Tanja Valenta
The University of Ljubljana, the Faculty of Theology, Slovenia

THE EFFECTIVENESS OF RELATIONAL FAMILY THERAPY ON THE (RELIGIOUS) LIFE IN ADULTHOOD AFFECTED BY LOSSES IN CHILDHOOD

Abstract

Despite of the severity of the loss of a parent and frequency of parental divorce there has been no assessment of the impact of resolving the unspoken and unmourned losses from childhood through relational family therapy and its impact on adult everyday life.

The aim of this paper was to estimate and assess the impact of relational family therapy on posttraumatic growth and to reduce symptoms of unresolved grief such as panic disorder, anxiety and depression.

Two cases of relational family therapy are described, with two adult women who experienced their fathers' death at an early age. One of them came into therapy with anxiety and panic disorder, the other with depression and frozenness.

In twelve sessions of relational family therapy they reached, together with an empathic therapist, the deepest grief they have never spoken of before. In both, the results were reduced symptoms and a more optimistic view of life.

This paper points at the value of relational family therapy techniques in resolving grief and reducing symptoms of panic disorder, anxiety and depression. A wider impact of relational family therapy on posttraumatic growth should be considered in future research.

Key words: *loss, bereavement, relational family therapy.*

Introduction

In today's society, grief is a phenomenon we often want to conceal. But grief is a feeling so deep and complex that its denial or dissociation may lead to psychopathological problems later in life (such as depression, or complicated grief, or panic disorder, or some other psychosomatic disease).

Grieving the loss of a close person is among the most painful experiences in human life.

In the case of Jesus weeping at the tomb of Lazarus, God shows deep compassion for human sorrow although he knows that Lazarus will be revived. It shows how to get in touch with sadness deep inside in order to start a new life, to raise Lazarus (Jn 11:1-44).

The loss of a parent in childhood is a traumatic experience that can bring about several difficulties in adaptation and psychopathological problems during child's development (Cerniglia et al. 2014, 545).

Most of the studies have not considered the differences in adult functioning and religious life of an adult person after the unspoken loss is resolved in psychotherapy (relational family therapy).

This article will therefore present the relational family model of resolving trauma associated with the traumatic loss of a parent in childhood. In doing so, we will use the description of two cases. Both illustrate the connection between trauma and dissociation, with consequent painful sensations felt by our clients due to dramatic past experiences that have not been mourned.

In many ways, these cases are about relational trauma: in their very core, the losses were marked by traumatic events that resulted in the loss of significant relationships. Relational family therapist is therefore repeatedly faced with the challenge of how to approach a traumatized client without re-traumatizing her. Above all, this is the challenge of how to approach the newly discovered trauma with extreme sensitivity, address it and start to empathetically process it.

The experience of death is followed by bereavement, which is a common human response to any loss of change in life (Marques et al. 2013, 1214) (Rothschild 2000, 136) (Bowlby 1980, 192). Death is not the only loss that triggers the process of mourning; this process also accompanies changes such as divorce, chronic illness, the loss of a job or home, or disability. There is also the loss of our dreams or expectations. Every change in life occurs through loss, after all. All losses awaken sadness and grief is necessary, because only with the knowledge that one needs to let go one can transform this experience, own its essential parts, and allow oneself to move on (McGoldrick, 1997, 143). Life events which are sufficiently stressful and traumatic can result in the perception which is similar to mourning; so they are accompanied by symptoms such as shock, distress, anger and despair, as well as intrusive thoughts related to the traumatic event (Stroebe, Abakoumkin and Stroebe 2010, 89). Similarly to other stressors, stress caused by a loss may increase the probability of problems or deterioration of physical and mental health (Shear et al. 2011, 110).

When the current loss becomes one of a series of various losses in one's life (including the departure of one of the parents, moving places, and trauma and abuse) that have never been mourned and processed,

this can trigger a difficult reaction shown as a complication in mourning. Complications in grief affect approximately 6–18% of the bereaved adults (Marques et al. 2013, 1213). All these studies mainly discuss about the complexity of unmourned contents which consequently deeply affect interpersonal relationships that can become highly dysfunctional.

It is a true paradox that precisely through the loss in adulthood; children repeat the traumatic experience of loss, all because of their unconscious needs and desires to resolve a trauma.

It can be said that the likelihood that complications arise in mourning is affected not only by the current circumstances of death but primarily by the historical background of the individual's losses, e.g. whether the individual, before this latest loss, suffered from any anxiety disorder (Marques et al. 2013, 1214).

1. Family system and loss

The death of a family member strongly shakes the balance, creates large changes in the family structure and requires an entirely new family strategy. There is no common response to the death of a family member. The response of each family member and the family as a whole is determined by the context of the family. This context consists of several factors such as the nature of death, the position of the deceased in the family, the family history of previous losses; the family involvement in social, cultural, religious environment – family orientation. The time of death within the family life cycle is also important (Anderson and Sabatelli 2007, 123).

Families need to reorganize a new system without the deceased, which is an extremely complex and painful process. This may mean a shift in guardian or managerial functions, changes in social networks and family orientation shift (McGoldrick, 1997, 145).

As far as the death of a parent is concerned, studies show that the psychological profile of the surviving parent and the quality of the bond between surviving parent and bereaved child can impact the psychopathological symptoms of the pre-adolescent and adolescent (Cerniglia et al. 2014, 545) (Luecken 2000, 841).

Successful resolution of mourning depends on the ability of a family to deal with several important tasks: how each member of the family is able to accept the reality of death, if they can share the feelings of pain and sorrow, if the family system can be restructured as a response to the loss, if they can move towards future by forging new relationships and setting new goals (Anderson and Sabatelli 2007, 124). However, when families are unable to grieve, they remain frozen in time – they dream of the past, their feelings are in the present and they await the future with horror (McGoldrick, 1997, 133).

2. Childhood and loss of a parent

Many previous studies have identified the relationship between parental loss and psychopathology later in life. Even in developed countries with low adult mortality, parental death during childhood is not a rare event. But even more children are exposed to disrupted family relationships due to temporary separation or divorce. Permanent separation from a parent following divorce has been associated with worse psychological outcomes than parental death (Nicolson 2004, 1017) (Takeshi 2014, 404).

In one of the studies participants reporting a history of parental divorce show a significantly higher prevalence of psychiatric disorders, particularly alcohol and drug abuse disorders compared with control subjects with no such experience. Participants having experienced the death of a parent reported poorer overall health, but the prevalence of psychiatric disorders after 17 years of age was not significantly higher than that of the control subjects (Tebeka et al. 2016, 678).

At this point it is worth mentioning the results of a developmental psychology theory, according to which children between 6–9 years become aware that they are separated from their guardians and at the same time they depend on them. The loss of a parent or a guardian during this period when the child recognizes his dependence of carers can undermine the child's survival and create the experience of helplessness and sheer horror. According to development theory, from the child's perspective the loss of a guardian due to permanent separation equals the guardian's death: for the child, the psychological impact is the same in both cases.

Individual experiences of loss and mourning in childhood are individually unique and embedded into the context of social environment. According to research, the impact of such losses was reflected particularly in the areas of trust, relationships, self-image and sense of self-worth, loneliness and isolation, and the ability to express feelings (Ellis, Dowrick and Lloyd-Williams 2013, 57). Recent studies have even shown that due to the loss of parents, either because of death, or abandonment, or separation, in the brain of a child and later adult permanent lifelong impairment of the stress regulating system can occur (Preter, Klein 2014, 346).

Early experience of parental loss has long-term effects on HPA axis activity. Higher basal cortisol levels in healthy adult men who had experienced early parental death shows that disturbances of primary attachment in childhood can have long-term effect on the HPA axis and was associated with increased cortisol responses (Nicolson 2004, 1017) (Tyrka et al. 2008, 1148).

The effect of loss was moderated by levels of parental care; participants in this research who had been abandoned by parents and had experienced very low levels of care had attenuated cortisol responses. According to these findings, early parental loss induces enduring changes in neuroendocrine function (Tyrka et al. 2008, 1147).

In addition to that, genetically informative studies showed that genetic and environmental risk factors act and interact to influence liability to panic disorder, its childhood precursor separation anxiety disorder, and heightened sensitivity to CO 2, an endophenotype common to both disorders. Childhood adversities including parental loss influence both panic disorder and CO 2 hypersensitivity (Battaglia et al. 2014, 455).

The exact mechanisms through which loss and other difficult experiences exert these effects are as yet unknown, but may include sensitization to later life events and chronic stressors, mediated by some combination of neurobiological changes and detriments to psychological protective factors such as self-esteem, coping efficacy, and ability to maintain positive social relationships (Nicolson 2004, 1017).

Several decades of research link childhood parental loss with the risk of major depression and other forms of psychopathology. Neurobiological systems that regulate stress reactivity are likely involved in the vulnerability to psychiatric disorders after exposure to childhood parental loss (Tyrka et al. 2008, 1148).

However, these risk factors varied depending on the kind of loss, the parent involved, and the type of psychopathology.

In one study, authors examined the association between parental loss (any loss, death, and separation) during childhood and lifetime risk for seven common psychiatric and substance use disorders. They also examined the extent to which the influence of parental loss contributes to adult psychopathology. Parental separation was associated with a wide range of adult psychopathology, whereas parental death was specifically associated with phobia and alcohol addiction. Maternal and paternal separations were almost equally associated with most forms of psychopathology. The results in this study suggested that parental loss is connected with adult psychopathology, but parental separation had the strongest impacts on the risk of depression and drug abuse/addiction. According to findings in this study there is a suggestion that early parental separation has stronger and wider effects on adult psychopathology than parental death (Takeshi 2014, 404).

3. Posttraumatic growth and religion in adult life

Posttraumatic growth has gained more popularity in the recent years as an important concept to consider when working with traumatized youth and adults. Posttraumatic growth is defined as positive changes stemming from a traumatic experience. Posttraumatic growth is further understood to be the ability to create meaning from traumatic events. In other words, despite terror and pain, there is an opportunity for a traumatic experience to lead to positive growth (Tedeschi, Calhoun 2004, 15). Common domains of posttraumatic growth include changes in the

perception of self, enhanced interpersonal relationships, changes in life philosophy, altered religiousness and spirituality and new life directions.

In a study of traumatized adolescents authors estimate that adolescents with psychotherapeutic support showed reduction in many psychiatric symptoms compared with adolescents with no such treatment. So these results highlight the need of psychotherapeutic support for traumatised adolescents and their parents to prevent long-term psychological impairment and to develop posttraumatic growth (Vloet et al. 2014; 622, 624).

Posttraumatic growth is now being studied within the context of religion and spirituality. Research shows that positive religious coping, religious openness, readiness to face existential questions, religious participation and intrinsic religiousness are associated with posttraumatic growth (Nelson, 2011, 2). Research in this area is being conducted with varied populations of children, adolescents and adults, including children and adolescents experiencing chronic illness and parental divorce and adults who are returning from military deployments. While this research is still in its early stages, the impact that posttraumatic growth has on positive health outcomes warrants special attention. Exploration of the role that religion and spirituality play in individuals' everyday lives, especially following trauma exposure and experiences, is recommended by the authors (Tedeschi, Calhoun 2004, 16).

In a study of connection between attachment theory and religion they found that people with avoidant childhood attachment style reported significantly higher rates of sudden religious conversions during both adolescence and adulthood, irrespective of parental religiousness. These results suggest that God and religion may function in a compensatory role for people with a history of avoidant attachment; which means that God may serve as a substitute attachment figure (Kirkpatrick, Shaver 1990, 315).

4. The resolution of mourning according to the relational family therapy model

Relational family therapy emphasizes the importance of resolving affects in primary families. Affects are psychobiological states which are compulsively repeated throughout life in order to be resolved.

Traumatic experiences, such as various losses and abandonment, are recorded in neurobiological, somatic structure of an individual's mental structure, staying there, especially if no system member was able to accept the child exposed to trauma and help him process, recognize and regulate the affect caused by trauma. In such cases, traumatic experiences or dysfunctionally stored stressful experiences persist not only throughout this individual's life, but are transferred to next generations.

If loss is recorded in human psyche already in childhood (abandonment, abuse), in addition to heavy emotions accompanying present loss or death of a close person, unprocessed affects from the past are unintentionally reactivated and compulsively repeated (Gostečnik 2011, 6; Gostečnik 2012, 13). Unmourned and unprocessed losses in the past can affect one's functioning today. All losses and traumas that have not been processed can be transmitted to next generations and thus affect the functioning of an individual who has not even experienced them. Losses that are traumatic and, as such, often unprocessed, unmourned and non-integrated, are transmitted transgenerationally, as claimed by the author, as an established and statistical phenomenon (Cvetek, 2009, 145). When examining the multigenerational effect of loss, we can learn a lot about how families work, what happens when everything stops, and how to change these patterns. Loss can make survivors stronger, awaken their creativity, and encourage them to aim at achievements, or leave behind a devastating legacy which is even stronger when nobody has faced the loss. So we can follow the pattern of losses left by previous generations about which we know nothing (McGoldrick 1997, 133), while they live on (Gostečnik, 2011, 6).

5. The application of relational family therapy in resolving complications in bereavement

Case 1

The client came to therapy because of ongoing health-related agony. She was visiting a doctorbecause of the terrible fears that she would get sick and die and her father suggested that aconversation with a psychologist could prove very useful. Her whole body shuddered at this advice. She felt deep shame, anger and fear that her body literally betrayed her. But the doctor's words stayed with her, and finally she decided to visit a therapist.

After the initial time and punctuality related problems she eventually met the therapist.

The therapist soon sensed that the most fundamental dynamics of the most painful experiences of client's youth played out between the two of them. The client's father died in her childhood due to some strange complications that she had failed to grasp. An uncle entered her world – a person who in many ways started to play the role of her father. She felt as if her father was substituted. Even in therapy she initially made an agreement to meet one therapist, but then, due to a strange incident, agreed to work with another.

When she finally came to her initial session, she experienced deep shame and occasionally a poignant pain caused bybetrayal and deceit.

The client's body quickly began to reflect even deeper shame and concealed disgust which triggered a genuine repulsion reaction during therapy. Soon after the first few meetings, the therapist began to feel a slight irritation, and it did not take long to discover that the client had been sexually abused by her uncle, who had been a kind of a surrogate father. This led to further complications regarding the time of their sessions, because the client behaved in an extremely confused manner, as if she was re-entering a dangerous place where she would have no control. She feared what would be revealed there. However, the therapist with her empathetic approach created a safe space which the client passionately embraced, at the same time being utterly afraid of commitment.

Here the therapist started to feel extreme shame and irritation. When she regulated these feelings of shame and utter repulsion, the client slowly began to understand thatshe was irritated by the helplessness of a child who had been naked and ashamed, without the protection of a father. She had actually never mourned this loss and abuse. Soon she started to rememberthat she had missed her father, looking for a 'substitute' in her uncle who had been very friendly, as her mother had persuaded her. But the uncle soon began to sexually abuse her, and thus she lost the last protective figure. She could not confide in her mother, fearing that she would hurt and therefore lose her, too. She was convinced that her mother would not understand and believe her, and would even harshly reject her. She attempted to deeply suppress all of these painful, unresolved feelings, but her body spoke in an even more radical way, through the fears of getting ill. Actually, the fear of illness was a covert alliance and the only identification with her father, because he had been ill, too; her brain identified her father with illness. On the other hand, being ill was the only safe feeling, on the basis of which she could deny all the other fears, the feelings of shame, painful trauma, and being rejected. Over and over again, she concealed helplessness, which she hated most, withillness or the fear of it, and constantly turned to people who, because of her illness or fears, took care of her.

She also wanted the therapist to repeatedly tell her she would be okay: something she had never heard in her life in spite of her profound longing to hear this very sentence since her father's death. This was the fundamental need of security which she had never been able to admit to herself; and this need also led her to marriage. But as one would expect, her marriage was full of new fears and horror. Even her motherhood did not bring any resolution; with her husband as well as children she lived an alienated life, which she was deeply ashamed of.

In the therapeutic process, all these feelings of shame, deep rejectedness, and above all the abuse, kept surfacing. She has always wanted to give the impression that she is capable of managing everything by herself, that she did not need anyone, therefore she allowed nobody to enter

her world. Consequently, she let her husband to be present at therapy sessions, but only as an observer, watching from afar how his wife slowly tried to 'fix herself', as he quietly uttered during therapy several times.

Later, also due to her husband's frequent absences, she started to feel very unsafe during therapy. In every possible way she began to look for other sources of help, from esoteric to self-help groups. The therapist felt being substituted, at times rejected, discarded and betrayed, which she began to gradually address. This aroused the deep shame in the client, and slowly she managed to start talking about herself. The therapist understood that the feelings which the client triggered in her with substituting therapists were a central theme in the client's life. When they started to consistently address this theme, both felt that they were opening a new chapter which they would be able to continue.

Case 2

The client came to therapy due to depression, as she herself described her condition. She could not move forward in life, as if being stuck. Recently she has broken up with her boyfriend, which resulted in even deeper feelings of helplessness and sheer abandonment. Although she had long ago foreseen this breakup and did not feel a true connection in this relationship, when it actually happened, she suffered immensely and was constantly thinking about this person. She was not able to study for university exams, or to seek a job, even though she lived at home and was financially dependent on her parents. It was as if she hasfrozen her life.

In the beginning, the therapist saw helplessness, guilt and humiliating shame. Very soon they arrived at a deeply traumatic experience in the client's life: as a young girl, she had lost her father to whom she was attached on a very deep level.

During treatment, the client constantly gave the impression that she was to blame because she did not behave properly or decide correctly. Her vision and perception were not real; and sometimes she felt that she could have changed a lot had she reacted at the right time. Now and then she had irrational thoughts that could have prevented the death of her own father if she had reacted at the right time.

In therapy sessions, the therapist addressed strong injustice and shame for which the client could not understand where it came from, but with the therapist's help, she soon realized that whenher fatherhad died she had felt extremely exposed. The fear of a repeated exposure created defence mechanisms that did not allow anyone to enter her inner world. Therefore she skilfully turned every relationship to a caring one, which enabled herto feel control, while she did not need to confront her own vulnerability, which still pursued her in a rather catastrophic form.

In the therapeutic relationship, the therapist deeply felt this wounded little girl, overwhelmed by guilt and shame. When she and the client

started to address this, the client began to cry violently. Tears poured down her cheeks as if they would never stop, as if now for the first time she started to mourn the long repressed loss that she has never dared to address directly.

Shame and guilt were nothing but very strong defensive postures, which she cultivated to protect the deep feelings of being rejected and abandoned.

The therapist was aware that there were many steps, a long process of waiting for the two of them, which basically meant that together with the therapist, in a secure relationship, the client would be able to relive the most critical departures in her life, from her father to the boyfriend, friends, colleagues, etc.

And when anger emerged for the first time, the therapist knew that the client finally began the process of enteringher deep world. All distressing vibrations accompanying the loss of her father had been recorded in the fibers of her body where they had simply frozen.

These insights opened a whole new world for the client. Gradually, she could part from those heavy feelings and thus look more optimistically at the future.

Conclusion

To conclude, we can say that one of the most effective therapeutic approaches to unresolved trauma and unmourned contents, which are often darkened with abuses, is the therapist's deep, respectful and empathic attitude. We maintain that the relational family therapy model is especially applicative in these cases, since due to its basic organization, it addresses psycho-organic structures with implicitly stored organic memory, the memory of the trauma that has been dissociated. Such empathic and respectful attitude enables the client to first recapture old traumas. And then later on, which is also essential, through the relationship with the therapist, which is different from previous relationships, she can not only address old unresolved contents, but emerges from them on the basis of new experiences enabled by such a therapeutic relationship. Gradually, layer by layer, the therapist reveals the contents which are very fragile and vulnerable. We could compare the therapist to an archaeologist who has to touch the most fragile findings with utmost sensitivity.

This enables the client to find the way out of this sore situation of unmourned contents and to begin fully, or at least more fully, to live life and relationships that were previously covered with old, unresolved sediments. Through relational family therapy, the therapist could establish a new relationship at the point where this relationship had been lost because of the trauma.

From this point of view, even a very traumatic experience, such as the death of a close person, brings new, added value and finally gets a meaningful place in client's life and memory.

Literature

Anderson, Stephen A., and Ronald M. Sabatelli. *Family Interaction*. 4thedition. Connecticut: Pearson. 2007.

Battaglia, Marco, Anna Ogliari, Francesca D'Amato, Richard Kinkead. Early--life risk factors for panic and separation anxiety disorder: Insights and outstanding questions arising from human and animal studies of CO2 sensitivity. *Neuroscience & Biobehavioral Reviews*, part 3, Vol. 46. 2014: p. 455-464.

Bowlby, John. *Attachment and Loss*. Vol. 3. London: Pimlico. 1980.

Cvetek, Robert. *Bolečina preteklosti*. Celje: Celjska Mohorjeva družba. 2009.

Cerniglia, Luca, Silvia Cimino, Giulia Ballarotto, Gianluigi Monniello. Parental loss during childhood and outcomes on adolescents' psychological profiles: a longitudinal study. *Current psychology*. vol. 33. 2014: p. 545-556.

Ellis, Jackie, Chris Dowrick, Mari Loyd-Williams. The long-term impact of early parental death: lessons from a narrative study. *Journal of the Royal Society of Medicine 106.* 2013: p. 57-67.

Field, Nigel P., and Charles Filanosky. Continuing Bonds, Risk Factors for Complicated Grief, and Adjustment to Bereavement. *Death Studies* 34, No. 1. 2010.: p. 1-29.

Freud, Sigmund. *Mourning and Melancholia*. Ed. James Strachey. Vol. 14, *The Standard Edition of the Complete Psychological Works of Sigmund Freud*. London: Hogart Press. 1917.

Gostečnik, Christian. *Inovativna relacijska družinska terapija: inovativni psiho-biološki model*. Ljubljana: Brat Frančišek, Frančiškanski družinski inštitut, Teološka fakulteta. 2011.

Gostečnik, Christian. *Relacijska paradigma in travma.* Ljubljana: Brat Frančišek, Frančiškanski družinski inštitut. 2008.

———. *Govorica telesa v psihoanalizi*. Ljubljana: Brat Frančišek, Teološka fakulteta, Frančiškanski družinski inštitut. 2012.

Harvard Medical School. Coping with complicated grief. *Harvard Mental Health Letter* 23, No. 6. 2006.: p. 1-3.

Herman, Judith L. *Trauma and recovery.* New York: Basic Book. 1992.

Kirkpatrick, Lee A., Phillip R. Shaver. Attachment Theory and Religion: Childhood Attachments, Religious Beliefs, and Conversion. *Journal for the Scientific Study of Religion,* 29 (3). 1990.: p. 315-334.

Letter, Harvard Mental Health. Coping with complicated grief. *Harvard Mental Health Letter* 28, No. 6. 2011.: p. 6-6.

Luecken Linda J. Parental Caring and Loss During Childhood and Adult Cortisol Responses to Stress. *Psychology and Health* vol. 15. 2000: p. 841-851.

Marques, Luana, Eric Bui, Nicole LeBlanc, Eliora Porter, Donald Robinaugh, Taylor Dryman, Mireya Nadal-Vicens, John Worthington, Naomi Simon. Complicated Grief Symptoms in Anxiety Disorders: Prevalence and Associated Impairment. *Depresion and Anxiety,* No. 30. 2013.: p.1211-1216.

McGoldrick, Monica.*You can go home again: reconecting with your family*. New York: W. W. Northon & Company, Inc. 1997.

Melges, Frederick Towne and David Ray DeMaso. Grief-Resolution Therapy: Reliving, Revising, and Revisiting. *American Journal of Psychotherapy* 34. 1980, p. 1-51.

Nelson, Stephanie D. The posttraumtic growth path: An emerging model for prevention and treatment of trauma-related behavioral health conditions, *Journal of Psychotherapy Integration,* 21 (1). 2011.*:* p. 1-42.

Nicolson, Nancy A. Childhood parental loss and cortisol level in adult men, *Psychoneuroendocrinology* 29. 2004: p. 1012-1018.

Otowa, Takeshi, Timothy P. York, Charles O. Gardner, Kenneth S. Kendler, John M. Hettema. The impact of childhood parental loss on risk for mood, anxiety and substance use disorders in a population-based sample of male twins. *Psychiatry Research*, Vol. 220 Issue ½. 2014.: p. 404-409.

Preter, Maurice, Donald F.Klein. Lifelong opiodergic vulnerability through early life separation: a resent extention of the false suffocation alarm theory of panic disorder. *Neuroscience&Biobehavioral Reviews 46*: part 3. 2014.: p. 345-351.

Rosner, Rita, Gudrun Lumbeck and Edgar Geissner. Effectiveness of an inpatient group therapy for comorbid complicated grief disorder. *Psychotherapy Research* 21, No. 2. 2011.: p. 210-218.

Rothschild, Babette. *The Body Remembers, The Psychophysiology of Trauma and Trauma treatment*. 1stedition. New York: W. W. Norton & Company. 2000.

———.*The Body Remembers, Casebook*. New York: W. W. Norton & Company. 2003.

Schore, Allan N.*Affect regulation and the origin of the self: The neurobiology of emotional development.* Hillsdale, NJ, England: Lawrence Erlbaum Associates, Inc; England. 1994.

———. The effects of early relational trauma on the right brain development, affect regulation, and infant mental health. *Infant Mental Health Journal* 22, No. 1-2. 2001.

Shakya, Yagya Laxmi, R. Acharya, M. P. Gupta, M. R. Banjara and P. N. Prasad. Factors determining self-harm. *Journal of Institute of Medicine* 32, No. 3. 2010.: p. 14-17.

Shear, M. Katherine, Naomi Simon, Melanie Wall, Sidney Zisook, Robert Neimeyer, Naihua Duan, Charles Reynolds, Barry Lebowitz, Sharon Sung, Angela Ghesquiere, Bonnie Gorscak, Paula Clayton, Masaya Ito, Satomi Nakajima, Takako Konishi, Nadine Melhem, Kathleen Meert, Miriam Schiff, Mary-Frances O'Connor and Michael First. Complicated grief and

related bereavement issues for DSM-5. *Depression & Anxiety (1091-4269)* 28, No. 2. 2011.: p. 103-117.

Siegel J., Daniel. *The developing mind: How relationship and the brain interact to shape who we are.* New York: Guilford press. 1999.

Stroebe, Wolfgang, Georgios Abakoumkin and Margaret Stroebe. 2010. Beyond Depression: Yearning for the Loss of a Loved One. *Omega: Journal of Death & Dying* 61, No. 2. 2010.: p. 85-101.

Sveto pismo stare in nove zaveze: Slovenski standardni prevod. Ljubljana: Svetopisemska družba Slovenije. 2013.

Tebeka, Sarah, Nicolas Hoertel, Caroline Dubertret, Yann LeStrat. Parental Divorce or Death During Childhood and Adolescence and Its Association With Mental Health.

Journal of Nervous & Mental Disease. Vol. 204 Issue 9. 2016.: p. 678-685.

Tedeschi, Richard G., Lawrence G. Calhoun. Posttraumatic growth: Conceptual foundations and empirical evidence. *Psychological Inquiry,* 15. 2004.: p. 1-18.

Tyrka, Audry R., Lauren Wier, Lawrence H.Price, Nicole Ross, George M. Anderson, Charles.

W. Wilkinson, Linda L. Carpenter. Childhood Parental Loss and Adult Hypothalamic-Pituitary-Adrenal Function. *Biol Psychiatry* 63. 2008.: p. 1147-1154.

Van der Kolk, Bessel A. The body keeps the score: Approaches to the psychobiology of posttraumatic stress disorder. V: Bessel A. Van der Kolk, Aleksander McFarlane and Lars Weisaeth, ed. *Traumatic stress: The effects of overwhelming experience on mind, body and society,* 214-241. New York: Guilford Press. 1996.

Vloet, Andrea, Michael Simons, Timo V. Vloet, Melanie Sander, Beate Herpertz-Dahlmann, Kerstin Konrad. Long-term Symptoms and Posttraumatic Growth in Traumatised Adolescents: Findings From a Specialised Outpatient Clinic. *Journal of Traumatic Stress* 27. 2014.: p. 622-625.

Wayment, Heidi A., and Jennifer Vierthaler. Attachment Style and Bereavement Reactions. *Journal of Loss & Trauma* 7, No. 2. 2002.: p. 129-149.