.2% were below 30 years and 29 or 31.9% were below 20 years). In most cases there was lack of funeral rituals which actually facilitates grief and helps to accept the reality and finality of death. It also helps to express thoughts and feelings about the deceased and draws social support net work to the bereaved.

Table 2: **Distribution of ETIG* scores of sample I (cases), Addis Ababa, 1996.**

Range of scores	No	%
<70	0	0.0
70-79	2	2.198
80-89	2	2.198
90-99	12	13.187
100-109	6	6.593
110-119	4	4.396
120-129	19	20.879
130-139	18	19.780

140-149	16	17.582
150-159	12	13.187
160-169	0	0.0
	91	100

Mean = 126.36, SD= 21.42

* Range of score that could be generated is (34 to 170)

The measure of correlation ($r=+0.843$, $P<0.001$) between the two grief inventories (ETIG and BTIG) indicates that these are two forms of the same test and that the BTIG is equally useful and reliable in measuring a grief reaction. Moreover, lack of significant difference between the overall mean scores of all items of both inventories indicates that they measure a grief reaction with a similar accuracy.

This implies that BTIG can serve as a quick paper-and-pencil screening tool for measuring the magnitude of unresolved grief. Moreover, all the seven items of BTIG were positively endorsed by respondents ranging from 96.2% to 97.8% (see paper II) (21).

All questions in the ETIG or BTIG refer specifically to the deceased person and the data obtained consist of a constellation of symptoms relevant to the bereaved individuals. This means that these inventories have high face validity in measuring grief. The issues of concurrent validity were already mentioned under methodology.

It has to be clear that we are not trying to delineate a cut-off point between normal and abnormal grief. Any such attempt has to take into consideration the severity of grief over time as grief will diminish as a function of time from death. We are dealing with cases of abnormal grief (i.e. chronic and possibly severe) and one of the purposes of this study is to propose counselling services for these chronic mourners. Recommending all of them for counselling is quite unacceptable. Those who score less than 1.96 standard deviation below the sample mean should be taken arbitrarily as suffering significantly less.

Therefore, we would like to suggest an arbitrary cut-off point on the BTIG for identifying cases of unresolved grief among close relatives of the 'red-terror' victims. This arbitrary cut-off point should be (-1.96 Z-score), which is 16.24 on BTIG (18). Those who score 16.24 or above on BTIG should be regarded arbitrarily as candidates for counselling for unresolved grief. This amounts to 89 (97.8%) respondents of sample I.

Significantly higher mean score and higher proportion of respondents above the cut-off point of probable 'caseness' on GHQ-30 indicate that close relatives of victims of the 'red-terror' (sample I) are probably in higher distress than sample II. However, the GHQ-30 has failed to identify 29 (31.87%) respondents as probable 'cases' from sample I. This subgroup of 29 has actually scored an average of 120.66 on ETIG, 15.034 on BDI and 40.103 on SAI, meaning that they too suffer from grief reaction, depression and anxiety. It is known that the GHQ gives greater number of falsenegatives when used in chronic disorders as in chronic grief, or it is only efficient in detecting disorders of recent onset (19,20).

Table 3: Response of 91 close relatives of the 'Red-Terror' victims (sample I or cases) to the Expanded Texas Inventory of Grief (ETIG), Addis Ababa, 1996.

Item	Mean Score**	
F 1	I cry inside for him/her	4.69
F 2	I still get angry when I think of him/her	4.66
F 3	since he/she died, I am more like him/her	2.89
F 4	I feel guilty when I think of him/her	1.71
*F 5	I am preoccupied with thoughts of him/her	4.64
F 6	I feel it is unfair	4.81
F 7	I feel he/she is stil with me at times	3.65

F 8	I have acquired the habits and interests of him/her	2.74
F 9	I have found someone to take his/her place	1.74
F 10	I would feel better if I could really cry	3.60
F 11	No one will ever take his/her place in my life	4.56
F 12	I hide my tears when I think about him/her	3.79
F 13	I have to laugh when I think about him/her	4.13
F 14	Now I can talk about the person without discomfort	1.81
F 15	Sometimes I dream about him/her	4.20
F 16	I cry when I think about him/her	4.37
F 17	A numbness comes over me when I think of him/her	4.22
F 18	I feel physically ill when I think of him/her	4.04
F 19	I feel I have adjusted well to the loss	3.55
F 20	I have never known a better person	3.81
*F 21	I cannot accept his/her death	4.01
F 22	I am now functioning as well as before	3.03
*F 23	I get upset when I think about him/her	4.37
F 24	Things and people around me still remind me of him/h	4.41
F 25	I very much miss the person	4.40
F 26	It is painful to recall memories of him/her	4.35
F 27	I try to avoid thinking of him/her	3.29
*F 28	I feel just like the person who died	3.18
F 29	My health has not been good since he/she died	4.15
*F 30	I still feel the need to cry for him/her	4.23
*F31	I get upset each year about the time that he/she died	4.01
F 32	I can't avoid thinking about him/her	4.29
F 33	I feel I have the same illness as him/her	2.62
*F 34	I have pain in the same area of my body as him/her	2.44

* The seven items of BTIG ** 1=completely false, 2=mostly false, 3=partly true and partly false, 4=mostly true and 5=completely true

Over all mean score for all items: ETIG=3.72 (range 1.71 to 4.81, SD=0.88) BTIG=3.84 (range 2.44 to 4.64, SD=0.77)

Significantly higher mean BDI score indicates that close relatives of the 'red-terror' victims are more depressed than the control group. The difference in SAI scores also shows that close-relatives of 'red-terror' victims suffer from a significantly higher magnitude of anxiety than the control group.

At this point one might challenge that though sample I suffers from a severe form of unresolved grief as mentioned earlier, significantly higher scores than sample II on GHQ-30, BDI and SAI could not be attributed only to the effect of the unresolved grief as the two samples are not identical in all respects. The authors would like to explain this issue as follows: 1. Both samples were selected randomly by drawing names from a hat. Eventhough respondents in both samples were known to 'woreda' representatives, this has not improved the chance of getting ideally stratified matched samples. 2. Sample I which has suffered the loss 18 years ago and the relatively newer generation from which the different strata of sample II were drawn do not necessarily match and in such circumstances bias in allocation can not be eliminated. 3. The solution to this problem was already mentioned under result and here it will suffice if the reason why BDI alone was chosen for these analyses is elaborated.

The defect of using the GHQ-30 in chronic grief was already stated. Furthermore, if it is used to compare respondents at each stratum, the numbers will be much smaller and this leads to larger 'standard error of difference' which leads to low t-values / Z-values and makes the difference in the

mean scores insignificant or less significant. The correlation between BDI and SAI ($r=+0.647$, $P<0.001$) as shown on paper II indicates that these two inventories are closely linked to each other and therefore the authors feel that it is unnecessary to repeat the analyses with SAI (21).

Now, referring back to Table 1 it is evident that respondents of sample I have higher mean scores than sample II on BDI at all strata except that widows/ers have slightly less mean score which is not significant. Most of the differences are significant except where the number of respondents is too few. The disadvantage of having fewer respondents in statistical tests was already mentioned. The authors believe that increasing the number of respondents at each stratum would help to bring the difference to a significant level.

American studies (8) have shown that the risk of clinical complication one year after a

Table 4: Mean score of the two samples (cases and controls) on GHQ-30, BDI and SAI and their level of significance, Addis Ababa, 1996.

Test material	Sample I Mean	(cases) SD	(n=91) Range	N(%)	Sample II Mean	(controls) SD	(n=87) Range	N(%)	Remarks
GHQ-30 score	11.90	9.68	0-30		6.29	6.49	0-3		Z=4.59, P<0.01
GHQ-30 score(5+)	-	-		62(68.13)	-	-	-	42(48.28)	$\chi^2=7.219$, DF=1, P<0.001
BDI Score	23.31	13.07	0-55		13.97	10.60	0-55		Z=5.247, P<0.001
SAI	51.95	15.19	22.80		43.16	11.28	21-80		Z=4.191, P<0.001

SD= Standard Deviation

loss is (4-49%) for any disorder, (14-34%) for pathologic grief, (4-31%) for major depression and 39% for panic disorders. Bereavement accounts for 15% of admissions to psychiatric wards and 20% of consultations from medical and surgical wards. Such an estimation of risk of complication and load to surgical or medical consultations due to bereavement is not available in our country and probably the awareness of this problem is minimal in general.

In conclusion, since the Amharic versions of self-rating scales used in this study are not yet concurrently validated with the corresponding English versions, their face validity have to be taken into consideration. Also, this study can not be absolutely immune from other short-comings like sampling bias or reporting bias. Keeping these in mind, the results of this study indicate that close relatives of the 'red-terror' victims still suffer from a morbid/ pathological/ unresolved grief. The results also indicate that they are more distressed, more depressed and more anxious than the control group. All these differences are statistically very highly significant. The authors believe that setting up bereavement counselling services for those who suffer would help in resolving the chronic grief and other complications like depression and anxiety. Once such counselling services are established, they can extend their services even to those whose bereavement is unrelated to the 'red-terror'.

The Amharic version of BTIG is as reliable as ETIG and can serve as a short paper-and-pencil screening instrument for measuring the extent of unresolved grief. For reasons already mentioned, we would like to suggest a cut-off point of 16.24 (i.e. 1.96 Z-score) (18) and respondents scoring 16.24 and above among close relatives of the 'red-terror' victims should be identified as probable cases of morbid grief and should be considered as candidates for bereavement counselling.

Acknowledgement

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References

1. De Vault RD, Zisook S. Unresolved Grief: Clinical Considerations. Postgrad. Med. 1976;59:267-

71.

2. Freud S. 'Mourning and Melancholia' (retracted by Clayton PJ, Desmarias L, and Winokur G. in Amer. J. Psychiat. 1968;125(2):168-78) SE 1917;14:243-58.
3. Lindmann E. Symptomatology and management of acute grief (retracted by Clayton PJ, Desmarias L, and Winokur G. in Amer. J. Psychiat. 1968;125(2):168-78) Amer.J. Psychiat. 1944;101:141-9.
4. Clayton PJ, Desmarias L, and Winokur G. A study of normal bereavement. Amer. J. Psychiat. 1968;125(2):168-78.

5. Jacobs SC. Diagnostic criteria for normal grief. In : Jacobs SC, editor. *Pathologic grief: Maladaptation to loss*. Washington DC: American Psychiatric press, 1993;363-5.
6. Wikan U. Bereavement and loss in two Muslim communities : Egypt and Bali compared. *Soc.Sci.Med*,1988;27(5): 451-6.
7. Warden JW. Abnormal Grief reactions: complicated mourning. In: Warden JW, editor. *Grief counselling and grief Therapy : A handbook for the mental health practitioner*. N.Y: Springer Publishing Company, 1991;65-78.
8. Jacobs SC, The complication of bereavement. In: Jacobs SC, editor, *Pathologic grief: Maladaptation to loss*. Washington DC: American Psychiatric press, 1993;39-54.
9. Faschingbauer TR, De vaul RD, Zisook S. Development of the Texas Inventory of Grief. *Am. J.Psychat*. 1977; 134(6):696-8.
10. Zisook S, De Vaul RD Click, MA. Measuring symptoms of Grief and Bereavement. *Am.J. Psychat*. 1984; 139 (12): 1590-3.
11. Lundin T. Long-term outcome of bereavement. *Brit. J. Psychait*. 1984;145:424-8.
12. Liberman S. Nineteen cases of morbid grief *Brit. J. Psyachiat*. 1978;123:159-63.
13. Park CM. Bereavement. *Brit. J. Psychiat*. 1985;146:11-17.
14. Goldberg DP. The detection of psychiatric illness by questionnaire. *Maudsley monograph 21*. London : Oxford University press, 1972.
15. Vachon MLS, etal. A controlled study of self-help intervention for Widows. *Am. J. Psychait*. 1980; 137(11):1380-84.
16. Beck AT, etal. An Inventory for measuring depression. *Arch. Gen. Psychiat*. 1961;4:561-71.
17. Spilburger CD, Gouruch RH, Lushene R. *State- trait anxiety inventory manual*. Palo Alto, California: Consulting psychologist Press, 1970.
18. Cohes W, Holiday M. *Statistics for social scientists*. London : Harper and row Ltd, 1982;51-63.
19. Finlay-Jones RA, Murphey E. Severity of psychiatric Disorder and the 30- items General Health Questionnaire. *Brit. J. Psychiat*. 1979;134:609-16.
20. Benjamin S, Decalmer P, Varan D. Community screening for mental illness: A validity study of the General Health Questionnaire. *Brit. J. Psyciat*. 1982;140:174-180.

21. Abdullahi AB, Hyder MA. Morbid grief II: The phenomenology of pathologic grief process, depression and anxiety among close relatives of “red-terror” victims. *Ethiop J Health Dev*. 1997;11(3):251-256.
22. Abdullahi AB, Hyder MA. Morbid grief III: The influence of variables on the degree of grief reactions, depression and anxiety among close relatives of the “red-terror” victims. *Ethiop J Health Dev*. 1997;11(3):257-261.