

## Professor Onja Grad

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Onja Grad is a clinical psychologist who works in the Outpatient Clinic of the University Psychiatric Hospital of Ljubljana with patients who lost somebody by suicide or any other unexpected and traumatic death. She also teaches at the University of Ljubljana School of Medicine – undergraduate and graduate students of medicine and psychology.

She works as a therapist with bereaved individuals, couples and families. Her research is focused on two topics: first, gender differences in bereavement and how these differences influence therapy, specifically the therapy of men. And second, how professionals (physicians, therapists, teachers, etc.) react when they experience a client's suicide and how they should be supported when it happens.

Her work with suicide survivors was acknowledged by IASP while she became the first recipient of the Farberow Award (Adelaide, 1997). She has been invited to give lectures and to lead workshops in different parts of the world. She has contributed chapters on postvention and bereavement after suicide in different international textbooks. She served as a Vice-president of IASP for two mandates (1999 - 2003).

### **Postvention for different groups in different cultures**

Shneidman's neologism "postvention" represents a rather new paradigm comprising a very complex and sophisticated set of different actions to help survivors after suicide. However, this is true only in some parts of the developed world, while it is an unknown and rather obscure word without any substantial connotation for the larger part of the rest of humankind. Therefore, we should realize that it is not inherently and generically connected to the act of suicide itself, but has relevant meaning and implications only where suicide has been recognized and acknowledged as a traumatic source of pain and frustration for those left behind. Even though we understand suicide as a medically, psychologically, biologically and psychosocially "explicable" behaviour, its aftermath brings additional social and cultural repercussions compared to any other type of death. If the suicidal act is accepted and understood differently in different parts of the world, it means that those left behind will be treated in accordance with the local "social contract", which may not necessarily comply with what suicide survivors need. If the environment's attitude towards suicide is full of prejudice and stigma, the same will apply to the survivors. If the attitude is benevolent and understanding, regardless whether the local explanation for suicide is so-called scientific or so-called shamanistic (or any other), the survivors will usually (hopefully) be treated by their environment as they would have liked or needed to be. If suicide is perceived as a socially unacceptable act, it is difficult to expect suicide survivors to be treated appropriately. Therefore, it is easier to understand why the earliest national suicide prevention programmes, including different postvention actions for the survivors, were introduced in the developed countries with lower suicide rates, while those (also developed) countries with the highest suicide rates have little or no such activities. It seems that social shame is stronger than any science. What, in this respect, is known about the countries in Africa, Asia, or South America that are not even on the "suicide map" – what is happening to suicide survivors there? How do their doctors, teachers, nurses etc. react to the suicide of their patient, student, client etc.? What kind of postvention do they need?