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# BEREAVEMENT AFTER A TRAUMATIC LOSS: EXPERIENCES, NEEDS AND PRACTICAL APPLICATIONS OF ONLINE SUPPORT

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**Coordinatore:** Ch.ma Prof.ssa Anna Spagnolli

**Supervisore**: Ch.ma Prof.ssa Sabrina Cipolletta

**Co-Supervisore**: Ch.ma Prof.ssa Ombretta Gaggi

**Co-Supervisore esterno**: Ch.mo Prof. Diego De Leo

**Dottoranda**: Dott.ssa Lorenza Entilli

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**Abstract**

The way of providing psychological support is changing, fast approaching the advantages provided by digitalization, particularly in light of the recent global upheavals. Also bereavement support is dealing with the implementation of different ways of reaching grieving people, and mental health professionals must investigate the possibilities offered by telematic tools, as well as the limits that online communication entails, especially for this specific population. The aim of the present study is to identify the practical implications, strengths, and limitations of the use of online bereavement support tools. In order to accomplish this aim, three studies were conducted and two specific bereavement experiences have been investigated: suicide losses and COVID-19 losses.

Study 1 explored cross-sectionally the psychological state and perceived social support of Italian suicide survivors, and investigated differences in gender, kinship, help-seeking behavior, employing a rule-based system (RBS) analysis, an inference engine system able to identify implications among a set of variables. One-hundred and thirty-two (103 females and 29 males) suicide survivors answered an anonymous online survey. RBS analysis identified different help-seeking behaviors: survivors experiencing low level of social support may avoid going to a psychologist and resolve to GPs, look for advice in online forums and rely on people out of their narrower informal network such as coworkers. These unique study's results offer insight to identify which specific areas would be fruitful to investigate while assessing social support in bereaved individuals.

In Study 2, a thematic qualitative analysis was carried out on 30 live-chat transcripts of written conversations between anonymous suicide survivors and a trained operator from a major Italian association providing online bereavement support. Five themes were identified to understand live-chat users' experience with the service and their specific needs: meaning-making, reactions to the loss, resources, needs, and interactions with the operator. Suicide survivors showed to use the live-chat as a safe space in which to disclose nonsocially desirable details (included suicidal ideation) and to make sense of suicide through the reconstruction of events and the deceased's motivations.

Study 3 explored qualitatively the bereavement experiences of twenty-five (23 females and 2 males) Italian family members who have lost a significant other to COVID-19 writing on a dedicated online support group. Thematic analysis of the posts showed five themes: group's uses

to respond to needs, shared crisis narrative, responses to grief, retelling narrative of death, and the context of the mourning process. Users were aware of the existence of the research and were also directly asked what they found particularly useful about the group. Participants used the group not only for memorialization purposes but also to share their loss experience and to find a community of other grievers equally shocked by the apparent unjustness of the death of their loved ones. The findings of this research might provide useful avenues for future research in order to fully capture the experience and consequences of Italian mourners' uses of online tools.

# CHAPTER 1

## Introduction

Losing a loved one can be a shattering, deeply significant experience, bearing a drastic life-changing impact for those who remain behind. Death is, in fact, an experience that all human beings are bound to endure at some point in their life, thus a topic of great philosophical and existential importance. Although individuals might never be ready to leave their loved ones behind, some deaths may be more unexpected and surprising than others; this is the case of violent or traumatic deaths as opposed to natural ones (De Leo et al., 2020; Merlevede et al., 2004).

A person grieving for a traumatic loss is typically referred to as *survivor* (Cerel et al., 2013) and literature suggests they face additional obstacles in their grieving process: difficulties to make sense of the loss, guilt, social withdrawal, higher family conflict, and consequent risk for continuing difficulties such as depression and posttraumatic stress disorder (PTSD) (Cvinar, 2005; Gillies & Neimeyer, 2006; Kaltman & Bonanno, 2003). Among the traumatic losses, suicide has often gained the attention of grief scholars; suicide bereaved have, in fact, been found to receive reduced professional help (Wilson & Marshall, 2010), reduced informal support (Sveen & Walby, 2008), and to have fewer opportunities to talk openly about their grief because of stigmatization (Pitman et al., 2018) as well as being at higher risk of suicidal ideation themselves (Mitchell et al., 2005). For these reasons, postventions (i.e. interventions with the bereaved after the loss has occurred) must be timely to be effective and to limit the risks of isolation and worsening of mental health conditions (Andriessen & Krysinska, 2012).

With the onset of the SARS-CoV- 2 pandemic in 2020, another type of bereavement has also imposed itself in the global scenario, namely COVID-19-related losses. A COVID-19 loss has specific contextual features (e.g., the impossibility to visit the patient at the hospital or to attend the funeral due to the social restrictions imposed to prevent contagion) that might determine its inclusion in the domain of traumatic experiences that are likely to cause grief complications (Carr et al., 2020; Eisma et al., 2021). The study of this new type of loss experience, which has abruptly inserted itself into the lives of many individuals and communities, transforming routines and schedules (including, in a way, this very research), is important to investigate because of the peculiarities it holds, which are new especially in the western context and on such a large scale: one for all, COVID-19 mourners' adaptation to loss

requires the reenvisioning of a meaningful future without the deceased, but takes place in a social context permeated by psychological unconnectedness and uncertainty about the future.

A further drastic effect of the pandemic is that the imposed social distancing forced many individuals in need of psychological support to resolve to telematic tools to get in touch with professionals (Di Carlo et al., 2021). This accelerated leap towards digitalization has generated changes in the offer of services that are likely to remain (Boelen et al., 2020; Garg et al., 2020).

The present study is an investigation of the experiences, needs, and practical applications of the diverse online support tools for mourning individuals. Specifically, the aim of the study is to assess the loss experiences of Italians mourning a traumatic death, their characteristics, and how they reach out for professional and informal support or not.

The present project focuses on the various uses of different digital tools (synchronous/asynchronous and involving the contribution of professionals or peers) to gain an understanding of the limitations and benefits of their uses for bereavement support. Online support could, in fact, reveal resourceful for a population that deals with the fear of stigma surrounding the modalities of the death (Sheenan et al., 2018), or might have difficulties or restrictions leaving their homes or not knowing what support services are available (Ross et al., 2018).

The globalization of communication due to the internet and, subsequently, to social media, has made various dimensions of private life more accessible and exposed to the outside world (Falconer, 2001; Refslund Christensen & Gotved, 2015): it is, therefore, important to consider how communications are mediated by the discourses surrounding the various means of dying (Scourfield et al., 2019). Do mourners disclose different emotions or considerations online than offline? Is there a common pattern in all bereaved persons using different forms of online support tools or are there specificities? Researchers are just beginning to answer some of these questions (Doveling, 2017) and the study of user experiences of mourners with telematic support in the next years will be pivotal.

Researchers will need to engage in the investigation of how lay people, as well as healthcare and public health professionals, engage with digital technologies and offer new insights into the implications of being able to reach another individual by presenting oneself, communicating, and interfacing virtually instead of via face-to-face encounters.

The three studies presented in this research will be inspired by existing basic research on the topic of traumatic bereavement, social support and new technologies and will answer to the following core questions:

- How do mourners use online telematic tools to respond to their needs?

- What are the characteristics, as well as the pros and cons, of asynchronous and synchronous bereavement online support?

- What are innovative methods or technologies for the support of the bereaved? and what could be the broader practical implications?

The present dissertation will critically debate the role, possibilities, and practical implications of online support tools for the provision of psychological support to mourners after a traumatic loss. In **Chapter 2**, the general theory on normal and non-normal bereavement will be introduced, together with an in-depth analysis of suicide losses and COVID-19 losses characteristics. The Italian scenario will also be presented in regards to both types of death. To conclude the chapter, some considerations on social support and its importance for the present topic will be provided. **Chapter 3** will start with a general introduction of the benefits and limitations of the online tools, then present the state of the art on digital tools for the telematic support of bereaved individuals, providing detailed information for the various existing tools and focusing on those of greatest interest to the current study: live chats and online support groups. **Chapters 4**, **5,** and **6** will report the results of **Study 1**, **Study 2,** and **Study 3**, respectively. Study 1 explored cross-sectionally the psychological state and perceived social support of Italian suicide survivors and employed an advanced rule-based system analysis (RBS) to investigate the implications between the perception of social support and help-seeking behavior. Study 2 is a data-driven qualitative analysis carried out on anonymous live-chat written conversations between suicide survivors writing to an operator that is trained to offer both informational support on the available resources and empathic non-judgmental listening, to foster emotion regulation and sense making. Lastly, Study 3 is a qualitative in-depth exploration of the bereavement experiences of Italian family members mourning the loss of a loved one to COVID-19: a dedicated online support group was created for research and support purposes and the exchanges between users and a moderator were collected and analyzed. Additionally, a short questionnaire and direct questions in the group to the users about usability and utility of the group enriched the analysis through the form of triangulation. Finally, in **Chapter 7** the final conclusions of this research will be drawn, with the presentation of a critical review of the results, considerations for future studies, and implications for the application of online tools with individuals bereaved by a traumatic loss.

To achieve the objectives of this research, after an initial quantitative collection of socio-demographic information on the Italian territory for the employment of the RBS analysis (Study 1), the two following studies (Study 2 and 3) focused on a more in-depth, qualitative investigation of the nuances of the online user experience of mourners. Qualitative methods were

deemed useful for the purpose of getting closer to a specific phenomenon (Ambert et al., 1995) and have been demonstrated to be a viable option when validity criteria are respected (Whittemore et al., 2001), as well as extensively used in the branch of bereavement studies (for a relevant review see Gilles & Neimeyer, 2006). Although a potential criticism of self-reported online data is its untrustworthiness (Hookway, 2008) the analysis of qualitative data in the online setting also holds a strength: especially when approaching the sensitive topic of mourning the death of a loved one, users may feel able to express and disclose their emotions more freely (Suler, 2004; Stephen et al., 2014). Moreover, the analysis of online content (e.g., blogs, social media posts) privileges the experience of the participant, as it contains rich, and sometimes 'naturalistic' detail about a phenomenon and its psychosocial ramifications (Garbett et al., 2016, in Prodgers & Gough, 2019, p.3).

The research is carried out with the collaboration of the Department of Mathematics of the University of Padova, which offered valuable practical support in the implementation of the RBS analysis (Study 1), as well as useful insights on the aspects of ergonomics and usability for the implementation of the practical studies (Study 2 and 3). Moreover, the research received the precious support of the De Leo Fund Onlus, an association born in Padova, Italy, in 2007 with the purpose of providing practical and emotional help to traumatic death survivors (either family members or friends) by offering free-of-charge in-person support, both individually or in groups moderated by a psychologist, as well as telematic support through telephone and a live-chat service operated by trained volunteers and psychologists during working hours. As for today, the De Leo Fund Onlus is among the few organizations providing support to survivors on the whole Italian territory with such modalities (https://www.deleofund.org/).

The research obtained ethical consensus from the Ethics Committee of Psychology Research of the University of Padua (one different consensus was obtained for each study) and was supported by a grant from MIUR (Dipartimenti di Eccellenza DM 11/05/2017 n.262) to the Department of General Psychology, University of Padua.

# CHAPTER 2

## Traumatic Bereavement

Death is an intrinsic event of human experience and it is something we all will experience at a certain point in our lives. When the human being is faced with a loss (of any kind, such as the loss of a job or the end of a relationship) she or he is confronted with the realization that that given thing, experience, or person will no longer be present in their life. Death is, then, the most definitive experience of loss of the human experience. When it comes to giving the last farewell to a loved one, be it a family member, a friend, or an acquaintance, we are faced with the existential awareness of the finitude of everything that surrounds us, including our own mortality.

Reactions to a death can be intense, and concern numbness, disbelief, anxiety from the distress of separation, depressed mood, sadness, and lack of interest in re-engaging in the world or forming new relationships (Neimeyer et al., 2010; Stroebe et al., 2007). To describe this series of emotions, the term grief is used: *grief* is defined as the primarily emotional/affective process of reacting to the loss of a loved one through death (Stroebe et al., 2008); therefore, grief could be intended as an individual personal response to loss, which includes a number of emotional, physical, behavioral, cognitive, social, and spiritual dimensions (Buglass, 2010). These grief reactions are now commonly accepted as culturally unique of loss experience and not simply forms of major depression, anxiety, or post-traumatic stress (Bonanno et al., 2007).

In fact, not only grief is cross-culturally specific (Klass, 1999) but it could be affected by personal and context-related differences, including the nature of the death and the circumstances surrounding the loss (Bowlby, 1980; Lobb et al., 2010; Wortman & Boerner, 2011), the kinship between the bereaved and the person who has died (Cleiren et al., 1994; Wortman & Boerner, 2011), the bereaved person's adult attachment style (van der Houwen et al., 2010). All these are considered secondary concurrent stressors (Stroebe & Schut, 2001), and play an important role in the intensity and duration of the bereavement reactions; while, for some, bereavement requires time and slow improvements, others seem to suffer intensely and then return to being able to make plans in their lives in a relatively short period of time (Bonanno, 2001).

As they learn how to adapt to their loss, mourners pass certain milestones: they learn to manage painful emotions and reactions (e.g., when returning or finding themselves in the place linked to the death of the loved person), they understand and accept their grief and restore a sense of purpose while starting re-imagining possibilities for a promising future (e.g., making new long-term

plans without the loved person). Moreover, recent studies have even confuted that one must necessarily experience acute sorrow or anxiety to have a non-pathological bereavement (Hall, 2014). In some cases, grief could also be experienced before the actual death. This reaction, which includes several of the symptoms of grief after a loss, is called anticipatory grief and refers to the cognitive, affective, cultural, and social reactions felt by the family in anticipation of the impending loss of a loved one (Knott, 1986). This eventuality could take place when discussing with families of dying persons, in the context of palliative care, and dying individuals themselves can experience anticipatory grief (Hottensen, 2010).

The final objective of the bereaved individual is to "restore a sense of mattering (i.e., the feeling that one's life is important and makes a significant difference) and belonging (i.e., the feeling that one fits in) in a world without their loved one present (Goveas & Shear, 2020). The process of bereavement, and ultimately of acceptance of the death, however, is not linear (Maciejewski et al., 2007). Sometimes phases of relative calm and routine reconstruction are alternated with periods of distress, which could become worse when closer to major cultural or social holidays or a recurrence (such as the birthday or the anniversary of the loved one's death), as a reaction to reminders of the deceased (Wilson et al., 2021). Some other times, however, the moments of acute distress may occur unexpectedly (Jacobs, 1993).

Despite the variable intensity of grief reactions, most individuals successfully cope with their loss and return to healthy levels of functioning around the second year of bereavement (Bonanno, 2001). However, unexpected and violent deaths have been found to provoke more intense distressful experiences and difficulties in the grieving process than expected ones (Kaltman & Bonanno, 2003).

While all losses might be regarded as traumatic by those who are left behind, *traumatic bereavement* is a specific loss experience and is defined as resulting from a death that occurred in a sudden, violent, or unexpected way, such as in suicides, homicides, and natural disasters (Kristensen et al., 2000). The term traumatic bereavement, in fact, incorporates elements of both trauma and bereavement, indicating the interface between the two and the sensitivity with which it is necessary to provide support to those who live a similar experience (Stroebe et al. 2001).

Traumatic losses happen without warning, hence, the mourners may consider the death of their loved ones as untimely and preventable: mourners may also regard the death, or manner of death, as unfair and unjust, if it was caused by accident, mistake, or by causes that involve someone's indirect responsibility. In some other cases, the death might, instead, be caused by a perpetrator with intent to harm. In both cases, there might be damage to the loved one's body or the belief that the loved one suffered, which is an additional stressor for mourners (Wortman &

Pearlman, 2015). Other deaths typically regarded as traumatic include those in which the mourner witnessed the death or those in which the mourner's own life was threatened, as well as those in which the person mourns more than one death (Barlè, 2017). Also, the context in which the death was notified could have a traumatic impact on the mourners (De Leo et al., 2020; Goveas & Shear, 2020).

In addition to the typical grieving reactions, those bereaving a traumatic death experience yearning to be with the departed, seeking out things or places associated with the deceased, frequent intrusive images of death, dreams, illusions, and even sensory hallucinations of the deceased (Jacobs, 1993). In fact, following a traumatic death, a mourner might experience enduring symptoms of both grief and trauma: symptoms of posttraumatic stress disorder (PTSD), such as flashbacks, sleep difficulties, and concentration problems (Barlè et al., 2017). Such violent, sudden, or perceived as meaningless deaths "can make the world appear dangerous, unpredictable, or unjust to the bereaved" (Neimeyer et al., 2010, p. 74) and pose several challenges to practitioners and grief scholars seeking to understand the intricacies of this type of bereavement.

**Bereavement Models**

A number of theoretically derived models of grief have been proposed in the decades. Most models hypothesize a normal grief process as opposed to various types of grief complications. The most renowned, Kubler-Ross's model, organized grief-related symptoms into phases, suggesting that grief is a process marked by a series of stages with predominant characteristics (Kubler-Ross, 1969). Kubler-Ross model identifies five stages: denial, anger, bargaining, depression, and acceptance. However, this model was considered to have limited empirical support, and few individuals are actually expected to pass through the stages in the expected order (Archer, 1999; Corr, 1993; Stroebe et al., 2001b). The model was later reconceptualized from *stages* of grief to *domains* of grief, to stress the possibility to move back and forth among the domains without a predefined path or progression (that was instead suggested by the term *stages*) (Kübler-Ross & Kessle, 2005).

Based on Kubler-Ross' theories, Jacobs (1993) proposed a synthesis of the model which still involved stages, although in a broader sense: the normal response to loss progresses through numbness-disbelief, separation distress (yearning, anger, anxiety), disorganization-despair, and, lastly, reorganization or recovery. To highlight the differentiation with Kubler-Ross' model, Jacobs specifies that the idea of grief unfolding through regular phases is an oversimplification of the more complex personal emotional process that accompanies grief (Jacobs 1993). This four-stage model

has found some empirical support (Maciejewski et al., 2007), however, such conceptualization of the bereavement process in stages (either fixated or flexible) has received several critiques (Holland & Neimeyer, 2010): authors claim that it creates expectations about how grief is supposed to proceed, diminishing the highly subjective nature of grief experience, and therefore suggesting ideas about pathological and non-pathological grief (Neimeyer, 1998).

Moreover, the expectation that bereavement will exclusively entail sorrow and pain determined an overlooking of the role of positive emotions following a loss (Hagman, 2001), when not directly being interpreted as indicative of an incomplete processing of the death (Deutsch, 1937; Sanders, 1993). In fact, authors suggest that positive emotions are not only present during bereavement (Folkman, 1997a, 2001; Folkman & Moscowitz, 2000) but represent an important resource in resolving grief (Keltner & Bonnano, 1997). Thus in addition to the risk of pathologizing individuals' responses to grief, stage models may also fail to recognize other important aspects of grief that may facilitate the mourning process (Neimeyer, 2010). Lastly, stage models are also criticized for relegating the individual to a passive role in their own bereavement journey (Neimeyer, 1998).

Other bereavement conceptualizations, instead, require mourners to actively complete tasks rather than pass through stages (Worden, 1996). These tasks are four in total and include:

1. Accepting the reality of the loss.
2. Processing the pain of grief.
3. Adjusting to an environment in which the deceased is missing
4. Finding an enduring connection with the deceased while continuing to engage in new relationships.

In Worden's model, the tasks may occur in any order without a fixed progression; however, for successful mourning to occur, the person must be able to achieve all four tasks (Worden, 1996). This model was also not exempt from subsequent changes. In fact, originally, the fourth task of the model concerned "withdrawing emotional energy and reinvesting in another relationship" (Worden, 1982), and was only later modified to reflect the important paradigm shift concerning the importance of maintaining a bond with the deceased (Davies, 2004).

Other researchers focused their grief models on meaning reconstruction. For example, Bowlby (1980) suggested that 'instinctive affectional bonds' (or 'attachments') are formed between child and caregiver in the early months of life as an adaptive response to the need for safety and security, and argued that the nature of one's earliest attachments predicts how one would react to

the loss. According to this model, the relationship between child and caregiver has a major impact on the development of each individual's particular attachment 'style' which will influence how she or he will shape their future emotional relationships. Individuals mourning the loss of a close person react to the separation (or threat of separation), whether temporary or permanent, from a security-enhancing attachment figure (Bowlby, 1980). Mourners with secure attachment styles would be least likely to experience complicated grief, while those with either insecure styles or anxious-ambivalent styles would be most likely to experience negative outcomes (Shear, 2005). Bowlby's model, then, also stresses the nature of the relationship with the deceased is a significant factor in the impact of the loss (Bowlby, 1980; Parkes & Weiss, 1983). Lastly, although the first conceptualizations of grief suggested that working through grief required "an initial attempt to maintain the attachment with the loved one, followed by a gradual withdrawal of emotional energy from the deceased" (Gilles & Neimeyer, 2006, p. 33), contemporary scholars now agree on the importance of a continued relationship with the departed (Bowlby, 1980; Klass et al., 2014).

Later on, cognitive information processing models have influenced new grief models: according to these models, the problems arising in coping with the loss are bound to the difficulty to resolve conflicting information (Horowitz, 1976). For example, as for the "Shattered World Assumptions Theory", sudden, traumatic events can shatter the individual's assumption of safety in the world, leading to feelings of unpredictability, impending danger, and general unjustness of life (Janoff-Bulman, 1992). The traumatic loss hacks the meaning and coherence of the mourner, who needs to modify old schemes and re-build new cognitive perspectives incorporating the loss in order to begin to re-establish a meaningful life (Janoff-Bulman, 1998).

In the Dual Process Model, Stroebe and Schut, (2007) stress, instead, the importance of understanding mourners' specific cognitions, what meanings they attach to their loss, and how these change over time to enable coming to terms with it. Specifically, this model addresses the cognitive processes of confrontation and avoidance, proposing two processes for optimal bereavement adaptation: 'loss orientation' (focusing on the loss itself) and 'restoration orientation' (the responses involved in adjusting to daily life and developing a new identity). The former could refer to the mourners' appraising and processing of some aspects of the loss experience itself, such as the relocation of bonds with the deceased, while the latter refers to the focus on secondary stressors that are consequences of bereavement, that could be distracting from the grief work or, ultimately, the rethinking and replanning of one's life in the face of the loss (Stroebe & Shut, 2010). An individual can only be involved in one of the processes at a time but both are necessary; moreover, although restoration processes generally replenish hope and energy, both require effort and can trigger anxiety in the bereaved.

Finally, contemporary grief theorists (Attig, 2001; Klass et al., 2014; Gillies & Neimeyer, 2006), suggest that successful adaptation to loss requires a process of finding, creating, or reconstructing meaning that has been challenged by the death of the loved one (Neimeyer et al., 2010). Among these, Constructivism adopts a postmodern approach to psychology and focuses on individuals' need to impose meaning on their life experiences (Neimeyer 2009). According to this model, unexpected and traumatic losses challenge individuals' sense of narrative coherence and identity (Neimeyer 1998), which support their whole assumptive world (Janoff-Bulman, 1992), thus undermining mourners' broader sense of meaning and coherence (Niemeyer et al., 2006a). The goal of grief work is, therefore, the reconstruction of a coherent self-narrative that is able to integrate the traumatic event (in this case, the continuation of life without the departed).

Drawing from the existing bereavement models, Gillies and Neimeyer (2006) outlined the three major activities by which mourners facing the loss of a close person engage in to reconstruct meaning in response to their loss: a) sense making, b) benefit finding, and c) identity change (Neimeyer, 2001; Neimeyer & Anderson, 2002):

a) Sense making:

   Cognitive and trauma theories (Folkman, 2001; see Gillies and Neimeyer 2006 for a review; Janoff-Bulman, 1992), suggest that the most difficult losses to elaborate are those that fail to make sense: a violent loss makes salient the unpredictability and illogicality of life itself, and leaves the mourners with existential answers that might remain unanswered about why this has happened to them (Davis & Nolen-Hoeksema, 2001). An experience often found in this type of population is the inability to make sense of the loss. A research by Currier, and colleagues (2006) on over 1,700 bereaved adults observed how the inability to make sense of the loss was the most significant factor reported by individuals mourning a traumatic death as opposed to those mourning a nonviolent loss, outweighing in importance even complicated grief symptomatology. Constructivist theories propose that the process by which bereaved individuals question, find, and make sense of their bereavement is central to the experience of grief and sense-making should be fostered in mourners (Neimeyer, 2000). In a study with bereaved individuals by suicide, Barth (2008) explored how suicide bereaved attempted to create meaning for their loss in a variety of ways, although most were unable to validate the meanings they found: the prevalent ways of meaning making were the creation of a loss narrative, an ongoing connection to the deceased, and a reframing of their own meaning structures.

b) Benefit finding:

Coping theories had already highlighted the importance of finding benefits in a challenging experience (Folkman, 1997; Janoff-Bulman, 1992; Taylor, 1983). The ability to find a so-called silver lining can help to buffer grief (Davis et al., 1998; Maercker et al., 1998): Davis and Nolen-Hoeksema (2001) found that the ability to discover or relinquish a positive meaning to the loss has a continuative effect in the adjustment course of the bereavement: the individuals who are able to articulate beneficial aspects of their loss experience show declines in their levels of distress, while their counterparts who do not have the ability to find positive meaning in their loss report increasing psychological distress. However, Neimeyer and Anderson (2002) caution that in bereavement benefits might not be seen soon after the death but instead arrive months or even years later, and that it is deeply linked to personal and social resources.

c) Identity change:

The last dimension identified by Gillies and Neimeyer is identity change. Informed by the Dual Processing Model of Stroebe and Shut (1999), constructionist authors concur that by reconstructing meaning in their lives in response to a loss, mourners necessarily reconstruct themselves. People who experience such growth report developing a changed sense of self: more resilience, confidence, empathy toward others and an increased awareness of life's fragility; sometimes this change also entails the adoption of a brand new role (e.g., in the family structure or in their social relationships) (Gillies & Neimeyer, 2006). Moreover, mourners could go through a spiritual or existential growth (Tedeschi et al., 1998) and spirituality is often considered positive for coping with loss (Wortmann & Park, 2008): mourners might take solace in the belief that their loved one is in a better place, stopped suffering or that they will be eventually reunited with the loved one (Barlè et al., 2017). In a qualitative examination of the spiritual experiences of suicide mourners (Jahn & Spencer-Thomas, 2018), spiritual experiences such as a sense of presence of the departed showed to have held deep meaning and to be often regarded as a positive source of healing and transformation. However, it is also common for mourners to experience negative (Jahn & Spencer-Thomas, 2014), or to even question their faith, sometimes abandoning it altogether (Wilson & Moran, 1998).

The transformation required for optimal bereavement processing, although not always present in all bereaved individuals, has been defined as post-traumatic growth. The literature

suggests that personal growth in bereaved individuals can be found in the first year after the loss and then after an initial drop observed again and more consistently several years later (Feigelman et al., 2009). In a longitudinal study (Kolves et al., 2020; Entilli et al., 2021) bereaved parents at 24 months since their loss were observed to experience a notable acceleration, compared to the previous observations at 6 and 12 months, in personal growth, especially regarding self-care, (although not for all) but also a clearer differentiation between those who were making progress and those who were having major difficulties making sense of their loss. In fact, although parents showed an improvement in their sense-making strategies at 24 months, only a few parents appeared to have arrived at a personal growth, and this might have been aided by higher resilience or a natural tendency towards positive thinking (Entilli et al., 2021).

All the above mentioned models seem to only offer a partial contribution to the creation of a much larger, and yet-unrealized, integrative model of grieving (Bonanno & Kaltman, 1999). Overall, in the last decade, it has started to grow recognition of the need for finding meaning following traumatic bereavement (McIntosh et al., 1993; Murphy et al., 2003). This could also include a broader reorganization of meaning, such as an existential one, defined as a sense of emotional investment in life which is thought to be outside our usual awareness (Davis, 2010).

**Complicated Grief and Prolonged Grief Disorder**

Because there is a significant overlap between the behavioral manifestations associated with the grieving process and symptoms of depression (i.e., insomnia, ruminations, and lack of motivation), the bereavement literature has shown little consensus on a clear and empirically defensible definition of normal and complicated grief reactions (Bonanno, 2001).

Complicated grief differs from normal grief, not in terms of the nature of the grief reaction, but in terms of the amount of distress and impact on daily life caused by the persistence, and pervasiveness of the reactions (Prigerson et al., 2009); in fact, in complicated grief, the progress of adapting and accepting the finality of the loss is more elaborated and slower (Simon 2013). Mourners experiencing grief complications fail to integrate the factuality of the loss into the pre-existing cognitive structures or expectations around the world, while maintaining distorted evaluations on their grieving process (de Groot et al., 2007; Malkinson, 2001; Shear et al., 2015) and previous research estimated that between 10% and 20% of grieved people are affected by CG (Complicated Grief) (Miller, 2012). Horowitz and colleagues (1990) established the first operational diagnostic criteria for CG: the current experience (at more than a year after a loss) of intense intrusive thoughts, severe pangs of emotion (that is, intense, time-limited grief bursts of

distress), unusual sleep disturbances, distressing yearnings, feeling excessively alone and empty, denial of implications of the loss to the self, excessively avoiding tasks reminiscent of the deceased and maladaptive levels of loss of interest in personal activities (Horowitz, 1990).

Later on, new diagnostic criteria labeled 'prolonged grief' were developed by Prigerson and colleagues (2006) with the aim of distinguishing between the core symptoms of CG and other trauma-related disorders. According to the criteria, the diagnosis should not be made until at least 6 months have elapsed since the death (Kristjanson et al., 2006; Maercker et al., 2012). More recently, Shear and colleagues (2011) slightly modified and updated the criteria, based on their diagnostic experience: persistent intense yearning or longing for the loss, suicidal thinking and behaviors, and rumination about circumstances or consequences of the death were evaluated as main symptoms for the diagnosis, with the persistence of symptoms at least 6 months after the death.

Currently, there is no differential diagnostic category in the fifth edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-5), for the CG, which instead includes criteria for its diagnosis in the section on 'Disorders Requiring Further Study' under the name of 'persistent complex bereavement disorder' (PCBD) (Enez, 2018). Similarly, the World Health Organization's International Classification of Diseases-11th Revision (ICD-11) does not officially recognize CG as a mental disorder but instead adopted a diagnosis termed prolonged grief disorder (PGD), conceptualized by Prigerson and colleagues (Prigerson et al., 2009). PGD is defined as persistent and severe yearning for the deceased, difficulty in engaging with social activities due to the loss, feeling of loss as a part of oneself, difficulty accepting the death, and anger, guilt or blame regarding the death.

Overall, CG symptoms have been found to be different from the ones of Post-Traumatic Stress Disorder (PTSD): for example, the primary emotional state in CG is sadness, while it is rather fear and horror in PTSD (Bryant, 2012; Shear et al., 2016); similarly, while yearning and seeking proximity to the deceased are often encountered in CG, these are usually not observed in Major Depressive Disorder, which is often diagnosed following a loss (Enez, 2018). Therefore, not only complicated grief, PTSD and MDD are not considered to share the same symptoms (Boelen, 2013; Stroebe et al., 2013; Zisook et al., 2014), but a conceptual difference has also been found between CG and PGD (Maciejewski et al., 2016).

Therefore, although there is not yet a consensus about the exact set of diagnostic criteria, authors concur that losing a close person to a traumatic and violent loss might entail major difficulties accepting the death and have consequent implications on mental and physical health. Research has found that in most cases, the symptoms associated with traumatic loss are

significantly more intense, pervasive and prolonged than those following a natural death, affecting virtually all aspects of the mourner's life. A longitudinal quantitative study (Murphy et al., 2002) found that five years after the death, a majority of mothers and fathers were still experiencing significant mental distress and PTSD symptoms. Further problems in accepting death may arise, then, if the person's willingness to die is thought or established.

**Suicide Bereavement**

The above-mentioned drastic life-changing impact on individuals remaining behind after a loss is especially present if the death is due to suicide (Sands & Tennant, 2010). A person bereaving due to the suicide of a close person or relative (either a family member, relative, friend, acquaintance, or colleague) (Cerel et al., 2014; Jordan & McIntosh, 2011), is generally called a suicide *survivor* (Cerel et al., 2013). The extension of this population was once estimated to be of six for every suicide (Shneidman, 1969). However, this conceptualization was strongly linked to the expectation that a grieving survivor would be biologically related to the person (Berman, 2011).

Jordan and McIntosh suggested a broader definition: a suicide survivor is "someone who experiences a high level of self-perceived psychological, physical, and/or social distress for a considerable length of time after exposure to the suicide of another person" (Jordan & McIntosh, 2011, p. 7). Additionally, Andriessen (2009) suggested that a survivor could be regarded as "a person who has lost a significant other (or a loved one) by suicide, and whose life is changed because of the loss" (p. 43). Moreover, Cerel and colleagues (2014) outline an important difference between a person who has been *exposed* to suicide and one that has been *affected* by that loss, thus associating the word *survivor* only to the long-term experience of distress related to the loss. A Recent study (Cerel et al., 2019) carried out in the United States on a single-state random-digit dial survey estimated that 135 people are exposed to a suicide death. Although there is no current empirical knowledge to predict who among the *exposed* ones will ultimately become a *survivor*, such differentiation can be useful to differentiate the intervention policies by identifying different sub-groups and their specific needs (Cerel et al., 2014).

These definitions expanded the spectrum by including also friends and colleagues in the range of possible survivors (Andriessen, 2012), and allowed researchers and mental health professionals to verify that, in the occasion of a person taking his or her life, the impact has an extended resonance that is not limited to the family but reaches a broader social contest (Berman, 2011). Recent literature findings suggest that the number of people affected by each suicide is more likely to be closer to 80 (Berman, 2011). Moreover, a recent meta-analysis of population-based studies investigating exposure to suicide, estimated that approximately one in 20 people (4.3%) are

impacted by a suicide in any 1 year, 21.8% during their lifetime (Andriessen et al., 2017b).

Suicide deaths are also strongly influenced by the culture and social context they belong to. In the majority of western countries, some striking gender differences have been observed, with the rate of suicide attempts being significantly higher in females, and the rate of death by suicide being higher in males (Wasserman et al., 2005). There is, in fact, substantial variability in suicide rates between and within countries, for example, by sex, age, and ethnicity (World Health Organization, 2014), with some countries experiencing low suicide rates and others being challenged with extremely high ones (World Health Organization, 2021). Nonetheless, suicide is considered a major public health issue. The global mortality rate is estimated to be 10.5 per 100 000, that is more than 700 000 yearly, one death every 40 seconds (World Health Organization, 2019). Suicide does not just occur in high-income countries but it is a global phenomenon involving all regions of the world. In fact, over 77% of global suicides occurred in low- and middle-income countries in 2019 (World Health Organization, 2019), and chronic poverty and acute economic events are considered important risk factors (Iemmi et al., 2016).

Literature has been divided on suicide survivors' reactions to the death of their loved ones. Some authors concluded that there is no empirical evidence that suicide survivors show more pathological reactions and grief complications than other mourners (Bolton et al., 2013; Erlangsen & Pitman, 2017; Miers et al., 2012; Sugrue et al., 2014; Supiano et al., 2012) and pointed out the higher number of similarities than differences within the two groups (McIntosh, 1993): like other deaths involving losing kin in war, natural disasters, and accidents, losing a close person to suicide survivors might facilitate the insurgence of post-traumatic stress symptoms: shock, numbness, re-examining the event, avoiding stimuli associated with the event, numbing of general responsiveness and/or increased arousal symptoms and difficulties on emotional, cognitive, and physical levels (Feigelman et al., 2018; Mitchell et al., 2004; Sveen & Walby, 2008).

On the other hand, other researchers claimed suicide survivors' reactions might be approached differently than for other bereaved groups (Ellenbogen & Gratton, 2001; Ness & Pfeffer, 1990). In a systematic review of controlled studies (Sveen & Walby, 2008), no significant difference between suicide survivors and other deaths survivors (including PTSD, mental health, depression, anxiety, and suicidal behavior) have been identified; however, when specific aspects of suicide bereavement were considered, the suicide survivorship experience appeared to be qualitatively different. In fact, suicide survivorship might imply a very specific set of emotions and experiences such as shame, guilt, a sense of personal failure, and feelings of rejection and anger toward the deceased (Jordan, 2017; Linde et al., 2017; Young et al., 2012) and blaming than all other survivor groups (Hanschmidt et al., 2016; Sveen & Walby, 2008). Losing a person in such

sudden and traumatic conditions leaves, in fact, mourning relatives and friends with feelings of responsibility for the death (Gall et al., 2014; Young et al., 2012) and, often, the never-ending search for the reason for the suicide (Myers, 2007). Some studies also reported relief in mourners, for example when the departed had additional severe mental health problems, when there was a history of violent behavior, or when suicide had already been attempted numerous times (Jordan, 2001; Maple et al., 2007).

One of the most important characteristics of this type of bereavement is that, since suicide is still a taboo in modern western society (Cvinar, 2005), survivors might experience high levels of stigmatization (Feigelman, 2009), which can be interiorized and generate self-stigma: this latter is referred to the negative stereotypes an individual develops by itself which can lead to shame, social withdrawal, demoralization, and even hopelessness (Corrigan 2009; Kučukalić & Kučukalić, 2017). The stigma experienced by suicide survivors is deeply related to others' social discomfort to address the topic of the death and avoidance of the subject, with survivors describing feeling blamed or gossiped about and, as a result, ending up concealing the manner of death or their own grief (Pitman, 2018a). In some other cases, survivors might refrain to talk about the deceased to avoid burdening others; as a result, they find themselves avoiding any argument concerning the death of their loved one, consequently invalidating their own grief (Peters et al., 2016) or decreasing the opportunities to find comfort in talking about the deceased or bringing back positive memories of the deceased (Feigelman, 2008a). These considerations raise two important implications: suicide survivors might struggle to find healing and restoration (Peters et al., 2016) and they might also deal with a drastic reduction of social support after the loss of a loved person (Sveen & Walby, 2008, Pitman, 2017), social isolation and fracturing of family relationships, which is often found in suicide survivorship as a result of mutual blame for the death (Lee et al., 2017).

The lack of social support represents an important hindrance to seeking help and a risk factor for isolation, and grief complications (Andriessen et al., 2017a). In fact, isolation in suicide survivors is related to higher levels of psychological distress, which increases as the time elapsed after the suicide increases (Scocco et al., 2017). Social stigmatization has been suggested as a factor implicated in the onset or exacerbation of suicidal thoughts among bereaved survivors of a significant other's death (Molina et al., 2019): suicide survivors experience an increased risk of suicidal ideation (Stroebe et al., 2005) and even fatal and non-fatal suicidal behavior (Guldin et al., 2017).

Moreover, perceived stigma is thought to alter the ability to seek professional help and become an obstacle to help and care for survivors (Link & Phelan, 2006). And finally, numbness, fatigue, or prejudice toward professionals might pose additional barriers to reaching proper support

(Cerel et al., 2019; Dyregrov et al., 2002; Jordan, 2004; McMenamy et al, 2008; Begley e Quayle, 2007; Cvinar, 2005; Dyregrov et al., 2011; Hanschmidt et al., 2016; Provini et al., 2000; Young et al., 2012).

Because of these reasons, interventions with survivors, or postventions, are "an improved response to and caring for people affected by suicide" (Andriessen, et al., 2017a) and, given the risk of suicidal emulation, have also a preventive role (Andriessen, 2009; Spillane et al., 2018). Support services that aim to act in this specific area of intervention are called for a broad and concerted approach, involving a range of sectors (national health service, non-profit associations, private practitioners), and targeting various settings, populations, and risk groups among carers, families, and communities affected by suicide (Andriessen et al., 2017a).

Some survivors might prefer the services to come forward (Peters et al., 2016); Socco and colleagues (2019) suggest that survivors should be contacted in person after the death notification and helped to work through their grief process, while Cerel and Campbell, (2008) highlighted the effectiveness of pro-active postvention protocols as receiving help sooner helps normalizing their shock and emotions. However, some other survivors might need enough time to feel ready to contact services (Fhailì et al., 2016; Pitman et al., 2018a).

Despite the provision of different sources of support, a high majority of suicide survivors might still declare to receive less help than they need (Wilson & Marshall, 2010), or might indicate little or no satisfaction with the professional help received (Provini et al, 2000): in fact, survivors often report that their first contact is unsatisfactory (Dyregrov, 2002) and complain about low levels of empathy and training on the part of professionals (Pitman et al., 2018b).

It should be also taken into consideration that some survivors might not access services but instead approach groups with other bereaved peers. In previous studies, the setting of mutual aid groups with peers has proven to be very useful for survivors (Groos et al., 2013; Peters et al., 2016; Pietila et al., 2002; Supiano, 2012): it provides a sense of forgiveness, involvement (Supiano, 2012) and a group of peers within to which share strategies, fight loneliness and create a new narration and find new insights (Miers et al., 2012), offer suggestions and foster hope (Peters et al., 2016). In fact, in a group of peers, it is more likely that survivors will not perceive pressure for the time and modalities they are adopting to go through their grief (Dyregrov et al., 2002). However, recent literature is lacking new explorations of how survivors mutually support each other and more studies are needed to investigate this important resource.

### *Suicide experiences in Italy*

In Italy, every year almost 4000 deaths by suicide are registered, 3.730 in 2018, according to the most recent surveys (ISTAT, 2018). The number of suicides in Italy has steadily declined since mid-1990 but witnessed a significant increase between 2007 and 2013, coinciding with the country's economic recession (Mattei & Pistoresi, 2019). Overall, the number of suicides in Italy is contained, compared to those in other European countries: in 2016, Italy had a mean of 5.85 suicide deaths per 100,000 inhabitants, while Slovenia, Belgium and France had respectively 18.09, 17.11 and 13.22 (Eurostat, 2021). Although the number of suicide deaths in Italy may not reach other countries' rates, the stigma surrounding suicide (a reflection of the cultural and religious Italian background) may cause difficulties for the survivors who would like to talk about their loss, find support or seek professional help (Scocco et al., 2019). For the same reasons mentioned in the previous paragraphs, in Italy, the exact extension of suicide survivors, as well as their general level of wellbeing and social support resources, is not precisely known.

To the best of the knowledge of who is writing, there are no universal and national programs for the direct outreach of suicide survivors: although it is possible that in many public hospitals close family members are presented with the possibility of undertaking psychological support, it rarely happens that these are offered free of charge or that doctors make sure to follow-up the family. Even less so if the person exposed to suicide is a friend of the deceased person and therefore had no contact with the hospital.

Currently, survivors (in those cases when they decide to actively seek support) access support services offered by therapists privately or by non-profit organizations, who mainly organize either mutual aid groups managed by a survivor or groups moderated by a professional. At the moment, there are only two services that offer presence and online individual support (via telephone or live-chat), in addition to group support in presence, at a controlled or free-of-charge price, and are both located in northern Italy, precisely in Padua: De Leo Fund Onlus (https://www.deleofund.org/) and Soproxi (https://www.soproxi.it/).

## The Outbreak of COVID-19

Recent world changes have imposed yet another type of loss experience under global attention: Coronavirus disease (COVID-19), a respiratory disease due to a virus labeled as SARS-CoV-2, first identified in December 2019 in Wuhan, China (Abel & Taubert, 2020). Two months after the first identification, in February 2020, Italy was the first Western country to witness the quick and fatal

diffusion of COVID-19 (Berardi et al., 2020; Marazziti et al., 2020); although a recent application of compartmental modeling and numerical optimization approach, set the likely introduction of SARS-CoV-2 to northern Italy on the 14th of January (Russo et al., 2021).

Since then, the virus has spread at an exponential rate; in March 2020 the World Health Organization declared the diffusion of SARS-CoV-2 a global pandemic (WHO, 2021). Italy had an initial decrease of detected cases in summer 2020, only to witness a worsening in October 2020 (Bontempi, 2021). After the first wave (2–8 March 2020) and the second wave (19–25 October 2020) (Chirico et al., 2021), at the moment the present study is being written, Italy is facing its third wave, as several other countries (Seligmann et al., 2020). According to the Italian Ministry of Health (2021), at 18 months after the first outbreak (when the present study is carried out), deaths have exceeded 4.561.446 deaths around the world and 129.093 in Italy only.

COVID-19 is an atypical SARS-like pneumonia that requires intensive care in 26–33 % of patients, 4–15 % of whom eventually die (Zhu et al., 2020; Wang et al., 2020). The clinical spectrum of COVID-19 can range from asymptomatic infection to mild upper respiratory tract illness, up to severe interstitial pneumonia leading to respiratory failure and even death (Chen et al., 2020; Li et al., 2020). Symptoms involve breathlessness, cough, and fever but can lead to acute anxiety or delirium in severely ill patients (Bajwahet al., 2020). However, a significant part of the population could develop an asymptomatic or mildly symptomatic infection, which could often go unrecognized and determine undocumented spreadings, hence contributing to the unwilling transmission of the virus (Li et al., 2020). Case-fatality rate of COVID-19 hospitalized patients in the early days of the Italian epidemic was around 20% (Giacomelli et al., 2020). Italy has, indeed, been one of the most affected countries, accounting for the highest death toll in Europe (22%) and for 15% of the global death toll (WHO, 2020). Advanced age and comorbidities are established risk factors for potentially severe cases of COVID-19, however, these variables have been deemed to be not enough to explain the high death toll among the Italian population, if compared to other countries with a similar old population such as Japan and additional studies are delving into other hypotheses based, for example, on the pollution as a possible vector (Anastassopoulou et al., 2021).

Dealing with a pandemic is an impactful experience that entails different and diverse challenges; the following paragraphs report the most poignant.

### *Long-term collateral effects of COVID-19*

Major disasters generally involve catastrophic events with significant loss of lives and widespread disruptions (Masten & Motti-Stefanidi, 2020). Usually, the emergency concerns a short-term crisis event, such as a hurricane or an act of terror. But in a pandemic, a scenario never faced by humanity since Spanish Flu in 1918, especially in western countries (Shokoohi et al., 2020), the extreme conditions can persist over months or even years, with ongoing deaths and important long-term collateral effects (Saltzman et al. 2018; Taylor, 2019).

Since the spread of the virus is still ongoing, the long-term effects of the pandemic are not yet assessable. While preliminary results from the first wave are starting to be exposed by the scientific community (Coccia, 2021), experts are hypothesizing future long-term scenarios for the general population (Gersons et al., 2020). In fact, the pandemic has affected the population over a wide range of issues, bringing about several types of losses such as loss of financial stability, loss of health, loss of future planning. The forced cancellation of events, the suspension of in-person school or childcare, the impositions of remote working regardless of the worker's ability to dispose of appropriate working space, and the drastic changes to recreational activities caused a suspension of routine and a breakdown of social relations as we knew them (Scheinfeld et al., 2011). Mayland and colleagues (2020) have confronted the impact of previous pandemics and specifically outlined the risk undergoing the diffuse uncertainty, the social isolation, and the multiplicity of losses in influencing bereavement outcomes.

In fact, above all it is the alarming contagiousness and lethality of the virus that has affected mainly the general population, tying together entire communities in what has been defined as a state of "mass bereavement" and affecting many with multiple simultaneous losses, defined by Scheinfeld and colleagues (2021) as compounded loss. The prevalence of negative mental health conditions is therefore likely to increase after the COVID-19 pandemic (Nobles et al., 2020).

### *COVID-19 deaths and bereavement experiences*

Strong preoccupation is posed on the reactions to COVID-19 losses in these particular and unprecedented conditions. Several authors (Gesi et al., 2020; Kelly, 2020; Kokou-Kpolou et al., 2020; K. J. Moore et al., 2020; Morris et al., 2020; Singer et al., 2020; Sun et al., 2020; Usher et al., 2020; Wallace et al., 2020; Zhai & Du, 2020) anticipated the unique or unprecedented reactions relating to COVID-19 losses.

An argument is found transversally: the post-COVID-19 community of mourners could witness a potential rise in grief complications due to the traumatic circumstances surrounding COVID-19 deaths (Eisma et al., 2020; Johns et al., 2020; Mortazavi et al., 2020). In fact, researchers have outlined how the

traumatic circumstances of a loved one's death may negatively impact the bereavement process (Kristensen et al., 2012; Neimeyer & Burke, 2017) and, although any death during this pandemic is expected to have accentuated negative impacts (Rosenbaum, 2020), it is anticipated that individuals bereaved by COVID-19 may be particularly at risk of developing grief complications (Eisma et al., 2020; Gesi et al., 2020). According to Carr et al. (2020), COVID-19 deaths fall within the category of *bad deaths* due to the specific conditions that characterize them: pain or physical discomfort (e.g., difficulties breathing, intubation), physical isolation from loved ones, psychological distress, lack of awareness or preparation, undignified and hasty treatment, and denial of medical treatments (Krikorian et al., 2020; Steinhauser et al., 2000).

Additionally, Bertuccio and Runion (2020) classify COVID-19 deaths as an *ambiguous loss* (Boss, 2010): the death occurs rapidly, unexpectedly for some, and closure often must be made without the physical presence of the body (Bertuccio & Runion, 2020). A recently proposed model of uncertainty distress poses the "unknown-ness," which characterizes the experience of COVID-19 losses, as the main cause of distress in mourners (Freeston et al., 2020). Singer et al. (2020) and Wallace et al. (2020) also consider the risks of pre-death anticipatory reactions, that is when preloss grief starts to be experienced once the family member becomes severely ill. An intense preloss experience is highly correlated with prolonged grief disorder (Nielsen et al., 2017). An additional challenge for mental health professionals is that the treatment of anticipatory grief and preparation to the loss of a family member is usually employed in the occurrence of a chronic uncurable disease, which is often characterized by slow progress, while the disease carried by COVID-19 has a short evolution that can lead to unexpected deterioration and death even within weeks: this reduces the window of opportunity for identifying high-risk levels of prolonged grief (Singer et al., 2020).

Lastly, not only are the circumstances of deaths occurring during this pandemic likely to increase the risk for prolonged grief, but the measures taken to mitigate pandemic spread may also enhance this risk (Brooks et al., 2020; Goveas & Shear., 2020). In fact, in addition to what literature advises us, that deaths occurred in the emergency department (ED) may put survivors at higher risk for complicated bereavement (Cooper et al., 2020), it is also to consider the traumatic impact derived from the inability of survivors to bury their beloved ones (Taylor, 2019).

Eisma and colleagues (2021) compared acute grief reactions among people recently bereaved due to COVID-19, natural, and unnatural causes and claims COVID-19 bereavement yields higher grief levels than natural bereavement (although not of unnatural bereavement). Among all the variables, the expectedness of the death explained this difference in grief between those who mourn a natural death and those who mourn a COVID-19 death.

The characteristics of the bereavement following a traumatic death have been discussed in the

previous paragraph; the specific factors associated with COVID-19 related deaths, that could potentially increase the risk of a more intense or prolonged grief reaction (Boelen et al., 2020; Eisma et al., 2020; Gesi et al., 2020; Goveas & Shear, 2020; Kokou-Kpolou et al., 2020; Masiero et al., 2020; Mortazavi et al., 2020; Wallace et al., 2020; Zhai & Du, 2020), include:

a) perceived violence of the death (e.g., death in ICU), as well as the hasty management of the body
b) shocking, premature, unexpected death circumstances/ unpreparedness to the loss
c) death perceived as unjust or preventable.

Moreover, mourners could be exposed to multiple secondary stressors such as:
e) contracting the virus/ quarantine
f) amplified social isolation due to restrictions/missing farewell
g) job loss and general abruption of future planning

Alternatively, the COVID-19 bereavement experience could be understood through four dimensions here reported.

**2.4.2.1 Uncertainty and Unpreparedness: the Collapse of the Health System and the Struggles of Practitioners.** Information on the SARS-CoV-2 virus was not immediately available, and several months passed before scientists could define the etiology, transmissibility, and weak points of the virus (Rabi et al., 2020). As a way to tackle the unfamiliarity and lack of full understanding of the virus, media initially adopted the narration of the "foreign invader" (Pappas et al., 2009, p. 743) or the "armed attack from an invisible enemy" (Spadaro, 2020) and soon allegories of war, doctors as martyrs fighting an invisible enemy at frontlines were often to be found in the mainstream media, which contributed fueling a "discourse of fear" around the events of those months (Rafi, 2020). Especially at its early stages, it could be argued that the pandemic experience has "laid bare the physical fragility and limited agency of human life" (Maddrell, 2020, p.108).

After an initial period of positive attitude in which physicians, doctors, and nurses were celebrated as saviors and the population tried to show support to each other during the lockdown (Imber-Black, 2020), the protracted limitations and the spread of the contagion generated anger and mistrust towards professionals and administrations as well, who were blamed for not having taken sudden measures (Yang et al., 2021).

Fear of contagion may move people away from each other. The prolonged uncertainty (regarding the duration of temporary suspension of socialization or, later in time, the possibility of the discovery of an effective vaccine) is known to lead to fear among citizens both at an ''individual and collective'' level (Girmaud & Legagneur, 2011), presenting substantial challenges on specific

subgroups, such as older persons (Carr et al., 2020; Goveas & Shear, 2020; Ishikawa, 2020; K. J. Moore et al., 2020), but also adolescents (Guessoum et al., 2020) and socioeconomically fragile people (Nanda, 2020).

Researchers (Moore et al., 2020; Rao et al., 2020) stressed the disproportionate impact of this pandemic on vulnerable subgroups: these patients appear less likely to access public health advice about COVID-19, are more likely to contract the virus and less likely to receive timely diagnostic and treatment services, which represents a serious risk to their life (El-Khatib et al., 2020; Kelly, 2020) Lastly, the pandemic took its toll also on physicians (Shanafelt et al., 2020) and mental health professionals (Mehta et al., 2021).

Especially during the early phase of the epidemic, the national health system was severely impaired: critically ill patients exceeded the capacity of ICUs and operating rooms had to be converted to makeshift ICUs, while temporary hospitals had to be erected to take in charge non-critically ill patients (Bollon et al., 2020). Also the number of other deceased not related to COVID-19 increased, as patients could not access medical attention (Rosenbaum, 2020). In this emergency condition, hospital staff was highly challenged in providing support to the dying patients and their families (Lissoni et al., 2020).

Since family members were not allowed in the hospital, information was mostly exchanged over the phone (Lissoni et al., 2020; Maddrell, 2020), including health and therapy updates, sudden health deteriorations requiring intubation and, also, notification of death. In several cases, people mourning a relative complained about the lack of humanity, carelessness and haste of physicians (Cipolletta & Ortu, 2021); however, several families also reported to have found comfort in communicating with their loved ones or being able to say goodbye thanks to nurses or volunteers holding the phone close to the patients' bed. This example of care and compassion of frontline health care workers, despite the critical situation, likely made a difference in mourners' capability to make sense of their loss and prepare for the departure (Wakam et al., 2020).

In fact, one of the crucial aspects of the bereavement process resides in the conditions in which an individual is informed of the loss of a loved one, which can affect the quality of dying and bereavement (Shoenberger et al., 2013). A recent review (De Leo et al., 2020) outlined the complexity of the death notification process: the circumstances of death (violent or natural), the quality of the communication between the notifier and the family (verbal or non-verbal), the characteristics of the context in which the notification is carried out, the presence or absence of sources of support, and the training of the notifier can all contribute to a more or less shattering reception of the tragic news. All the above-mentioned conditions have been, on a certain level, altered with the advent of COVID-19; these circumstances (e.g., the imposed physical distance with

the notifier) not only may impact as painful memories related to the loss of a loved one that will never be forgotten (De Leo et al., 2020) but may contribute to the traumaticity with which the family members will receive the news (Janzen et al., 2003-2004; Neimeyer, 2001).

A recent qualitative study has confirmed some of the anticipations of previous authors. In a recent study with twenty individuals bereaved by the first wave of COVID-19 from the most heavily impacted Italian region (Lombardy), Cipolletta and colleagues (Cipolletta in writing) have outlined the risk factors, the obstacles, and future perspectives for families mourning a relative to COVID-19. This first investigation confirms that experiencing loss during the COVID-19 pandemic can hinder meaning-making for grieving families (Eisma & Tamminga, 2020): in fact, participants reported that they were still incredulous and struggled to grasp it as real expecting the loved ones to show home at any moment; moreover, the indirect effects of the pandemic hindered them to undertake active actions such as obtaining practical and emotional support and attending to life changes (Neimeyer & Burke, 2017), which are pivotal for meaning-making and post-traumatic growth (Milman et al., 2017; Neimeyer, 2019).

In a similar scenario, first attempts to understand the use of telematic tools are being made. In a retrospective cross sectional study, Ersek and colleagues (2020) examined the impact of remote communication for end-of-life care on families during the COVID-19 pandemic. Remote communication with the patient and the healthcare team that was judged as “Effective” was associated with significantly better ratings of the overall experience of end-of-life care by bereaved family members, compared to those reporting that remote communication was “Mostly” , “Somewhat” , or “Not at All” Effective. Although these results strengthen the concept that remote communication could be a valid solution for broadening the scope of support offered to a patient and their family, the limitations of this specific study make it so that additional controlled trial studies should be carried out.

**2.4.2.2 Absence of rituals: the impossibility to say farewell.** During the first months of the pandemic, after the death notification, the grieving families were often left scattered, isolated in quarantine, sometimes suffering multiple losses or with other relatives admitted in different hospitals. This situation, although not present with the same entity everywhere, is still similar for COVID-19 losses in the second and third waves.

Being confronted with such an unexpected and unprecedented health emergency entailed various challenges regarding strategies to limit contagion, most of which have been kept in use up to the third wave: not only access to hospitals was restricted, but also travels across regions and States were limited, funerals were suspended or severely limited and social distancing measurement

implemented. All these restrictions endured proved useful to contain the spread of the virus (Courtemanche et al., 2020; Bollon et al., 2020) but contextually contributed to undermining sociality and social rituals for the population. Adding up to the generalized incertitude, impotence, and shock of the first months of the pandemic (Cipolletta & Ortu, 2020; Marazziti et al., 2020), social distancing requirements and confinement to the home hindered grieving people from mourning their loved ones in traditional ways, preventing them from benefiting from such an important resource.

In fact, through rituals, it is possible to communicatively enact a sense of closure, while also sharing grief with others (Wallace et al., 2020). Turning to religion, spiritual beliefs, friends, family, or any activity with others helps grievers to ease back into what they perceive as normalcy, and access new resources to ease meaning construction (Neimeyer et al., 2014).

The lack of a burial ritual, hence the opportunity for families and their communities to honor the deceased, share grief, and receive mutual support represented a dangerous and strongly felt lack (Imber-Black, 2020), even more so in the Italian context (Coppola et al., 2021).

Some studies suggest grievers could receive a sense of belonging and comfort from participating to a funeral (Albuquerque et al., 2021; Nesteruk, 2018) and also be prevented from socially withdrawing (Gamino et al., 2000). In a recent review, however, Burrell and Selman (2020) synthesized the existing research reporting the effects on grievers of attending funeral practices. According to this critical review of literature, the effect of funeral participation on grievers' mental health and bereavement outcomes is still inconclusive, as some studies present limitations such as no clear definition of the study population, no application of inclusion or exclusion criteria, no description of methods used for data analysis or application of unvalidated measures as well as high dropout or convenience sampling (Burrell & Selman, 2020).

However, other factors may come into play: Burrell and Selman outlined how, for both adults and children, the benefit of after-death rituals (including funerals) may rather depend on the ability of the individuals to shape these rituals and manage to say goodbye in a way which is personally meaningful for them. Cipolletta and colleagues (in writing) observed how the funeral could be perceived as necessary to disambiguate the loss and perceive the death as real. Additionally, the funeral could be of comfort when becoming an occasion for the informal network or the extended community to demonstrate their support (Burrell & Selman, 2020).

In the context of COVID-19, Burrell and Selman suggest that restrictions to funerals are not expected to necessarily determine poor bereavement outcomes, as it is not the number of relatives or even the type of funeral which determines how supportive the ritual will be in the following months, but rather how meaningful the occasion is made to be, and how connected it helps

mourners to feel. However, here lies a pivotal issue: as reported in Chapter 2, social support in bereavement is of extreme importance. In a scenario where sociality is limited, the kind of support that perhaps mourners may need most, that is practical support, might fail to be provided (Carr et al., 2020). Moreover, research stresses how being unable to participate to the funeral due to geographical distance may cause more distress in mourners (Nesteruk, 2018; Pang & Lam, 2002).

**2.4.2.3 Disruption of connectedness and social support.** Lack of social support is, indeed, the most missed factor by grieving families: lack of physical contact could intensify feelings of loneliness, which is a common part of any bereavement experience (Fried et al., 2015) but could lead to isolation and withdrawal in mourners and amplify the risk of negative bereavement outcomes (Selman et al., 2020).

Ironically, some of the public health measures required to control this infection can have negative effects on mental health (Brooks et al., 2020). Quarantine, for example, has been found to be associated with fear of infection, frustration, and anxiety due to a lack of clear information (Brooks et al., 2020). Kelly (2020) and Walsh (2020) discuss the implications for bereaved families: shared belief systems play a pivotal role in the meaning-making processes, as well as in the ability to look forward with a positive, hopeful outlook and, in some cases, be able to use spirituality and transcendent values to foster adaptation and positive growth.

Social support is a strong predictor of resilience following disasters or life-threatening situations (Saltzman et al., 2018) and plays a central role in promoting posttraumatic growth following exposure to trauma and disasters (Hall et al., 2010; Saltzman et al., 2018; Xu & Ou, 2014). In fact, Saltzman and colleagues (2020) also claim that social support may not only be important for reducing negative symptomatology but also for promoting positive adaptation following COVID-19.

As Stroebe and Schut (2020) highlighted, there is still relatively little consideration of positive or compensatory processes linked to the possible alleviation of grief in COVID-19 mourners. The ability to find a silver lining is pivotal to access meaning reconstruction after a traumatic loss (Holland et al., 2006). In Cipolletta and colleagues (in writing), for example, mourners felt relieved thinking their experience was of shared grief with an extended group of other people. Socially shared grief could be, hence, a key binding factor for the ability to make sense of the loss, and it could be a good starting point for clinicians intending to foster sensemaking. In fact, Abel and Taubert (2020) outlined the gains for those affected by a traumatic loss, thanks to the mobilization of compassionate communities, in this case, aided by technological tools.

**The Role of Social Support in the Bereavement Process**

Considering the broader experience of loss, in the last decades bereavement research has witnessed a shift from a traditional focus on emotional consequences of the death of a significant other, to one that also considers grief in its social, cultural, and spiritual dimensions (Hall, 2014). Recent pandemic events have stressed the importance of staying in touch with people immediately after a loss. The social context in which the individual is embedded, in particular, can represent a useful resource for those in mourning: as explained in the previous paragraphs, being able to obtain informal support from relatives and friends might make the difference, especially if professional support is lacking (Dyregrov, 2003).

Social support could be defined as the emotional, economic, and practical help or information provided to the affected individual by significant others, such as family members, friends, neighbors, and co-workers (House & Kahn, 1985). Social support has been considered to hold two different roles; first, according to the so-called *buffering effect* (Cohen & Wills, 1985), the availability of social support might protect individuals from the deleterious effects of stressful life events. Secondly, social support might have a *main effect* on general health, that is, it could facilitate a positive life (Stroebe et al., 2005b), regardless of whether or not one is confronted with stressful situations.

Later on, Cohen and Wills (1985) identified two major categories of social support measures: structural and functional. Structural support involves social integration, namely, the presence and numerosity of relationships in an individual; functional measures involve the resources available to the individual, such as assistance with daily tasks (practical/instrumental support) or reassurance that one is a worthwhile individual (emotional support). Importantly, Cohen and Wills claim that only specific measures of social support, and only among the functional ones, are likely to produce evidence of stress buffering, while structural indicators of social support are not involved in the buffering of highly stressful experiences (Cohen & Wills, 1985).

Stroebe and colleagues (2005b), compared the impact of social support on depression in a sample of widowed mourners and married counterparts. Results showed that no evidence of a buffering effect on grief, as social support was found to help widowed and married persons regardless. Stroebe and colleagues' results posed an important consideration, suggesting that, although social support might be helpful in general, the loss of a loved one might lead to a (more or less) sudden deficit in support that cannot be compensated by others. It might, therefore, be more appropriate to consider that the void left by the loved one cannot directly be compensated with the mere provision of informal support, as claimed by Bowlby (1973) in regard to the uniqueness of the

attachment figure: according to this, Weiss (1973) suggested the existence of two forms of lack of support: social loneliness and emotional loneliness. Social loneliness being the feeling that there is nobody to count on for support and consequent lack of social embeddedness, emotional loneliness, instead, implying a sense of utter aloneness and isolation, regardless of others being actually accessible or not. According to Weiss, the loss of an attachment figure creates an emotional void or loneliness such that social support offered by friends cannot heal it.

This conclusion, however, does not preclude possible benefits of providing social support. For example, one of the reasons for Stroebe and colleagues' results could be found in the fact that their sample included all varieties of reactions to the loss (Brown et al., 2008) and receiving support from others may appear ineffective if the bereavement event does not trigger a stress reaction for some individuals (Bonanno et al., 2002).

Therefore, despite some conceptual differences, the literature suggests social support may have at least a mitigating impact on grief (Sveen et al., 2014; Vanderwerker et al., 2004), for example facilitating the diffusion and adoption of coping strategies (Stroebe et al., 2005) or providing informal opportunities to express their feelings in a non-judgmental and empathic context (Breen et al., 2017), with the consequent effect of empowering the bereaved to engage in positive behaviors to foster mental health and well-being (Sallnow & Paul, 2015). Social support has also shown to be of critical importance for facilitating post-traumatic growth (Tedeschi & Calhoun, 2004).

The above-mentioned functional support conceptualized by Cohen and Wills (1985) could also be intended as a sort of perceived social support, which could be defined as "the psychological and material resources available from an individual's interpersonal relationships" (Rodriquez & Cohen, 1998). To assess perceived social support, standardized questionnaires have been created to assess respondents' perception of availability of different kinds of support, if needed. Although this type of measure does not determine whether support will actually be provided, perceived social support revealed a stronger predictor of a positive adjustment to stress than the receipt of support itself (Wethington & Kessler, 1986).

A large part of the generated research has focused upon various dimensions or types of perceived social support, centering on 4 dimensions: informational-emotional (e.g., the provision of both emotional support and guidance or advice), tangible (e.g., material aid or assistance in everyday activities), affectionate (e.g., the expression of love and affection), and positive support (e.g., availability of individuals with whom to do fun/distracting activities) (Cohen & Wills, 1985; Cutrona & Russell, 1990; Sherbourne & Stewart, 1991). This distinction is in line with Cutrona and

Russell's (1990) contention that bereavement may require various forms of support from others, ranging from nurturing to action-facilitating support.

The role of the informal support networking is, then, a resource that should not be underestimated (Burke & Neimeyer, 2013). Goldberg and colleagues (1988) found that larger social networks, and particularly family and friends with whom the bereaved has regular contact, were associated with a reduced risk of developing emotional problems. More recently, even school-based social support (that is, support provided by friends, peers, and even teachers) appeared to facilitate the adjustment of bereaved siblings (Howard et al., 2018). In literature, the interaction of mourners in group of peers (i.e., individuals who have experienced a similar loss) have been found to be beneficial for mourners (Pitman, 2018b): Brown and colleagues (2008) even suggested that bereaved people who provided support to others would show evidence of stress buffering, as the ability for a mourner to provide support to others was found to be associated with coping with spousal loss.

However, social support systems can also create stress if interactions are perceived as negative by the bereaved (Shinn et al., 1984; Finch et al., 1989). Traumatic death survivors are often found to lack social support from their own informal network, as the traumatic loss may increase family conflict (Cerel et al., 2008b) or inhibition to talk about the event to others and consequent withdrawal (Peters et al., 2016) such as in the suicide bereavement introduced in the previous paragraphs.

Overall, a scenario appears where traumatic mourners do not receive sufficient or timely informal support to moderate their grief experience (Breen & O'Connor, 2011) or receive less social support compared to other forms of bereavement, which may be due both to limited help-seeking or sharing by the bereaved individuals and the inability of the social network to support them (Andriessen et al., 2017b; Pitman et al., 2017). For these reasons, it is important for grief scholars and mental health professionals to investigate how to efficiently help traumatic survivors access different types of support more easily and find alternative ways to connect to them and respond to their needs. In the next chapters, the concept of support offered electronically, the advantages and disadvantages of these tools as well as the possibilities of use for this specific population will be presented.

# CHAPTER 3

## Digital Tools and Online Support

Since the advent of the World Wide Web, digital tools have been used widely to reach people in their homes (Lupton, 2017; Kraft & Yardley, 2009); in fact, a growing number of people turned to the Internet for health-related information and, consequently, a higher number of professionals looked for ways to provide support through this medium. The term 'digital health' refers to a wide range of technologies for the delivery of healthcare, provision of information to laypeople and helping the sharing of personal experiences, training, and education of healthcare professionals, as well as provision of help to people with chronic conditions to engage in self-care or the encouragement of others to engage in activities to promote their wellbeing and avoid deterioration of a physical or medical condition (Lupton, 2017). Given the topic of the study, in the present chapter the broader denomination of "digital tool" will be used to refer to the various ways of providing informal and professional support through telematics technology.

With the first launch of the commercial web that allowed access to the World Wide Web, around 1994, most websites offered a static delivery of information, that is, although

users were able to create and share content to some extent through blogs, online discussion, and message boards, information was delivered passively. It's only in 2004 that we witnessed the emergence of the 'social web' , also often referred to as Web 2.0 (Hiremath & Kenchakkanavar, 2016). The third iteration, Web 3.0, has already started to be mentioned by scholars as to the 'semantic' or 'intelligent web' , involving the 'Internet of Things' (Greengard 2015), in which sensor-embedded and other 'smart' technologies are increasingly interlinked and able to exchange information with each other (Lupton, 2017).

Although the origin of virtual/telematic support lies in telephone contact (Predmore, 2017), which has been utilized for emergency lines since the 1950s and is at present broadly utilized for aide services (Mohr et al., 2008; Situmorang, 2020; Stead et al., 2013), other mediums have become increasingly available to offer support, including Internet blogs, live-chats, Skype sessions, e-mails and text messaging (Beaunoyer et al., 2020).

This evolution in the provision of services had to take into account the particular characteristics of telematic communication; in fact, when an interaction takes place online, distinctive dynamics intervene regarding the verbal exchanges. Face-to-face (FtF) communication

has been replaced with what is defined as computer-mediated-communication (CmC); this type of communication has some peculiar characteristics: it is extremely fast and dialogic, the writing assumes strong characteristics of speech and uses a highly informal register; for example, opening and closing formulas are more similar to those of speech than to the classic ones of the formal style of written communication (Elia, 2010; Turner, 2010). Online language is, indeed, very rich and complex: it is also characterized by a "conscious intentionality" (Paccagnella, 2000) since while in the FtF interaction a gesture or an expression may inadvertently escape, in the CmC the emotion that is intended to be communicated is precisely sent (for example through an emoticon) with the intention of conveying a mood (Barnett, 2005). Laslty, CmC possesses something that FtF communication necessarily cannot have, namely multimodality, that is, the ability to use different types of information sources (written text, images, videos) in the same communication (Dino & Gustilo, 2015).

A concept around which the whole CmC revolves and without which the CmC cannot take place effectively is the online social presence (Tu, 2002), which is defined as the degree of awareness of another person in an interaction and the consequent appreciation of an interpersonal relationship (Walther, 1992). Online social presence is, therefore, the degree of feeling, perception, and reaction that generates from the awareness of being connected to another intellectual entity on CmC (Tu & McIsaac, 2002) and plays a determinant role in the ability to establish a relationship with other individuals online.

Current, existing digital tools for mourners could be divided into categories, each with its distinctive features:

- Synchronous/Asynchronous communication style
- Blended/ Exclusively online modality of interaction
- Professional/Peer-originated source of support

It is referred to as synchronous CmC when users (a sender and a received) exchange information simultaneously, either through writing or talking (e.g., live-chat or online counseling through skype), while asynchronous CmC when there is no simultaneity between sender and recipient and people can communicate by writing in the times they deem most appropriate (e.g., forums, online support groups, memorials) (Cacciagrano & Corradini, 2001).

This style of communication is strongly connected to the modalities with which online digital tools can be used: a blended-type of intervention presupposes that CmC moments (both synchronous and asynchronous) alternate with FtF moments which necessarily occur in real-time.

An example could be a periodic intervention carried out in a school or with hospital patients in which focus groups are periodically held in presence to talk about what has been addressed online (Erbe et al., 2017). Due to the great advantages offered by online tools, however, a large part of the interventions concerning digital tools are often carried out entirely online, such as therapy sessions in rural areas that would be otherwise difficult to access (Mallen & Vogel, 2005).

Professional support is referred to the intervention of a mental health professional (psychologist, psychotherapist, psychiatrist, counselor) or the cooperation of various professional figures with the aim of protecting and fostering the mental well-being of the individuals. Peer support, on the other hand, has been the focus of an extended variety of studies and investigations for several decades but has not been explicitly defined in the literature (Dennis, 2003). In the context of the present research, it could be defined as the provision of assistance and encouragement by an individual considered equal, hence the creation of a connection within individuals who have undergone maturational or developmental life transitions, sometimes distressful or painful, that are commonly employed to augment embedded social networks and alleviate social isolation (Dennis, 2003; Solomon, 2004), in fact, peer support showed to have a buffering effect on chronic and acute situational stressors (Bray et al., 2017; McLeish et al., 2017) (more details are reported in Chapter 2).

Through decades, various ways of offering peer support have evolved: starting with self-help groups, and arriving at peer-delivered services, peer-operated services, peer partnerships, and Internet support groups (Solomon, 2004). However, while totally peer-led groups are very accessible, they might not offer an adequate quality of care and privacy, especially if hosted online (Robinson & Pond, 2019).

**Benefits and Limitations of the Online Tool**

Online tools guarantee the removal of the barriers of space and time. Not only this reduces the time of intervention as well as social and geographic isolation (Farrell & McKinnon, 2003; Gary, 2001) by allowing to be connected over long distances without any travel time and reduced costs (Feigelman et al., 2008), but it might in some cases resolve the limitations due to physical disabilities or temporary inability to move (Panek et al., 2001). Digital tools are, in fact, becoming more and more accessible, even for elderly people or with problems related to autonomy or motor skills and it is possible to say that in today's digital era, all age groups are likely to participate in some way in virtual interaction processes (Döveling, 2015).

Another distinctive feature of a large part of digital tools is the partial or total lack of visual cues. This inconvenience could be used to users' advantage since a lack of visual cues of age, gender, ethnicity, or social status has been found to equalize individuals' status (Madara & White, 1997), hence allowing them to feel less pressure when using the service. This flattening of physical and social distances is considered to contribute to facilitating access to services or to online groups (Gilat et al., 2009). Related to this, the phenomenon of the "online disinhibition effect" (Suler, 2004) plays a leading role in the tendency of people to say and do things they may not say or do in face-to-face settings (Jooinson, 2001; Suler, 2004). The online disinhibition effect is possible thanks to six interacting factors of online communication, which contribute to altering users' self-boundaries: dissociative anonymity, invisibility, asynchronicity, solipsistic introjection, dissociative imagination, minimization of status and authority (Suler, 2004): when people can divide their online persona from their real-life identity, they might feel that whatever they say or do online can't be directly linked to the rest of their off-line lives, hence feel less vulnerable about self-disclosing. Asynchronicity as well could be useful to have the possibility to take time to answer or after someone has posted something emotionally challenging (Barak, 2008; Suler, 2004); in fact, asynchronous support allows users to spend as much time as they need composing a thought, a consideration or a question to precisely reflect their emotions (Tate & Zabinski, 2004), in the case of traumatic experiences, this also allows to express emotions and cry without the inconvenience of being in front of others (Barak, 2008).

With the sense of anonymity and privacy offered by online tools, individuals might, then, also be encouraged to share their experiences and discuss taboo and stigmatized issues, (Feigelman et al., 2008; Cipolletta et al., 2017). Another important feature is, in fact, that several online tools such as online support groups and forums provide public places to share memories and express emotions publicly and collectively (Falconer et al., 2011), a feature that acquires even more importance if experiences of trauma and crisis are involved (Arthur, 2009).

On the other hand, online tools have limitations that must be taken into consideration, especially if mental health support is involved. The lack of visual cues might determine difficulties in communication because of the impossibility to see non-nonverbal signals (Gilat et al., 2009), which could lead to misunderstandings or loss of valuable information for the therapist. Moreover, the same online disinhibition effect could manifest negative effects, which could lead to harmful behaviors such as aggressive language, flaming, trolling, or increased disengagement and drop-outs (Christopherson, 2007, Dillon & Bushman, 2015, Fox et al., 2015; Udris, 2014).

Moreover, while general web access is accessible 24/7, however, this is not the case for several modalities of online support, and the argumentation of the on-the-clock availability must be taken into consideration only for asynchronous support or for hotline services like crisis support. This feature of constant availability, particularly, might be deemed important by some users, who struggle with their grief and might be in need to access online support at any time (Cox, 2007); but the same 24/7 availability of contents could represent a problem: the amount of information made available to ordinary people, without the control of experts, could in some cases lead to patients engaging in self-diagnosis and worsen initial anxiety levels (Lupton & Jutel, 2015). Moreover, the constant availability of online support may decrease some clients' interest in face-to-face psychotherapy (Tate & Zabinsky, 2004).

Other authors listed the additional limits of online support: these involve privacy and confidentiality issues, legal and ethical considerations, credibility and quality of the support, but also users' knowledge of technical equipment, unstable connection and disruption of the flow of conversation, general accessibility, and digital divide between socio-economic levels in the possibility of accessing the internet (Cipolletta et al., 2021; Gibson et al., 2020; Lubas & De Leo, 2014; Lupton, 2017; Wells et al., 2007). In fact, there are structural preconditions for being able to establish virtual communication in a safe and accessible way: the availability of adequate technology, skills, and internet access, as well as a safe place from which to connect. In the case of crisis support, being able to establish contact from a safe place might not be enough, as operators might fail to intercede in an emergency and restore control in case of strong distress being experienced by the individual (e.g., panic attacks or acute suicidal ideation) (Leibert et al., 2006; Richards, 2009; Rochlen et al., 2004).

Not least, different sub-groups might have different needs and might appeal to different online resources; Gibson and colleagues (2020) call for the need to focus on diverse populations (i.e. adolescents, older adults, and rural communities) to be uniquely considered when developing online support groups and increased attention should also be paid to individuals with disabilities, whose need to find psychological support or relief could be due precisely to comorbidities and physical problems that might limit their movement (e.g., writing on a keyboard) or ability to speak.

Lastly, despite living in a technological era, it has been shown that artificial substitutes for social connection (such as video calls or online group events) might exacerbate pre-existing feelings of disconnection. This statement is especially important during periods of lockdown that promote social distancing/isolation (Pinto et al., 2020), the practical implications of which will be discussed in greater detail in Chapter 7.

## Digital Tools for Mourners and Online Bereavement Support

On the basis of what has been dealt with in the previous paragraphs, it is possible to state that the way we look for information or establish and keep connections has deeply changed with the digitalization, and an important part of the creation of meaning and of research of understanding and support has shifted onto the online dimension (Falconer et al., 2011; Moss, 2004), thus determining a change also in how people mourn (Arthur, 2009). In fact, with the expansion of the ability to connect between people offered by the evolution of the internet and social media, grief scholars as well became more interested in how the bereaved use the Internet to meet their needs (Gibson et al., 2020; Sofka et al., 2012; Walter et al., 2012; Wright & Caudill, 2020). In fact, the ever-expanding nature of the Internet provides to the bereaved individuals the ability to communicate and find resources and practical information virtually around the clock, as well as connecting them with peer and clinical support in a convenient, time-sensitive, and accessible way (Chapple & Ziebland, 2011; Feigelman et al., 2008; Ferguson & Frydman, 2004; Finfgeld, 2000; Gibson & Anderson, 2008; Hollander, 2001; Oliveri, 2003; Varga & Paulus, 2014).

On the Web, survivors look for practical information and stories (Chapple et al., 2015) they could not as easily retrieve in person. Moreover, they find supportive environments among people who have gone through similar loss experiences (Barak et al., 2008; Feigelman et al., 2008) along with an additional feature: the ability to write behind a screen and, if needed, in complete anonymity and at any time (Kramer et al., 2015). Leaving aside those tools that allow reaching a mental health professional more easily, for example by circumventing the problem of fatigue, which is common in bereaved people (Seiler et al., 2018), online tools in supporting the loss of a loved one have received particular attention for the use made of writing, both synchronous and asynchronous. In fact, the Web offers a space for individuals to create stories and memorials that could foster the transition "from his death to our life" (Ratnarajah et al., 2014, p. 51). In their book Voices of Trauma: Treating Survivors Across Cultures, Drozdek and Wilson (2007) explain the benefits of verbally expressing the distress due to traumatic experiences: the "unspeakable" becomes speakable when it is communicated and shared, and that through this process it also becomes more meaningful and more bearable (Arthur, 2009).

## State of the Art on Digital Tools for Mourners

Understanding mourners' use of online resources is an important factor in determining the value of Internet-based services to support users. In this paragraph the state of the art on digital tools for mourners will be discussed: specific attention will be put on online discussion groups.

First of all, it is difficult to assess easily the efficacy of bereavement support in a broader way because studies differ by the definition of grief and the assessment of its pathological levels (Wagner et al., 2020) (As explained in Chapter 2). For example, in their review on the efficacy of psychological interventions for grief in bereaved adults, Johannsen and colleagues (2019) included only studies that assessed grief using one of the versions of the Inventory of Complicated Grief-Revised (ICG-R) or Prolonged Grief Disorder-13 (PG-13). Also, according to a following review from Wagner and colleagues (2020), sometimes cognitive-behavioral studies interventions have stronger effects on posttraumatic symptoms than on prolonged grief: possibly because the majority of the included treatment protocols in their study are largely tailored to treat distressing memories associated with the loss and reduce avoidance using exposure-elements, thus addressing the mutual grief and posttraumatic stress symptoms more than the specific symptoms of prolonged grief (Wagner et al., 2020).

Survivor's needs, however, are complex and diverse and necessitate a concerted effort to provide support (Andriessen et al., 2019) offered on several levels such as direct outreach by agencies community support, the provision of individual grief counseling as well as mutual aid groups (McIntosh et al., 2017). This diversification of resources could be of help precisely for those reluctant or unable to access other forms of support face-to-face (Andriessen et al., 2019). Online resources not equivalent to cognitive-behavioral interventions are not always an exclusive alternative to other forms of help, but are usually an accompaniment to it: for example, Bailey (2017) showed how participants while seeking help elsewhere (including towards face-to-face professionals), preferred to seek help from more than one informal source online.

However, face-to-face experiences with professionals are not always easy or evaluated as positive by those relying on online support: the most common barriers to utilizing professional mental health support are the worry that it might be too painful to speak about the grief experience (Andriessen et al., 2019), the belief that it is too difficult or useless to find help (Lichtenthal et al., 2015), or a fear of stigmatization, especially for those bereaved by suicide (Cvinar, 2005) (details are reported in Chapter 2). In Schotanus-Dijkstra's (2014) analysis over the exchanges of suicide survivors in online support groups, participants reported being skeptical of turning to services having experienced how they failed to help and treat their loved ones while they were still alive, while those who turned to professionals complained about a lack of understanding. Because of this, only a minority of bereaved people may actively seek and access traditional forms of support (Currow et al., 2008; Entilli et al., 2021; Provini et al., 2000).

The online resources that are currently used for psychological support can concern both synchronous and asynchronous support, as well as professional and peer support, and are here listed.

### *Online Counseling and Self-help Tools*

Online counseling services are therapeutic interventions offered in synchronous mode (generally via video call) in which communication between patient and professional is facilitated by CmC technologies. While some see it as a transfer of the more common face-to-face interview, others believe it should be seen as a distinct type of intervention, a new resource that can complement existing interventions (Richards & Viganò, 2013). Online counseling with a professional can also take place through contact via e-mail or through support groups (Baker & Ray, 2011), although this makes the support asynchronous. These applications of digital tools could be defined more broadly as "Internet-based interventions" that is, treatments that are mainly delivered via the Internet with at least some therapeutic tasks delegated to the computer (Andersson & Titov, 2014).

Although these forms of support have been around since 1960 (Situmorang, 2020) and there are, nowadays, numerous online practitioners offering this support, there is very little efficacy or effectiveness data for online treatments (Baker & Ray, 2011; Rochlen et al., 2004). According to Rochlen ad colleagues (2004), the few studies showing positive results lacked adequate methodological structure such as sufficient controls and empirical data.
More recent investigations (Richards & Viganò, 2013) claim that a growing body of knowledge shows online counseling can have similar impacts to face-to-face encounters and is capable of replicating the facilitative conditions as soon as professionals are aware of the distinct nature of online counseling, its own defining features, dynamics, and issues compared to face-to-face ones. At present, the key processes underlying the efficacy of a therapy, for example, how a therapeutic alliance is actually created in the online interaction with a professional, are not fully understood, and sensitive attention must be paid to the nuances of interpersonal interaction that occur in counseling sessions (Barnett, 2005; Cipolletta, 2015; Cipolletta et al., 2018).

Recent studies have also examined several aspects of the uses of online tools to come to terms with a personal loss: Dominick and colleagues (2010) evaluated the efficacy of a psycho-educational Internet self-help tool to educate and support recently bereaved individuals; the goal of the website was to help users normalize their grief to enhance their adaptive adjustment. Users perceived the tool as helpful for understanding their grief and for coping with it. However, the tool was addressed to users who were grieving an expected, natural death of a parent or older relative,

hence the tool has not been tested with complicated grievers, who might instead have different reactions.

***Live chats***

These services are listed among the synchronous online support as well. Live chats are a textual online counseling modality that is considered very advantageous in contexts of intense emotional load or crisis, such as suicidal ideation and recent suicide bereavement (Barak et al., 2008; Barak & Grohol, 2011; Cipolletta et al., 2021). A key feature of live chats is that, in addition to ensuring anonymity, they provide the opportunity to interact with a qualified person, an operator, or a trained volunteer, who is not perceived as intimidating and who communicates empathically through writing. In the case of bereavement support, survivors are able to speak more freely without feeling exposed and therefore more vulnerable, asking questions that would have been difficult to ask in other contexts. Overall, live-chats could be good opportunities to approach people who may be insecure about reaching out for help in person and would then be contacting live-chat services to "test the waters" (Predmore et al., 2017). This is an important feature because research suggests topics discussed on live-chats are often of a more serious nature than those discussed on the phone (Child Helpline International, 2005; Haner & Pepler, 2016).

Live chats can be used as therapist-led group interventions using chat rooms (Gollings & Paxton, 2006; Harvey-Berino et al., 2002; Woodruff et al., 2001; Zabinski, et al., 2004) or as chat support, rather than counseling, accompanied by a self-help website (Hasson, et al., 2005), and there is a growing body of literature analyzing the processes involved in online chat interactions including the working alliance (Hanley & Reynolds, 2009), the session impact (King et al., 2006), and the user attitudes towards online chat counseling (Skinner et al., 2005). Some difficulties are sometimes encountered in live-chats and concern the obstacles to a fluid interrelation between users and operators, due to the lack of non-verbal signals (Cipolletta et al., 2021; Gilat & Shahar, 2009) or to the slow pace of the communication, which may limit the range of techniques being used (Williams et al., 2009). A systematic review from Dowling & Rickwood (2013), investigated the evidence for the effectiveness of individual synchronous online chat counseling/therapy and concluded that although there is emerging evidence to support the benefits of the use of online chat, the overall quality of the studies, including the few randomized control trials identified, is poor, and further research is needed.

### *E-mail support*

It is a method of provision of a mental health-related or wellbeing service that allows parties to asynchronously communicate via email and to engage with professionals in a support interaction. In the context of peer support, e-mail systems could be used by groups of peers to exchange information or support to individual members who are facing similar situations, hence creating a systematic connection between people for the purpose of giving and receiving emotional support (Greer, 2000). Computerized e-mail interventions also can be implemented in a cost-efficient manner and can create written records of patient interactions that can be examined and used as treatment signs of progress (Miller & Gergen, 1998).

E-mail support is more often used in the context of health psychology: for example, Tate and Zabinsky (2004) report a web-based self-help treatment for headaches involving six weekly modules teaching applied relaxation and autogenic techniques. This treatment was found to produce significant clinical improvements on numerous headache parameters compared with wait-list controls. From this experience, unrelated to the support for mourning, however, derives an observation of great imposition: although the authors estimated the web-based program to be 12 times more cost-efficient than traditional psychotherapy for headache, an important obstacle was represented by the high rate of dropouts (more than 50%) which are a common problem in such programs and represent a significant obstacle in the drawing of conclusions (Clarke et al., 2002; Tate & Zabinsky, 2004).

Asynchronous feedback from clinicians such as the one offered through e-mails has also been used to supplement a primarily self-directed writing protocol (Lange et al., 2001) where users facing posttraumatic stress and grief, received e-mail feedback from a clinician and recommendations: when compared with wait-list controls in a small-scale trial, the e-mail protocol demonstrated superior effects that were statistically significant and clinically meaningful. E-mails have also been used as a follow-up practice, although telephone contact was preferred by those involved in the follow-up program (Goldman et al., 2004).

### *Memorials*

Virtual memorials are sites of remembrance that offer virtual spaces where death can be assigned meaning for both the deceased person and the bereaved person through common or alternative practices of grief (Maddrell & Sidaway, 2010). They do not intend to substitute physical remembering places, but rather to offer a different way of accessing them (Brubaker et al., 2013; Roberts, 2004). Memorials offer exclusively asynchronous communication and, sometimes, peer

support: users establish a relationship with other mourners and share experiences but also honor the deceased through the posting of photographs, personal thoughts, or anecdotes. Memorials can be found in the form of independent individual web pages, set up by family or friends of the departed, or more formalized online memorial websites, similar to online cemeteries (de Vries & Rutherford, 2012; Lester, 2012; Roberts & Vidal, 2000), operated by commercial or non-commercial organizations (Krysinska & Andriessen, 2013). In the last decade, Facebook has also established itself as a virtual place to host memorials (Degroot, 2012, Mazzone, 2011), in some cases posing legal and practical implications for the disposition of the digital remains of the deceased user (McCallig, 2014). Memorials offer a space for memorialization that is unbounded by the offline physical space and time (Westerlund, 2020), and provide a unique venue for the bereaved to express their feelings and maintain their bond with the departed (Mitchell et al., 2012; Walter, et al., 2012). Such places often become a place to strengthen or create personal spiritual beliefs: Krysinska and colleagues (2015) highlighted the important role of religion and spirituality in memorialization groups for mourners, which is a resource that can help the bereaved to cope with their loss (Becker et al., 2007).

The main limitation found by the use of memorials is that these pages have almost no moderation or, in any case, do not contemplate the intervention of a mental health professional, which can lead to indiscriminate and uncontrolled use of the platform: memorial websites, after an initial positive effect, were in fact observed to provoke negative rumination and consequent reluctance to let go of the deceased (Bell et al., 2015; Forman et al., 2012; Westerlund et al., 2020).

### *Online Support Groups and Forums*

Specific attention should be given to online support groups and their advantages. Authors have generally found face-to-face grief support groups to be beneficial (Nolen-Hoeksema & Larson, 1999; Steiner, 2006; Thuen, 1995), especially in those cases where individuals struggle with insufficient coping resources or informal support (Banach et al., 2010; Caserta & Lund, 1993). However, face-to-face support groups (for grief and other issues) might reach only a small proportion of eligible individuals and can be difficult to access (Steiner, 2006; Taylor, 2011). A growing body of research has, then, explored the potentialities of online support group participation (Barak & Dolev-Cohen, 2006; Barak & Gluck-Ofri, 2007; Cerel et al., 2009; Cipolletta et al., 2017; Cipolletta et al., 2020; Feigelman et al., 2008; Gibson et al., 2020; Hartig & Viola, 2016; Massimi, 2013; Oliver et al., 2015; Robinson & Pond, 2019; Varga & Paulus, 2014; Wright & Muhtaseb, 2011; Ybarra & Eaton, 2005). Barak et al. (2008) state that online support groups might be considered a possible supplement to more traditional professional treatment; but for Döveling

(2015), their contribution lies more in affecting people's general well-being than causing therapeutic change.

Online support groups are online discussion sites where participants interact with each other, or with professionals, by sending messages and replies, with a (mostly) asynchronous mode. Either support groups and forums vary in terms of their structures, hierarchy, and leadership: some are professionally conducted, either affiliated to agencies or free-standing community groups, others are peer-facilitated, where users share a similar loss experience and experienced survivors act as moderators, evaluating the adequacy of messages and the presence of spam (Coulson & Shaw, 2013). They can also be further differentiated into single-loss types (e.g., specifically designated, for example, for suicide survivors) or general bereavement support groups, including survivors from a variety of different death causes, (e.g., accidents, natural causes, illnesses, suicides and /or homicides) (Feigelman, 2008). There is no limit to where such a group can be hosted, as long as these criteria are met; some support groups are also hosted on Facebook groups or Reddit (Olivier, 2015).

With the opportunity to meet other people with similar experiences and discuss issues related to loss and bereavement, survivor support groups have historically played an important role in helping bereaved people, especially suicide survivors, in their grief work and have also actively given their contribution to suicide prevention and against stigma and shame (McIntosh et al., 2017). In fact, the possibility to receive and provide emphatic support has been listed by Westerund (2020) among the main reported reasons why bereaved people join online grief and support groups. Support groups are an important opportunity for survivors to find other people who have experienced similar experiences, to be able to share a personal story in a safe and empathic space that can facilitate the sharing of experiences (Kummervold et al., 2002), eased by the perceived similarity with others (Wright, 2016) and the reassurance that they are not the only ones (Paulus & Varga, 2014). This safe virtual space, enhanced by the anonymity offered online, is particularly important for those experiencing stigma and lack of social support such as suicide survivors (Barak, 2008; Feigelman et al., 2009).

In an interesting study, Massimi (2013) observed three distinct support groups on a website where bereaved individuals could participate in online support groups and reported the use made of its specific features (e.h., The Memory Box) for the remembrance of the departed and the obtainment of social support from family. Paulus and Varga (Varga & Paulus, 2014; Paulus & Varga, 2015) examined posts in a grief support group: firstly, they analyzed qualitatively how newcomers constructed their initial posts to display their eligibility for membership (2014), then they examined the responses of the community to these posts (2015). The results showed grievers'

need to feel supported by peers through validation of their "nonnormal" grief (i.e., a violent death) and also the system of resources that is mobilized by the meeting of peers in these types of groups.

An important issue to consider when talking about the support offered virtually to survivors is meeting their need to make sense of the loss. In fact, in several studies (Delgado & Wester, 2020; Halliwell & Franken, 2016; Varga & Paulus, 2014) mourners try to understand why the death had occurred and also tried to make sense of it, an important step in their grieving process (see Chapter 2). Through the writing of posts, survivors are willing to maintain a relationship with the deceased (Westerlund 2020): in fact, the transposition of speech online also offers the occasion to personally address the departed (Krysinska & Andriessen, 2015) and by writing on these virtual spaces, survivors try to foster the continuing bond with the loved one (as explained in Chapter 2). Although Neimeyer and colleagues (2014) claimed that a popular Western discourse adopted by those surrounding the bereaved person might pressure the bereaved to 'let go' of the deceased, thus challenging the narrative of the continuing bond (Neimeyer et al., 2014).

Studies find that support group participants also look forward to sharing their suffering, thoughts, and feelings with non-judgmental others who are able to listen, relate, and understand, by virtue of their own experience (Swartwood et al., 2011). The kind of empathic listening received fosters normalization of their experiences, validation of their emotions, and strengthens a sense of community (Nove-Josserand & Godet, 2015; Steiner, 2006). A direct effect of the sharing of emotions online is emotion regulation (Calkins & Hill, 2007; Doveling, 2015; Rimé, 2007): bereaved individuals receiving support online were found by Doveling (2017) to compare themselves and their experiences with others in a horizontal (i.e., not through a downward comparison) and nonjudgmental way, hence demonstrating to be using the virtual space as a place where the mutual ground is emphasized, also posing the bases for the provision of mutual support between members (Roberts, 2004; Walter et al., 2012).

Online peer support might, therefore, increase wellbeing by providing a particularly expressive, understanding, supportive, informative, and permissive environment for bereaved persons to share and negotiate their stories of loss and grief (Neimeyer et al., 2014). Consequently, this could help support group users make sense of their experiences of loss in personal, practical, existential, and spiritual terms (Lobb et al., 2010; Neimeyer et al., 2010).

Another important resource offered by online groups is the request for information. Schotanus and Dijkstra (2014) investigated the self-help mechanisms, grief reactions, and experiences with health-care services of mourning people writing in online forums. Compared with online groups for somatic illnesses, mourning people would engage less in "chitchat" and more on expressions of support or empathy, providing advice, and recognition. An analysis of forum

messages has also confirmed that users validate and normalize other users' grief experiences while also providing appropriate psychosocial support (e.g., acceptance, understanding, and attention to difficult emotions) and useful information and resources (e.g., about coping behaviors) (Swartwood et al., 2011).

Ultimately, survivors obtain great benefits from the exchange of similar experiences (Barak, 2008; Varga & Paulus, 2014): overall, research has shown that the mean effect size of online synchronous groups versus asynchronous groups is not statistically different (Barak et al., 2008), despite recent systematic reviews are lacking; however, text-based and e-mail interventions were found to be statistically superior to forums, audio or video support (Barak et al., 2008). In listing the benefits of writing in online groups, however, it is important to bear in mind the constant sense of loss that is felt by the bereaved (Stroebe & Schutt, 2010), despite all positive resources they might find or actualize.

As for health-related online support, therapy guidance was found to generate larger effects than unguided peer support interventions (Andersson et al., 2014); however, in bereavement support, a recent study (Westerlund, 2020) suggests that most of the online group members might be using digital resources independently of how they value other forms of help, that is, that a respondent devalues psychiatric or primary care does not mean that the individual will ''automatically'' seeks out digital resources as an alternative or complement. Still, although support groups are often very accessible, informal, and peer-facilitated, they typically do not offer any connection to clinical professionals or moderation from experts and questions arise as to their quality of support and privacy protection (Aitken, 2008; Finfgeld, 2000; Robinson & Pond, 2019).

As argued by Gibson and colleagues (2020) relatively few hospice organizations are offering online support groups at the moment. Countries such as the United Kingdom and Canada offer online education and support groups through Virtual Hospices (i.e., http://www.virtualhospice.ca/) or foundation websites (i.e., CancerCare, MISSFoundation, Firstcandle, The Alcove, and SUDU-Sudden Unexplained Death in Childhood Foundation), while countries like Italy offer only private services (for example associated with a psychotherapy office or a private foundation).

Overall, the implications on the uses of web-based bereavement interventions are promising, considering how their low-threshold approach might reduce barriers to bereavement care. With advancing technology and the continued evolution of online practice, more organizations and individual providers are likely to consider developing online grief support (Gibson et al., 2020), therefore future research should further examine potential moderators, differences between subgroups' needs and assess the ethical implications and long-term benefits of online support group

participation.

In the next chapters, three operational studies, of which two specifically concerning the uses of online tools to obtain professional and peer support, will be presented.

# CHAPTER 4

## Study 1: Assessing Social Support and Help-seeking Through a Rule-based System Analysis Among Italian Suicide Survivors

### Introduction

Individuals mourning the loss by suicide of a significant person face an increased risk of developing physical and psychological issues and need timely support (Pitman et al., 2014). Literature suggests that the most common barriers to utilizing professional mental health support are the worry that it might be too painful to speak about the grief experience, the belief that it is too difficult to find help, or a fear of stigmatization, specifically for those bereaved by suicide (Bell et al., 2012; Cerel et al., 2019; Link & Phelan, 2006; Scocco et al., 2019); moreover, the research for professional help may also be hindered by prejudice toward mental health services or lack of economic resources (Feigelman et al., 2008).

Survivors in need of consoling and understanding might then turn to their families and friends, but because Western society is not particularly grief literate (Glanz, 2006), the informal support network might not necessarily know how to effectively be of support to them (Hollander, 2001; Steiner, 2006; Swartwood, 2011) hence determine yet another flaw in the survivor's support system. In fact, social support is a widely assumed factor in the moderation of bereavement outcomes (Kreicbergs et al., 2007; Stroebe et al., 2005b; van der Houwen e tal., 2010) given that some factors are present, such as the goodness of fit between the needs of the bereaved person and the support that is offered (Aoun et al., 2019; Vachon & Sylianos, 1988).

Help-seeking behavior in suicide survivors was previously studied in relation to personality traits, coping styles, and perceived closeness to the decedent (Drapeau et al., 2016) (i.e. the impact of personality, coping, and perceived closeness on help-seeking attitudes in suicide bereaved adults). However, in Drapeau's study the recruitment was carried out mainly through suicide support services. In fact, sampling on suicide survivors is often generally focused on people who had already obtained support (McMenamy, 2008) or, at best, were referred to peer support groups (Feigelman et al., 2009). The survey from McMenamy and colleagues (2008) assessed the needs of survivors in terms of formal and informal sources of support, resources used in healing, and

obstacles to finding support since the loss; however, the sample included only one person not related by blood to the decedent. Scocco and colleagues (2019) focused specifically on a group of suicide survivors already seeking for help and investigated how grieving and depression can influence the intensity of stigma in this group of survivors.

As the majority of survivors' studies has generally focused on people who had already accessed support services (McMenamy, 2008), pivotal information is lacking over how different sub-groups of survivors (i.e., females/males; relatives/non-relatives) seek help in their formal and informal support network: whether they resolve to different types of support, where they actually look for it, what is helpful to them. A clearer picture of how different groups of survivors may use informal and formal support is needed and could guide professionals in identifying individuals at risk of experiencing poor social support. Much is still unknown about how different sub-groups of survivors (i.e., females/males; relatives/non-relatives) seek help in their formal and informal support network: whether they resolve to different types of support; where they actually look for it, and what is helpful to them. Artificial intelligence research is already used to identify people at risk of self-harm and suicide (Fonseka et al., 2019). Among these computer programs, rule-based systems (RBS) can be used to perform inferences on data that could not be obtained with common analyses. RBS is generally used in fields requiring automated processing of large bodies of knowledge (Ligeza & Nalepa, 2011) but their inference engine system is apt to be employed to trace paths for in-depth exploration or provide information for tailored services.

The aim of the present study was to obtain a panoramic of the psychological state and perceived social support of Italian survivors, including those who have not sought for help, and investigate possible differences for gender or kinship. This initial investigation on the Italian territory served to gather information on the Italian population and to set up a subsequent study (that will be presented in Chapter 5). Moreover, through the study the scope was to explore the relationship between perceived social support and reported help-seeking behavior; in doing so, the feasibility of rule-based systems (RBS) to conduct extended analyses on restricted amounts of data was tested.

## Method

The present study is a cross-sectional study conducted on suicide bereaved people in Italy.

### Study Setting and Sample

An anonymous questionnaire was launched online in April 2019. Between April 2019 and January 2020, a total of 228 people answered to it, and of these 132 met the criteria to be included

in the study. Inclusion criteria were: being more than 18 years old, residing in Italy, and having experienced a loss by suicide. Individuals from the same family could participate.
The survey was accessible only online: as it was composed of numerous sets of questions, participants that partially completed the questionnaire (over 50%) were included in the dataset. Participants were recruited through local advertisements, social media (i.e., Facebook), and snowball sampling (Goodman, 1961). Approval from the Ethics Committee of Psychology Research of the University of Padova was obtained. On the first page of the questionnaire, participants were provided with information about the study and the consensus form; they were also informed of the possibility of obtaining free of charge support in case they had reached the survey webpage while looking for help or should the questions trigger acute distress: contact details were provided at the beginning and at the end of the questionnaire.

**Measures**

Sociodemographic information about the participant and the decedent were collected as well as the participant's and decedent's age at the time of the death and their relationship/kinship with the departed. Participants were also asked to rate their perceived closeness to the decedent on a scale from 1 (Not close) to 3 (Very close). Closed questions investigated: a) whether and how much time the participant had waited before looking for help (including barriers to reaching support); b) where they had looked for information or advice; c) the perception of helpfulness from their informal support network; and, d) the type of social support received from each person in their network. Participants could indicate in which amount (on a scale from 0 "not at all" to 5 "very much") different resources in their informal network (close relative, partner, friend and co-worker/classmate) had or had not provided a specific support. Measures of different types of social support were created on the basis of the four domains of the Medical Outcomes Study Social Support Survey (MOS-SS): emotional/informational support, tangible support, positive social interaction, and affection (Sherbourne & Stewart, 1991).

As for the formal support, participants were asked: e) which professionals and services they were able or not able to access (psychologist/psychotherapist; general practitioner, psychiatrist, professional support group, mutual aid group); f) whether they had used online support (such as online forums, crisis live-chat services or email support); and, g) which was for them particularly helpful and/or requested (on a 7-point Likert scale from 'Not at all' to 'Very much').

Life satisfaction, general wellbeing, and perceived social support were investigated through standardized questionnaires:

- The Life Satisfaction Scale (SWLS) (Diener et al., 1985; Di Fabio & Busoni, 2009), a 5-item self-report questionnaire, composed of a 7-point Likert scale ranging from "completely disagree" to "completely agree" (Cronbach's alpha ranging between 0.79 and 0.89). In order to avoid creating a questionnaire with an excessive number of questions, for the present study, only the item "I am satisfied of my life" was used. This singular item was deemed sufficient to assess the general level of life satisfaction.

- The WHO-5 Wellbeing Index (WHO-5) (World Health Organization, 1998), a 5-item self-report questionnaire rated on a 6-point Likert scale. (Cronbach's alpha of 0.88)

- Multidimensional Scale of Perceived Social Support (MSPSS) (Zimet et al., 1988; Di Fabio & Busoni 2008), a 12-items self-report questionnaire measuring perceived social support from three subscales: family, friends, significant others (Cronbach's alpha of 0.81 to 0.98 in non-clinical samples)

Lastly, two ad-hoc questions on suicidal thoughts were posed to investigate whether the participant had suicidal thoughts (i.e., "After a loss some people experience the idea of willing to take their own life. Has it happened to you?" ) and, if yes, when this had happened since the loss (e.g., after one week, after more than 6 months, and so on). The choice was made to avoid participant burden (i.e., to maintain the number of items and time required to fill-in the questionnaire as low as possible). The use of a single item of the LSF (in this case "I am satisfied of my life") was already present in literature (Lucas & Donnellan, 2012) and there is evidence that this specific single-item life satisfaction measure performs very similarly to the SWLS (Cheung & Lucas, 2014). As in other similar studies (Westerlund, 2020), participants could choose to skip questions regarding suicidal ideation (apart from the standardized questionnaires, which were mandatory) should they found them painful or distressful to answer.
A complete list of the questionnaire's item is reported in Appendix A.

**Data Analysis**

Descriptive and correlation analyses were carried out to obtain a general picture of the groups of respondents. Linear and logic regressions were used to test the mediating effects of age, gender, kinship, time passed since the loss, wellbeing, life satisfaction, suicidal thoughts, and perceived social support of participants.

A rule-based system (RBS) analysis was used to identify possible implications among all the variables included. An RBS is a computer software wherein human practical knowledge is

accumulated and employed as a series of "if-then" associations (Pam, 2013). The algorithm used to perform these analyses is called Preference and Rule Learning (Polato & Aiolli, 2019), a classification algorithm that automatically builds and selects the most important features in the decision. In our experiments, the classification tasks aimed at finding a correlation between the input features and the target variable. The considered features are logical rules built on top of the independent variables. In PRL, the most relevant rules can be selected in two ways: “by margin” , which are the rules which guarantee good confidence in the classification, and “by weight” which are the rules that have a higher impact on the decision. As a first step, the algorithm tested all the independent variables included in the study with the four dependent variables: wellbeing, life satisfaction, suicidal ideation, and perceived social support. The most promising set of implications (i.e., those showing to discriminate within the variables with a probability higher than 0.5) was selected and rules were extracted. For this second step, two analyses were conducted: one by ‘weight’ and another by “margin” ; both showed a good overlapping.

For the present study, the first 50 rules extrapolated “by margin” between the use of formal/informal support and perceived social support were selected and analyzed: specifically, the group of questions regarding the perceived social support and a macro-group of questions regarding the style of informal and formal support-seeking. The questions covered: 1) whether the person after the loss had looked for support; 2) which kind of informal social support (emotional, informational, practical, physical) was received by every person or group of people; 3) which people in the informal support network participants relied on; and, 4) if and for how much time participants used professional support and services.

## Results

The demographic and psychosocial characteristics of the respondents, as well as the answers regarding how they have sought for help, are reported in Tables I and II.

Seventy participants of 123 (56.9%) had sought professional help after the loss and 53 (40.2%) did not. Of these, 37 were male individuals. Details over how much time participants had waited before looking for support and receiving it are reported in Table I.

Many participants who looked for support (43.9%) stated they did not find obstacles in reaching out for help. Lastly, only 20 participants out of 123 (15.2%) received a direct outreach from mental health services. Those who declared not having received any form of outreach (103 out of 123) answered that they would have liked to receive it in 60 cases (45.5%), and those who had received it were for the majority (90%) satisfied with the support received.

The most used support service was a psychologist or psychotherapist (72.3%) and a General

Practitioner (59.4%). Psychiatrists were indicated in 42.6% of cases, and there was no significant difference between the use of formal support groups (37.6%) or mutual aid groups (39.6%). As for what was found useful by participants, 61.4% indicated "not feeling judged", 47.5% the possibility to "rely on a specialized professional" and 41.6% the possibility to "receive advice and information" . In the professional support received, the "feeling of not being understood" (28.7% of cases), the "costs of the services" (21.8%) and the "lack of specific knowledge by professionals" (18.8%) were the most unsatisfactory aspects.

As for the uses of online services and telematics support, only 18.1% of participants declared to have used them: the most employed ones were online forum groups, either administered by a professional (10.6%) and by other survivors (10.6%); telephone services and live-chat services were used respectively by 8.7% and 7.7% of the respondents, while the least used was support via email (96.2% declared they have not used it).

Twenty-seven participants out of 102 (26%) had previously received psychological support; the numerosity of this subgroup did not allow more complex analyses of this data with other variables (e.g., ANOVA), such as whether they managed to receive help quicker or their general level of wellbeing. The most valued resources were the support from a psychologist/psychotherapist (selected by 55.3% of participants; 18.9% answered it was "Very useful"); the least was support through chat/email (selected by 25.8%; no participant answered it was "Very useful"). Lastly, 53% stated they still needed support: 40.6% selected a psychologist or a group administered by a psychologist (24.8%); a psychiatrist or a GP were indicated only on a few occasions (5.9% and 3%, respectively).

As for the answers to open questions, some participants stated that they would have preferred a free-of-charge psychologist, or rather a professional specialized in traumatic bereavement. Others indicated that they had difficulties accessing the online support, which they had found but were not properly guided to log it in. Some, expressed the need to help their partner or relatives, and one person who lost the niece explained she was not feeling "worthy" of help.

As for informal support, the most perceived form of help was from parents, indicated 101 times out of 132 (76.5%; in 26 cases "very helpful"), and from friends or other relatives indicated 106 times out of 132 (80.3%, in 26 cases as "very helpful"). Partners as a form of support were indicated 76 times out of 132 (57.6%, in 18 cases indicated as "very helpful"). The least helpful type of informal support was offered by co-workers or classmates (16 times indicated it as not helpful at all). Also informal groups were included in this item: 14 times these were indicated as not helpful at all, and only 52 times, overall, were selected as a source of support.

**Table I.**

*Participants' sociodemographic data and answers on help-seeking.*

| Factor | N°(%) Respondents (Total =132) |
|---|---|
| Gender | |
| Female | 103 (79,2%) |
| Male | 29 (20,8%) |
| | |
| Marital status | |
| Single | 59 (44,7%) |
| With partner | 73 (55,3%) |
| | |
| Employment | |
| Unemployed | 49 (37,1%) |
| Employed | 83 (72,9%) |
| | |
| Religiosity | |
| Non-believers | 64 (48,5%) |
| Believers | 68 (51,5%) |
| | |
| Kinship | |
| Relatives (close relatives and partners) | 74 (57,8%) |
| Non-relatives (4 missing) | 54 (42,2%) |
| | |
| Closeness perception with decedent | |
| Not very close | 8 (6,3%) |
| Averagely close | 39 (30,5%) |

| | |
|---|---|
| Very close | 81 (63,3%) |
| | |
| Decedent's gender | |
| Female | 34 (26,2%) |
| Male | 96 (76,8%) |
| | |
| Suicidal thoughts | |
| Yes | 49 (44,5%) |
| No | 61 (55,5%) |
| If yes, after how much time? | |
| 1 week | 126 (95,5%) |
| 1 month | 119 (90,2%) |
| 1 month < > 6 months | 109 (82,6%) |
| > 6 months | 126 (95,5%) |
| > 1 year | 126 (88,6%) |
| | |
| Sought for help | |
| Yes | 70 (56,9%) |
| No | 53 (43,1%) |
| If yes, after how much time? | |
| 1 week | 25 (35,7%) |
| 1 month | 24 (34,3%) |
| > 1 month | 14 (20%) |
| 1 month < > 6 months | 3 (4,3%) |
| 1 year | 2 (2,9%) |
| >1 year | 2 (2,9%) |
| | |
| Received support | |
| 1 week < | 50 (37,9%) |
| 1 month | 11 (8,3%) |

| | |
|---|---|
| > 1 month | 2 (1,5%) |
| > 6 months | 2 (1,5%) |
| Never received it | 5 (3,8%) |

**Table II.**

*Time from loss and questionnaires' scores*

| | |
|---|---|
| Participant's age | Mean = 42,3 y.o.; |
| | SD = 14,9 |
| | Min = 19 y.o / Max = 73 y.o. |
| Decedent's age | Mean = 38,9; |
| | SD = 17,6 |
| | Min = 15 y.o. / Max = 90 y.o. |
| Average time from loss | Mean= 66,2 months; |
| | S.D. = 7,9 |
| | Min = 1 month / Max = 20 years |
| SWLS (Life satisfaction) | Mean 3,17; |
| | SD = 1,94 |
| | Min = 2 / Max = 5 |
| WHO-5 (Wellbeing) | Mean 12,55; |
| | SD=4,35 |
| | Min = 9 / Max = 21 |
| MSPSS (Social support) | Mean 3,80; |
| | SD = 1,10 |
| | Min = 2 / Max = 4.90 |

### 5.3.1 Correlations

Correlations showed a positive relationship of perceived social support with wellbeing (r =.22, p =.015) and life satisfaction (r =.32, p =.001). As for suicidal ideation, it correlated negatively with life satisfaction (r =-.36, p =.000), wellbeing (r =-.18, p =.049) employment (r =-

.18, p =.034) and kinship (r =-.26, p =.009), whereas positively with gender (r =-.17, p =.043), that is, close relatives and women had a higher number of suicidal thoughts. Life satisfaction correlated negatively with the age of the participant (r =-.19, p =.033) and positively with their religiosity (r =.18, p =.034) and kinship (r =.31, p =.001) with the departed (binarized in 1= family relations and 0 = non-family relations). Correlations, including the most significant ones, are reported in Table III.

**Table III.**

*Correlations (Pearson correlation; 1-tailed)*

| | Life satisfaction | Wellbeing | Social support | Suicidal ideation |
|---|---|---|---|---|
| Life satisfaction | - | .54** | .32** | -.35** |
| Wellbeing | - | - | .22* | -.18* |
| Social support | - | - | - | -.06 |
| Suicidal ideation | - | - | - | - |
| Age | -.19* | -.08 | -.07 | -.15 |
| Gender | -.11 | -.02 | -.13 | .17* |
| Marital status | | | .18* | |
| Employment | -.06 | -.05 | -.06 | -.17* |
| Religiosity | .18* | .13 | .10 | -.02 |
| Kinship | .31** | .12 | -.13 | -.22** |

**. ≤ 0.01; *. ≤ 0.05

### 5.3.2 Linear regressions

The results of regression models are reported in Table IV. As for life satisfaction, 42% of its variability was explained by the model with religiosity, decedent's age and kinship as predictors. The kinship with the deceased revealed to be the more predictive variable: those who have lost a relative or a partner have poorer life satisfaction than non-relatives. Life satisfaction was higher for those who reported to be religious and also higher when the age of the decedent at the death was higher. Moreover, participants whose age was higher at the time of the loss had higher wellbeing. Females reported less social support than males. Those who had a partner reported higher social

support. Logistic regressions were used to analyze binary data about suicidal ideation with several dependent variables, but no significant results emerged. Lastly, social support was predictive of life satisfaction (β= .338).

**Table IV.**

*Significant results of linear regression*

| Dep. Variable | $R^2$ | Coefficient | Ind. Variable | Standard Error | β | t | ρ |
|---|---|---|---|---|---|---|---|
| Life Satisfaction | | | | | | | |
| | ,418 | ,000 | Religiosity | ,396 | ,383 | 3,782 | ,000** |
| | | | Decedent's age at the death | ,201 | ,298 | 3,058 | ,003** |
| | | | Kinship | ,500 | ,500 | 4,214 | ,000** |
| Wellbeing | | | | | | | |
| | ,274 | ,040 | Participant's age at loss | ,944 | ,464 | 2,612 | ,011* |
| Social Support | ,539 | ,006 | Age | ,211 | -,433 | -2,899 | ,005** |
| | | | Gender | ,266 | -,214 | -2,187 | ,031* |
| | | | Marital status | ,222 | ,248 | 2,481 | ,015* |
| | | | Employment status | ,236 | -,232 | -2,292 | ,024* |

**. ≤ 0.01; *. ≤ 0.05

### 5.3.3 Rule-based system analysis

The results of the RBS analysis are schematically reported in Table V. Regarding whether the person after the loss had looked for support [1], participants who experienced low social support searched in forums for advice and information, whereas high social support was experienced if participants had searched into informal groups not connected to bereavement support. As for which degree of support participants perceived from different people in their social network [2], low social

support was experienced by those who indicated that a close relative has helped “nothing at all” or “partially” ; but also by those that indicate that the partner was a “good” or “very good” support source. Moreover, low social support was experienced if friends or other distant relatives were indicated as “not helpful at all” , “partially helpful” or “neutral” .

Participants were also asked to indicate which kind of informal support was received by every person or group of people [3]. High social support was experienced if participants did not feel the need to “Be able to confide and talk about the loss with no fear” nor “Looking for some distractions during the day” . As for the people to rely on [4], a high level of social support was experienced if participants resolved to close relatives for “practical support” , to “obtain physical comforting” , or to “have someone to remember the departed with” . When participants relied on informal groups to have advice or practical support, social support was low; on the contrary, social support was high if they look for informal groups to have someone to confide in.

The last set of questions investigated if and for how much time survivors used professional support and services [5]. Low social support was experienced if participants had not turned to a psychologist or only used one or two encounters. High social support was experienced if participants had not looked for support groups; but also high social support was experienced if participants had looked for support groups within one/two encounters and encounters for 1 year.

**Table V.**

*Implication rules*

| | | |
|---|---|---|
| 1) WHERE THEY HAVE LOOKED FOR SUPPORT | Looking for help in informal groups (e.g., church, book clubs) | High Social Support |
| | Looking for help in online forums | Low Social Support |
| 2) DEGREE OF PERCEIVED SUPPORT | Friends are indicated as helpful | High Social Support |
| | Friends are indicated as not helpful | Low Social Support |
| | Close relatives are indicated as not helpful | |
| | Partner are indicated as helpful | |
| | Colleagues are indicated as helpful | |
| 3) TYPES OF INFORMAL SUPPORT | Not needing others for ‘distractions’ or to “confide with someone” | High Social Support |

| | | |
|---|---|---|
| | - | Low Social Support |
| 4) PEOPLE TO RELY ON | Close relatives for: Practical Support; Physical Comfort; Sharing Memories. | High Social Support |
| | Partner for: Advice | |
| | Friends for: Physical Comfort | |
| | Colleagues for: Talking about the departed | |
| | Informal Groups: Someone to confide to | |
| | Friends for: Talking about the departed | Low Social Support |
| | Informal groups: Advice; Practical Support | |
| 5) USE OF PROFESSIONAL SERVICES | Not going to a psychiatrist | High Social Support |
| | Not going to support groups (i.e., mutual aid groups) or going systematically for one year | |
| | Not going or going shortly to a psychologist | Low Social Support |
| | Going to the GP often | |

## Discussion

The present study offers an overview of the bereavement experience of a sample of Italian suicide survivors, specifically: a) the general characteristics and psychosocial state of a sample of Italian individuals bereaved by suicide; b) the way suicide survivors have dealt with formal and informal help-seeking; c) the relationship between survivors' perceived social support, life satisfaction and wellbeing; and, d) the way perceived social support may influence the professional support seeking.

A majority of females answered the questionnaire: this was expected, as males may tend to seek less for support (Addis & Mahalik, 2003); also the majority of decedents was expected to be male, as suicide occurs more often in males (Varnik et al., 2008). Life satisfaction of participants was below average and, differently from what suggested by literature (Bonanno & Kaltman, 2001; Cerel et al., 2013), was negatively correlated with age and positively with being a close relative or partner of the departed. Higher life satisfaction was found when the decedent's age was more advanced (Bratt et al., 2017) and in religious people; this latter result is in line with the claim that

spirituality could have a buffering effect on mourners and represent, for some, an important coping resource (Becker et al., 2007; Tedeschi et al., 2006). Overall, despite the variability in the time passed since the loss, the sample of survivors showed to have been impacted in their life satisfaction by the suicide loss and this observation is important because, for example, Diener and Seligman (2002) found life satisfaction to be a significant negative predictor of suicidal ideation.

Almost half of the respondents reported having had suicidal thoughts, a good number of which more than once, a common trend previously observed by Pitman and colleagues (2014). Some results regarding suicidal ideation such as relationships with gender and employment status are consistent with the literature (Nock et al., 2008); however, differently from what outlined by Stroebe et al. (2005b), in our sample social support did not show a direct correlation with suicidal ideation. Also, only close relatives and partners showed high rates of suicidal ideation (Pitman et al., 2016), compared to friends and coworkers. No significant results emerged by the time passed since the loss: according to Stroebe (2005a), buffering and recovery effects promoted by social support (respectively obtained recently after the loss and in the longer term during the bereavement process) are mediated by different processes and may be likely to have a different time course. Lastly, the search for help decreases after 6 months/1 year; this could indicate a renunciation to look for support, an alarming issue considering literature suggests grief related issues may last up to 2 years (Entilli et al., 2021; Kõlves et al., 2020).

The results offer insights over the obstacles Italian suicide survivors might face when seeking support: fear of stigma and lack of economic resources were the most reported obstacles by those bereaved who did not look for help. Consistently, survivors who did obtain support indicated the need for trained professionals that could welcome them in an empathic way and the necessity to not feel judged. This is in line with previous research where the bereaved report disappointment by the scarcity of community resources and the lack of response, empathy, and competence (McMenamy et al., 2008; Westerlund et al., 2020). Suicide bereavement support services are not yet widely used in Italy; especially in southern Italy and in rural areas, where there are few or no associations or specialized services. These results might confirm the usefulness of the development of telematic services, both by telephone and online. In fact, face-to-face support groups, when accessible, are often used by suicide survivors to obtain advice and comfort from peers (Cerel et al., 2009), but our participants showed to prefer online groups instead and this might have to do either with the above-mentioned fear of stigma, lack of services or economic concerns. The existence of live-chat services is even less known than common bereavement support services, and this is reflected in the low number of participants reporting to have used them. This survey also aimed to obtain an overview of how common the use of online tools was among suicide survivors and the

results provide confirmation that it is necessary to promote the use of such services, possibly offered free-of-charge and through specialized associations.

In previous studies such as in Westerlund (2020), family was considered the biggest source of support; in our study, parents and friends revealed the most valued source of help, whereas partners in a smaller amount. However, other relatives and co-workers appeared to have a role in support, as they may have been the only resource survivors could rely on, when support from closer relatives is missing. Lastly, informal groups not related to bereavement support (such as sport or church groups) were not indicated often or reported to be useful: although community help may seem a useful resource for the bereaved person, the component of fear of being stigmatized and judged must be considered and could have contributed to the inhibition of access (Sheehan et al., 2018).

Perceived social support was associated with life satisfaction and wellbeing in suicide survivors. Some authors suggest that these three constructs may be part of the same supra-construct, and therefore belong to the same higher-order construct (Diener et al., 1999). As for suicide bereavement, Ulmer and colleagues (1991) confirmed that higher life satisfaction and social support, among others, were strongly associated with purpose, and could play a role as moderators in recovery from bereavement. Although these results could be of relevance for any type of loss (both traumatic and non-traumatic) (Bratt et al., 2017), this is particularly important for suicide survivors who, as already mentioned, may struggle significantly more with disclosing about the death of their loved ones (Sheehan et al., 2018): actively supporting survivors in obtaining informal and professional support could have direct effects on their reported well-being and life satisfaction, two conceptually distinct constructs, but which are, however, strongly interrelated with the mental and physical health of bereaved persons (Leopold & Lechner, 2015).

General levels of perceived social support were low and females reported feeling less supported than males: this result was unexpected, as females are usually more socially supported than males (Kendler et al., 2005), although they also tend to express grief emotions more often (Rubinstein, 2004). Moreover, in our sample older people result as less supported: this could have to do with the fact that female survivors represent the majority of the sample and also the likeliness for older respondents to have lost an important part of their social support network, such as a partner. Participants in this study were recruited mainly through social media instead of associations and the sample includes survivors who did not seek help or rely on informal support only. Survivors who did seek help reported to have searched overall in the month following the loss, to have been able to receive it within one month, and to be generally satisfied with the support. It is possible that the anonymous survey was able to reach for a sub-group of female survivors who may be struggling

with social support.

The RBS was employed to find implications between the answers to the social support questionnaire and which specific person may have provided useful help. Survivors experiencing low social support showed to resolve to online forums to look for help: the online context offers important peer-support (Barak et al., 2008) that could be difficult to obtain if survivors are afraid of experiencing stigma or struggle to talk about the death (Peters et al., 2016); moreover, informal gathering occasions, such as book clubs or church groups, could be approached only by survivors who do not fear stigmatization and are already perceiving high social support; another interpretation of the results is that social support increases in the moment these respondents attend the informal groups.

RBS analysis highlighted how Italian survivors experiencing high social support might be seeking different sources of support from different people, hence being able to extend their requests to close relatives, partners, friends and even co-workers. The literature suggests (Walker, 2003) that being able to obtain social support from differentiated sources facilitates both parties in providing/obtaining what is requested: in this study, suicide survivors with high social support can obtain practical support from close relatives, physical comfort from friends and several types of memorialization occasions and informational support from partners, informal groups and even co-workers. For those who manage to access informal groups, these could be the places they may resolve for advice and even practical support when primary support is lacking; we don't have data on whether this group of survivors is feeling better despite relying on informal groups for such amount of support.

The limits of the study reside in the difficulty of sample generalization: it focuses on Italian survivors and the sample size was, in some cases, insufficient for in-depth analyses. Future studies should investigate survivors of different nationalities and employ a reduced number of questions to maximize the use of the RBS analysis. Another limitation is in the data collection: full completion of the questionnaire can be obtained when the respondent is physically present (for example when accessing services): surveying participants anonymously and online might imply the risk of several missing answers: however, this strategy allowed to reach to people who had not looked for help, as per the aim of the study.

The results of this study are unique in providing knowledge over the ways perceived support could influence formal and informal help-seeking in suicide survivors: survivors with strong social support from their families may not feel the need to contact a psychiatrist (who is often sought when there are more severe symptoms) nor support groups. Survivors with strong support from their families may already be receiving all the support they would be looking for in support groups;

however, the results also show that a systematic use of the support groups could offer the same support in time, probably in accordance to Stroebe model of buffering/recovery effect (2005a), as groups are indeed a place that fosters the inhibition of maladaptive responses and the facilitation of adjustive counter-responses.

The results support Westerlund's (2020) hypothesis that survivors seeking support online might be using digital resources independently of how they value other forms of help, meaning that respondent's devaluation of psychiatric/psychological support or primary care does not imply that they will seek out digital resources as an alternative or complement to their care.

The conjoint analysis of descriptive results and RBS also shows - consistently with literature (Sveen & Walby, 2008) - that suicide survivors may be inhibited to look for professional help because of the fear of being stigmatized or not understood. Survivors with scarce support from family may not get in contact with a psychologist or abandon soon after: this could have to do with the unsatisfaction for lack of training or with economic factors, two other issues that emerged in the survey. Survivors may then resolve to their GP, with whom they may have more confidence; this observation calls to a specific attention to GP's preparation to support suicide survivors, as they can play a meaningful role in suicide postvention (Fhailí et al., 2016).

RBS analysis was shown to be feasible and could be further implemented in the study of help-seeking behavior: the unique results of such analyses offer insight to identify which specific areas would be fruitful to investigate while assessing social support in a bereaved individual, as well as being able to assess risk factors and predict help-seeking trajectories. In fact, an expanded knowledge over how survivors look, or do not look, for help is important to inform practitioners of what bereaved individuals look for and what they could offer them. This initial exploration provided data, not previously available, on the experience of suicide bereavement in Italy, as well as literature confirmations that allowed the two subsequent studies to be approached with greater awareness: in study 2, specific attention was given to how participants described their approach with a traumatic bereavement support tool offered online, free of charge and anonymously; while in study 3 it was investigated how emotional and information support is provided within a group with peer survivors and moderated by a professional.

# CHAPTER 5

## Study 2: Live-chat Support for Traumatic Bereavement

### Introduction

Traumatic survivors might find several other barriers along the way such as prejudices toward health professionals (Feigelman et al., 2008), or lack of energy (Schneider et al., 2011). Suicide survivors, specifically, might also be faced with stigmatization and therefore limit their possibilities to receive timely support (Pitman et al., 2018; Sveen & Walby, 2008).

Professionally led online chats are a way to overcome the obstacles traumatic survivors usually face. A "live-chat system" is a form of online support or service offered through instant messaging platforms that support a two-way synchronous communication (Turel, Connell & Fisk, 2013). This modality of tele-support, that allows a direct and immediate communication, is increasingly growing (Krysinska & Andriessen, 2013; World Health Organization, 2018) to supplement traditional telephonic support and has already been employed in different crisis contexts effectively such as suicide prevention or counseling for fragile groups (Haner & Pepler, 2016; Predmore et al., 2017): users appreciate the accessibility and confidentiality obtained through the tool. In fact, being able to reach for support from home helps users to feel safe in their own environment (Stephen et al., 2014); the chat tool additionally offers discretion in case the user prefers not to be heard on the phone (Haner & Pepler, 2016).

What is generally considered a drawback of written counseling, that is, the lack of non-verbal signals (Gilat & Shahar, 2009), could in some cases be compensated by the use of relational connotations in the text, such as repeated exclamation points or question marks, but also using slang, dialect, and local idioms, that allow more nuanced expressions (Cipolletta, 2015). More importantly so, the perceived anonymity or unidentifiability that derives from the only-text communication could represent an actual encouragement in exposing through writing, as a result of the "disinhibition effect" (Suler, 2004) presented in Chapter 3; for these reasons, the anonymity and unidentifiability, typically offered by professionally led live-chats, are considered critical factors in the online provision of support and mental health (Suler, 2011). Moreover, text-provided online counseling is considered fruitful in contexts involving grief or intense emotional burden: writing about a traumatic experience could be therapeutically beneficial (Barak & Grohol, 2011) and allow one to "draw out emotions" through typing (Stephen, 2014).

Little research has been conducted on the potentials of online interventions in supporting

suicide survivors (Krysinska et al., 2017). This is the first study to explore how live-chats may represent a valuable tool to offer support to this population. The aim of the present study was to explore how live-chats could support people bereaved by suicide seeking help through a synchronous support tool with trained operators. Since one of the goals of this investigation was to assess the qualities and limitations in the use of live-chats as a first-aid tool in traumatic bereavement support, the study was guided by three questions:

a) How do users use the live-chat service?

b) What kind of users are they? (e.g., what are their experiences with offline support?)

c) What expressions of appreciation or problematics can be identified in the support offered through the live-chat?

## Method

### Study Setting and Sample

Written live-chat conversations were retrieved from the archives of one of the two Italian associations (namely, the NGO De Leo Fund) providing free-of-charge support for traumatic bereavement. The chat support service is flanked by an identical support service provided by telephone and free-of-charge; both are addressed specifically to individuals who have lost a close person due to a traumatic death (i.e., by accident, homicide or suicide).

The service is not accessible to minors. In the case a minor accesses the live-chat and declares to be underage (operators are trained to assess the age of the user as soon as they perceive it is possible to ask it), she or he is informed of the impossibility to continue the conversation without the consent of an adult for legal reasons, not before having assessed the minor is not in immediate danger. In case the death reported does not fall into the group of violent deaths, the user is redirected to support groups or services as close as possible to those needed; finally, if the person has called for a need not related to a loss, the operator provides the contact of the Samaritans, a free telephone listening service accessible all week during working hours. At any time, users could interrupt the chat session without having to provide explanations; if the user believes that she or he has obtained the requested support, the operator concludes by saying "I hope this conversation may have been useful" and at the end of the conversation a question appears on the perception of the usefulness of the support, to which the user can answer positively or negatively by pressing the green icon with a raised thumb or red with a down thumb.

Live-chats are single-use but can be accessed multiple times, through the association's

website. All of the participants included in the present study were using the service for the first time and wrote from different regions of Italy (the service is advertised online as accessible from all over the country and can only be received from within the country itself).

The inclusion criteria were (a) being older than 18 years old; (b) reporting that the loss was due to suicide, regardless of its recency; and (c) being a first-time user.

The response time, once the user has written in the chatbox, is approximately less than a minute. While an operator is busy writing in the chat (the server can only hold one chat conversation at a time) a second operator is always present to answer the phone or help if needed. Each operator is a volunteer with training in psychology (i.e., psychology students or trainees who have already graduated) trained in the principles of empathic support and specifically trained to respond to bereaved users with an awareness of the characteristics of the telematic tool. The supervision is carried out by psychologists experienced in telematic support, with whom the operators meet systematically to discuss the calls they have answered and receive supervision and feedback.

The collection period ranged from December 2014 to January 2019. This time range was chosen because the service has started in 2014. Although the number of chats recovered for this study is significantly reduced, the contacts via chat to the association are actually more frequent: about one per day in 2019, when the study was launched. Data were added until theoretical saturation was reached, namely, the point at which gathering further data would yield no additional theoretical insights (Bryant & Charmaz, 2007). Thirty chat conversations were selected for the analysis. The chat duration ranged from 21 min to 117 min (mean duration: 69 min). The total length of the analyzed chats was 27,963 words.

Detailed sociodemographic information about the users was not collected in order to grant anonymity and effectiveness of the service; however, it was possible to retrieve these details from the chats. Twenty-seven users were women, and three were men; only nine users reported their age, which was on average 35.7 years ($SD$ = 11.9). The age of the deceased was inferred by the context, which ranged between 16 and 60 years, with a majority (16 of 30) of the people having been between 20 and 40 years old. Eleven users out of thirty were siblings of the deceased. The time passed since the loss ranged from a minimum of 48 hours to a maximum of 10 years. Although the average time distance from the loss was 12.75 months, half of the deaths (15 of 30) had happened between 1 and 3 months before the chat and were therefore significantly recent. Details are shown in Table VI.

Extracts of operator-users' conversations are reported in the results: the brackets at the end of every extract indicate the number of the participant, gender and kinship with the departed (e.g., when it is reported 'Parent' it is to be intended that the participant lost a child to suicide).

## Data Analysis

The present study employed a thematic analysis approach (Clarke & Braun, 2018), which was chosen due to its theoretical flexibility and for the purpose of identifying, analyzing, and reporting patterns of meanings across a dataset (Braun et al., 2019). The analysis was data-driven, hence focused on what was identified within the data, following an inductive approach and not a pre-existing theoretical framework (Richards & Richards, 1995).

Analysis was conducted through the software ATLAS.ti.8™ (Friese, 2017). Two coders (one of which is the author) with previous experience in conducting live-chats (they did not conduct the analyzed chat conversations, nor knew the user or the operator) familiarized with the data, operated a first general codification, and then grouped the codes around central meaningful concepts (Tuckett, 2005). A third coder, an experienced psychotherapist and qualitative researcher, revised the themes and engaged in conversations with the previous two, to develop a shared analytical framework. The fourth coder, an experienced Professor and researcher on the topic, revised the final code network. Reflexivity was sought through repeated comparisons and step-by-step discussions about alternative interpretations of the results between all of the coders and the author (Watt, 2007).

## Ethical Considerations

The study was not advertised: users voluntarily contacted the platform by writing in the chatbox, available on the right bottom corner of the association's website, and agreed to have their conversation recorded for research purposes before the live-chat session started, in accordance with the General Regulation for Data Protection (GDPR, UE, 2016/679). All personal data reported in the conversation (e.g., names, cities) were anonymized before starting the analysis. The Ethics Committee of Psychology Research of the University of Padova approved the study.

**Table VI.**

*Sociodemographic details of participants*

| Total number 30 |
|---|

| | |
|---|---|
| Gender | |
| Females | 27 |
| Males | 3 |
| | |
| Age | |
| 20-30 y.o. | 8 |
| 31-40 y.o. | 6 |
| 41-50 y.o. | 4 |
| 51-60 y.o. | 3 |
| >60 y.o. | 0 |
| Not obtainable | 9 |
| | |
| Kinship with the departed | |
| Sibling | 9 |
| Parent | 3 |
| Adult children | 6 |
| Partner | 6 |
| Friend | 3 |
| Relative | 3 |
| | |
| Time since the loss | |
| < 1 month | 6 |
| 1-3 months | 9 |
| 3-6 months | 3 |
| 6-12 months | 2 |
| 12-36 months | 4 |
| >36 months | 5 |
| Not obtainable | 1 |

## Results

The analysis produced five main themes. Table VII reports the main themes, subthemes and codes, while Figure I shows the relations (unidirectional and bidirectional) between the main themes.

### Meaning Making

Users employed the space offered by the live-chat to reconstruct the events that led to the suicide and provide a context to the operator: they usually started the conversation by reporting when and how the death had happened and how they received the tragic news; then, they usually moved to the last days before the death and their last interactions with the deceased. Several users referred to their previous attempts to help the deceased: the stories were permeated with a preoccupation for not having properly understood the situation or not having done enough.

The last time we saw each other ...on the morning before the event he wished me a good day. We had talked until late. (P 12, F, partner)

When he came to me I tried to help him and make him come to reason. I even advised him to go to a specialist, a psychotherapist and that he might have benefited from medical support for his [depressed] mood. (P5, F, aunt)

Users attempted to reconstruct the departed's life and their relationship with that person. The descriptions of the deceased were often polarized toward their good qualities: users focused on features such as happiness or energy or described them as brilliant. In five stories, the deceased was described as the survivor's central source of strength. Despite this, in some cases, users also reported their difficulties with reading the decedent's behaviors indicating that due to their reservedness, they were occasionally very able to disguise their emotions and intentions. In an attempt to make sense of the behavior of the departed, users connected their loved ones' fragilities to past experiences or structural features of their own personality and reported to the operator their daily struggles: some of the decedents had had previous contacts with psychological or psychiatric support and, in one case, had already attempted suicide. Some of these decedents were described as impulsive or angry; in three cases, they were described as aggressive, if not openly abusive, toward their female partners. In one of these cases, the partner was the one using the live-chat.

We only had her, an extremely strong bond both with me and my husband. (P8, F, mother)

Every time I asked him how he was doing, his answer was always, "Good. Don't worry. Everything is OK," except nothing was ok. (P23, F, sister)

[He] was very moody and had little self-esteem. He always felt inadequate despite being a genius. (P4, F, sister)

She had already tried with medicines twice, the third with the hairdryer. The last one was fatal. (P15, F, sister)

My boyfriend took his own life under a train. Since that day I have ceased to exist. The relationship between the 2 of us was sick, so much so that it became clear that to me and my friends that he wanted to drag me into his gesture. (P11; F; friend).

Some users felt the need to also use the virtual space to talk about themselves in relation to the departed: they explained their role in the relationship with the decedent: some of them described themselves as strong, selfless, and capable of "moving forward" , others revealed past difficulties or

traumas that led them to feeling weak or vulnerable, linking this to their actual striving to move forward.

> The pain is great, but I think to be strong enough to be able to bear with all of this. (P13; F; partner)

> I don't know if I can do it and if it's worth it .[...] Before all this happened I frequently had nervous breakdowns. (P16, F, daughter)

Survivors struggling to understand the reasons for the deceased's choice listed and reviewed all of the aspects that could have been linked to the suicide, clinging to the need to find an external explanation: an unfavorable diagnosis, the end of a relationship, even a programmed or a vindictive act. For others, there were several and various causes of the suicide; therefore, they had renounced finding a specific answer. On several occasions, survivors expressed their attempt to understand what the person was thinking and feeling while completing suicide, or posed questions to the operators to help them in this search for meaning.

> "It's always that damn question that runs in my head 'why?'" (P7, F, daughter).

> "Can the end of a relationship lead to something so extreme? I can't wrap my head around it" (P8, F, mother)

> "Was he thinking about us? What was he feeling in that moment? Has he felt fear?" (P19, F, cousin).

> "You reckon it wasn't an external event that made him take that decision? Was it an idea he had in himself? (P5, F, aunt)

> I wish I had understood… this wouldn't have happened. Although I know he also had health and financial problems. (P 26; F; partner)

> We'll never know what triggered in him the desire to disappear, to punish his partner; he used to write her texts like, "Everybody will tell you that you have no responsibilities, but you in your heart know it is not like that." (P5, F, aunt)

On their part, operators often encouraged the survivors to make sense of the suicide by searching for an understandable reason for what had happened and considering suicide as a personal choice. It was observed that the users who did not focus on finding a reason for the loss described the loss as a turning point in their life and showed some levels of forgiveness

> Death, like life, is a mystery. . . . I forgave myself for my weaknesses and shortcomings. . . . I think above all about the meaning of his choice. It makes you understand the importance of life—that happiness is the people we love, love for ourselves, the act of listening to each other, and having the courage to find our own path without taking everything for granted. (P6, F, sister)

**Reactions to the Loss**

Users who had experienced a loss within the past 6 months reported feelings of incredulity, shock, and difficulties in finding a direction. Also, all survivors reported anxiety, fear, and acute distress, sometimes described as an "emotional swing." Their narrations were characterized by a sense of injustice and powerlessness: they directed expressions of criticism and blame to themselves or others, such as relatives or professionals, for not having picked up the clues. The group was observed to have different attitudes: those users addressing critiques toward others and the deceased in the chat had experienced more anxiety and feelings of having been abandoned, whereas the critiques toward themselves co-occurred with anger and guilt. Guilt was one of the most recurring themes (thirty-eight times, 22,84%):

> I know it's still early, but we keep feeling awful and cannot find a direction. (P8, F, mother)

> Whatever his torment could have been, it was his moral obligation to think about his 15-year-old daughter, about his elderly mother. (P3, M, brother)

> I was unable to protect my daughter. I was at work that night. . . . I would work a lot for their needs [referring to her four children]. But I did not do enough. . . . [The advice I gave to my daughter] was not useful; in the end, nothing was useful. (P10, F, mother)

The users reported feelings of loneliness and detachment, while others actively withdrew from people. Overall, the recency of the loss and feelings of powerlessness and uncertainty were often linked to anger and, in one case, with suicide ideation:

> I often feel left apart, like I was forgotten with no one to help me. (P7, F, sister)

I preferred to get away from everyone. I can't show myself smiling and carefree when instead I am tormented by many thoughts. . . . With longtime friends, I have cut my ties. I isolated myself from everyone. (P3, M, brother)

Last night, I thought about taking a lot of paracetamol. Then, I thought about Dad: would he like this, or would he prefer to be proud of me for what I do every day on my job? But damn, it's difficult. . . . I don't know if it's worth it to continue. I ask myself sometimes, and the answer is no. (P17, F, daughter)

**Resources**

Nine users of thirty referred having sought professional help (from psychologists, psychotherapists, or family doctors). However, most of the reported experiences were characterized by low satisfaction with the support they obtained due to a lack of specific preparation by the professionals; this contributed to the users' feeling of being not understood. Users who had not reached out for support were still uncertain about how to find appropriate help. Some of the obstacles were represented by numbness, scarce knowledge about the different services, or the actual lack of such services. In addition, when the operator tried to assess which resources they could count on in their informal support network, survivors reported that support from friends decreased after some time, and family conflicts became frequent.

I went [to the psychologist], but after the first meeting, I realized it couldn't work. . . . She couldn't tell me anything more than that I have all the right to feel "depressed." (P12, F, mother)

I tried to go to a psychologist, who made me try the MDR method [EMDR] for heaven's sake I felt like a moron …(P2, F, sister)

I do not know what to do. Nobody wants to talk about what happened [...] My friends closed the case as if nothing had happened. (P4, F, sister)

[Our mother] now hates us because we are still alive and [her son] is not. And don't make me start about the continuous discussions between her and our father. I'm always anxious. I can't find peace. (P20, F, sister)

Some survivors resorted to faith as a way to cope with the sorrow: this was mainly about finding comfort in prayer or in imagining that the departed had stopped suffering, while there were no references to feeling the presence of their loved one. Lastly, others used justifications about the

reasons for them not having acted or noticed warning signs, or they used rationalizations to distance themselves from the emotional pain.

> When I see my mother crying, I invite her to join me in prayer and transform her tears into prayers. (P6, F, sister)

> If I haven't asked my brother anything, it was only to respect his privacy. He'd always been very reserved in his private life. (P3, M, brother)

> No one is to blame for the foolish act of someone else, I know. (P13, F, partner)

**Needs**

The most frequent need (reported forty-four times, 31,2% ) involved practical support, including requests about where to find services, the costs, and modalities of support. Survivors were usually interested in finding face-to-face support, either a psychologist or free-of-charge support available in their areas. Two users expressed the need to find stories from other survivors, whereas some others asked about the services available at the association hosting the live-chat. Some users, however, preferred to use the live-chat as their main source of support and explained that they had waited a long time, even years, before realizing they might need someone to talk to.

> Unfortunately I have to find a way to tackle this thing and I don't know where to start from [...] I looked for some information on the web but I wouldn't know...Then I read about your foundation. In this regard, may I ask if you have any services to recommend? I live in the province of [omissis]. (P13, F, partner)

> I pretended for a long time that my life could flow normally. I denied the pain to avoid going crazy. Now, I realize that everything still needs to be metabolized. (P18, F, partner)

Secondly, users expressed the necessity to receive emotional support and be reassured about their responsibilities in the death of their loved ones. Two opposite needs were expressed by different users: the need to talk with someone (seven times, 7,7%) and, less often, the need to be left alone (three times, 2,3%). Moreover, users requested specific advice and suggestions regarding the development of their grieving process or how to behave with others.

> I am writing you so that someone can convince me that what I am writing is actually excessive. . . . I would like anyone to tell me that I have no faults. (P16, F, sister)

How can I help my mother? (P20, F, sister)

"I wanted to ask… after ten years how is it possible that I have not yet metabolized mourning (loss of the mother from suicide) is this normal?" (P26, F, partner).

**Interactions With the Operator**

Operators offered non-judgmental support, provided information on available services, and gave direct feedback to the users through empathic listening. The operator's tasks involved three actions: exploration, support, and reconstruction. During exploration, the operator posed questions inviting the users to self-disclose, this was pivotal for the investigation of the extent of the user's social network and the identification of possible resources (e.g., "Are you able to talk about how you feel to the people around you?").

During the 'support' task, the operator often engaged the user in a discussion over which support could be better for the user, posing questions on their preferences and necessities; then the operator would refer to a list of available services or browse the Web during the conversation, sharing links or telephone numbers to direct the users to available services. The live-chat was hosted on the website of the association and it was possible for the user to browse the informative webpages (containing further advice about the bereavement process) while chatting; the users' online navigation while browsing the webpage was visible on the operator's chat box. When instead users asked for emotional support, operators offered reassurance and normalized the users' feelings and fears by listening empathically.

- [Operator] From the list of free-of-charge services that we have available here, we can see that there is an association in [omissis] called [omissis], do you happen to know it?

- [User] No, I do not know them.

- [Opertor] We do not know if they deal specifically with suicide losses but it might be useful for what you need. if you want I can leave you their telephone number and their email address so that you can contact them and ask them for more information

- [User] It would be much appreciated …….. my GP never suggested anything except for a paid psychologist. (P11, F, mother)

[Operator] It mustn’t be easy to deal with this situation, and it’s understandable that you are encountering difficulties when talking to others. Would you like to tell me about it? (chat with P29, F, partner)

- [Operator] From your words I understand that you must have suffered a lot, it must have been very difficult for you to go on.

- [User] well yes it was a lot. let's say that now I survive because I don't think about it as often as before but when I think about it it's terrible [...] my apologies for writing a lot

- [Operator] Don't worry, this is your space and you can use as you see fit

- [User] Thank you, I have been needing to talk to someone for a long time. (P19, F, cousin).

Operators were also trained to identify dysfunctional behaviors, and foster users’ specific resources to find more efficient coping tools: whenever users reported the use of positive strategies, the operator reinforced them, or in the opposite case, the operator offered alternatives to maladaptive coping behaviors and asked the user whether they would like to put them into practice. An extended extract shows the interaction between the operator and the user.

- [Operator]: are you able to talk with anyone about how you feel?

- [User]: to be honest, I can't speak with anyone about what happened [...].

- [Operator]: following an event of this kind, the whole family may undergo a strong change and may need time to find the right energies to reorganize [...] It can be difficult to show others your pain and for this reason it was brave of you to contact us today and to share your story.

- [User]: honestly, no one of those around can understand how we feel. [...] This is why I preferred to get away from everyone.

- [Operator]: it is true that few could understand your pain, but it might help to have someone to share your thoughts with. It is important for you to have the opportunity to express your grief and avoid isolation. Do you think you can do that?

- [User]: Thank you. I am aware that getting away from the world costs me a lot from

a human point of view. But it would make no sense to try to find relief from my thoughts when all around me, [in my] family, there is absolute sadness. [...] I think I can try yes. (chat with P3, M, Brother).

Lastly, during the reconstruction phase, the operator helped users to embrace a new point of view, such as by leading them to the understanding that they had no responsibility for the departed's choices. Operators also avoided supporting the expectation that grieving is something that one is supposed to overcome.

- [Operator:] As you say, he would choose to accept or not accept your advice. I believe you did everything you could to help him.

- [User:] I hope so. Yes, actually if he had an idea, that was that, and no one could take him away from that. (chat with P4, F, sister)

- [User]: I am aware I am not ok. . . . everybody tells me, "Enough, you have to get back on your feet." . . . but I can't, and I am feeling worse and worse . . .

- [Operator]: People tend to give advice, and advice has to be intended as that only. After that, you are the person responsible for yourself, who has to do what she feels like. Everybody has their own timeline and needs when in grief. (chat with P2, F, sister)

Throughout the conversation, and especially toward its ending, the operator renewed the service's availability for a second access and two users declared they would like to have a second chat conversation. Feedback from the users was also collected throughout the conversations: overall, the users felt that they had been listened to and that they had experienced a moment of relief during the day or had gained a clearer idea about how to find support. The main drawback of the live-chat tool was represented by connectivity problems: the conversation was not interrupted abruptly, but the lagging may have impacted on the communication's flow.

It's been very helpful. A bit of relief for today. (P13, F, partner)

You clarified many many things to me .. thank you very much for your availability and courtesy. (P1, M, brother)

Users considered some specific features of live-chats very useful: anonymity, accessibility (both geographical and economical), quick response time, the possibility to write in their own time and to receive information in the form of direct links, and the opportunity to take notes from the advice offered by the operators. One user explained the difficulties to access support:

> If I am able to talk to you at the moment, it is solely because I have the baby asleep on my legs and the big one has been taken to the pool by my friend. (P12, F, Cousin).

> I can't really talk about it without crying but by writing I am able to elaborate more". (P21, F, sister)

> Luckily, this communication will remain written. I'll let it be read to my son, who's always saying there's none who can help him . . . grrr. (P26, F, partner)

Overall, no suspiciousness or hostility on the part of the user, which could have stemmed from the inability to see or hear the operator, was encountered. On the contrary, the possibility to write "behind a screen" was listed among the positive qualities of the live chat.

> Sometimes it is easier to talk to those who do not know you, you are less afraid of being judged" (P14, F, Sister).

**Table VII.**

*Themes, subthemes and codes of the thematic analysis*

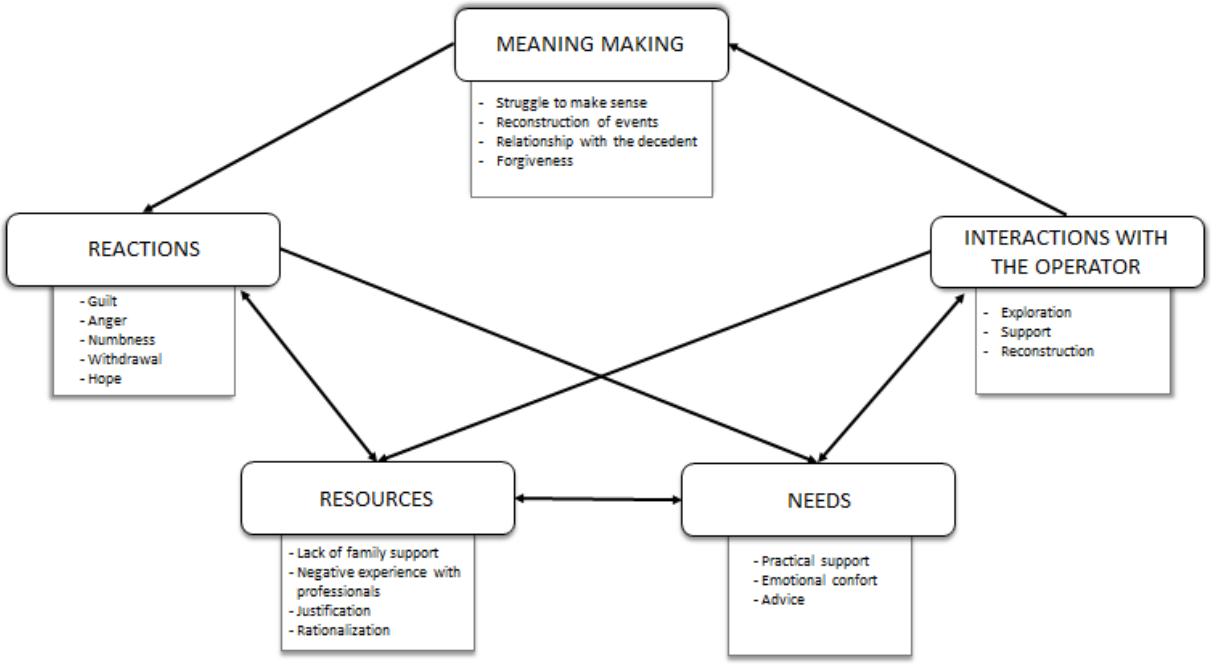
| Themes | Subthemes | Codes |
|---|---|---|
| Meaning making | Reconstruction of the events | Recalling the day of the death |
| | | Recalling the last interaction with the deceased |
| | | Attempts to help the deceased and warning signs |
| | Reconstruction of the user's role | Family unit and working life |
| | | Self-description as strong |
| | | Self-description as selfless |
| | | Self-description as weak |
| | | Self-description as selfish |
| | | Past difficulties |
| | | Striving to move forward |
| | Reconstruction of the deceased's 'role | Cheerful, brilliant or selfless person |
| | | Affection for family and friends |
| | | Lack of economic and family problems |
| | | Private person or able to disguise emotions |
| | | Sensible person |

| | | |
|---|---|---|
| | | Impulsive, angry or abusive person |
| | | Lack of lucidity |
| | | Previous psychological support |
| | | Previous suicidal attempts |
| | Reconstruction of the relationship with the deceased | Kinship with the deceased |
| | | Reciprocal trust and support |
| | | Deceased as the main source of strength |
| | | Conflicts or sporadic contacts with the deceased |
| | Search for causes and motivations | Difficulty to find an explanation |
| | | Multiple contributing factors |
| | | Economic/job related and family problems |
| | | Impossibility to prevent the act |
| | | Questions on the last thoughts of the deceased |
| | | Personal weaknesses and pas traumas |
| | | Suicide as programmed act |
| | | Suicide as a vindictive act |
| | Loss as a turning point | Change |
| | | Forgiveness |
| Reactions to the loss | Emotions | Numbness |
| | | Uncertainty |
| | | Fatigue |
| | | Sadness |
| | | Anxiety, Distress and Fear |
| | | Anger |
| | | Guilt |
| | Attempts to cope with the loss | Criticizing others, themselves or the deceased |
| | | Abandonment |
| | | Injustice and powerlessness |
| | | Suicidal ideation |
| | | Loneliness and not being understood/ or listened to |
| | | Withdrawal |
| Resources | Professionals | Psychologists/Psychiatrists |
| | | Physician |
| | | Experience with online support |
| | | Feedback on the received support |
| | Informal support | Friends |
| | | Family |
| | | Partner |
| | Personal resources | Proactivity |
| | | Religion |
| | | Justification |
| | | Rationalization |
| | | Introspection |
| | | Hope |

| | | |
|---|---|---|
| Needs | Practical support | Awareness to be needing help<br>Need for formal support<br>Request for information about available services nearby<br>Search for information on the web<br>Search for information about the association<br>Search for survivors' experiences |
| | Emotional support | Need to be comforted<br>Need to talk with someone<br>Need to be left alone |
| | Advice & suggestions | Need for advice, suggestions<br>Anonymity<br>Accessibility |
| Interactions with the operators | Exploration | Invitation to self-disclosure<br>Request of clarifications and details<br>Request of feedback on the service |
| | Support | Emphatic listening<br>Emotion validation<br>Provision of advice<br>Provision of information on services |
| | Reconstruction | Fostering change of perspective |

**Figure I.**

*Conceptual map of the relations between the main themes*




## Discussion

The aim of the present study was to explore how live-chat services support users who have experienced a suicide loss with their bereavement process. As shown in the network model represented in Figure I, the opportunity of meaning making was the most poignant theme observed for the users and was located in a superordinate relationship with the others. The attempt at sense making, through the strenuous search for the motivations and the rumination over the failed attempts to help the deceased, resulted in guilt, helplessness, and anger (Linde et al., 2017). As expected, blame and criticism were directed toward others or themselves but, in some cases, also toward the decedent (Sveen & Walby, 2008). For those who reported the loss to be a turning point, being able to find positive aspects in their loss represented an opportunity for acceptance and, ultimately, post-traumatic growth (Ross et al., 2018).

Differently from offline services, and worthy of noting, is the speed in establishing a contact, six participants contacted the service between 24 hours and three weeks after the loss, and the majority of the users (twenty of thirty) experienced their loss within 6 months. Users contacting the live-chat service showed a lack of family support and social isolation (Begley & Quayle, 2007), or complained about a lack of specific preparation among professionals. Missing social support,

negative experiences with professionals and scarce knowledge about the available services may contribute to users' isolation or inability to access care (Hanschmidt et al., 2016).

With limited personal and social resources, users who felt responsible for the suicide resorted to justification, rationalization or faith to obtain emotional relief and come to terms with the loss (Burke & Neimeyer, 2014). However, it was only through the discussion with the operator that the users were able to access a new reconstruction of the events and express forgiveness and hope for the future. In this latter case, survivors could use the chat not only as a tool for immediate reassurance but as an additional resource for reconstruing the relationship with the departed (Neimeyer, 2019), as well as an occasion to re-live and make sense of the traumatic experience of the death notification (De Leo et al., 2020). A suicide loss could disrupt the coherence of the matrix of personal meanings through which individuals experience their personal world. In order to regain such a structure, survivors have to find a sort of ''silver lining'' in their loss experience and reorganize their identity as survivors (Gillies & Neimeyer, 2006).

The role of the trained operator was pivotal and delicate. Each operator was trained to explore sensitively users' needs and resources and provide appropriate referrals when requested (Gould et al., 2012); furthermore, whenever users showed that they were ruminating over the same questions, the operators were able to guide the discussion toward more adaptive questions. Some survivors appeared to not have looked for help and to have ended up writing in the live-chat in search of a less threatening form of support (Predmore et al., 2017). Upon feeling protected by anonymity and the nonthreatening presence of an operator who communicates empathically through writing, survivors can pose questions that are hard for them to share publicly, reveal nonsocially desirable details (such as abusive behavior), or express anger toward the deceased. Moreover, the perceived confidentiality could help users to reveal any suicidal ideation (Gould et al., 2012). Live-chats could be particularly helpful for users who struggle to find support and to integrate their loss into a wider personal meaning, as they are at the greatest risk for bereavement complications (Neimeyer et al., 2006).

During the chat conversations analyzed in the present study, no issues concerning ethical or legal risks emerged; however, it is of pivotal importance that professionals writing in the chat are also trained in relevant ethical standards for confidentiality (Barnett & Scheetz, 2003).

Overall, our study shows a scenario in which survivors are struggling to find appropriate support, even when navigating online and in which physicians are not trained to provide information (Lee et al., 2017). For these reasons, the live-chat could be the ending point after an unfruitful "research" by the survivor.

Collecting this group's reported needs and experiences is extremely important for the

research because most of the studies focus on survivors who "had already been 'successful' in their help-seeking efforts" (McMenamy, 2008). The users appreciated being able to write without feeling exposed and the possibility to see the information provided in written form (and to save the text). Anonymity and accessibility are highly valued, together with the opportunity to take time to ponder what to write and reflect on what remains written in the text. Lastly, the exchange of information (e.g., telephone or email contacts) is made easier and quicker through the chat. Users disclosed significant amounts of information in the chat, and in no cases did they express suspicion or open hostility toward the operator. In fact, the only problem reported had to do with connectivity problems.

The present study holds some limitations: as the live-chat interface suggests, in terms of affordances (Lupton, 2018), for a quick communication (the text box appears in a corner of the website page and the space for writing is reduced), detailed information was difficult to retrieve, and the conversations were often very fragmented or succint. While short sentences may be useful in emergency conditions, this streamlined way of communication did not allow the sharing of details that could have enriched the context. The limit of a fragmented conversation, due to the overlapping when chatting or lag, is a challenge often dealt with by facilitators of online services (Stephen et al., 2011). Also, given the emergency context in which the service is provided, priority was given to psychological support instead of details collection and, in some cases, socio demographical information about the user was partial. Moreover, the study focuses on Italian survivors only, and further studies should be implemented in other countries.

The present being the first explorative analysis into live-chat support, it offers various insights over the growing uses of digital tools in health and psychological services. The information gathered through the conversations analyzed in the present study has a strong ecological power, as they were retrieved from real conversations in an emergency context. In fact, differently from when interviews are conducted, the data recorded from the live-chats also involved twenty people out of thirty who had been bereaved for less than 6 months, which is the time period usually considered for interview studies. Further studies should focus on ways to assess the effectiveness of the live-chat support with ethical sensitivity, that is, on finding ways to contact the users for a follow-up.

The next research, Study 3, focuses on virtual exchanges between operator and bereaved user, as well as the interactions between the mourners as peers. The results of Study 2 shed some light on the reasons why mourners seek online support, and this increased awareness was also employed in Study 3 to understand how mourners want to approach the telling of their story online and how it is possible for the moderator to show closeness and empathy through the written tool.

# CHAPTER 6

## Study 3: A Case Study of a Facebook Group to Support COVID-19 Bereaved Users

### Introduction

The COVID-19 pandemic caused by the spread of the coronavirus disease (SARS-CoV-2) first identified in December 2019 in the Chinese province of Wuhan, quickly spread to global dimensions (Abel & Taubert, 2020). The Italian population was severely hit by the first wave of the pandemic (Boccia et al., 2020) and witnessed one of the biggest clusters globally (Bollon et al., 2020). In mid-March 2020 the number of excess deaths (i.e., the difference between the observed numbers of deaths in a specific time period and the expected numbers of deaths in the same time period), compared to the average number of all deaths that occurred in 2015-2019, resulted in almost 50% of excess rate (Alicandro et al., 2020) and for such a high number as many families in mourning must be considered.

In addition to the loss of a family member, social restrictions adopted to contain the contagion have greatly impacted mourners' support seeking: a recent investigation on Italian mourners (Cipolletta et al. 2021b) showed how COVID-19 mourners were strongly impacted on receiving informal and professional support. Lower perceived support within the family or social network is known to predict greater distress, especially for grievers in need of practical and instrumental support (Carr et al., 2020); consequently, during the first pandemic wave, several relied on virtual relationships to deal with the isolation, particularly through the use of social media (Goel & Gupta, 2020). The uses of social media have been observed to be an important resource, during the pandemic, against loneliness among young adults (Lisitsa et al., 2020) or to seek medical information and COVID-19 awareness (Saud et al., 2020); there are, however, no studies currently investigating how COVID-19 survivors have sought for support during the pandemic or whether they have preferred professional over informal support.

Online groups, as already introduced in Chapter 3, offer the possibility to communicate through great distances and to express grief through writing; an important resource for mourners (Ferguson & Frydman, 2004; Finfgeld, 2000; Stephens et al., 2014). A good amount of research around online grief, including the studies examining online grief support groups, has been, however, conducted mainly through quantitative research designs (Elder & Burke, 2015; Feigelman

et al., 2008; Hartig & Violea, 2016; Houwen et al., 2010; Lenferink et al., 2021; Lubas & De Leo, 2014). Paulus and Varga carried out an important qualitative study on the discourse patterns in grieving newcomer's writing in online forums (2014) and the responses to their introductory messages from other forum members (2015). Swartwood and colleagues (2011) also analyzed the structure, format, and content of replies posted to messages in online grief support groups, focusing on the type of helping skills displayed (Swartwood et al., 2011). However, Paulus and Varga and Swartwood only examined the peer responses to initial posts, leaving an open question on how group members structure and shape their subsequent narratives and how their way of providing support can change over time.

At the onset of the COVID-19 pandemic, several online communities appeared in Italy with the intent of disseminating information, both in good faith and with a misinformative intent (Gallotti et al., 2020); COVID-19 mourners were also observed to spontaneously associate in online groups, mainly hosted on Facebook, to collect similar experiences of loss and find a space for the memorialization of their loved ones (Cupit et al., 2021; Testoni et al., 2021); previous studies have already been carried out on social networks to study the provision of mutual support or the sharing of bereavement-related experiences; of these, several indicated particularly Facebook as an interesting observation site (Frost, 2014; Kasket, 2012; Keskinen et al., 2019).

The analysis of social networking sites requires an ethnographic gaze that takes into account the peculiar aspects of online communication. By the definition of Kozinets (2010, p. 60) "Netnography is participant-observational research based on online fieldwork" that "uses computer-mediated communications as a source of data to arrive at the ethnographic understanding and representation of a cultural or communal phenomenon" . This methodology was successfully employed to explore users' construction of grief online (Davidson & Letherby, 2014; Gustavsson, 2013; Harju, 2015; Varga & Paulus, 2014).

The importance of the present investigation is supported by the fact that COVID-19 mourners: 1) find themselves grieving during a pandemic; 2) share a large-scale traumatic event; 3) belong to a Western country and have access to social networks, in which they very likely look for support. Exploring how mourners use online tools during a pandemic is pivotal, as ways to obtain social support have drastically changed to comply with the restrictions. In fact, a pandemic in a Western digitized social context is an unprecedented event, and further in-depth research could be needed to assess, quantitatively and qualitatively, the impact on grieving families, investigate the risks of grief complications, the strategies for accessing support, and understand what could be implemented or fostered to help mourners.

The aim of the present study was to investigate how COVID-19 bereaved people use digital resources, specifically a support group on Facebook created for the purpose, to talk about their loss: how they choose to report their stories, how they find confrontation with other peers and discuss strategies, which aspects of the experience are most useful to users. The study ultimately aims to gain knowledge on how participation in an online asynchronous group can represent additional bereavement support for people with a traumatic bereavement.

At the moment the present research is being written, online grief support groups and their relevance for death studies and COVID-19 bereavement have not yet been investigated. The results could increase the understanding of how mourners use online mutual bereavement support and provide a preliminary examination of its potential to ameliorate the suffering of family members who are struggling with a violent death during a pandemic.

The central question of this research was, 'How do Italian individuals bereaved by COVID-19 use online discussion groups to narrate their bereavement, share their grief and make sense of their loss?'. Additional questions that guided an in-depth inquiry of the data were:

- Which self-help mechanisms, grief reactions, requests to the moderator or the user, and experiences with informal support or health-care services are communicated in the group?

- How do users interact between each other and the moderator?

- What kind of support do users look for and offer? And what do they look for in the group?

- What do users appreciate of the online group discussion? What is useful to them of the platform or the content shared and what would they change or add?

Hence, the study focused also on the usage and the usability (affordability, navigation, perception of usefulness) of the asynchronous support group hosted on Facebook. Since no similar analyses were carried out, the present inquiry has an explorative intent: the study reports a case study of a single online discussion group experience and analyzes the data with a computer-mediated thematic analysis methodology.

## Method

The present study reports the posting and related experience of Italian users on a discussion group dedicated to individuals who have lost a significant other to COVID-19. The main context being the online dimension, the study is partially informed by notions of the most recent

netnographic studies (Hanna & Gough, 2016; Kozinets, 2002; Langer & Beckman, 2005), as well as indications for qualitative inquiries in psychology (Braun & Clarke, 2014).

**Context**

The context of a Facebook discussion group was chosen after the observation that, soon after the beginning of the pandemic (in March 2020), a Facebook group called "*Noi Denunceremo - verità e giustizia per le vittime del COVID-19 "("Willing to denounce - truth and justice for COVID-19 victims")* started collecting experiences and complaints of family members bereaved by COVID-19. The description on the group page reports: *"We were born to ensure that, if someone has responsibilities, if someone could have acted and chose not to, if someone has put some kind of interest ahead of the lives of thousands of people, he / she (or they) pays criminally for his actions and answers for his negligence. And to do this, and do it in the appropriate places, we decided to set up a non-profit committee with the aim of collecting every single complaint and making it available to the judiciary at every stage of the investigation and the process that will ensue". (https://www.facebook.com/groups/noidenunceremo)*

Along the several daily posts of users denouncing or asking for justice (at the moment the present study was conducted, in June 2021, the group counted roughly 50.000 members), it has been observed that some users had started sharing their personal experience of loss in the form of memorialization posts: users posted recent photos of the decedent (often a stand-alone portrait, at times a photo portraying them with their loved one) and a short description highlighting the positive qualities of their loved ones and describing who this person was for them or what has happened from the hospitalization since the death notification, which are the days that remain with more uncertainties and unresolved questions for these grieving individuals; these posts received several comments and emoticons offering short condolences or showing affection.

This was the first and most accessible public expression of grief for mourners after the first wave of the COVID-19 pandemic and since the deaths had occurred across all regions of the country, for the first time we witnessed the expression of condolence shared online on a national level. Because of this, it was deemed interesting to analyze the content of these interactions between users.

However, an ethical problem arose, as the group was accessible only with the authorization of the administrators and therefore the contents shared in it were not technically publicly accessible. Group administrators did not answer the request for permission to present ourselves in the group as researchers and ask individually each user the permissions to use the material (with the reassurance that all data would be appropriately anonymized), nor informing all the users of the possibility to

participate to the research through a general communication in the community (an option sometimes used, if the material extension does not allow to request permission under all individual posts). Therefore, after deeming the posts written by users of great relevance for the understanding of COVID-19 bereavement experiences, the solution was found to create a Facebook group similar to the one in question, not focused on denouncing administrations but, as clearly indicated in the title and in the description, focused on discussion and dedicated to those who have lost someone to COVID-19.

**Study Setting and Sample**

A total of 25 users (23 females and 2 males) enrolled in the group; of these, only 21 users (19 females and 2 males) wrote systematically in the group, the remaining 4 users were considered inactive or *lurkers* (Sun et al., 2014).

Since participants enrolled in the group directly from Facebook, age or other socio-demographic information were not collected but it was possible to retrieve, from the written content, information on the gender of the user and on the relationship with the departed, which was mostly a parent. Moreover, from the text it was possible to deduce for almost all the participants when they suffered the loss, and consequently establish how much time had passed before they found the group and asked to access it. For example, the mean time passed since the loss, was 4.55 months, although there were cases where the user had lost the significant other days before and others where the loss had occurred during the early months of the first wave, 12 months before. Details are reported in Table VIII.

Participants were recruited once the discussion group was already online: the first two participants were informed of the existence of the group by a common acquaintance with the researcher as they had already participated in a different study involving interviews and regarding their bereavement experience; they did not know the researcher directly. Following recruitment was carried out through snowball sampling and advertising through different channels: local administrations, churches, and non-profit organizations were contacted through mailing list contacts and informed of the existence of the discussion group, as well as the aims of the research; several local administrations redirected the communication to social services and local presses, who recontacted the researcher to obtain further details; the latter wrote informative articles that were published on the local online newspaper or in the bulletin on the local town website.

Subsequent advertising was carried out online, by posting in Facebook groups related to COVID-19: apart from the group '*Noi Denunceremo*' that left unanswered the request of posting the link on their group, all other Italian Facebook groups who accepted to disseminate the link for

participation in the study focused specifically on exchanging information about COVID-19: updates on the creation of a vaccine, discussions on how to apply the newest social restrictions and advice regarding the symptoms and the testing.

Lastly, several articles were written and advertised through the University of Padova and the De Leo Fund Onlus. In every moment of the process, it was made clear that De Leo Fund's services were detached from the study and that their references were provided only because they are the main association of mourning supporters in Italy that is able to provide support telematically.

No compensation was provided to participants. Some of them came to know the group through the local advertisement and presented themselves via email, reporting some details about their stories and how they were feeling. The majority (20 on 25) asked directly on Facebook to be accepted in the group (by simply clicking on the Facebook button "join the group"). Prior to being accepted into the group, participants had to mandatorily answer the questions:

- Have you lost a close person due to COVID-19?
- Do you accept the rules of the group?
- Do you acknowledge that this group is part of a study aiming at analyzing the bereavement experiences of users online? After being added to the group please read the first communication pinned at the top of the page, containing all the details of the study.

Since it was not possible to write extensively about the study or share an external link neither in the questions nor in the rules' section, the details on the aim of the study, acknowledgments, and data protection were made available through a link to a Google form pinned at the top of the main page so that new users could read them and decide whether to stay or sign off.

Participants to the discussion group were chosen according to the following inclusion criteria to evaluate suitability for an online group:

a) having a real profile: active for more than 1 year, with personal photos and interactions with other users, possibly with a seemingly real name

b) having a single-owned Facebook account (e.g., not having a shared profile with another family member)

c) being of major age

Exclusion criteria for the preliminary inclusion in the group was the reported level of distress: initial assessment for those users requesting to be added to the group via email was carried out by evaluating their presentation and their requests or the motivations they reported to explain

how they found out about the group. Only in one case was it preferred to direct a user to the external listening and support service. In applying to join the group, she had in fact shown severe emotional suffering from the recent loss of his mother. For this case, an alternative resource was provided: the administrator got in contact with the user and explained the reasons why the group may not have been the best resource for him and provided the contact for the De Leo Fund Onlus. In a second case, a female user presented herself via email, explaining she had read about the group online and she had lost her father 15 days before: in this case, due to the short time passed since the loss, she was asked if she had sought professional support and, after her negative response, she was offered both to join the group and to contact the De Leo Fund for telephone, chat or Skype support offered free of charge.

In addition to this, rules to be applied once entered in the group were also employed, which concerned the violation of the group rules:

a) not using aggressive language

b) not posting fake news or political ideas

c) not posting off-topic content

The rules of the group had to be accepted in order to be included into the group and were always available on the page. Lastly, in the case users started showing signs of acute distress once entered in the group (e.g., writing about feeling emotionally overwhelmed and showing of not benefiting or interacting with the group, talking about putting their own physical integrity or that of close people at risk) would have been asked to get in touch with the same support association provided to users deemed to be in severe distress before joining the group. No exclusions from the group or situations that put users at risk in any way occurred. During the six months of usage of the group, two users left the group mid-process but they confirmed their consent to use what they had written up to that moment.

At 6 months after the start of the group, it was proposed that users of the group compile an anonymous questionnaire on the satisfaction and usability of the group: a total of 8 users answered to the questionnaire and compiled sociodemographic information regarding their age (mean 43.5, SD 12.6), their gender (6 females; 2 males), their marital status (4 with a partner; 4 single or widowed), current employment status (6 employed; 2 unemployed), region of origin (6 northern, 1 central, 1 southern regions). Users were also asked the time since the loss (mean 9.5 months; SD 4.8 months) and the kinship with the departed: 6 users had lost a parent, 1 a grandparent and 1 a partner. Following questions focused on how they had found the group, how long they had been in the group and whether they had sought professional support in addition to joining the group: their answers stated they had actively searched for support groups on Facebook or through other

networks, and that they had on average been in the group for more than 5 months. Four of them stated they had not looked for professional support (i.e., psychotherapist or psychiatrist) at all. Users who declared to be currently followed by a professional reported to feel supported on an average of 4.6 on 5, while all users were also asked how much they felt supported by their family and friends (2.75 on 5). Details are reported in Table IX

**Data Collection**

Data collection lasted 6 months (from November 2020 to April 2021) until the inclusion of new material was deemed sufficient and theoretical saturation was reached: this is the point at which gathering more data does not lead to more information related to the research questions (Flick, 2018). The group continued being accessible and it is still active today, to allow new and old members to benefit from the mutual confrontation.

At the end of the data collection, a single data set was created, containing 290 posts (42 original posts and 248 comments), for a total of 22.671 words, comprehensive of users' and moderator's posts. Details are reported in Table VIII.

Generally, netnographic studies require the researcher not to reveal the researcher's role, in order to avoid biasing the observation; in fact, users knowing that their writing may be taken into consideration for a study may feel inhibited to share something or decide to show a different part of themselves based on social desirability (Amatulli et al., 2019). For these reasons, when observing an online group, the intents of the research are usually illustrated after the collection of the data (i.e., passive/active observation with hidden observer) not to bias the relationship with the researcher/moderator; however, studies have outlined the utility of users participating in the amelioration of an online group: for example, case studies (Vonderwell, 2002; Wang, 2018) could be found in literature where the instructor or moderator of an online group is also one of the researchers. In fact, generally netnographic studies could be intended to be multi phased or to entail the application of multiple methods (Costello et al., 2017) and several authors (Brodie et al., 2013; Cherif & Miled, 2013; De Valck et al., 2009) considered netnography as encompassing both observation of communication in an online community and qualitative in-depth interviews with community members.

In the present study, the users participated actively in the research, indicating to the researcher which features of the support group they deemed more useful: they were informed about the aims of the study and contributed with feedback. However, considering the difficulties in recruitment due to the delicacy of the conditions for grieving participants, their socio demographic

information was not collected, because a further request to provide personal details could have burdened the user, undermining collaboration with the researcher.

Data collected for the present study was of three types

a) the qualitative content of the posts written by the users

b) the answers to specific questions on the usage of the group

c) the answers to an anonymous questionnaire

All posts, both from users and the moderator, were collected in a word file that was constantly updated with the new posts and viewed by both authors to follow the progress of the group. After 6 months, the request for informed consent was renewed, to allow users the possibility to remove certain posts in case they no longer felt comfortable sharing them for research purposes: no posts were excluded, and the remaining posts were used for the qualitative analysis.

In the middle of the data collection (around 3 months) and at the end of it (6 months), the moderator proposed a conversation between users about the utility of the group and what could be implemented, allowing the users to co-participate in the creation of the content.

Lastly, the questionnaire aimed at collecting sociodemographic data (e.g., age, gender, time from loss) although this information was also retrievable from the conversations and qualitative data (through the open ended questions) that could have been observed from the analysis of the posts, for example by asking very specific questions on which posts they might find helpful and which distressing. Moreover, the questionnaire was used to collect quantitative data on the use of the platform. In fact, the questionnaire was created to assess accessibility ("Did you appreciate being able to access the group via Facebook?"), affordability ("Did you appreciate the possibility of interacting with other users asynchronously?") and navigability ("Did you find it easy to navigate the page?") of the page (Proctor et al., 2011). The questions in detail are presented in Appendix B. The questionnaire was anonymous and fillable on Google Forms and was made available to the users at the end of the 6 months of usage, together with a post describing the nature of the anonymous questionnaire and the repetition of the study's aim.

Participants could choose to answer to any type of inquiry or none. In all three conditions, the extensiveness of engagement did not require revealing a considerable amount of private information: writing the posts was always optional (users were always reminded that they were not expected to engage in a specific behavior) and the closed questions and the interviews focused more on the user experience. In order to make the data collection richer, triangulation from the above presented sources was created, as well as confrontation with the second coder: data triangulation allows to conduct investigations of a contemporary phenomenon within its natural context using

multiple sources of evidence (Guion et al., 2011), while continuous supervision allows to reach reflexivity, hence full knowledge of the quality of the material being collected (Flick, 2019). In fact, such studies are grounded in a particular setting, in a particular time, and offer an in-depth exploration of a phenomenon.

**Table VIII.**

*Socio Demographic Details of Users and Interactions in the Group*

| Factor | N of respondents (total N =25) |
|---|---|
| Gender | |
| Female | 23 |
| Male | 2 |
| Kinship | |
| Daughter/Son | 13 |
| Niece | 1 |
| Partner | 2 |
| Unknown | 9 |
| Time since the loss at the inclusion in the group | |
| Mean | 4.55 months |
| SD | 3.69 months |
| Activity in the group | |
| Active | 21 |
| Lurkers | 4 |
| Total number of posts and comments | 156 |
| Of which interactions between users | 84 |
| Of which interactions with the moderator | 72 |

**Table IX.**

*Socio Demographic Details of Users who Answered to the Anonymous Questionnaire*

| Factor | N° of respondents (total N =8) |
|---|---|
| Age | |
| Mean | 43.5 |
| SD | 12.6 |
| Gender | |
| Females | 6 |
| Males | 2 |
| Kinship | |
| Adult children | 6 |
| Niece | 1 |
| Partner | 1 |
| Marital status | |
| With a partner | 4 |
| Single or widowed | 4 |
| Employment status | |
| Employed | 6 |
| Unemployed | 2 |
| Region of origin | |
| Northern | 6 |
| Central | 1 |
| Southern | 1 |
| Time since the loss | |
| Mean | 9.5 |
| SD | 4.8 |

| | |
|---|---|
| How often accessed the group | |
| At least once a week | 4 |
| One or twice a week | 0 |
| Once or twice a month | 3 |
| Once a month | 1 |
| | |
| How often written actively in the group | |
| At least once a week | 1 |
| One or twice a week | 0 |
| Once or twice a month | 3 |
| Once a month | 4 |

**Procedure**

The online group was accessible 24/7, only via a personal Facebook account. The possibility to access the group was kept open for the whole duration of the process (that is, it did not stop in November soon after having been opened), to ensure adequate numerosity and the possibility for other participants to obtain support regardless of the participation in the study.

The researchers have a background in clinical psychology and bereavement support; the first coder, the author of this manuscript, is a psychologist and Ph.D. student in Psychology, the second coder is a psychotherapist and Professor of Health Psychology and both are experts in online support for bereaved individuals. They have not suffered a loss by COVID-19 and only share with the users the same nationality.

By the time the researchers worked on the present study, they had just completed a different study including interviews with recent COVID-19 mourners, which has benefited on the understanding of the phenomena once the present study started. Despite engaging in a study with other participants with a similar bereavement experience, the coders had no prior understanding or anticipations of how individuals mourning by COVID-19 would have behaved online in a support group. In this sense, prior observations of the phenomena under study in the present research may have influenced the research both ways: through an enhancement of knowledge over how to interact with the users (e.g., knowing what language and attitude to use to approach mourners) but also by influencing the structuring of the data analysis (e.g., in the identification of themes and patterns). For these latter reasons, reflexivity and mutual confrontation were used extensively.

The first post in the group was written by the researcher, presenting herself as a psychologist and stating that her role would be to moderate the group and occasionally share content about positive grief strategies. She reminded participants of the goals of the group and stressed that the

primary objective of the group was to provide peer bereavement support. The researcher used a single professional Facebook profile showing her name, last name and professional title. After the initial presentation post, new topics of discussion with an open invitation to users to contribute with their experience or opinion were posted systematically at the beginning of the weekend, in the late afternoon, to give all the possibility to see the newest posts and participate in the discussion. Users were invited to write their thoughts; no directions on how to write posts in the group were given. The average response time was of 24 hours. The posts (21 in total on the part of the moderator) included:

a) open discussion and invitations to share personal opinions or experiences (N=8)

b) psychoeducational posts (N=7)

c) posts written to emphasize something important said by a user and pick up the conversation from that particular contribution (N=6)

The psychoeducational posts were not taken from an existing face-to-face intervention or a controlled trial intervention, but were formulated by the researcher and moderator, based on her experience with bereavement support and continuously supervised by the second coder, an experienced psychotherapist. The topics proposed by the moderator in the group followed the general group processes: fostering universality, group cohesion, installation of hope, modeling, and provision of information (Esplen et al., 2018; Yalom & Leszcz, 2020):

- Universality: users introduced themselves freely. When they shared something, the instructor made sure to reconduct the experience to the ones of others, making direct connections and tagging, in the case.

- Engagement: no homework assignments or contact through telephone was made as in other studies (Trachtenberg, 2020). Engagement was important, as this being an asynchronous support, it could have been easy to have a drop out once users stopped writing. When this happened (only twice, one of which after winter holidays), the facilitator wrote a “welcome back” post and actively started a new conversation.

- Personalization of content: posts followed a determined structure of content; however, the content of the posts was personalized based on the experience reported by participants in their conversations.

- Authenticity of the conversation and linearity: to increase group cohesion, the facilitator focused on supporting nonlinear texting interactions between group members (e.g., preferring natural interactions between multiple participants instead of text exchanges between a participant and a facilitator). By proceeding this way, old posts recently commented would reappear at the beginning of the page. The discussion pace was not such to cause posts to overlap, but the timing was certainly

impacted. However, this did not represent a problem since all posts and reactions on Facebook are dated and these nonlinear interactions typically result in more authentic, cohesive discussions that support therapeutic presence online. Additionally, a non-linear interaction was considered when reactions (e.g., likes, hugs, hearts, crying emojis etc) were used.

- Modeling and socialization techniques: no modeling or socialization techniques were needed. Participants already had their own style for interacting in the group and none posted inconvenient posts, content, or emojis. The facilitator also did not find herself in the need to direct users on how to interact properly with each other (e.g., asking to reformulate or ask something differently).
- Facilitator's journaling: at the end of every post exchange (or better, when a post stopped having active replies), the facilitator updated her journal, noting down the exchange processes between users and adding personal considerations to be used for the qualitative data analysis.

**Data Analysis**

The total number of posts (included comments) considered is 156, collected in a range of 6 months, from November 2020 to April 2021. Given the purposes of the study, a thematic analysis was employed to analyze the written text (Braun & Clarke, 2014).

The analytic approach that characterized the study was collaborative (it included the users in an active way), iterative, and conducted as follows: (a) repeated readings of the posts; (b) identification of patterns and variability of patterns and thematic/discursive features; (c) generation of interpretations as to what these patterns accomplished; and (d) reflexive and transparent demonstration of claims through discussions among the researchers involved, especially considering that one of the coders was also the moderator. Both researchers are experts of qualitative studies: initial familiarization with the data and coding was carried out by the author as first coder. Then, the dataset was passed on to a second coder, who did not have access to the group and therefore did not have any preconceptions on the data; in fact, the moderator only requested supervision when in doubt on how to interact with the users in specific instances and regular meetings were held to record reflections about intriguing aspects of the data (Potter & Wetherell, 1987). Reflexivity was sought through repeated comparisons and step-by-step discussions about alternative interpretations of the results between all the researchers.

Three broad questions sensitized our analytic process, as Braun and Clarke's (2014) process for conducting thematic analysis was followed:

(a) What are the users accomplishing in their posts? (b) How are they constructing their group experience in order to achieve this? and (c) What discursive resources are being used? (Potter, 2004).

The qualitative data analysis software ATLAS.ti™ 9 was used to systematize the analysis process, using the memo, comment, and coding features. The answers to the questionnaires were analyzed qualitatively with the use of simple tables (given the shortness of the answers) and quantitative data was analyzed descriptively. The study was reported according to the Consolidated Criteria for Reporting Qualitative Research (COREQ) checklist and the APA Journal Article Reporting Standards.

**Ethical Considerations**

The Ethical Committee of Psychological Research of the University of Padua approved the study. Literature on grief and bereavement (Carmassi et al., 2016) suggests interviews with mourning people can be carried out even at one month after the loss, if the consensus of the participant is respected and ethical guidelines are followed strictly. The moderator expressed on several occasions that it was possible to reach for her in case problems arose. The research was conducted in respect of participants' needs and specificities in relation to grief (Bentley & O'Connor, 2014; Stroebe et al., 2003)

Previous authors (Guion et al., 2011; Smith et al., 2018) have noted the potential ethical issues surrounding the retrieval of data from online discussion forums, in particular the role of informed consent. While usually the data are of public domain, hence its consent is not necessary (Attard & Coulson, 2012; Prodgers & Gough, 2019), in this case the conversations were shared on a private group and participants were aware of the research purposes.

The major ethical issue the author had to face concerned the use of personal accounts on Facebook: the moderator had her own professional account which was used only for work-related reasons (i.e., dissemination of research work and networking), but the majority of users accessed the group via their personal accounts: this put them at risk of sharing personal information and became recognizable, hence vulnerable. Among the rules to be mandatorily accepted to be admitted to the group was a non-disclosure agreement, that required all users not to report content read by other users outside the group. This obviously relied mainly on a pact made on trust, but the same dynamic exists for groups that meet face to face, where it is not possible to control what users reveal outside of the group. Although this could be identified as a major privacy issue, the utmost attention was given to this aspect: the moderator constantly reminded users not to share personal precise

information, but only details that could not harm their privacy. Moreover, the moderator could view each post and consent to publication, to check for the posting of harmful content or violating the group's rules. Lastly, another rule of the group recommended fair language and no dissemination of fake news. In no case did users have misunderstandings or engaged in aggressive discussions. Considering the reason why Facebook was chosen, that is to be able to reach the greatest number of people, the risk-benefit ratio was considered adequate.

Consent to use the posts was asked again at the end of the data collection, to allow participants to reflect on whether they wanted to ultimately share everything they had written during the several months of usage of the group. For the qualitative analysis of the posts, all personally identifiable information was obfuscated. Each user was assigned a coding number; and no information concerning individual participants was revealed or were changed to be unrecognizable.

**Results**

The analysis of the written text and of the interview produced 5 themes, reported in Table X: group's uses to respond to needs, shared crisis narrative, responses to grief, retelling narrative of death, context of the mourning process.

**Thematic Analysis**

***.1 Groups' Uses to Respond to Needs***

This theme collects all the exchanges between users and also between user and moderator, to record the main needs of the participants in the group, as well as the uses the participants made of the platform to respond to them.

In their introductory message, some of which are several lines long and very detailed, new users introduce themselves and their story, recounting who the loved one they lost was to them and the conditions under which the death occurred. In these messages, also the motivation to be in the group is often reported, which is linked to the need to find people who have experienced the same situation, to talk about the personal loss experience (which is described by Maria as "her own drama" and by Marco as his "Odyssey"); but also, to the need to find comfort from solitude, as Carmen states.

> Good morning. I too, like you are, am here to talk about my drama. I am so angry, you are never ready for the death of a loved one. After reading the medical record I found many errors and a lot of blunders from doctors .... (Maria, F, daughter)

Thank you for accepting my request .. Tomorrow I will write about my odyssey .. so much anger, so much pain but also a great desire to go back to life, now unfortunately I only survive. (Marco, M, son)

Good evening and thank you for creating this group, on January 28th I lost my father, he was 73 years old but he was in perfect health [...] I have to be strong for my mom and for my son, it's very difficult but I have no alternatives and maybe even for this I searched and found this group. A hug to all of you who, I am sure, will understand my pain. (Rita, F, daughter)

Thank you for accepting me in the group. I lost my mum on March 2, just over seven months after my dad. I was orphaned and I feel terribly lonely.
(Carmen, F, daughter)

Users also often celebrated the memory of their loved ones in the form of a short memorial: it was common for users to write posts on the occasion of one or two months passing from the loss, up to the anniversary of one year after death. In fact, some users had suffered their loss during the first wave, around March/April 2020, and were writing in the group exactly 12 months later. These posts have a very similar structure to the memorial posts that are usually shared on Facebook: users share a photo of their relatives and describe their life and their qualities. An important difference lies in the fact that instead of being a one-way communication with the deceased, and therefore becoming a potential occasion for rumination, in this group the sharing of such posts is followed by the comment of the other users who provide support. In this extract, Carlo writes a post on the occasion of the 12 months anniversary:

- 22/03/2020. 22/03/2021. Time passes inexorably, the memory of the good things done together remains ... We are beginning to understand the reason for all the deaths in [omissis] in those months, including yours dad and everything seems even more absurd ... You loved life and it was denied to you for a stupid selection, unfortunately you were over eighty. Having to live in a country where we don't count for anything either alive or dead makes me very rueful. (Carlo, M, son)

- Hi, I am very sorry that your father was treated like this because he was over eighty [...] I am very sorry, sometimes I wonder why me, why my dad, why this virus has arrived. Unfortunately, I don't think I will ever find an answer to my questions and

even if that were the case, nothing will make go away the sadness. Be strong and carry on. (Lucia, F, daughter)

It should be noted that these posts are sometimes copy-pasted within other public groups on Facebook (the administrator observed this because she was present in all the other existing Italian public groups on COVID-19).

In writing about their personal experience, it is important to bear in mind that people might share personal details about their lives which are not completely inherent with their loss and may also be sensitive data. In this group experience, there were no cases in which the moderator had to intervene (for example, the posting of images with minors or too detailed information about the user's life), but the fact that everything that was written was associated with a profile and easily connected to a name and a face may represent a criticality that should be kept in mind.

The most frequent interaction observed between users is the offering of emotional support (20,95%). Support is offered by users by providing empathy, comprehension, the wish to feel better, or the sending of "virtual hugs" . Users declare themselves equal to the person who is writing, reassuring them they have had similar experiences and that they are feeling the same way.

Rita, I feel close to you. Today it is a month since my father ended, and I find myself so much in your words that they remind me exactly of my dad.
(Rita, F, daughter)

- I am sending you my strength.
(Anna, F, niece)
- Anna thank you very much, I really need a lot of it!
(Lucia, F, daughter)

A user offers comfort to another group member by making her reflect on the fact that she had done everything possible to protect her father and that she would have had the same kind of doubts even if she had not hospitalized him.

Mara, I am close to you. Today it is a month since my father ended and I find myself so much in your words that they remind me exactly of my dad and he too was fine and had never gone to hospital, all this is heartbreaking but I ask you how would you feel if you

hadn't hospitalized him and he hadn't made it at home ... even if surrounded by your love don't you think the sense of guilt would have been excruciating? I was unsure whether to have him hospitalized since the ambulance doctor asked us if we would prefer to treat him at home ... Obviously underestimating the situation, but my mom said that the hospital was better and to date, although I have the exact same thoughts as you, I say to myself that if he had not gone [to the hospital] I would have damned myself because I would have thought that instead in the hospital he would have been able to survive. Think about the fact that he was hospitalized at [omissis], the hospital of excellence in [omissis] and even like that there was nothing to do. Try to think that you have done everything you could for him ... And while I tell you this I try to do it too, it is difficult so difficult I know ... I am close to you. (Rita, F, daughter)

Throughout all the interactions, to a story reported by a user other members respond by reporting a part of their own experience, tracing similarities and using these to make the other feel that they are not the only ones.

Hi, I'm very sorry that your father was treated like this [hospitalization denied because he was over eighty]. They did this to me too, my sister-in-law's grandfather was in hospital sick from COVID-19, he had a heart attack and given his age they no longer tried to revive him. In my opinion it's a horrible thing to do (Mara, F, daughter)

I'm so sorry for your dad. We are three brothers who lost their father in October; only my sister lives in the same town as my parents. Today I would like to tell you a little about my brother who is also a doctor like you. In September, when he learned that my dad had COVID-19, he would have liked to go and see him immediately but he couldn't do it because of his commitments in the hospital; despite the distance he tried to take care of dad by keeping in touch with the doctor who cared for him at home. [...] He [the father] was very afraid of going to the hospital and also of being intubated, he even wanted to go home when he was told they would intubate him. It was my brother who convinced him to let himself be intubated. [...] My brother couldn’t find peace for not being able to be in the hospital with our father, he was my dad's pride. The last week of my father's life, my brother told us that medicine could do nothing else for him, that there was nothing left but to wait and he never let us lose hope. He was the one who called me to give me the news after

hearing it from my sister. [...] One day I asked him how he managed to continue to treat his patients and he replied: dad was proud of me and my passion for medicine; that's what he would expect me to do, to keep saving lives and then my patients are important to me. I have always greatly admired those like you who decide to put their lives at the service of others, today more than ever. I send you a big hug Mara, give yourself time, listen to your heart. (Lucia, F, daughter).

Users also asked questions in the group regarding how other users were facing particular obstacles; interestingly but not surprisingly, these problems were all related to their difficulty in processing the loss and the social limitations imposed as a preventive measure or related in general to the COVID-19.

I wanted to ask to the group if there is anyone who is starting to feel better during these days or at least not thinking about it too much. I feel better and worse on alternate days. (Anna, F, niece)

Good evening it's been days I have been thinking of writing and today I finally found the strength to do it, I would like to ask you how you live the continuous images that come from the news, from social networks and from all that surround us concerning the hospitalizations and the virus. (Rita, F, daughter)

The advice offered in the group especially comes from older users, who help newcomers by proposing pieces of advice previously discussed in the group: as a matter of fact, in five cases the group members proposed advice that had been discussed previously in the conversations with the moderator, such as avoiding isolation, looking for resources in the support network or taking time for themselves, knowing that each person experiences grief at a different pace from the others (the extracts from Lucia and Carlo, two early members are an example). The group is also used for the discussion of strategies: users share what they do during the day and what has been useful to them; this type of sharing allows even users who do not interact often, the lurkers, to find information and this could lead to them implementing some of the strategies reported.

The only advice I feel I can give you is not to isolate yourself for too long, it's important to find a friend who can listen to us when we need to let off steam.
(Lucia, F, daughter)

My thought, if you allow me, is to talk with other about your grief, the feelings of sorrowness you have. (Carlo, M, son)

- I send you a big hug Mara, give yourself time, listen to your heart.
(Lucia, F, daughter)

- Thanks Lucia. I also send you a big hug for the loss of your dad. Yes, I'm doing exactly what you said. (Mara, F, daughter)

Moreover, a small number of users, among those present for the longest time and who showed to have different resources to draw upon, used the group to share the improvements they felt they had regarding their grief. This can be useful for other users who read, as it instills the hope to be able to feel better. It is important to remember that in mourning it is common to find short moments of positivity and growth, followed by a return to sorrow and negative feelings and grievers are not always able to get better after several months. The presence of the moderator, who reminded on each occasion that the path of mourning is personal and has a different time for everyone, made it possible to avoid that users, reading about the well-being of another user, were disheartened. In fact, there have been occasions where users have reported not be able to see differences and to continue feeling overwhelmed and even these experiences have been accepted as normal expressions of mourning.

It seems to me that I am feeling a little better, I am trying to concentrate as much as possible on my children and my family ... even if sometimes, unexpectedly, memories and a lot of melancholy assail me.
(Giorgia, F, daughter)

Today it is 10 months since my father's death but the mood, as far as I'm concerned, is the same as on March 22nd.
(Carlo, M, son)

The group served, therefore, as an opportunity to discuss and find experiences similar to one's own. Outlining the similar experiences was important to make users more comfortable in sharing their emotions and, at the same time, find comfort because of the shared experiences. This soon also strengthened group cohesion.

It is noteworthy that no information (e.g., requests for medical or legal advice; references to other groups posting of news articles from external sources, political discussions) were exchanged or requested.

Three users wrote, while interacting with the moderator, about the advantages of being able to write instead of verbally expressing their painful emotions or, more in general, they commented on the usefulness of asynchronous writing, because this allows them to take time to reflect on the their response, for example to a question posed by the moderator:

> Unfortunately I still can't talk about those days nor talk about what I experienced, I only did it in this group ...but I often think about it ... I relive those nightmarish days in my mind. (Rita, F, daughter)

> - [Moderator] Might I ask you what I have [previously] asked of the others: is there a time of day when you feel, even for a moment, slightly better?
> - [User]: I have to reflect to answer your question. Let me take time to think about it (Franca., F, partner)

Communication in the group, being asynchronous, is characterized by long moments of pause between one response and another (ranging from one day to several months). In fact, in some cases users resume conversations after months, or, as in the case reported here, a new user re-reads old conversations after some months.

> I read your post only now Anna, I can only be deeply close to you and I can't imagine the pain you went through. (Giorgia, F, daughter)

There were, however, situations in which the conversation involved various users who responded in a short period of time, establishing a dense, almost synchronic communication.

***.2 Shared Crisis Narratives***

This theme encompasses the narratives that group members adopt to talk about themselves and their experience of loss. Participants were also systematically asked by the moderator to think about how they felt, report their emotions and any significant changes. This allowed the users to express their feelings through writing.

Users do not seem to have difficulties expressing and talking about how they feel: in fact, they report different ranges of emotions, which they describe as fluctuating and ranging, for example, from "helplessness, to anxiety, to deep sadness and melancholy" (Giorgia, F, daughter). The emotions that recur most often, however, are anger and frustration, together with a deep sorrow defined as totalizing, which does not diminish but rather strengthens over time. Some address this anger to those responsible for the deaths of their loved ones, identified in the doctors and politicians or local administrators.

> It's been 5 months since he left us and I realize how time does not erase anything on the contrary it strengthens my pain. (Giovanna, F, unknown)

> Sometimes I think I'll go crazy with pain and frustration, other days I'm angry with life, I know it's no one's fault that my dad passed away but I feel so vulnerable and sad .... Lucia, F, daughter)

> In six days they killed her. Since that day I have been full of remorse and anger. The remorse of having taken her to hell will accompany me for the rest of my life. And the anger is wearing me out. Believe me, if I were certain of someone's responsibility in all this and if I had a rifle ..... I would kill them all. (Carmen, F, daughter)

In regards to the last two extracts, it is important to note how Lucia talks about anger in general terms and also associates sadness and frustration with it, which are expected emotions in bereavement, while explaining that she is aware that nobody is to blame; Carmen, on the other hand, reports anger as a totalizing emotion that is strongly linked to the search of specific responsibilities. This is also reflected in her choice of words: she would “like to kill” the responsibles, and describes the death of her loved one as a “murder” , the hospital in which her mother was cured a “hell” and her own anger as something that is “wearing her down” .

Like Carmen, for many of these users, expressing feelings of anger also leads to sharing the remorse and the sense of guilt for having brought their loved one to the hospital: many of them, in fact, say they insisted on the hospitalization, thinking it was the safer thing to do at that time.

> - Too many things haunt me unfortunately .. from contagion to death in a hospital where he didn't even want to go. Guilt haunts me because it was I who invited her to go. I am tormented by the treatment (or the lack of treatment) received. It torments me that she

died there without me. I have not been able to see her or stand beside her ... I do not think I will ever be able to work through such a tragedy. (Loredana, F, daughter)

- I have this remorse everyday. I acted thinking I was doing him good, I was going to save him. I asked him to trust me. (Mara, F, daughter)

The constant return to painful emotions is perceived by the participants as a "step back" to when the bereavement was recent, and involves a difficulty, shared by almost all participants, to find a direction. In fact, several users report to be feeling lost; in some cases, the severe pain gives way to apathy and lack of interest.

There are days when I manage to be rational and it seems to me to take a step forward and days when I fall back into the most absolute sense of guilt and it seems to me that I have returned to the starting point. (Mara, F, daughter)

[I feel] Bewilderment. Everyone tells me that I am strong but in these two months I have realized that I was strong because it was my father who always gave me strength. Now I am no longer strong. In fact, sometimes I don't know who I am anymore. I had so many plans and now I don't know what I want to do anymore. He used to describe me to his friends as a determined girl, but today I'm not anymore. I don't know what to do, I feel stuck. (Franca., F, partner)

I feel empty inside and completely alone despite having a family of my own. Often, I would like to fall asleep and never wake up again. (Carmen, F, daughter)

The difficulty of imagining a direction for these people also has a strong impact on their ability to hope to be well again. One participant talks about how the feeling of apathy also affects her hope that the pandemic will be resolved.

Not only I am no longer able to look at images on the news or read news about it ... unfortunately I am no longer even able to be interested in this pandemic to end ... because now covid has transformed my life into a sad survival. (Loredana, F, daughter)

Users show difficulty to accept the death of their loved one, in making sense of it and therefore in re-inserting the events in a frame of meaning that allows them to restructure their new identity without their family member. In fact, phrases such as the one of Mara, showing a desire (not actuable) to go back to the days when her father was alive rather than concentrating on what is happening in the present, are frequent.

> I can't stand anyone who says "life has to go on", but they don't know that I would just like to go back. (Mara, F, daughter)

> I too feel lost and sometimes I struggle to understand who I am. Every day I would like to receive a call from my dad and tell him many things. (Lucia, F, daughter)

> Four months have passed since the last time I saw my father ... From his hospitalization and it seems to me that I have not yet realized his disappearance, it seems to me that at any moment he must return, the other night I dreamed that I discovered that he was still alive ... having not seen his body, I dreamed he would return ...
> (Rita, F, daughter)

It is the users themselves, through the posts they write, who share their attempts to find explanations for their emotional suffering: in many posts (18,44 %), they trace their pain and inability to find meaning in the loss to the painful awareness that their loved one died alone, or the impossibility of being able to say goodbye either in the hospital and through the funeral. The inability to predict the death of a loved one, given the sudden worsening of the symptoms or because the departed was considered fairly young or healthy, also seems to have had a strong impact on the possibility of preparing for death, and therefore hindered the processing of the event.

> The final straw that destroyed me for good was the image of my dad in the last farewell given on video call. [....] Not being able to see him was a death in half for me. As much as halved was the ability to say goodbye in a the ceremony lasted only 10 minutes with Our Father included in the price. (Silvia, F, daughter)

> - I think, as far as I am concerned, that not being able to give a word of comfort rather than a caress to my father are the reasons that lead me to so much sadness and

melancholy [...] Unfortunately, not having been close to our loved ones neither in sickness nor for a last farewell, made mourning more difficult and never subsided. (Carlo, M, son)

- Thank you for these words of comfort. It 's true, not having given the last farewell was the coup de grace for me. (Anna, F, daughter)

- My father has never had any health problems, this was his first and last time in the hospital. He was afraid of diseases in general and the thought of him there alone with his fears hurts me. (Mara, F, daughter)

- Mara, I am close to you today it is a month since my father ended [...] my dad too was fine and had never gone to the hospital before. (Rita, F, daughter)

A sentiment shared by many users is that they feel alone in their pain as they are misunderstood by the people close to them, who put pressure on them to overcome the grief and do not take into consideration how much the conditions in which the loss occurred are challenging to the mourners. A small number of users reinforces the idea that no one can understand their grief and that, consequently, they have to create a place for themselves in order to give each other strength.

It is hard to go on with such a boulder on the shoulders, only those who have known this [loss] can understand. Only those who have truly loved never stop suffering!!
(Anna, F, niece)

Condolences Mara and Rita, we are all devastated by these so absurd deaths. Be strong, I know it's hard, I've been suffering for almost a year now. Talk about it, it helps. We're all in a boat, let’s not make it sink. (Carlo, M, son)

***.3 Responses to Grief***

Numerous examples of responses to grief that could be more or less maladaptive for the grieving process are shared by the users in the group. Among the maladaptive coping strategies, as well as the general coping mechanisms, ruminative thoughts appear often: numerous users talk about how often they find themselves retracing the last moments before saying goodbye to their loved ones beyond the hospital doors, describing these thoughts as intrusive and persistent. In fact, since they were not allowed to visit their loved ones in the hospital, they are left with incomplete information on what happened in the hospital and struggle to get a clear idea of what happened before the death.

They took him to the hospital because in their opinion [of the doctors] it was the right choice, for me that seemed the best decision .. Now I say what if he stayed at home? ... I don't know this thought is like a nail in my head and it doesn't leave me. (Camilla, F, daughter)

I often think about it ... I relive those nightmare days in my mind, retracing the various moments as she said and I feel like I'm dying. (Rita, F, daughter)

Two users reported social withdrawal from others because they felt misunderstood or felt pressure to overcome their loss, while in two other cases two different users spoke of preferring to manage their pain privately, an attitude that inevitably leads them to not share or express their painful emotions to others. For this subgroup of users, writing in the group could be a way to find understanding support or less threatening ways to talk about what happened.

Although I have many people who are close to me and try to distract me, I often pushed them away because I wanted to be alone. (Mara, F, daughter)

Most of the time I even avoid the subject with my husband. (Lucia, F, daughter)

I can hardly open up even with my relatives, I don't want to be seen down and maintaining a façade behavior tires me and stresses me a lot. And when I'm finally alone I can abandon myself to emptiness, sadness and my pain. (Franca, F, partner)

Unfortunately I still can't talk about those days nor write about what I experienced, I only did it on this group ... (Rita, F, daughter)

In several cases the moderator invited these users to identify new resources in their informal support group or, if necessary, to find strategies to talk about their pain to their loved ones effectively and by avoiding misunderstandings and conflicts. Here is reported one of the extracts from the moderator.

- If we feel like it, we could reassure the other person about the possibility of saying words like "death" or of saying the name of the person who died without fear. Hearing the

name of someone we lost again might make us cry, but it helps remind us that this was a real person, known and loved by others as well. We could also explain that the bereaved person prefers honest communication to consoling or forcingly positive phrases: no one expects them to solve the problem, what you ask for is to be listened to without judgment. If this proves difficult, we could simply explain that we prefer to have someone sit in silence with us and respect our moments of reflection, without feeling the obligation to have to talk about something. (Moderator)

- Thanks, I really felt the need for these words! (Giorgia, F, daughter)

A smaller part of the users, however, reported having good support from their family which, by sharing the mourning for the loved one, was able to provide the practical and emotional help users needed. Among the adaptive coping mechanisms identified, in fact, there is also the will of some other users to ask for and obtain support from their family: as in the case of a user who identifies in the family a valid point of support to keep alive the memory of the father. In several cases, the presence of children is indicated as the motivation to address the mourning. There are also few cases in which the users report their worrying about their family members:

I have many good memories of my dad that I share with my wife and children, whom I also thank for listening to me carefully. (Carlo, M, son)

The burden of which I write of is my mother's pain which adds to mine. Thinking about what she is feeling, thinking about her in her home without her life partner anymore is terrible, she has never lived alone and now I don't know how she will go on. (Rita, F, daughter)

Some users report having started therapy, explaining that they have understood that they were unable to manage their pain on their own. In other cases, users report examples of their personal therapeutic journey to other users to provide comfort and closeness. The research of the group itself could be considered a positive coping strategy, because it involves a proactive research of support.

(Goodmorning, I decided to start going to a psychotherapist, I think that after a year passed it is more difficult to make it by oneself.
(Elsa, F, unknown)

- Sometimes "I stop" and think, then I cry, even crying I think it helps.
(Benedetta, F, daughter)

- I know. also according to my psychiatrist I should stop for a moment and listen to my pain but I don't feel like it; or rather it goes by the day, some evenings I cry and I need to vent. I am close to you. (Lucia, F, daughter)

It is important to note that those people who, while suffering from their loss and continuing to seek meaning in the death of their loved ones are also the same ones who report the most adaptive coping mechanisms: they are able to cry and feel their emotions, to go beyond anger and the search for blame for what happened, they seek distractions during the day, cultivate hope and make plans for the future.

When I cut out some time for myself and go out to walk on the hills , a passion that my father passed on to me, it seems to me a more normal life and gives me hope for the rest of day. (Carlo, M, son)

I hope to be able to resume studying soon. It was my biggest dream and also my father's joy and I don't want COVID-19 to take all of that away too. Thanks for all your words. (Mara, F, daughter)

***.4 Retelling Narrative of Death***

Through writing in the group, users attempted to create a new narrative regarding their grieving experience. In this sense, some users have shown that they can use the group to ask themselves different questions, think constructively and go beyond their sense of guilt or ruminative thoughts. This way of thinking may not be available to all users, but the fact that it is shared and readable by others could also help non-writers and lurkers to find examples of different questions, which allows accessing new ways of searching for meaning. Through the tool of the written post, users have the opportunity to construct their identity, their role in the family, and how this has changed with the loss of a loved one. This allows them to identify and express what has changed

with the loss and understand where they could recover the necessary resources from and lay the ground for the creation of a new personal meaning.

> Everyone asks me if I am studying, if I have started studying again. Everything revolves around that. I am a medical student and everyone expects me to return to study and complete my studies. [...] The medicine that I loved so much in a certain sense betrayed me.
> (Mara, F, daughter)

> As a family member [of the departed] and as a local political administrator, this pandemic has shaken me a lot, because for the first time I have not given answers to the problems of my people. It's hard, I'm missing my Daddy so much but I have to try in every way not to let my villagers fall into what I had to go through ..
> (Marco, M, son)

Also through the written post, users find a space to present who was the person they have lost: to do so, they draw on memories prior to their death and in this way they attempt to restore a linearity in memories which is helpful to realize that their loved one was not only the person they saw shortly before being admitted to the hospital, but was defined by all the experiences they have had and passed on to others.

In talking about their loved one and the relationship they had with them, some users choose to speak to the loved one in the first person and use affectionate appellations. Referring to loved ones as if they were still alive, recovering and sharing memories to put them in a new relationship (as does Carlo who wonders if the passion for trekking in the mountains handed down by his father may help him to lessen his pain and move forward) are ways to maintain the bond with the deceased.

As expected, the mourners had the tendency to present their loved one in a clearly positive light but the intervention of the moderator was pivotal, in these phases, to avoid rumination over the memories. The moderator invited the users to think about what to take from loved ones as a lesson or resource to be able to cope with pain (as in Giorgia's example) asking: is there something that your loved one has taught you that could come handy, at the moment? Is there any passion, characteristic or way of dealing with events that your loved one has passed down to you?" For some users, this was the occasion to discover or rediscover something new about the departed by taking their role, such as Camilla, who writes about the struggles and accomplishments when taking charge of the family business.

To find strength I try to think that I can't remember my father's life as in those 2 hellish weeks and I try to remember the joyful and happy moments together and force myself to put all our smiles before this pain ... It is very difficult .. but I try.
(Rita, F, daughter)

Rummaging through your things I found the toolbox still ready to leave your home because you believed it [possible] even though you knew it was impossible. You were this, an example. It was an honor to have you as dad, sometimes we worked together sending us to hell only to end up at the bar and be alright again. Yeah dad, you remember how many beers together in summer afternoons. Then the passion for the mountains, you were there, you were a dad and a friend ..... Hi dad, Hi friend.
(Carlo, M, son)

My mom was the most patient, generous, selfless and good person I have ever met. I thought so too before she left. She was always ready to help as she could. I have rarely heard her complain about anything, although her life was not easy (she was the first of 5 children, she lost her father at 5). I would like to have her patience and availability towards others, her goodness of mind.
(Giorgia, F, daughter)

I think my father was much more than what we could understand .... I took over his bureaucratic commitments and it is so complicated ... and seeing myself being successful .. (you know the bureaucracy how it goes... a success is a party) I feel gratified in a certain sense ... (Camilla, F, daughter)

A group of users, composed of individuals who showed to be the most shocked by the loss (often reporting difficulties in realizing the disappearance, along with rumination and anger), use the space in the group to simply review the events that led to the death of their loved ones: they trace in detail what happened, from the first symptoms through the worsening of the illness and the several communication problems with the hospital, while raising doubts about the proper treatment of their loved one. In the reported case, Maria, who lost her mother in the first months of the pandemic, writes:

My 61-year-old mother has a respiratory arrest on 20/1 I call the ambulance. They bring her to the hospital: bilateral pneumonia diagnosis. In [omissis] hospital there is no room, they decide to take it to the [omissis] hospital complex. After 5 days she is transferred to do echo cardio and she feels worse. First intensive care then cardiology ward. The hospital is saturated with patients with pneumonia. Mom recovers and in March she starts rehabilitation there. On friday [omissis] my mother is discharged from the subacute wards for "emergency coronavirus sanitation": they told her for your safety we will discharge you, rehabilitation will be done later. On day 9 fever begins, after several calls to the doctor and a week of waiting we decide to send her for x-rays. But how is it possible I wonder if the pneumonia was cured on [omissis]... certainly if my mother was not in the hospital she would not have caught the virus ….  (Maria, F, daughter)

In other cases, however, users use this space as an opportunity to retell the story of loss through a more structured narration of a story than just reporting the events, which is composed of a background, the inclusion of other characters, the posing of questions, and the reporting of personal reconstructions. Silvia, for example, starts her long post by explaining to the readers that she needs to recount the story of how her father died to make the event more concrete, then she turns to her departed father in the first person:

It's been four days since my dad died. I still don't know how much I really understood the event, since there was a lot of distance between me and this fact. I feel the need to tell this story, to make it mine, to feel it concrete. It is a sad story, as perhaps many have heard something similar these days. The story that is making us all more isolated from the world, but at the same time more united in the face of this inexorable pandemic. The paradox of COVID-19. [...] Dad but if you are somewhere in the hyperuranium floating lightly, as perhaps you have not been in your earthly form, do you realize the immense emptiness you leave here? [...] I love you daddy. As someone has suggested to me these days I am sure of this Nothing remains, nothing disappears, everything evolves. You will be everywhere. (Silvia, F, daughter)

I'll tell you my terrible story. [omissis] February, I take my Daddy to the emergency room in [omissis], they keep him in for presumed pneumonia until March, and then they release him. After 5 hours I bring my Father back more dead than alive and I stay for 16 hours in the emergency room, crowded until the first light of dawn. I was beyond belief.

I went on swallowing a cup of tea and begging God to give me time to take care of my Mommy, then I would gladly fly alongside my Father. My Father after unreal phone calls where he told me they were letting him die… on March [omissis] he dies .. A cold phone call from the hospital and I am alone at home with my Mother who did not get out of bed. I needed to make myself strong, but this strength was not coming to me, because the person dearest to me was missing. My Daddy. (Marco, M, son)

The users of the group, therefore, use the posts not only to search for meaning (e.g., by addressing questions in the group or to themselves to try to understand why it happened and if and who has responsibilities for it), but also to start retelling their new narrative of death; a new story that encompasses their new possible identity without the loved one.

Similarly, some users were observed to express hope for a possible future life: these posts concerned the possibility of having a funeral or re-embracing distant loved ones or witnessing the birth of a grandson which, in the case reported here, becomes a symbol of hope and rebirth for the whole family of the user who was touched by the loss of the householder. Writing and sharing this, co-constructed in the confrontation with others, is important because it allows one to start embracing the reality of the loss and to plan what could happen in the future so that it is not the loss of the loved one that establishes the end of their ability to experience the world.

I can’t wait to have a ceremony where we can give a last farewell to our father [...] Also, now with the new closures due to the red zones I am not going to work at the moment ... But I hope to go back soon and have a fresh start, that’ll help me. (Camilla, F, daughter)

For me, hope at this moment is my nephew who will be born soon. He will have my dad's name: [omissis]. Unfortunately, I don't know when I'll be able to go to [omissis] to meet him. [...] I think we will make a video call all together to get to know the baby, I think we will cry with the joy of knowing him even if at a distance. Then next year my sister would like my brother and I to be stepfathers when the baby will be baptized and that makes me very happy I can't wait to be able to go. We would also like to have a ceremony in memory of my father, a great celebration to greet him. (Lucia, F, daughter)

***.5 Context of the Mourning Process***

This group shows all the references that users made to the social context in which they were experiencing their bereavement and to the role the pandemic had on it.

Unlike other grieving forums where each user shares a personal story that is only partially similar (for example in the mode of death) to the other members on the platform, in these cases COVID-19 mourners shared very similar experiences and found themselves immersed in a context that constantly reminds them of the conditions in which death of their loved ones occurred. Although it is important to remember that not all people experienced the pandemic in the same way (e.g., people with larger houses or resources might have managed better their quarantine), it is noteworthy that experiences such as the continuous exposition to images about COVID-19 or the impact of the introduction of new measures to prevent a second pandemic wave (which were adopted precisely in the months in which the group was operative), were experienced and recounted by all the users who wrote in the group and, according to them, had a major impact on their ability to process their loss. Infact, for some users, their grieving is so much embedded into the context of the pandemic that they identify it as the major obstacle to grieving and describe the pandemic as a tragedy or a collective trauma.

> More than not being ready [to say farewell to a loved one] I'd say it's a huge trauma, and this modality [the social distancing] amplifies it. (Maria, F, daughter)

> [Now] things all around seem to make no sense compared to the enormity of what happened to me, the tragedy that I have lived and am experiencing everyday. (Giorgia, F, daughter)

> I don't think I'll ever be able to work through such a tragedy. It is the tragedy that is "processing" and transforming me. (Loredana, F, daughter)

Images of hospitals and coffins were frequent on television. A user asks the group how the others are managing the continuous exposure to the news reports that show the images of patients intubated in the hospital. In fact, users report great unease in continuously finding references to death from COVID-19 on television or in conversations between people, because it forces them to rethink the conditions in which their loved ones died.

Seeing photos of patients in beds with masks, helmets or intubated tears my soul apart..., every image or video that represents the covid wards or the medical staff is as someone were thrusting lower and lower that knife I felt planted in my heart since he left. I try to avoid seeing the news but the images are everywhere. The thought of what she has been through goes beyond any worst imagination and takes my breath away. Forgive my outburst but I'm tired of this pain. (Rita, F, daughter)

Seeing the devastation of this period afflicts me, but I don't want to see anything anymore, I'm already sick. (Anna, F, niece)

The health emergency has also significantly changed social rituals and meeting occasions. Users discuss how the limitations add hurdles and pain to their attempts to mourn. For example, Lucia has not yet been able to visit her family abroad due to restrictions on traveling by plane. Getting closer to the winter holidays, another user starts a discussion on the new prevention measure imposed, which prohibits large family reunions.

Given the health situation I don't know when I will be able to go home and this brings me down even more. (Lucia, F, daughter)

I cried but very little compared to my other family members. Now it seems to me that it is coming all over me. I wanted to know if others feel this way too, maybe it also has to do with the fact that they are closing down everything? [referring to the the increased social distancing measures implemented during autumn/winter]. (Anna, F, Niece)

Perhaps the period we are experiencing does not help and it seems to me that I am living in suspense between all the things that need to be done ... (Franca., F, partner)

The problem is not how many people will be able to sit at the same table for Christmas, the problem is that 64,000 families will have an empty chair. (Maria, F, daughter)

In general, some users talk about how anything about their external context, such as the urban landscape heavily compromised by the limitation to sociality, reminds them of the first wave of the pandemic, in which their loved ones died.

Unfortunately, when I walk across the village and I see an empty and silent street, I go back to those sad days of March. (Carlo, M, son)

The way in which the pandemic was managed also led to a general loss of trust in doctors and open distrust of administrations, which would not have done enough to avoid contagion within structures that received fragile people, such as nursing homes and hospitals. Not being able to trust medicine anymore is an important obstacle for one of the users, a medical student, who shares in the group her disappointment, linked to the loss of her identity as a medical student. Some users, on the other hand, talk about how they realized that the society in which they live privileges profit rather than the health of citizens. In the last extract, Silvia, who continues to address her father in the first person, describes him as a victim of a "society based on the continuous stride for money and sacrifice for a job" .

The medicine I loved so much in a way betrayed me. I feel anger and disappointment. (Mara, F, daughter)

Our politicians knew well in advance of the tsunami who would invest and they did nothing but protect themselves. [I feel ] anger against the health workers too who, by their will or by someone's indication, have not done the impossible to save a generation of human beings. (Carmen, F, daughter)

In the meantime, I start to write about you, dad, because for me you are not only the victim of a virus, but you are also the victim of a society based on the continuous need for money and the continuous sacrifice for work. Because it's while working that you got this fatal blow. (Silvia, F, daughter)

The users with the most difficulty finding meaning and accepting their loss are those who have most often cited the desire for justice.

I would like justice so much! because they took him from us without a reason ... he was healthy but he paid with his life for the sanitary panic of those damned months.

> Thinking about him alone in his last days leaves me peaceless. I talk about the responsibility of doctors with everyone I can, with everyone. (Anna, F, niece)

> I want revenge for the inability of politicians. I have this sense of emptiness, powerlessness and a desire to reach him. (Marco, M, son)

In an attempt to break away from the constant thought of the secondary effects of the pandemic, some users talk about a return to normality which is however only partial, due to the upheaval that the pandemic has caused in their lives.

> I wonder in the long run how we're going to deal with this all. When will we return to normal (although it really doesn't exist for us, really), like a Saturday night out. (Mara, F, daughter)

> .... I see many people happy to be able to return to normality and on the one hand I too am happy to be able to do other than home-work-home but on the other hand I feel that my normality is not normal because I have lost a very important person and I have an immense emptiness inside. (Franca., F, partner)

**Table X.**

*Table of themes and subthemes*

| Themes | Subthemes |
|---|---|
| 1) Group's uses to respond to needs | |
| | Newcomers' messages and motivations |
| | Using posts as memorials |
| | Request and offering of emotional support |
| | Second stories |
| | Request of advice |
| | Offering of advice form older users |
| | Sharing improvements |
| | Advantages of the writing tools |
| 2) Shared crisis narrative | |

| | |
|---|---|
| | Anger and frustration<br>All-encompassing and non-abating pain<br>Regret and guilt<br>Swing of emotions and phases<br>Lack of direction<br>Difficulties accepting the loss<br>Personal explanations to non-acceptation<br>Feeling misunderstood outside the group<br>Giving strength to each other |
| 3) Responses to grief | |
| | Ruminative thinking<br>Social withdrawal<br>Support from family<br>Starting face-to-face therapy<br>Allowing oneself to cry<br>Looking for leisure during the day<br>Cultivating hope |
| 4) Retelling narrative of death | |
| | Presenting own role<br>Presenting relationship with the departed<br>Use of appellations or first-person references to the deceased<br>Memories to keep the bond with the departed<br>Revisiting the events<br>Retelling a story<br>Planning the future |
| 5) Context of the mourning process | |
| | Pandemic as collective trauma<br>Avoidance of the news<br>Impact of contagion prevention measure<br>Disappointment towards administrations and hospitals<br>Desire for justice<br>Desire for going back to normality |

**Users' Feedbacks on the Group Participation**

On two occasions, the moderator proposed directly, through a dedicated post, to start a conversation over the aspects that users had found useful and on what they proposed to change or to see more often on the group. Users wrote about the posts they appreciated and specifically agreed on the fact that the group had provided them a place where feeling understood and welcomed. One participant also stated that she preferred to avoid reading some posts for fear of feeling excessive emotional weight.

> I particularly appreciated the post on how to manage emotions and how to make family members understand ... Because we are often misunderstood. Then just being able to come here and find understanding helps a lot. Although I must say that sometimes I have avoided reading so as not to feel too bad ... (Anna, F, niece)

> I totally agree with Anna, it also helps me to find understanding in the group; at work and sometimes even with my husband or my in-laws I seem to have to justify the fact that I still feel bad (even if I have made some progress) after 7 months; here in the group I can openly say I feel bad without being ashamed.
> (Lucia, F, daughter)

Some of the requests about topics to cover regarded the post-pandemic scenario: users showed to be in a contradictory situation where their hope and looking forward to a return to normality was accompanied by feeling that they could not return to a normal life as before the loss.

> If possible I would like to have some suggestions on how to live the post-pandemic How can I not feel this emptiness? how not to feel envious of those who have not lost anyone? :( (Mara, F, daughter)

> Knowing that there is a group like this to turn to eventually is useful, a little lifeline. One aspect that could be addressed, I don't know how, could be that of changes in family dynamics and relationships after the sudden death of a loved one. (Rita, F, daughter).

The topic of family conflict (or misunderstandings due to the grief) and the change of role and family dynamics imposed by the loss of a loved one was recurrent among the users' requests.

**Satisfaction With the Group**

The satisfaction and the overall use of the group was investigated through the anonymous questionnaire. Users were asked how often they used the group: the respondents on average accessed the group at least once a month up to a maximum of at least once a week and wrote in the group once or twice a month. Users rated their satisfaction with the use of the group (mean 3.62 of 5, SD = 0.4 on a scale from “not at all” to “very much”) and declared to be feeling involved in the conversations with the other users an average of 3.62 of 5 (SD = 0.7) as well.

When asked if there was a particular post which provoked nuisance or distress, only one user answered “yes” , then specifying that it was a conversation in which another user had told how she had managed, thanks to acquaintances among the doctors, to get in touch with their loved ones in hospital. A second participant, who stated that they did not receive particular disturbance from the conversations, later specified in the following open question, which allowed them to explain their choice, that in general at some moments it was emotionally burdening to read what other people had to go through, due to the pandemic.

All users (8 out of 8) appreciated and deemed useful the proposed discussion online at a fixed rate, listing very different reasons: from the opportunity to create participation and sharing in the group, which would help to promote reasoning on important issues, to the sharing of practical advice but also to support the group’s morale.

Users also reported in detail which post or conversation they found useful: some concerned informative posts that normalized the fluctuation of emotions in bereavement and validated their feelings. In some conversations, the theme of accepting that mourning has different times for each person and that it is important not to expect too much from oneself in those days when suffering is more acute was often treated, and this has also been reported among the issues that provided the most positive emotions. In fact, another user reported an intervention by the moderator reporting the sentence "how we expect mourning to be and how it really is" , accompanied by an image showing a straight line for the first example and a twisted line for the second. Another user, on the other hand, deemed useful a conversation about finding a way to replace the normal rites to say farewell to the person who is no longer there (for example, some users reported having lit candles, having put up photos of the departed with the other family members or continuing writing commemorative posts on their personal Facebook page).

Finally, users found useful the conversations about guilt and the advice that some users gave to those who seemed to suffer the most from the remorse of taking their loved one to the hospital. Only one respondent, having written that he had found the regular discussion useful, added that in some moments he preferred not to read the posts in order not to “reopen old wounds” .

Overall, the content shared in the group either by the moderator or the other users was deemed appropriate, useful and adequately sensitive, by the totality of the users. When asked if they would have preferred to discuss with other users in a different way, two participants answered they would have preferred to meet face-to-face or on a dedicated platform, while the rest stated they appreciated the use of Facebook as a virtual venue.

On a scale from 1 Not at all to 5 Very much, users felt supported by the other users in the group by an average of 3.25 (SD 0.6) and also stated they all felt safe when sharing their personal story of loss on the platform; the reasons given for this choice were very similar:"Because talking about it helps" ; "Because we are all suffering" ; "Because we are all alike" ; "Because (what we talk about) is unfortunately the pure truth" .

**Usability of the Group**

Lastly, the last dimension to be investigated through the questionnaire was the perceived usability of the platform. The totality of the respondents, found it easy to navigate the page (e.g., finding old conversations, talking to more than one user, following the exchange of other people's comments) and appreciated being able to access the group via Facebook (e.g., ease of access by phone).

A question investigated how users felt whenever they saw a notification informing them that a user had posted something new. This question was asked to verify that there were no anticipated distress reactions. Users spoke of feelings of curiosity, expectation or neutrality, while only one user reported feeling some kind of anticipatory sadness when seeing new notifications.

All of the eight respondents stated that they appreciated being able to write about their experience instead of expressing it in words, while two users answered "no" when asked if they appreciated the fact of being able to discuss with other users asynchronously instead of in real time. Finally, to the question "what do you think you have achieved by participating in the group?" . Users reported feelings of mutual support; of belonging to a group and of "not feeling alone in the tragedy" ; understanding. One user, however, commented "perhaps anguish for having read other tragedies" . Appendix B reports all questionnaire's items.

**Table XI.**

*Answers to Anonymous Questionnaire*

| Factor | N of respondents (total N =8) |
|---|---|

| | |
|---|---|
| Age | |
| Mean | 43.5 |
| SD | 12.6 |
| | |
| Gender | |
| Females | 6 |
| Males | 2 |
| | |
| Kinship | |
| Adult children | 6 |
| Niece | 1 |
| Partner | 1 |
| | |
| Marital status | |
| With a partner | |
| Single or widowed | 4 |
| | 4 |
| | |
| Employment status | |
| Employed | 6 |
| Unemployed | 2 |
| | |
| Region of origin | |
| Northern | 6 |
| Central | 1 |
| Southern | 1 |
| | |
| Time since the loss | |
| Mean | 9.5 |
| SD | 4.8 |

| | |
|---|---|
| How often accessed the group | |
| At least once a week | 4 |
| One or twice a week | 0 |
| Once or twice a month | 3 |
| Once a month | 1 |
| | |
| How often written actively in the group | |
| At least once a week | 1 |
| One or twice a week | 0 |
| Once or twice a month | 3 |
| Once a month | 4 |
| | |
| Would have preferred a completely anonymous profile instead of Facebook one | |
| Yes | 6 |
| No | 2 |
| | |
| Found easy to navigate in the page (e.g., find old conversations, following other users's exchange of comments) | |
| Yes | 8 |
| No | 0 |
| | |
| Appreciated the possibility of accessing the group through Facebook (e.g., for the ease in accessing it through the phone) | |
| Yes | 8 |
| No | 0 |
| | |
| Appreciated the possibility of meeting other users asynchronously | |
| Yes | 6 |
| No | 2 |
| | |
| Appreciated the possibility of writing about your experience instead of talking about it | |
| Yes | 8 |
| No | 0 |

## Discussion

The present study analyzes qualitatively the content of the post exchanges between members of a Facebook group for COVID-19 mourners. In addition to the analysis of the posts written by the users, questions were asked to the participants themselves both in the group, as an opportunity for receiving feedback and for the improvement of the support tool, and through an anonymous questionnaire. The responses to the questionnaire were few compared to participation in the group (a total of 8 of 25 participants); users may have felt not engaged enough to provide additional information about their experience. Despite this, the triangulation of the three sources of information (the written posts on the webpage, the direct feedback provided by the users and the answers to the anonymous questionnaire) allows making some important assessments on how COVID-19 mourners use online support groups and what they find useful.

Although with the creation of an online group it was hoped to reach a base as more heterogeneous as possible, as expected the majority of the users included were women. In fact, women are more likely than men to be members of online support groups, and, the present research, they were also more active in its use (Chapple & Ziebland, 2011; Feigelman et al., 2008; Oliveri, 2003).

According to the recorded interactions in the group and the answers to the questionnaire about the group usage, current members accessed and wrote in the group on average once every two weeks, while some new members took their time to learn how the group worked before posting (Nonnecke et al., 2004) and only a small number were non-posters, which is a more evident phenomenon in larger online boards (Kahnwald, 2007).

Since their introductory message, users provided an indication of how they intended to use the platform: similarly to other grievers (Robinson & Pond, 2019), COVID-19 mourners looked for others with the same experience with whom to share their pain and feel understood; if in the case of suicide survivors this necessity is due mainly to the fear of social stigma (Barak, 2008; Hollander 2001), in the present case it was the need to find someone who understood the great pain due to the suddenness and violence with which the loss occurred almost as a strive to unite against adversity.

In line with this assumption, current members answered the newcomers' posts by offering empathy and second stories, that is, proposing their own experience based on similarities with the initial one (Paulus & Varga 2015), which welcomed newcomers' experiences and implicitly legitimized their membership in the group. This is consistent with other findings showing that

grieving individuals seek online support to validate their grieving experiences and ensure what they were going through is normal (Varga & Paulus, 2014; Swartwood et al., 2011).

In addition to the exchange of emotional support, although previous studies of online support groups for grief have noted the lack of direct requests for advice (Morrow, 2006), in the present group some users explicitly asked for advice: requests concerned mainly issues linked to the context of the pandemic (e.g., how to cope with the images on the news). No legal, medical or off-topic advice was asked, which may depend on the fact that this group, differently from a forum, was not perceived as a place where such discussions could be started, or can also mean that the rules were clearly presented and users understood that it was not possible, for example, to ask for medical or legal advice in the group

The other members often gave recommendations on how to cope with the problem based on their personal experiences, while simultaneously reassuring the user that the unique features of their grieving were, in fact, not unusual (Morrow, 2006). In some cases, members also indirectly encouraged other users to find face-to-face support (Giles & Newbold, 2011) by recounting their own experience, thus representing an important resource for those individuals in doubt whether to seek help from a professional. In fact, considering the questionnaire results, some users could have actively sought out the group and might therefore be enticed by conversations in the group to seek professional face-to-face support.

Unlike other bereavement support forums where each user writes about their bereavement at an unspecified time, members of this group were united by the fact that they were all grieving for their loved ones during the pandemic, having lost a close person in a short time window of just over 12 months and in the context of an ongoing pandemic. The sense of cohesion was very present in the group: considering the answers to the questionnaire, the perception of being among equals might have increased the feeling of safety and protection in the group. References were also often made to how the pandemic had changed their lifestyle, one above all, the tightening of precautionary measures, which had a strong impact on their offline life, their search for support, and their ability to make future plans.

As in other losses which are perceived as unexpected and premature, group members showed an intense and protracted search for meaning, resentment and anger (Hall, 2014). One of the uses that were made of the group was precisely to give vent to this anger, seeking consensus in others: group members looked for physical culprits to blame and reported disappointment or anger towards physicians and administrators. Angry mourners perceived the death of their relatives as unjust and showed struggles to assimilate the loss experience into their pre-loss beliefs and self-narratives (Janoff-Bulman 1992; Park & Folkman 1997) which allows one to maintain consistency

with the person they previously were. This struggle to find culprits was previously observed in Italian COVID-19 mourners (Cipolletta et al., 2021b) and could be specific of deaths that affect large parts of the population as natural disasters in which, however, it is possible to identify the human role in the aggravating circumstance. The continuous search for culprits, however, could be harmful, as it can hinder access to other emotions such as sorrow, sadness, melancholy, and ultimately allow the mourning process (Dutton & Zisook, 2005).

Writing about painful emotions, including anger, in a constructive way could, however, be beneficial (Dutton & Zisook, 2005; Kemp, 2005). Moreover, emotional language has been found to enable the staging of one's story as an experience that other members could relate to and sympathize with (Bar-Lev, 2008). Users themselves reported, in the questionnaires, the benefits of being able to write about their emotions through the posts: while some group members use the posting on the group to retrace in detail and re-live the steps that led to the ominous epilogue, some others use it as a virtual place to create a new and coherent narration of what has happened, including where their responsibility for the loss lies and what are the resources they could draw on to rebuild their identity. In this sense, the written posts allowed the retelling of a new narrative where mourners can attempt to accommodate to the loss by reorganizing, deepening, or expanding their beliefs and self-narrative to embrace the reality of the loss (Janoff-Bulman 1992; Neimeyer et al., 2010). If the former style allows to review the loss story to obtain mastery, coherence and emotion regulation rather than avoidance, the latter allows to narrate the overall impact of loss from a "self-distancing" perspective, situating the loss in the broader landscape of previous experience and the new identity, possible also through the changes occasioned by the loss. Overall, the group proved to be a place where it was possible to share with others the stages of their personal path of processing the loss.

In a longitudinal study Davis et al. (1998) claimed that by six months into bereavement, nearly 70% of participants reported having made sense of the loss. When this does not happen, it could lead to complications in the bereavement process (Eisma, 2021). Acute grief was not observed in the group members (which were however originally filtered through the exclusion criteria); therefore, it is not possible to ascertain the level of distress of COVID-19 grievers, nor was this the intent of the study. Overall, while it should not be assumed that all COVID-19 mourners are bound to develop complicated grief, it is important to understand how the extreme circumstances of this loss may open the way for some sort of grief complications in order to timely identify risk and protective factors (Wallace et al., 2020).

The posts shared in the group were, in a few but significative cases, copy-pasted within other public groups on Facebook: this might mean that writing on Facebook allows to share with

more ease posts written for a specific purpose (e.g., to appear in a memorial group) via the share button, so that they end up on other Facebook groups such as the one in question (Munson, 2011); vice versa, it could make it possible to share reflections from inside the group to outside (although this was not observed, since the present group was private).

Writing in an online group additionally represents an opportunity to maintain and enhance members' relationships and bonds with the deceased (Bailey et al., 2015; Moss, 2004; Sofka et al., 2012). Particularly, communication with the deceased person on Facebook pages, is associated either with sense-making or with maintaining relational continuity with the deceased person (DeGroot, 2012). In some cases, however, the online environment could become a place for ruminative thoughts where users might use the web page to interact with the deceased more than with other users (Westerlund, 2020). The use of support groups as memorials may therefore increase and amplify negative ruminations and a reluctance to ''let go'' of the deceased (Stroebe et al., 2008). The presence of the moderator is important because it allows to intercept these ruminative thoughts expressed in the form of written posts and to intervene, for example by asking the user to reflect on what the departed has left to the user as a gift to use to overcome difficult moments or as a legacy, hence bringing forward relational connections rather than relinquishing them (Neimeyer et al., 2010).

Normally, some online interventions, especially those that refer to cognitive behavioral therapy, use protocols borrowed from face-to-face protocols (Trachtenberg, 2020). The present study was not meant to exactly trace a face-to-face intervention: Yalom and Leszcz (2005) suggested that online translations are not simply recreating face-to-face groups in a different format; rather, the development of online groups requires clinicians and researchers to consider the obstacles of the online context utilizing the uniqueness of the online setting to carry out the therapeutic group processes (Yalom & Leszcz, 2005). Trachtenberg (2020) suggests that whether utilizing synchronous or asynchronous components in online text-based groups, personalization and tailoring of therapeutic content and group processes are crucial. Asynchronous online group interventions may be less likely to simulate therapeutic group processes, but facilitators can obviate this by providing tailored detailed feedback or resources to participants (e.g., writing longer posts like in forums; articulating their answers; leaving time to ponder the answers).

Online group participation should not be considered as a substitute for individual work, but it could be a valid support for those seeking the meaning of what happened and seeking comfort and understanding from others. In addition to the forums, which already provide this to bereaved users (Barak et al., 2008; Oliveri, 2003), this platform might allow the reconnection through memory and

imaginal conversation with the departed (while avoiding rumination), consolidate benefit finding and restore life goals.

As in other online support groups, participating in the present group might avoid the feeling of isolation and foster important resources for grieving: connectedness, hope, meaning making, both by sharing their own strategies and reading those from others (Jedan et al., 2019; Swartwood et al., 2011). In fact, individuals already struggling with relational issues and informal/formal support may resolve to virtual support (Barak et al., 2008; Entilli et al., 2021b): participants in online support groups find it easier to discuss grief issues with their group than with family members or friends, as the group members show better understanding and are easier to reach for support and help (Feigelman et al., 2008; Oliveri, 2003; Pendry & Salvatore, 2015).

Group members were made to interact through the facilitation of the moderator until they started doing it autonomously. In Westerlund (2020), after an initial inhibition, newer users started to interact, while older stopped; this was expected to happen also in our group but in 6 months we have observed older members to come back online and provide advice to newcomers. Westerlund hypothesized meeting others with the same grieving experiences for support and sense-making might be mostly researched at the beginning of the grief period; however, in our group old members did not seem to behave as in Westerlund's study but instead took up the role of moderators' support. This behavior should be tested after 1 year of usage to check if older group members are still interacting in the group.

Westerlund's study (2020) observed more satisfaction with current psychological health among individuals who perceived more support from different sources, among the digital resources. An online group such as the one analyzed in the present study could prove useful for those people who are already receiving face-to-face support or who are in the waiting list, for example, to be placed in a face-to-face support group or to start individual therapy with a professional. As for those who might not want to receive professional support, the use of the group could be a valuable resource for those who do not show a high level of suffering, such as the people included in the present study.

These qualitative results are particularly useful, as they show all the struggles of individuals who find themselves mourning during a pandemic and support previous existing literature: COVID-19 survivors may be exposed to a high frequency of deaths or to different secondary losses such as their job, their routine or lifestyle (Bertuccio & Runion, 2020; Scheinfeld et al., 2021) and may overall experience what Maddrell (2020) defined as a high 'emotional-viral-load' ; in such an emotionally impactful environment, grieving individuals are bound to be constantly reminded of their loss and it's violent circumstances.

These findings offer some insight into the experience and suffering of those who have lost a loved one to COVID-19. This type of results can, for example, inform a more correct communication between practitioners and families, also for some specific issues such as the death notification (Bajwah et al., 2020): for example by acknowledging the distress caused by this complex and unique situation, and considering offering an open and honest conversation with the families.

A greater understanding of the talk in online grief support forums could be beneficial for support providers to better understand the complex ways in which people construct their grief. Overall, the study provides valuable insights and evidence to keep investigating the unknown consequences of this global health emergency in people's lives.

## Strengths and Limitations

Participants to this study were informed from the beginning that their posts could have been used for research purposes: this may have determined a selection within individuals interested in participating (even though the study was always presented primarily as a service and is still active) as well as it may have changed the way users chose to talk or not to talk about certain topics. In the latter case, however, it must be borne in mind that this was an online forum and that in any case it was subject to some precise rules, such as the prohibition to post material regarding medical issues or similar. Also, individuals might be nonetheless more prone to disclose online compared to offline (Suler, 2004). It is also important to consider that, in the group we purposely created it was also possible to observe stories of sharing hope, personal resources and reciprocal support; a very different narrative from the one it would have been observed should the administrators of the group "Willing to denounce" had given their consent to use the posts written on their page.

The inclusion of participants in the co-construction of the group is a valid solution for those situations where it could be difficult to find data due to the unicity of the sample or other intervening issues, such as the present one.

Moreover, because of the modalities by which participants were recruited, it was not possible to obtain information on their socio demographic condition (apart from gender and their relationship with the decedent) or psychological state (for example to check for improvements after some months of usage): although the registration of improvements could have been a useful addition, it was not the objective of the study.

Since the users were not in direct contact with the moderator, it was also not possible to identify indicators of high distress. However, being an asynchronous group with no obligation to participate, users could refrain from accessing whenever they deemed it necessary. In addition, the

possibility of receiving additional free individual online support was reminded among the important communications of the group (i.e., pinned at the top of the virtual page).

As for the quality of intervention, few publications systematically describe the translation process or standardized guidelines used to maintain the integrity of the original intervention (Rini et al., 2014). The aim was not to evaluate the efficacy of a specific intervention, however, the lack of structure in the intervention might represent an obstacle to the possibility to replicate precisely the study or make confrontations.

Another limitation of this type of support could be the difficult application: if on the one hand the use of Facebook speeds up and simplifies the access of users in a support group, on the other hand, there are not always the conditions to create a similar group, also simply due to the lack of trained professionals who lend themselves to managing and moderating the group.

The platform was reachable only through a Facebook profile: this poses relevant ethical problems concerning privacy issues: text-based groups can produce a substantial amount of data, which if linked to identifying information and disclosed can cause significant harm. Participants were informed that the information shared would be kept safely and in confidence. Limits of confidentiality were disclosed fully and in simple-to-understand language, and the participants knew they had to abide by the rules of not being able to report sensitive information outside the group.

An intrinsic limit of the study is the role of the moderator, who was also the coder in the analysis. Participants were informed that the moderator would participate in the data analysis only at the end of the data collection. Having moderated a group for six months may have affected the type of analysis done; ample space was therefore given to the comparison with the second coder to support the discussion over the coding choices and reflection. The informed gaze of the moderator could, however, also have made it possible to "access" the data more easily.

The triangulation of different types of qualitative and survey data and the insight offered by the active participation of the users and the researcher/moderator allowed to bring about the complexity of the many variables inherent in the phenomenon being studied. For example, the co-participation in the group created opportunities for the researcher to explore additional questions by the act of investigating a topic in detail, while the anonymous questionnaire allowed to investigate questions regarding the perceived usefulness of the tool. The response to the questionnaire was low (8 out of 25 people) despite having been created to be anonymous. This may mean that the users of the group are willing to share their posts but not to be so deeply engaged in participating in the research that they answer the questionnaire.

It is important to note that the unique situation in which this study took place, critically transformed by the COVID-19 pandemic, in addition to the restricted time frame in which the deaths occurred, might limit the present study's findings from being generalized to other similarly created survivor groups. Further studies could assess whether other survivor groups (i.e., for support to different modalities of deaths) have started to show similar characteristics to the present one, after the COVID-19 pandemic.

Despite some limitations, results could be useful to enhance our ability to theorize about some larger collection of cases. Findings from these studies may substantiate the theory on traumatic bereavement while simultaneously providing insights into how people think and behave in a particular online environment.

Future studies should, first of all, use a more structured method of access and recruitment, for example by recruiting people through an association that offers support. In future emergency scenarios requiring a lockdown, such as other pandemics or other natural disasters, these results could inform on how to offer immediate relief and promote the feeling of being understood in people facing violent and unexpected loss.

## Conclusions

The present study helps to understand how grieving individuals make meaning of their experience, particularly through the use of stories and post-writing (Neimeyer, 2000). Online support groups moderated by a professional could become places to engage in troubles-telling, share stories, receive advice and co-construct a description of grief that validates their experience and supports them in the process of meaning-making.

The findings of this study suggest that there are both positive and negative features of online support as experienced by members with COVID-19 bereavement. In particular, the interaction between peers may provide a unique perspective and understanding that is hard to achieve in the offline world. Thus, online support may be a useful adjunct to traditional forms of support.

# CHAPTER 7

## General Discussion

In the previous chapters, this project provided an overview of bereavement theories and models, as well as the state of the art on digital tools and postvention. This theoretical framework contextualized the results of the previously discussed three studies focused on traumatic death and online support. The following paragraphs will discuss the practical implications of the findings, the strengths and limitations of the study and, finally, the conclusions of the overall research.

This thesis answered the following questions:

- What is the general psychological state of an Italian traumatic survivors population, specifically those bereaved by suicide? How their sociodemographic, psychological condition and perception of social support is interrelated with their informal and formal help-seeking research?

- Which tools, with their specific features, are transversally more apt to respond to the diverse needs of different individuals grieving from a traumatic loss? What are the potentialities and limitations of two specific tools, namely live-chats and online support groups for these bereaved individuals?

- Overall, what are the implications for using online tools for grief counseling and support, when it comes to traumatic support? And what considerations on the effectiveness and usefulness of synchronous or asynchronous online communication to respond to the needs of traumatic bereavement can be drawn?

Study 1 offered an overview of the bereavement experience of Italian suicide survivors: through an anonymous questionnaire, it was possible to reach a consistent number of participants and obtain a view of their general characteristics and psychosocial state after their loss (considering varying kinships), the way they have dealt with formal and informal help-seeking and the relationships between their perceived social support, life satisfaction, wellbeing, and suicidal ideation. Additionally, the RBS system allowed a novel approach to the investigation of the way perceived social support may influence professional support seeking. As there were no similar

studies that addressed Italian survivors without relying on associations for bereavement support by, instead, seeking participants through an anonymous questionnaire (with the aim of intercepting survivors who had not sought help) this study provided a baseline for gathering information also on this sub-group of Italian suicide survivors as well as to test the feasibility of the RBS analysis.

Study 2 represents a first step toward analyzing live-chats as a form of first support to survivors of suicide. This tool was chosen because it is becoming increasingly used in the Italian context and is already employed for other types of mourning (namely acceidents, homicides, and, more recently COVID-19 deaths). Because of their accessibility, anonymity, and possibility to offer informational support on the spot, live-chats could be particularly appealing to specific survivors who otherwise would probably not be reached by support. The results of this and further studies could be used to inform practitioners and operators about how to effectively and sensitively provide such online services. Lastly, Study 3 provided a case study experience of an online support group moderated by a psychologist for COVID-19 mourners. The investigation enhances our understanding of how Italian COVID-19 mourners make meaning of their experience, particularly through the sharing of stories and requests of advice to others. Online support groups, especially those moderated by a professional, could represent feasible virtual places to engage in trouble-telling, sharing of stories, seeking advice and co-construct a description of grief that validates COVID-19 mourners' violent loss experience in the process of meaning-making.

The studies consider two different kinds of traumatic loss: suicide and COVID-19. While much is known about suicide bereavement, little is still known about COVID-19 bereavement, especially in the long term and bearing in mind that, at the time of writing this study, less than two years have passed since the beginning of the pandemic, and no solid studies on the effects of restrictions (e.g., lockdowns, travel restrictions, being unable to visit recently mourned family members and the impossibility of celebrating the funeral) on bereavement are yet available. Therefore, it's not yet possible to establish the traumatic extent of this event, which can vary between individuals, communities and from country to country. Still, numerous authors (Amy & Doka, 2021; Eisma et al., 2021; Stroebe et al., 2021) have already hypothesized that COVID-19 bereavement could, in fact, lead to complications of bereavement, which should attract the attention of mental health professionals. For this reason, and considering that the COVID-19 pandemic began in the middle of the proceeding of the present work, which lasted a total of three years, the coders of this study decided to focus part of the research on exploring this area.

Despite some understandable differences with suicide grief, such as the feeling of rejection, shame, and ruminative thoughts over the motivations (Bell et al., 2012; Pitman et al, 2017) (see Chapter 2), the bereavement from COVID-19 related deaths could be embedded with unique

challenges and may yield higher grief levels than natural bereavement (Gesi et al., 2020) and share some grief features with other traumatic bereavement experiences (Eisma et al., 2020). Survivors of COVID-19 who had to take care of their dying relative at home may, in fact, face some amount of stigma, related to others' fear of contagion or blame (Zhai & Du, 2020); this anticipation and/or perception of stigma differs from the one involved in suicide bereavement, but it can still potentially impact on the help-seeking behavior (Logie & Turan, 2020; Lueck, 2021). Lastly, the restrictions endorsed by Governments to slow the spread of the disease have required the population to limit outdoor movements, and psychotherapists and other mental health professionals had to rethink their way of offering grief counseling (Van Daele et al., 2020). Not only fear of stigma then, but the very inability to move from one's home and access their general community places and services outside their lockdown zone might have hindered survivors' access to support.

Eisma and colleagues (2021) stated that death unexpectedness entailed in COVID-19 losses might explain a considerable part of grief variation with the lower grief reactions of natural losses: the rapid worsening of symptoms that does not allow the family to prepare for the loss, as it is a disease that can force even people in good physical health to be hospitalized (Cipolletta et al., 2021b; Zhu et al., 2020; Wang et al., 2020). Although a good part of suicide deaths are considered unexpected and unpredictable, there are some cases in which family members expected the death of their loved one (Groot et al., 2006). Both in the case of deaths from COVID-19 and of suicide, the issue of death unexpectedness plays an important role and will probably be explored in future studies. Furthermore, as suicide loss could be linked to suicide ideation (Pitman et al., 2014), also the COVID-19 pandemic, aggravated by the contingent social restrictions, has lowered mental health and increased suicide cases (Aquila et al., 2020; Gunnell et al., 2020; Lueck, 2021).

A perhaps unique feature of COVID-19 mourning is that there is a strong perception of injustice and the desire for revenge or clarity or, as previously mentioned, to be able to inform others so as not to have the same experience befall upon other families (Cipolletta et al., 2021b). It was therefore useful to observe how the participants used a virtual place for grieving which was hosted on a popular social network.

Interestingly, the discussed findings also provided a gendered perspective on mourning since the three studies were observed to include a majority of women participants compared to males. This result could confirm previous statements that it is indeed women who seek the most help (Addis & Mahalik, 2003), or who are more used to express grief publicly (Rubinstein, 2004) and that, unfortunately, although support is provided online this does not appear to be appealing to men grieving a loss. Grand and colleagues (2017) argued that socializing in mourning seems to be in conflict with the western traditional male role (Grad et al., 2017), and Westerlund (2020) suggested

that visiting and spending time on a static memorial website might not require the same level of commitment, opening up or involvement in the communication with other users than more engaging virtual spaces. These results might suggest that it is difficult to study mens' reactions to traumatic losses even if the study is conducted through online communication.

However, the nature of the studies and their confidentiality did not allow us to acquire some of the socio-demographic information and made it difficult to identify, for example, a particular subgroup of women for whom the online tool may appeal to, such as women with a low level of perceived social support, an indication that derived from the results of the survey study (Study 1).

**Practical Implications for Mourners and Online Tools**

The two operational studies presented (Study 2 and 3), despite being both hosted on online platforms (and therefore sharing some of those advantages considered typical of the use of online tools), have different structures and, consequently, different applications. Study 2 (namely the study on live-chat support), being synchronous and anonymous, was found to be particularly useful for grieving individuals looking for immediate comfort or information, in fact, short response times are a specific feature of these tools and could be of great use to those who have suffered a recent loss and who are in need of finding a direction for obtaining proper support (Gilat & Shahar, 2007).

It is also worth noting that some users approached the service several years after the loss, declaring they had not sought psychological support or had negative experiences with professional support. This is consistent with the results of Study 1 showing resistance or abandonment after a few failed attempts, within 6 months and 1 year after the loss, and reveals that some live-chat users might also be in search of emotional validation and reassurance. Moreover, given the possibility of anonymously accessing the service, users could talk about non-socially desirable topics (including suicidal ideation), which seems to be an additional motivation to implement this type of service, considering it is already used for suicide prevention (Luxton et al., 2011).

Overall, anonymity and accessibility were highly valued, together with the opportunity to take time to ponder what to write and reflect on what remains written in the text. Consistently with literature, users considered the lack of video-audio contact and the presence of the screen as a shield rather than a barrier, that allowed them to express their emotions openly and outwardly, without feeling judged or even type and cry at the same time (Stephen et al., 2014). In fact, when there are no visual or social cues to monitor, more attention can be given to communication tasks (Sproull & Kiesler, 1991) and the perception of safety and ability to express emotions freely in a safe context is enhanced. Lastly, the exchange of information (e.g., telephone or email contacts) is made easier and quicker through the chat. All these results are consistent with previous literature (Cipolletta et al.,

2018; Cipolletta & Mocellin, 2018; Cook & Doyle, 2002; Reynolds et al., 2013) investigating various forms of online counseling and psychotherapy.

The live-chats, were also shown to be good opportunities to approach people who may be insecure about reaching out for help in person and would then be contacting live-chat services to "test the waters" (Predmore et al., 2017). This is an important feature because research suggests topics discussed on live-chats are often of a more serious nature than those discussed on the phone (Child Helpline International, 2005; Haner & Pepler, 2016). In fact, within online services, live-chats are particularly feasible in the context of crisis support (Gilat & Shahar, 2007). However, the anonymity of the support does not allow professionals to follow up on users. One criticality of the tool is, indeed, the lack of follow-up or interventions for users at high risk of self-harm.

The implementation and adoption of a live-chat service is not without obstacles and risks for the protection of privacy. Luckily, training programs have been developed to raise the awareness of ethical issues and promote the development of specialized skills for the effective provision of online counseling (Anthony & Goss, 2003). Still in line with the results of the survey, Italian mourners seem to be unfamiliar with relying on live-chat services for their needs, likely due to these services only recently experiencing growth throughout the country. In these cases, much is done by the associations themselves who are committed to spreading the presence of such services. While we argue that live-chat users may be in need of informational support on the spot, different ways to approach and support mourners, especially actively, should be implemented to meet the different needs of survivors, which vary between the time passed since the loss, the gender, kinship with the decedent and personal preferences (as presented in Study 1).

Similar considerations can be made for online groups: both the services could represent opportunities to bring people close to professional support through a monitored first contact with a non-threatening figure (namely an operator or a moderator) who is also trained to approach survivors in an empathic way. In fact, literature shows how mourners might look at peer-led online groups as a way to firstly memorializing their loss and only secondly as a way to look for support (Krysinska & Andriessen, 2013; Santino, 2004), therefore memorialization-only groups (or those such as the ones found online in the Italian context, focused solely upon complaining and reporting to institutions) can be of little use if not harmful to mourners. Rather, it is necessary to create online discussion groups in which the right balance is offered between contact with peers and trained professionals.

Paulus and Varga's findings (2014; 2015) already suggested that the possibility to obtain validation in an online support group might prompt grieving individuals to seek online support. Furthermore, the presence of the moderator could represent a vital element in influencing online

interaction (Attard & Coulson, 2012; Rourke et al., 1999; Tu & McIsaac, 2002): it could impact on user satisfaction (Gunawardena & Zittle, 1997), the depth of online discussions (Polhemus et al., 2001) and overall group engagement, in fact, when the level of social presence is low, interaction is also low (Garramone et al., 1986; Tu, 2002). Guided online-based interventions showed more adherence over completely unguided interventions (Baumeister et al., 2014; Domhardt et al., 2019), and researchers argue that efforts to change are likely to be successful when individuals receive timely monitoring and feedback on their progress (Brendryen, Drozd, & Kraft, 2008). With such feedback, individuals can be motivated by their own achievements, they can modify their strategies and gauge the proximity of their goals (Kraft & Yardeley, 2009).

Among the users included in this study, no hostility nor suspiciousness was recorded toward the operator/moderator, and information was always considered reliable, sufficient, and understandable. This observation suggests that users had no difficulty considering the operator/moderator as a professional and reliable source despite the lack of audio-visual cues; this is consistent with the assumption that online customers learn the role of service-receivers and service providers from offline encounters (Turel et al., 2013) and therefore have pre-existing expectations of what they are likely to find, even if they are first-time users.

Research suggests that users resolving to online services may be looking for different types of formal support, including search support, navigation support and decision support (Chattaraman et al., 2012). In the live-chats especially, users relied on the operators to find services in their local area, to gather information of what each different service offers and to decide which is the best option for their needs. Among the key dimensions identified by DeLone and McLean (2003), online customer satisfaction is bounded to: reliability, empathy, assurance, and ease of understanding of the information provided by the operator. In the present study, the ability of the facilitators to offer empathic listening and accurate information was confirmed to be important influencing factors for satisfaction with online support (McLean & Osei-Frimpong, 2017).

Barak and colleagues' (2008) narrative review of online support argues that, in contrast to online therapy and counseling interventions, online support groups should not be expected to produce long-lasting changes in mental health, however, could be instead fruitful in the fostering of users' empowerment, through general emotional relief, an elevated sense of control, and a sense of improved wellbeing (Robinson & Pond, 2019). In our study, it was observed that even the possibility to offering support to other peers could be adopted and possibly used to strengthen the feeling of community to combat loneliness (Bartone et al., 2018; Brown et al., 2008). The primary exchange of emotional support observed in our group should not be taken for granted; previous studies (Coulson, 2005; Reifegerste et al., 2017) identified the communication of informational

support as the primary function of an online group for individuals living with irritable bowel syndrome. These results could stress that information exchange may be an important part in online groups dealing with health issues, while emotional support rather than informational support is more central in bereavement support groups (Cipolletta et al., 2020).

This also suggests that individual online tools should not be offered indiscriminately to users; depending on the problem, different users may or may not appreciate some features of the online tools that another population might instead not use. The population of traumatic mourners should therefore be specifically analyzed and should not be assumed that they will find comfort and support in an online tool that has proved useful for others.

Finally, a consideration must be made with respect to the recent events of global significance that have also involved mental health professionals: digital services such as the ones described in Study 2 and particularly in Study 1 might represent an important form of technology-mediated interaction, able to provide first-aid support and normalize overwhelming emotions, in the context of temporarily limited movement. First-hand experience from China (Zhou, 2020) with the use of telehealth during the pandemic outbreak shows promising results. The provision of mental health support through telehealth could likely help patients to maintain psychological well-being and cope with the grieving. However, for most mental health care professionals willing to offer support telematically, the transition towards online support could be cumbersome (Wright & Caudill, 2020). The American Psychiatric Association and American Telemedicine Association have divulged best practices indications for implementing videoconferencing-based telemental health (APA-ATA, 2018); these include important administrative issues such as licensing requirements; insurance for coverage for virtually-delivered services; and protocols for the adherence to confidentiality and security regulations. In the case of bereavement support, professionals might encounter users with disturbed grief or depression and hence face major challenges in delivering care (Wright & Caudill, 2020). In fact, in this case, professionals must facilitate the processing of the stressful/traumatizing circumstances surrounding the loss and map out and reconstruct the circumstances of the death (Boelen et al., 2020), an operation that is commonly done in online therapy sessions but is not advised in live-chat support or in online support groups.

Therefore, we argue that online tools for grief support should be considered as a viable additional support, but still bearing in mind their intrinsic limitations, also in light of Westerlund's (2020) considerations that individuals facing a traumatic loss will likely come to the conclusion that there is simply insufficient help to ease the pain and heal the wounds after their loved one's death.

**Strengths and Limitations of the Research**

The present research is a composite creation of three different studies, with the intent of exploring a specific phenomenon in Italy and as such it presents several limitations as well as strengths; some of these are due to the study design, while some others are intrinsically linked to the use of online tools and are worth exploring.

First of all, the focus on the Italian population exclusively has determined a difficulty of sample collection and generalization, as the extension of Italian suicide survivors is not as spread out as in other countries. The sample size in Study 1, is then, at points insufficient for complex analyses and required, instead, the application of a cross-sectional study design, which made it difficult to determine causal inference and only provides a snapshot instead of a long duration assessment (Levin, 2006).

Moreover, Study 1 was limited by the use of the survey to collect data: common challenges in web surveying are the reduced experimenter control (Stieger & Reips, 2010), the relatively low response rates (Shih & Fan, 2008), and the relatively high levels of item non-response (Heerwegh & Loosveldt, 2008). Also, some unique ethical considerations arise when assessing a delicate topic such as suicide bereavement through an anonymous survey (Allen & Roberts, 2010; Buchanan & Williams, 2010). Although these problems had been taken into account (participants were informed they could refuse to answer and were given a reference to contact in case they felt distressed while filling out the questionnaire), conducting such anonymous searches can always present risks for the participants. Despite all, the anonymous questionnaire is the most frequently adopted type of internet research (Buchanan & Hvizdak, 2009) and it seemed the optimal compromise to establish contact with survivors who have not sought support and gain a little more understanding of this part of the population that is often not represented in suicide survivorship studies (McMenamy et al., 2008).

Another limitation of the research is represented by the fact that in both the live-chat study and the group study, priority was given to anonymity or, in any case, to the analysis of the written text, rather than to the collection of socio-demographic data. This implies that there was a lack of information that could have told us a little bit more about the participants. However, Study 2 and 3 being mainly informed by qualitative methods, the reduced participation did not represent an obstacle, and the focus on the written data rather than requests on socio-demographic information allowed the participants to feel less pressured into participating in the study. In fact, as with all qualitative studies, our findings are not intended to be generalizable to the larger phenomenon of live-chat users or online discussion forums. The construction of grief online is here only initially

explored, and a full investigation of the grief narrations present on these interfaces for online bereavement support might shed additional light on the way Italian mourners seek, access, and use online support services to deal with their grief. A particularly useful tool in the present research, with regard to the online support group, was the employment of triangulation of various observation points and sources. This application of complementary qualitative and quantitative techniques was employed to minimize (although not eliminate) the subjectivity of the observers (Jonsen, & Jehn, 2009) and decrease process distortions (Greene and McClintock, 1991); the application of between-methods triangulation also allowed the leverage of the strengths throughout the different methods employed while mitigating their weaknesses and providing a more valid interpretation of the collected data (Jonsen, & Jehn, 2009).

Scheinfeld and colleagues (2021) suggest it may not be ideal to focus entirely on online support during a time of communal grieving, multiple losses, and social distancing. While online tools might be useful for protecting anonymity and allowing quick response time, it is important to bear in mind that these benefits come at the price of the absence of physical presence and verbal cues: physical touch is often a strong form of soliciting and receiving social support while grieving (Robinson et al., 2015), while nonverbal communication is pivotal in the creation of positive experiences of social support, as well as in the expression of emotions (Albrecht & Adelman, 1987; Attard & Coulson, 2012; Varga & Paulus, 2014).

However, on a broader level, throughout the research, the topics of loss, loneliness, and search for sense-making and emotional support were investigated in an environment where the body is not meant to be present, also known as a "disembodied environment" (Trachtenberg et al., 2020). Weinberg and Rolnick (2020) explained that in an online environment, users are able to maintain their own body and can sense it while sitting in front of a computer, just like one would in a therapy room. If we observe these points as being valid to the research, then it is reasonable to assume that, with due care, some type of connection between users can be established even in the case of a user sharing her/his bereavement experience.

**Indications for Future Research**

The survey study was an attempt to acquire knowledge regarding a still little-known population in Italy, namely people in mourning from suicide. Subsequent studies willing to explore other types of bereavement should consider using a system of algorithms such as RBS analysis, together with a larger sample of participants, possibly decreasing the variables and focusing primarily on the help-seeking support, as fewer number of variables makes the analysis more accurate. Since the live-chats were found to be a tool with interesting implications, future research

might continue to examine the feasibility of this service for recent traumatic losses (where users might be shocked, numbed, and in need of timely support), as results suggested this could be the population to benefit more from this.

Considering the two operational studies, in particular the one involving the online support group, research should orientate on new creative ways to investigate qualitatively the experiences of the users, as well as ways to engage participants and, when possible, include them in the co-creation or even shaping of the online group. Even user studies or adjunctive questions evaluating the user experience (such as those included in the COVID bereavement study), used whenever possible, could produce useful material for the development of targeted services. It has also been proposed (Attard & Coulson, 2012) that studies should assess whether the involvement of professionals monitoring information exchanges in the group might interfere with the group dynamics and how users react to the presence of the moderator/researcher.

One issue is important to consider when it comes to creating online services dealing with bereavement support: when translating face-to-face interventions or protocols into online versions, the content is typically entirely matched (Trachtenberg et al., 2020); however, as we have discussed throughout the research, the sample of participants interested in face-to-face group support may not be equivalent to the sample interested in attending online group support. Therefore, efforts should be made to consider the potential demographic characteristics, needs, interests, and potential areas of distress that may distinguish these two groups. Future research studies should be directed toward assessing who would benefit most from online support. As Schultze (2006), Migone (2013) and Cipolletta and colleagues (2018) suggest, the goals for online-provided support should not be on the research of increasingly sophisticated technology but instead focus on critically understanding what that specific tool is able to offer to the user. Also, as Kraft and Yardley (2009) state, there is the need to research how digital interventions can best be designed to hold the interest of the user and avoid drop-outs (Matano et al., 2007), which could also further undermine the mourner's confidence in the possibility of improved wellbeing.

It is also pivotal to bear in mind that such tools might not reach all individuals in need. The so-called ‘digital divide’ (Lupton, 2017) could limit the extent to which those from more socioeconomically deprived backgrounds may benefit from digital interventions (Murray et al., 2005). Although this problem may diminish as the Internet grows more ubiquitous, for example, young people already routinely use the Internet daily, with minimal differences in access due to socioeconomic background (Kraft & Yardley, 2009), it is equally important not to assume that a service located online would be accessible to everyone and, together with the need to help people achieve a decent digital literacy, it is important to advocate for measures of social justice that allow

mitigating the above mentioned digital divide.

Further studies could examine longitudinally whether survivors access live-chat services a second or a third time (implying that they find them useful on an ongoing basis or if it is rather a tool that should be structured and expected to be single-use) and, more importantly, assess changes in the use of an online group over the course of 6 months, to distinguish the motivation for users to remain as participants in the group. While the main motivation for initial use in online tools is the expected utility of use, continued use is probably heavily influenced by the experiences had during the use, which in turn fuels expected future utility (Kraft & Yardley, 2009). Engagement with the users may be increased by offering relevant, individually tailored material and feedback, which has been shown to increase group/program use and engagement (Strecher et al., 2008). The present study has shown that it would be useful to broaden the research of online tools on different aspects of support and counseling, in particular those aspects which might harm the fluidity of the interaction between user and operator/moderator, such as environmental privacy or technical problems (Cipolletta et al., 2018).

Research on the content of mental health–specific online forum postings has mainly attempted to understand loss experiences or the construction of online interaction with other users rather than the user experience of accessing, for example, the forums and online groups and researchers still lack insight into key questions on how online they are perceived from the perspective of their users (Smith-Merry et al., 2018). With the foreseen increase in demand for online support tools, developing a close collaboration with IT consultants could become increasingly frequent, as well as advantageous. With their expertise, an easily accessible, readable, and user-friendly platform can be created, as its implementation may be outside the scope of most mental health practitioners' skill set. The present study was in fact informed by the collaboration with the mathematics department, in addition to that of general psychology. However, in addition to sensibility over the characteristics of the medium used, it is important to keep in mind that the adequacy of the therapeutic approach informing the intervention, and the preparedness of the operator/moderator ultimately determine the quality of the encounters between themselves and the user (Cipolletta et al., 2018). For example, the literature states that distress levels acceptable in face-to-face groups could be not adequate for online participation (Trachtenberg et al., 2020; Winzelberg et al., 2003); however, authors also conclude that more research is needed to clarify what can be considered an appropriate level of distress in an online environment (Trachtenberg et al., 2020).

Last but not least, as mental health professionals continue to explore helpful ways to use technology with patients/clients, it is critical that research keeps investigating the evaluation of the

efficacy of online practices and assesses the clinical outcomes to establish an evidential base behind this practice.

# CHAPTER 8

## Conclusions

Looking at the results of the three studies presented and the literature analyzed to support them, this project aimed at answering the following question: what are the implications of advances in information technology for the future of psychology interventions regarding the nuances of online bereavement support?

The use of online tools for bereavement support, as for any type of issue related to mental health, is expected to have an ever-increasing presence in the context of psychological support: if this scenario had already been foreseen for years, the advent of COVID-19 has in some cases forced mental health professionals to establish connections with mourners virtually, in others accelerated the adoption and improvement of various online support strategies. In this scenario, mental health professionals must pay attention to the quality of first-aid support that will be offered to mourners. It is essential to know what the needs of this population are in order to respond adequately (e.g., will mourners benefit most from asynchronous or synchronous support?), and it will be necessary to consider not only the benefits but also the limits of the tool (e.g., what happens if the mourner experiences strong distress? Is the tool suitable for mourners who might have co-occurring depression symptoms?), and ask questions critically (e.g., is the online service offered by virtue of its benefits or just to adopt a cost-effective alternative?).

The results of the presented studies can be seen as just some of the examples of the digital resources' potential to approach mourners, provide monitored and quality information on support, and for continuing bonds with the deceased.

Although digital tools have been shown to have a strong clinical value and efficacy (once the limitations of online support are resolved where possible), the author want to specify that support specifically aimed at traumatically bereaved people has unique characteristics that must be taken into consideration when creating a similar tool: the anonymity, speed of response or speed in obtaining information is significantly eased (and must be controlled by an operator or a moderator, in the absence of these by a peer expert) as well as the possibility of meeting other people and communicating one's pain through writing, which is likely the most useful and important feature that is shared among most of the online tools. Still, the bereaved person may, in the long run, benefit from receiving support in person, especially if the symptoms of complicated grief or prolonged grief disorder are invalidating. Consequently, those types of online support, which do not involve a structured therapeutic intervention, but rather aim to provide the bereaved person with

additional or different support than what they would get offline, should be understood as a support to the mourning path and not a substitute for psychological support.

This project contributes to the field of new technologies and the growing services offered virtually: the results may guide future research on the subject of emergency traumatic support and have important implications on the implementation of support tools for first-aid help and new training strategies for interventions in response to traumatic events with bereaved individuals and communities.

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# Appendix

## Appendix A.

*Items of Study 1's questionnaire*

1. Sociodemographic information

- How old are you?
- What is your gender?
  Female · Male
- What is your marital status?
  Single/widowed · Married/with a partner
- What is your current employment situation?
  Employed · Unemployed
- What part of Italy do you reside in?
  North · Centre · South
- What is your level of education?
  Elementary school title · High school qualification · University Degree · Higher education qualification · Other
- Do you consider yourself a believer?
  Practicing believer · Non-practicing believer · Agnostic · Non-believer
- If you indicated believer, what faith are you referring to?
  Catholic · Orthodox · Protestant · Jewish · Muslim · Other
- Have you experienced, or are you experiencing, mourning the suicide of a loved one?
  Yes/No
- What was the gender of the loved one you lost?
  Female · Male

2. Bereavement experience

- Have you experienced more than one loss from suicide?
  Yes/No

* If you have experienced more than one death from suicide, please refer to the most recent bereavement when answering the following questions.

- Would you say that your life was significantly affected by this loss?
  Yes/No

- Indicatively, how long ago did your loved one take their own life?
  Months ___; Years ___
- How old were you at the time of the loss?
  Years ____
- How old was the departed?
  Years ____
- Who was this person to you?
  Father / Mother · Son · Partner · Brother / Sister · Friend · Classmate/Colleague · Other
- How would you indicate the level of closeness you had with this person?
  1 Not very close · 2 Quite close · 3 Very close

3. Suicidal ideation

- Following the death of a loved one, some people think they are harming themselves or wanting to take their own life. Has it happened to you?
  Once only · More than once · No, never · I prefer not to answer

- If you selected yes, please indicate roughly how long since the loss. You can select more than one answer.
  · Less than a week from the loss
  · In the month following the loss
  · Between 1 and 6 months from the loss ·
  · After about 6 months
  · After about 1 Year
  · More than 1 year after.

4. Help-seeking behavior

- Did you seek psychological support following the death of your loved one?
  · Yes, I looked for support on my own
  · Yes, my family member or friend looked for me
  · No, I did not seek support

- If you indicated 'No', is there a possible reason on this list?
  · I did not feel I needed psychological support
  · I was afraid that a professional would not be able to make me feel better
  · I did not think I was close enough to the person who took their own life to have to ask for psychological support
  · None of the above

- If you indicated 'Yes', how long after the loss was psychological support sought?
  · Less than a week from the loss
  · In the month following the loss
  · Between 1 and 6 months from the loss
  · After about 6 months
  · After about 1 Year
  · More than 1 year after

- How long was it before you received the help you applied for?

· I immediately got the support I was looking for
· I had to wait a few weeks
· I had to wait a few months
· I had to wait more than 6 months
· I never got a reply / I gave up

- Did you encounter any difficulties or obstacles in your search for support?
  Yes/No

- If you answered Yes, please indicate one or more possible difficulties or obstacles you encountered in seeking support:
  · The fear of feeling judged / a
  · The need to hide from others that death occurred by suicide
  · The fear of not being able to get better
  · The absence of energy
  · Low confidence in support services
  · The absence of services in the area in which it resides or the waiting times that are too long
  · The too high costs of services
  · None of the above

5. Outreach

- In the post-loss period, have you been referred to professional support directly from the hospital, police department, company, school or other bodies involved?
  Yes/No
- Would you have liked this type of service?
- Yes/No
- Was this type of service useful to you?
- Yes/No

6. Types of support received

- Following the death of your loved one, did you seek information and / or guidance to manage your bereavement?

  · No, I didn't look for anything
  · I searched for information on websites (articles, blogs)
  · I bought books and material on the subject
  · I searched online forums of people with my own experience
  · I looked for informal meeting groups unrelated to bereavement support (e.g., creative work groups, religious groups, sports clubs)
  · Other: _____

- Please indicate to what degree you have received support from each of these people or groups of people.

If you have not sought support from that particular person or group of people, select "Not requested".

| | Not at all | A little | Neutral | A lot | Extremely | Not requested |
|---|---|---|---|---|---|---|
| Close relative | | | | | | |
| Partner | | | | | | |
| Friend or distant relative | | | | | | |
| Classmate or coworker | | | | | | |
| Informal meeting groups | | | | | | |

*By "informal meeting groups" it is meant, for example, creative work groups, religious groups, reading clubs and the like.

- What kind of support have you received from each person, or group of people, listed?

If you have not looked for that particular type of support, select "Not Required"

You can indicate more than one answer

| | Not requested | Close relative | Partner | Friend or distant relative | Classmate or coworker | Informal meeting groups |
|---|---|---|---|---|---|---|

Being able to talk about mourning without fear

Find some distraction during the day

Practical support (e.g., help with meals or tidying up the house)

Knowing to have someone to call in case of acute pain

Get physical comfort (e.g., a hug)

Having someone to remember the departed with

Having someone to ask for advice on how to behave

- Read each statement carefully and indicate how you feel about it

Choose the appropriate answer for each item:

| Completely disagree | Strongly disagree | Disagree | Neutral | Agree | Strongly agree | Completely agree |
|---|---|---|---|---|---|---|

There is a person
in particular who
is close to me
when I need it

There is a person
in particular with
whom I can share
my joys and
sorrows

My family goes to
great lengths to
help me

I have the help
and emotional
support I need
from my family

I have one
particular person
who is a real
source of comfort
for me

My friends go out
of their way to
help me

I can rely on my
friends when
things go wrong

I can talk about
my problems with
my family

I have friends with whom I can share my joys and my sorrows

There is a particular person in my life who cares about how I feel

My family helps me make decisions

I can talk about my problems with my friends

7. Social support and satisfaction

Indicate if and for how long you have used one or more of these services (indicatively). If you have not used it, select "Not Requested".*

| | Not requested | One or two meetings | Up to five meetings | Continuous meetings for more than six months | Continuous meetings for up to one year | Continuous meetings between one and three years | Continuous meetings for more than three years |
|---|---|---|---|---|---|---|---|
| Psychologist /Psychotherapist | | | | | | | |
| Psychiatrist | | | | | | | |

General practitioner

Support group administered by a psychologist

Support group administered by a peer survivor

- Before the loss of your loved one, did you receive psychological and / or psychiatric support?

Yes/ No

- Have you ever used any of these online services?

| | Never used | Only once | More than once | Systematically |
|---|---|---|---|---|
| Telephone support service | | | | |
| E-mail support service | | | | |
| Live-chat support service | | | | |
| Online forum with other survivors administered by an operator or a psychologist | | | | |

Online forum with other survivors without the administration by an operator or a psychologist

8) Appreciation of the professional support received

Based on your experience, please indicate to what degree and if you have received support from one or more professionals or services.

Select "Not Required" if you have not sought support from that particular professional or service.

| | Not at all | A little | Moderately | Neutral | Enough | A lot | Extremely | Not requested |
|---|---|---|---|---|---|---|---|---|
| Psychologist /Psychotherapist | | | | | | | | |
| Psychiatrist | | | | | | | | |
| General practitioner | | | | | | | | |
| Support group administered by a psychologist | | | | | | | | |
| Support group administered by a peer survivor | | | | | | | | |
| Telephone support service; e-mail service, live-chat service | | | | | | | | |

Online forum
administered by
a psychologist

Online forum
NOT
administered by
a psychologist

- Regarding those forms of support for which you have selected 'Much' or 'Very Much', are there any features that you believe have helped you?

· Ability to speak without feeling judged
· Ability to receive support without leaving home
· Possibility of meeting with a properly trained professional
· Possibility of meeting with someone who has lived the same experience
· Ability to speak or write protected by anonymity
· Ability to receive information and advice

- Regarding those forms of support for which you have selected 'A little or ‘Not at all', are there any features that you believe have not helped you?

· Feeling of being judged
· Costs and/or distance from the service
· Lack of professionalism or specific knowledge
· Feeling of not being understood
· Lack of anonymity
· Not being able to see the person you interact with in the presence

- Is there any help and / or service that you would have liked to receive but did not receive?

· Psychologist/Psychotherapist
· Psychiatrist
· General practitioner
· Support group administered by a psychologist
· Support group administered by a peer survivor
· Support service by telephone, e-mail or chat
· Online forum with other users in mourning for suicide
· Other:

- Do you currently think you need access to one or more of the listed support forms?

It can indicate more than one answer
Choose one or more of the following options

· Psychologist/Psychotherapist
· Psychiatrist
· General practitioner
· Support group administered by a psychologist
· Support group administered by a peer survivor
· Support service by telephone, e-mail or chat
· Online forum with other users in mourning for suicide
· Other:

9) Wellbeing and social support
For each of the five statements, please indicate the answer that most closely resembles how you have felt in the past two weeks.
The higher numbers correspond to a greater state of well-being.

In the past two weeks:

| | Always | The majority of time | More than half the time | Sometimes | Never |
|---|---|---|---|---|---|
| I felt cheerful and in a good mood | | | | | |
| I felt calm and relaxed | | | | | |
| I felt active and energetic | | | | | |
| I woke up feeling fresh and rested | | | | | |
| My everyday life has been full of things that interest me | | | | | |

- Using the scale from 1 (completely disagree) to 7 (completely agree) below, indicate your degree of agreement with this statement.

| | Completely disagree | Disagree | Slightly disagree | Neutral | Slightly agree | Agree | Completely agree |
|---|---|---|---|---|---|---|---|
| I am satisfied with my life | | | | | | | |

10) Final information

- Through which channel did you find this questionnaire?

· Through social media
· Through an association that deals with support for mourners
· Sent by a family member or friend
· Sent by a family member or friend who had already completed this questionnaire
· Other:

- If you wish, you can write here suggestions or information on issues that, in your opinion, were not covered by our survey of experiences in seeking support from suicide mourners.

**Appendix B.**

*Items of Study 3's questionnaire*

1) Personal data and information about the user

- How old are you?
- What is your gender?
- What is your marital status?
- What is your current employment situation?
- What part of Italy do you reside in? north · centre · south
- How long ago have you lost your loved one?
- Who was this person to you? parent · grandparent · sibling · partner · other
- How did you find the group? social networks · newspaper article · local services · other
- Indicatively, how long have you been enrolled in the group?
- In addition to joining the group, did you seek professional support?
- From 1 to 5, how much do you think you have adequate support from the professional you are addressing? (If you selected "No" skip this question) [1 Not at all - 5 Very much]
- From 1 to 5, how much do you feel you have adequate support from your family and friends?

  [1 Not at all - 5 Very much]

2) Questions on the use of the group

- How often, approximately, do you log into the group?

  · At least once a week
  · One or twice a week
  · Once or twice a month
  · Once a month

- How often, approximately, do you write in the group?

  · At least once a week
  · One or twice a week
  · Once or twice a month
  · Once a month

- How would you rate your experience in writing and sharing your experience in the group so far? [1 Not useful at all - 5 Very useful]
- How much did you feel involved in the group conversations? [1 Not at all - 5 Very much]
- Did you experience any kind of difficulty/problem or discomfort using the group?

- If so, with respect to what? (If you answered "No", skip this question)
- Was there a post or conversation that caused you great distress or anguish?
- If so, what were we talking about? (If you answered "No", skip this question)
- Is the discussion proposed by the moderator through posts, on a regular basis, useful or would you prefer a different way to discuss between users? [Yes it is useful / No, it is not useful]
- If so, how is it useful to you?
- If not, which modality would you prefer?
- There is a particular post or conversation, with the moderator or with another user, that you feel has been of great support to you (e.g., some advice that you still try to put into practice or a phrase that has particularly helped?)
- If so, which one? If not, why?
- Would you prefer to compare yourself with other users in a different way? (e.g., presence, via video, on a dedicated platform)
- If so, how? (If you answered "No", skip this question)
- Do you think that the content shared in the group by the moderator is appropriate, useful and adequately sensitive?
- If not, why? (If you answered "Yes", skip this question)
- Do you believe that the content written by other users is appropriate, useful and adequately sensitive? If not, why? (If you answered "Yes", skip this question)
- From 1 to 5, how much did you feel supported by the other users in the group? [1 Not at all - 5 Very much]
- When writing something in the group, did you feel safe to share a part of her experience of losing her? If so, why? If not, why?

3) Usability of the tool

- Where do you mainly access the group from? [Smartphone · Personal Computer · Shared Computer
- Do you think that Facebook is a suitable platform to host a group similar to the one in which you participate?
- If so, why? If not, why?
- How do you feel when you receive notifications about the group during the day? (e.g., curiosity, distress, annoyance or neutrality, or other)
- Would you have preferred to be able to write to the group with a completely anonymous profile, rather than Facebook?
- Did you find it easy to navigate the page? (e.g., find old conversations, talk to more than one user, follow the exchange of other people's comments).

- Did you appreciate being able to access the group via Facebook? (e.g., for the ease in accessing it by smartphone)
- Did you appreciate the possibility of interacting with other users asynchronously (i.e., not in real time)?
- Did you appreciate the opportunity to write about your experience instead of talking about it?
- Did it cause you any kind of annoyance having to use the group with your personal profile, rather than an anonymous profile?
- What do you think you have obtained, mainly, from the exchange that has taken place in the group so far?
- Is there anything you would recommend adding or improving in the group?