Bereavement After Traumatic Death
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Foreword

Without question, the loss of a loved one is difficult and problematic for the surviving family and loved ones. However, deaths that occur under sudden and often violent circumstances produce their own burdens and issues among grieving relatives and significant others.

The editors and individual chapter authors of this book have produced an important compilation of information to address the range of traumatic losses – by accidents, suicides, homicides, sudden deaths of infants, or from natural disasters. These losses share several commonalities as outlined and detailed here. Among these commonalities is the non-normative nature of the losses. These deaths are not those we ordinarily conceptualize when thinking about how or when we expect that someone will die. People die at all ages and from numerous causes, of course, but the deaths considered here seem “improper” to us on many levels, largely because they are not the norm. For instance, they do not occur with some forewarning over a period of time or are not accompanied by a known or diagnosed disorder or medical condition or necessarily at an advanced age. They are sudden and unexpected as well as often violent, and therefore produce a different and perhaps complicated process and trajectory when those who remain behind after the death attempt to mourn and confront the loss as part of the continuation of their own lives. As non-normative losses, they also fall somewhat out of the realm of the experience, and perhaps even the training, of those caring individuals who provide therapy, support, and other assistance during the survivors’ mourning.

Traumatically bereaved individuals as well as mental health professionals or others who provide assistance to these bereaved will find clear, understandable explanations of terms, common experiences, and even theories of grief and bereavement in this collection. Not only is basic knowledge about grief and mourning presented, but also addressed are the myths (those inaccurate beliefs so often held and voiced) surrounding loss and particularly grieving for traumatic deaths. Further enhancing this information throughout the book are quotations from traumatic death survivors that reveal their very personal experiences, thoughts, and
feelings. Traumatic death survivors will find the book to be informative, compassionate and sensitive, helping, and healing. What to expect as one tries literally to survive the sudden, unexpected, and often violent death of a loved one is conveyed in an accessible form. At the same time, caregivers will discover the book’s emphasis on postvention – those efforts performed in the aftermath of a sudden and unexpected death intended to help individuals deal with their loss and the frequently complicated bereavement processes that occur. These chapters will provide caregivers with a better understanding and insights to facilitate the help they provide to traumatic grief survivors on their healing journey. Important potential aspects of postvention are discussed, including, for example, social support systems as well as more formal structures such as support groups and therapy.

This volume adds to the resources available regarding losses by suicide as well as other sudden and traumatic deaths. It is apparent that more information exists and is conveyed here with respect to loss by suicide, but it is clear also that the shared aspects of sudden, unexpected, and traumatic loss will be informed more generally by what has been revealed about loss specifically to suicide. It is also hoped that research and clinical experience regarding the other specific traumatic losses will be encouraged and expanded.

This book is a tremendously valuable resource that will benefit the caring community of individuals who attempt to help in the healing journey of the traumatically bereaved as well as the survivors of these losses themselves as they proceed on their journey.

John L. McIntosh, PhD
Interim Executive Vice Chancellor for Academic Affairs
and Professor of Psychology
Indiana University South Bend, IN, USA
September 2013
Along the sides of the rural highway to the clinic I attend there are shrines to people who have lost their lives while traveling this route. Over time the memorials change – new flowers, a child’s teddy bear, once-used clothes, and other belongings – as tokens of remembrance. They acknowledge the importance to family and friends of the lives lost and invite others to share in the grief and celebration of these lives.

Suicide in a family or of a close friend is devastating, leaving behind a person with unanswered questions and mixed emotional feelings. Such loss can affect workplaces, clubs, schools, and whole communities such as a rural village or township.

In Australia a memorial quilt has been made by the Salvation Army for those who have taken their lives. It displays the faces of young people. Beside each face is an account of their cherished role in the family, the positive memories they have left behind, and then the questions: Why did he/she do this? What went wrong? Why didn’t we know? Could we have done things differently?

This book explains why such actions are so important to those intimately affected by someone’s traumatic death but also their significance for local and wider community networks.

The personal accounts of how others experience grief will help validate the feelings of loss, disappointment, and bewilderment at the complexities, which are so often experienced. There are suggestions of how to help – practical things to do, appropriate responses to childhood grief, to a parent’s loss of a child, and to distress in school and workplace communities.

Formal studies of grief – especially prolonged and disabling grief – and the interventions that have been shown to be helpful are described and their potential for replication in other places and settings is presented. Philosophy and religion can provide solace and some comfort, at least.

This book covers what can be done to provide support and succour in work settings, schools, and front-line services – such as in mental health teams where such tragedies occur only too frequently. And for individuals and groups that aim to support and intervene, there are practical ex-
amples of community networks and resources that can be emulated or set up in other environments.

In Australia, where Professor Diego De Leo is the director of the Australian Institute for Suicide Research and Prevention, suicide bereavement is a national priority. The government has funded projects to provide practical assistance following suicides, service coordination, access to professional help, counseling, community networking, and especially appropriate interventions for indigenous communities in which suicide rates are so high.

Those who manage or work in programs to help and support the bereaved in many countries will have their resolve and involvement strengthened by the analyses and problem-solving approach set out in this book. The arguments are strong for greater collaboration, shared resources, and multidisciplinary enquiry and research.

Ian W. Webster
Physician
Chair of the Australian Suicide Prevention Advisory Council
Australian Government Department of Health and Aging
Canberra, ACT
September 2013
To Them.

Their physical absence is unbearable, their emotional presence overwhelming.
Acknowledgments

This book is a result of the enthusiasm around the activities of the De Leo Fund of Italy. We are indebted to all of those colleagues who have joined the Venetian network to assist those bereaved by a traumatic death, and who have donated their time to that cause with great dedication.

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Introduction

The memory of joy is no longer joy; the memory of pain is pain still.
Lord Byron

In the world, every year, more than 1.2 million people die on the streets (World Health Organization [WHO], 2009). Road accidents are the second leading cause of death among those aged between 5 and 29 years. Low- and middle-income countries have the highest mortality rates for this cause, with more than 90% of all deaths resulting from road accidents, although they have only 48% of all circulating vehicles (WHO, 2009).

In many high-income countries, mortality related to road traffic injuries has declined over the years, albeit it still represents an important cause, whereas in most low- and middle-income countries such a welcome trend has not yet been observed. About half of the deaths relate to vulnerable road users (pedestrians, cyclists, moped riders, and motorcyclists), and this proportion is higher in poorer nations (WHO, 2009). In many countries, legislation relating to road safety is inadequate and/or infrequently adopted. To be effective, prevention of accidents requires multisectoral interventions that need coordinated efforts between different institutions. So far, only a limited number of countries have adopted a national strategy to prevent traffic-related accidents.

Suicide is also an alarming phenomenon: In the last 45 years it has increased by 60% (Bertolote & Fleischmann, 2005). According to WHO, each year there are about 1 million people in the world who decide to take their own life, and this figure is predicted to increase by 50% by the year 2020 (Bertolote & Fleischmann, 2005). Similar to the estimates for road accidents, it has been estimated that 85% of all suicide deaths occur in low- and middle-income countries (Krug et al, 2002). In many industrialized countries, suicide is the second or third cause of death among adolescents and young adults.

Although these data are troubling, only a few countries have included suicide prevention as one of their priorities: In many societies, there is
a substantial lack of awareness of suicide as a serious problem; in others, to openly discuss this phenomenon is still taboo. However, some countries have developed national programs to fight suicide, and have organizations that advocate for preventative efforts. International organizations have also been established, such as the International Association for Suicide Prevention (IASP), which brings together experts from various disciplines with the aim of promoting scientific exchanges and advancing preventive activities.

In 1999, WHO launched the Suicide Prevention (SUPRE) campaign, with the objective of identifying, evaluating, and possibly reducing risk factors for suicide. SUPRE was meant to increase international awareness of the problem of suicide. One of the aims of this important initiative was also to provide support to family and close friends of people who had died by suicide. And in fact, in recent years, the level of interest devoted to postvention – the term coined by Shneidman in 1971 to indicate tertiary prevention for those relatives, partners, or friends who have survived the suicide of a loved one – has expanded significantly. There is a clear need to help and assist these people, who often continue to suffer for a long time the consequences of that traumatic type of death.

In 1999, the IASP established a taskforce dedicated to suicide “survivors.” One of its objectives was to publish (in collaboration with WHO) a list of the existing agencies, services, and nongovernmental organizations (NGOs) – at the European level – whose main aim was to support survivors.

In 2000, a suicide survivor from Australia, Raylee Taylor, provided the first draft for a WHO publication on how to set up a support group for survivors: Preventing Suicide: How to Start a Survivor’s Group (revised in 2008; WHO, 2008a). In subsequent years (2003–2010), the Australian government brought forward a number of initiatives in the area of suicide prevention, including the distribution of a support package for survivors originated by the Ministerial Council for Suicide Prevention of Western Australia: Information & Support Pack for Those Bereaved by Suicide and Other Sudden Death (Clark & Hillman, 2007).

As evidenced by the IASP-WHO inquiry, specialized structures have been created also in European countries in support of the family and friends of people who have died by suicide. In this volume, we particularly describe work carried out in nations such as Norway and Belgium.

The social and psychological impact of suicide on family and community members is enormous. Shneidman (1969) stated that for every death by suicide at least six people are deeply affected by the psychologi-
cal, somatic, social, and financial consequences of the traumatic event. And if suicide occurs in a school or a work environment, its impact can easily fall on hundreds of people. With a few important peculiarities, grief reactions of suicide survivors have characteristics in common with bereavement due to other forms of unexpected and violent death (such as a road accident, homicide, sudden infant death syndrome [SIDS], accident in the work environment, natural disaster, etc.). For this reason, experts agree in using the term traumatic grief to generally refer to the process of mourning related to all unexpected and sudden deaths.

In the term mourning we usually include a very wide range of psychophysical processes, both conscious and unconscious, triggered by the loss of a person of attachment. Mourning, then, shall be used to refer to both the set of psychological reactions and individual behaviors that are experienced due to the loss of a significant person, and also the rituals and social and collective practices that are publicly observed within different cultures, around the event of death (Crozzoli Aite, 2003).

For all traumatic deaths we should probably assume – as suggested by Shneidman for suicide – that at least six people who survive the event will be deeply affected by it. It is therefore important that we give careful consideration to all those people who live this type of painful experience, and especially to those individuals who do not seem to have enough resources to be able to cope with their own grief or to discover how to get ahead in life without the loved one.

In this volume, we talk about traumatic bereavement in a surprisingly simple and straightforward way, “taking advantage” of tragic personal experiences and, professionally, of three scholars who have a well-established international reputation in the field of postvention. So in a language accessible to all, we describe step by step what happens after a sudden and unexpected death, including the most common reactions, and what kind of problems survivors face after the loss of a family member or close friend.

This work is designed for professionals and volunteers involved in bereavement support, but it is also one of the few books that can be read with profit even by those who have suffered the traumatic loss personally, and want to know what to expect and how to best be helped.

Diego De Leo and Alberta Cimitan
The death of a beloved person is a universal experience, a painful event, and leaves an indelible memory, which inevitably disrupts the lives of the survivors. The experience of loss nearly always has an impact on the overall situation of the entire family group and nearest friends. It would be simplistic to consider the impact of a loss without paying attention to the multiple consequences and implications of such an event (De Leo, 2010a).

Psychological reflections on loss and on issues related to the affective state of mourning characterize many perspectives, both interpretive and theoretical. We owe to Sigmund Freud the conceptualization of grief as a constant experience of our lives that occurs whenever we suffer a loss. This consideration of mourning was used by Freud to explain the depressive phenomena linked both to the loss of a beloved person and to that of a significant internal object, meaning by this the internalized image of another human being.

With *Mourning and Melancholia* (Freud, 1915/1976), psychoanalytic theory began to put in close relation melancholia (depression) and mourning, considering the latter as a psychic condition. The bereaved person is forced to suffer the detachment from an object on which he/she has made “libidinal” investments: Libidinal energy is withdrawn from the lost object and reinvested in the ego until the mourning is resolved, making this energy available for new investment. This process can bring to an end the “work of mourning.”

For Freud, the libidinal disinvestment could take a long time; it is difficult to say which aspects are to be disinvested first and whether the entire process follows a specific sequence. An important aspect of Freud’s elaborations on the bereavement process regards the repression of aggressive feelings toward the deceased. In fact, the presence of these
implies that a certain part of the work of mourning is accomplished at an unconscious level, with the failed (or incomplete) recognition/acceptance of the suffered loss.

Even if libidinal energies are being withdrawn from the lost object, the ego ends up identifying with it. Thus anger and resentment are directed toward the self with the “advantage” that this self-punishing mechanism avoids the expression of open hostility toward the person who died. According to Freud, then, when there are ambivalent feelings of both love and hostility, the process of mourning can be much more difficult and “abnormal” (Freud, 1915/1976).

Melanie Klein (1940) assumed that the condition of mourning involves the temporary regression to early stages of development, with the consequent danger of collapse and disintegration of the inner world of those who have suffered the loss. The emotional development of every child goes through the integration of libidinal and aggressive drives connected to the pleasant and frustrating features of the objects, which – by virtue of this merger – become *total*. This process is accompanied by the anguish of loss of *partial objects* (previous libidinal investments), thereby leading to the emergence of feelings of sadness and guilt. Every process of mourning in adulthood would be the reissue of feelings experienced during the psychic life of childhood in relation to separations from significant figures. In Klein’s view, the elaboration of mourning thus coincides with a reconstruction of the inner world, only possible if the subject in early infancy has been able to consolidate the relationship with their good objects.

Again from the psychoanalytical perspective, Erich Lindemann (1944) was perhaps the first to provide important insights into unexpected and traumatic grief, basing them primarily on observations performed on family members of soldiers who died in the Second World War, and on the victims of a fire that erupted in a night club in Boston, Massachusetts—the Cocoanut Grove. His work anticipates many of the concepts that are now part of posttraumatic stress disorder. In fact, he identifies five main elements in reaction to a violent and unexpected bereavement: somatic disorders, concerns with the image of the deceased person, feelings of guilt, hostility, and disorganized behavior. There are two types of reactions to traumatic grief: a “delayed” form, potentially lasting for several years, and a “distorted” one, characterized by social withdrawal, psychosomatic disorders, hypochondriac elaborations, and manic hyperactivity. For Lindemann, mourning involves the verbalization of experienced guilt and the management of feelings of fear and hostility, and passes through
the emancipation of the relationship with the lost object, the readjustment to the environment, and the formation of new relationships.

In the psychological analysis of mourning, a vital contribution was made by Bowlby (1969, 1973, 1980) and his assumption of an ambivalent relationship between attachment and loss. According to the author of the attachment theory, childhood experiences of relationships influence the style of personality and relationship in adulthood. The way people deal with separation and loss of a loved one is then related to patterns of internalized relationships with each other. In the third volume of Attachment and Loss, entitled Loss, Sadness and Depression (Bowlby, 1980), Bowlby focuses on the psychopathological consequences of mourning, taking into consideration the many forms of developmental blocks and regressions that the individual may experience after a significant loss. The author stresses that, to overcome the consequences that the loss brings with it, subjects face lengthy and complex dynamics and intricate intrapsychic and interpersonal processes. For Bowlby, grief is essentially similar to separation anxiety. He considers mourning as the forced separation from an attachment figure, which is followed by a period of protest and then a longer period of research of the missing figure (analogous to animal behavior). After some time, these reactions cease, since they are not effective in allowing the reunion with the attachment figure. The individual then enters a phase of despair and depression, followed by the reorganization phase, characterized by the restoring/restructuring of one’s own life condition. The “internal” presence of the deceased can be comforting and facilitate this reorganization (Cleiren, 1991).

The family systemic and relational symbolic approach considers mourning as an event that can only be analyzed in the interpersonal context in which it takes place. To understand the reaction to the situation of the bereaving individuals, we must consider the resources, history, relations, and dynamics of the family to which they belong (Andolfi & D’Elia, 2007).

Within the systemic approach, the concept of the family constellations of Bert Hellinger should be mentioned (Hellinger, 2003). According to this recent (and somewhat controversial) perspective, our lives are conditioned by fates and feelings that are not only ours but are also part (and a consequence) of the lives of our ancestors. So it seems that we continue to act within an archaic structure, blind and unconscious, under the charge of cohesion and belonging to the family system. Therefore, if a family member has taken their own life, a member of succeeding generations – someone who knows nothing about this predecessor – will
bring upon himself/herself this fate and will eventually follow that tragic destiny. So, according to Hellinger, serious illness, death wishes, and problems at work may result from systemic family tangles that can be brought to light through the reconstruction of the "constellations."

In the cognitive behavior approach, the central role is played by thoughts and beliefs of the person: The same event can trigger different emotional and behavioral responses, depending upon the significance individuals assign to it. For example, the emotional response to the death of a loved one might be, at any given time, sadness, if the predominant thought is to have suffered an irreparable loss, or anger, if we believe that we have suffered a gross injustice.

The cognitivist Guidano (1987) states that loss and grief can represent an interruption of the sense of self as perceived by the subject; therefore, mourning can end only when the subject has become able to reorganize their sense of self. In this perspective, importance is given to the analysis of changes in the vision of the self, others, and the future, as a result of the loss.

Several other authors have made important contributions to our understanding of bereavement, based on cognitive principles (e.g., Marris, 1974; Parkes, 1970, 1987) or on more purely behavioral or sociobiological ones – for example, Littlefield and Rushton’s study (1986) on the biological “value” of the deceased is of considerable interest.

In general, however, from the 1980s onwards the contributions to the scientific model of stress have focused on clinical-theoretical constructs mainly related to the stress of separation. According to these studies, the loss of a loved one may be followed by dysfunctional thoughts and beliefs (e.g., conviction of one’s own guilt), with these ideas also leading to emotional disorders, both acute and chronic (e.g., depression), as well as to inappropriate coping strategies in dealing with the stress and the changes that mourning entails (Sgarro, 2008).

**Some Key Terms**

Before going deeper into the central themes of mourning, it is appropriate to clarify some aspects of our terminology. In many articles, we find that the term bereavement indicates the loss of a loved one and the state of mourning that follows; however, many authors use the term grief interchangeably, which certainly identifies the same concept but, in par-
ticular, focuses on its reactive aspects (the lowering of mood and changes in behavior following the loss).

Some confusion may also arise from the distinction between the terms *survivors* and *bereaved*, since they are also often used interchangeably. *Survivor* is used to designate those individuals who are left behind after the traumatic death (e.g., a death due to suicide) of a loved one. As mentioned above, *bereaved* refers to the mourner, and is a term applied in the context of any cause of death, including a natural cause (e.g., stroke or cancer). *Survivor* is a term used especially in American contexts, while the second – *bereaved* – is more commonly used in countries of the British Commonwealth (the United Kingdom, Australia, New Zealand, South Africa, etc.). Although in this book the terms *survivor* and *bereaved* are often used interchangeably, we prefer to use the term *bereaved* for someone who lost a loved one. We tend to consider those as *survivors* who have remained alive after a natural disaster or a catastrophic event, e.g., people who have been in a tsunami, mass shooting, earthquake, accident, etc. Of course one may be both a bereaved person as well as a survivor (e.g., someone who has been in a tsunami and lost a close person).

*Suicide survivor* is also an expression that can have different meanings: Used as just mentioned, it indicates those who are left in the world after a “dear and near” one has died by suicide, but *suicide survivors* are also those who have made a suicide attempt that did not lead to death (De Leo, Bertolote, & Lester, 2002). In this book, *suicide survivors* is used to refer to those “left behind” after a death due to suicide. We will never use this term to refer to those who made a suicide attempt.

**“Normal” Mourning**

**The Stages of Mourning in Various Theories**

The reactions following the death of a loved one can be very intense and powerful; people may feel anxious, lonely, and confused. Feelings and reactions difficult to understand and communicate to the other may easily arise: disbelief, shock, anger, fear, and guilt. Like a wound that needs time to heal, mourning is a painful experience of separation that takes time and effort to gradually find a different balance and a new meaning in life.

To better understand the pain of people who have suffered a loss, in recent years several scholars have questioned the effects of grief and
the factors that facilitate or hinder its elaboration and acceptance. In the course of months or years, many of the bereaved are able to give meaning to the experience of mourning, integrating it into their life history (Barry, Kasl, & Prigerson, 2001; Latham & Prigerson, 2004; Prigerson, 2005). However, at least at the beginning, the “normal” pain that results from the loss of a loved one is accompanied by feelings of disbelief and unreality and various manifestations of physical and mental discomfort.

Over the years, theories of mourning (Bowlby, 1963; Bowlby & Parkes, 1970; Kübler-Ross, 1969) have described the different stages of its development and, although they have never been tested empirically (Prigerson, Shear, Jacobs, Reynolds, Maciejewski, & Davidson, 1999) they have gained wide acceptance anyway, eventually being generalized to various situations of loss. Denial, disbelief and shock, anger, depressed mood, despair, and finally acceptance, represent steps that, although varying with different individual paces and sequencing, happen more or less in all persons.

Some authors (Bowlby, 1980; Engel, 1962; Parkes, 1970) have described the steps by which the person moves into the difficult process of mourning thus:

- The *stage of shock* (intense despair, denial, rejection, and anger). This may take a few moments or a few days;
- The *stage of desire and search* for the lost person, which can last months or even years;
- The *stage of disorganization and despair*, in which the reality of the loss begins to consolidate, and the survivor finds it hard to live in a habitual environment, becomes apathetic, indifferent, and unmotivated;
- The *stage of the reorganization*, in which the most painful aspects of grief begin to subside, and the individual feels the sensation of returning to life again.

Mourning thus provides a series of steps that, if properly completed, may lead to the reestablishment of a balance and the cessation of the experience of intense pain (Scocco, Frasson, Costacurta, Donà, & Pavan, 2004).

According to Worden (1991), the bereaved person should attempt to fulfill some tasks to accelerate the recovery process:

1. Accept the reality of the loss;
2. Work on their pain;
3. Limit the presence in the environment of objects that remind them of the deceased;
4. Disinvest the relationship with the deceased in favor of other relationships.

From her experience with terminally ill patients, Elisabeth Kübler-Ross wrote *On Death and Dying*, published in 1969, in which she described five different types of reaction to a fatal outcome (cancer related): *denial, anger, bargaining, depression, and acceptance*. This five-step model is a tool that enables an understanding of the most frequent mental dynamics of the person who has been diagnosed with a terminal illness, but psychologists mostly have found that the same model is also applicable in the mourning process. It should be noted that this is a *phase* and not a *stage* model; this means that the phases can also alternate, or re-present several times during the bereavement process, with different intensity and without a precise order; this is because emotions do not follow special rules.

*Phase of Denial or Refusal:* “It is not possible” and “I cannot believe it is happening” are the most frequent phrases voiced when faced with a diagnosis of terminal illness, or at the news that a loved one has died. This phase is characterized by denial; in other words, a “primitive” defense mechanism capable of altering the reality test. This type of defense, usually characteristic of pathological dynamics (psychotic), can be appropriate and functional when facing the communication of a diagnosis of terminal illness or a death, as it protects the person from excessive anxiety and allows them to take time in considering the tragic events while getting organized.

*Phase of Anger:* After the denial, strong emotions begin to manifest; these are mainly anger and fear, and they are able to explode in all directions, directed toward the family, the hospital staff, and God. The phrase most frequently used is: “Why to me?” This phase represents a very sensitive moment in the reaction to the knowledge of a terminal condition or for the person who is forced to face the reality of bereavement. It represents an extremely critical time, which can constitute both the moment of greatest need of help and also the time of rejection and withdraw.

*Phase of Bargaining or Plea Bargaining:* In this phase, the person begins to see what they can actually do, and how the project may involve new hope, starting a kind of negotiation, which – according to personal values – can be established with both the people who constitute the social network of the subject, and with religious figures. At this stage, persons begin to regain control of their lives, trying to repair the repairable.
Phase of Depression: This phase occurs when the subject begins to be aware of the loss or, for the terminally ill patient, when the disease progresses and the level of suffering increases. Depression, in this phase, is divided into two types: reactive and preparatory. Reactive depression is due to the awareness of the aspects of one’s own identity, body image, decision making, and social relations that have been lost. Preparatory depression expresses rather the anticipation of losses that are happening or close to happening, or – in case of bereaved people – it manifests itself as the fear of further losses.

Phase of Acceptance: The subject is able to understand and elaborate what is happening or what has happened, and finally becomes fully aware and accepts the reality. During this phase, anger and depression may always be present, though of generally decreased intensity.

Myths About Grieving

As highlighted by the examples above, for decades well-known authors and theorists have written that the process of bereavement follows certain steps, and it is a generally accepted opinion that this is a fact (Parkes, 1998). The reality is that the available studies do not confirm the existence of different phases and that theories on the phases of grief are not actually supported by scientific research (Dyregrov & Dyregrov, 2008). If it is true that most mourners may experience an initial collapse, a phase of shock, a phase of reaction, and a phase of reorientation, this is not necessarily proven in all cases. That the process of mourning should be characterized by well-defined sequences, where emotions follow in a particular pattern, is far from being proven scientifically, but it continues to be a kind of rather passively accepted myth. In reality, there is no one way of crying, as there is no “correct” way of experiencing grief. Each individual must find their own way and at their own pace.

Another false myth is the belief that everyone has to go through the grieving process. In many people, professionals or not, there is the idea that to end the bereavement process, the “work of mourning” is necessary. The work of mourning means going through an emotional process in which people are confronted with the reality of loss, review all the events preceding and following the loss, focus on the memories of the person who has been lost, and gradually reach (complete) detachment...