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Psychosocial risks and protective factors in death care workers during the Covid-19 pandemic

Ph.D. candidate:

Annalisa Grandi

Tutor:

Prof. Lara Colombo

Ph.D. Coordinator:

Prof. Marco Tamietto

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Table of contents

Introduction

Every people, every civilisation is characterised by how it deals with death and how it cares for its dead, and our current knowledge of ancient peoples has also become possible thanks to the study of their necropolises. Death is one of the most difficult events that humans have to deal with. Saying goodbye to a person with whom we were closely connected is a painful experience full of feelings and meanings. Death has always aroused great interest among people, who have searched in all disciplines for meanings and ways of dealing with the pain it causes. Religions in particular have played a central role in providing eschatological answers. Indeed, every cult ascribes an explanation to death, in part to contain the fear that the thought of dying evokes in people and to provide a form of support to the bereaved in the face of loss. Death forces us to confront the issue of separation, the end of an emotional bond, the end of a relationship, and at the same time confronts us with our own finitude (Boschetti, 2003).

Our society has undergone significant changes in the last century. The demographic situation has changed due to the emergence of large urban settlements and the gradual abandonment of small communities and rural areas. Since the 1930s, we have gradually witnessed the development of the phenomenon of the medicalisation of life and hospitalisation: now "people are born and die in hospitals". In the past, only the poor and destitute died in hospitals; everyone preferred to die at home (Ariès, 1974). The proliferation of hospitals has begun to hide every unpleasant image that

can be associated with death. The same rooms for which the bodies of the deceased are destined are in the basement to hide them from the public and – at the same time – to conceal what is partly seen as a failure of the healthcare system (Carden, 2001). These historical changes in today's society have led to changes within the family, at the level of structures and relationships. On a social level, rituals play a lesser role today compared to the past and the social and collective dimension is less important, especially in large urban centres, to the detriment of the sense of protection and social security that the old communities guaranteed. As a result of this lack of participation in the extended group, death today is a difficult experience to bear (Boschetti, 2003). In the past, death mainly took place in the home, and friends and relatives accompanied the dying person in the last moments before their passing and supported the family during the illness and grieving process. The care of the dying and the body of the deceased was entrusted to families and the community, whereas now hospitals and death care workers respectively take care of it.

Death care in Italy

Social changes have led to the emergence of professionals who are entrusted with tasks that were previously undertaken by the community: these professionals now have the task of accompanying the family in the difficult decision-making process following the death of a loved one and acting as a guidance in the dramatic moment in which the bereaved find themselves. In this scenario, the death care professions fall into the sphere of professions defined as "helping professions" at the relational level, i.e. where the operator provide support to people in difficulty through emotional involvement (Messina, 2004; Bordone and Di Dio, 2003).

The death sector is a little-known reality in our country, probably due to the issues addressed, which are more easily suppressed rather than deepened. In Italy, the main national regulation for the

funeral sector is the "Mortuary Police Regulation" (D.P.R. 285/1990), which sets out the criteria to be followed for everything that is essentially part of the process from death to burial (i.e. transport of the body, post-mortem diagnostic examinations, autopsy and treatment of the corpse, provisions for cemetery services, mortuaries, etc.).

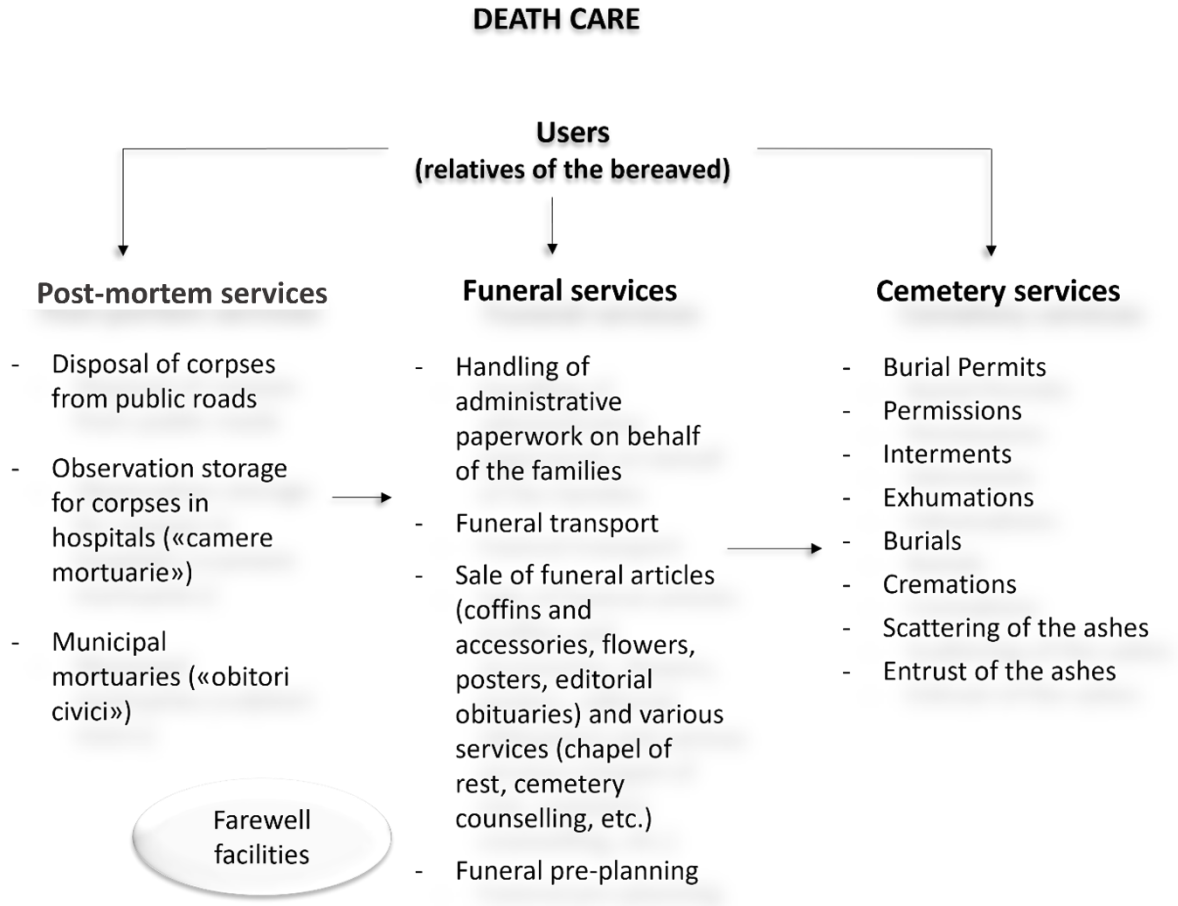


Fig.1. Subdivision of services in the death care in Italy (*source: Sefit, 2008*).

When we talk about the death care sector, we refer to all the services that are necessary from death to burial or cremation and destination of the ashes (SEFIT, 2008). The main areas of activity in the sector are post-mortem services, funeral directing services, crematoria and cemeteries services (see Figure 1). In order to better understand the characteristics of these professions, it is appropriate to briefly outline the functions they perform, going back to the specific activities of each service.

The post-mortem includes the administrative procedures, the hygienic care and the observation of the corpse in the following 24 hours after death. They are carried out in special rooms – mortuaries – for bodies from hospital wards. Refrigerated rooms, i.e. mortuaries, are provided by the municipalities for the storage of bodies from unsuitable homes, deaths on public roads or corpses that are the subject of investigations by the judicial authority. This type of activity falls into the category of public services that municipalities and health authorities are obliged to make available to citizens.

Cemetery services include activities related to the management of cemeteries, i.e. places of remembrance of local communities; cremation facilities may generally be located within cemeteries. In contrast to burial, cremation has the advantage of saving money and space (SEFIT, 2008). These services fall into the category of paid public services, except in cases of poverty where the services are offered free of charge.

Funeral directing services include administrative activities and the provision of services and supplies required for the rites of farewell to the deceased and the transfer of the deceased from the place of observation (mortuary or home) to the cemetery where the burial takes place, often passing through a place of worship first. In some regions, structures have been created for the farewell – which have long been widespread abroad – where observation functions and farewell rites can be performed, offering bereaved more ritualised conditions and greater comfort. These activities are of an economic nature and therefore chargeable (SEFIT, 2008).

Regarding this last category of services, we can make some further considerations to understand how they differ from other countries. While in the United States the role of the embalmer is clearly defined and also recognised at the level of specific training (Cathles et al., 2010), in Italy, as in other countries (Davidsson Bremborg, 2006; Pringle & Alley, 1995), embalming procedures are rarely used,

except as a precautionary measure in cases where the preservation of the corpse is seriously at risk. Normally, in these situations, only formalin-based preservative injection (D.P.R. 285/1990) is practiced, the so-called "sanitary and hygienic treatment". Tanatopraxis and tanatoesthetic procedures are also procedures that belong more to international contexts. The role of the funeral director is to take care of the transfer and arrangement of the body and to organize the funeral ceremony (SEFIT, 2008). From the time of death to the funeral, about three days pass on average. Therefore, the completion of the bureaucratic part and the organisational part must be done quickly and efficiently. In some cases, the time is prolonged, e.g. if the body has to be autopsied or transferred to another country. The roles at the front- and back-door can be described as follows: the first involves dealing with the bereaved for the purchase of the service and arranging the ceremony, the second involves housing and transferring the body and managing the paperwork/accounting.

In contrast to other international realities, in Italy funeral homes have emerged with some delay and are only beginning to grow in numbers in recent years. Some of them are "ceremony rooms"/chapels of rest – a structure that offers some services and a farewell hall/chapel – while others are funeral homes, that is, completely autonomous in terms of the services provided. The slow development of this type of reality is also partly due to the local culture, where it is common for the deceased to be mourned at home or in hospital mortuaries. The idea of the loved one being transported to an other, new and unknown facility was difficult to accept. The most traditional Italian reality does not consist of funeral homes, but of small local realities, funeral service agencies (in Italian "onoranze funebri" or "pompe funebri"), which can be more or less autonomous in the provision of services. In other words, some have the staff in charge of dressing and transferring the body, the means of transport (hearse), the staff in charge of organizing the funeral ceremony; others (most of them) deal

exclusively with the sale of funeral services to the bereaved/clients and the organization of the ceremony, leaving the other services, viz. i.e. the hire of the hearse, the staff for dressing and transport, the delivery of coffins, the furnishing of the burial chamber, to third party service providers (called "Centri Servizi"). This leads to a rather fragmented situation about tasks that can be performed by different professionals depending on the reality. Therefore, it can (often) happen that the funeral director who sells the service and organizes the funeral ceremony and the professionals who take care of the dressing of the body and its transport do not belong to the same working reality.

Psychosocial risks in death care

When we speak of psychosocial risks, we refer to those factors that, in addition to aspects of work design and organisation, also concern the environmental, social and relational contexts that can potentially cause physical or psychological harm in direct and indirect ways (Cox & Griffiths, 1995). Possible effects of exposure to psychosocial risk factors include the occurrence of stress, burnout, bullying and harassment (Bisio, 2009).

Theoretical framework

A useful theoretical framework that can help read organisational contexts to identify potential areas of risk is Job Demands-Resources (JD-R) theory (Bakker & Demerouti, 2014) a theoretical framework that is now widely validated and supported by ample evidence in the occupational field. This approach goes beyond previous models, such as the demand-control model (Karasek, 1979) and the effort-reward imbalance model (Siegrist, 1996) which, according to the authors, considered a limited

number of variables that not always showed to be relevant for all jobs. At the base of the JD-R theory is in fact the assumption that every profession is characterized by two main orders of factors: job demands and job resources. The former concern physical, psychological, social or organisational aspects of work involving considerable use of physical and/or psychological energy. The latter, job resources, are physical, psychological, social or organizational aspects of work that are useful in achieving work goals, stimulate personal growth and learning of the individual and help reduce the negative effect of job demands. According to JD-R, it's important to maintain a balance between the two factors: job demands in fact can increase the risk of disengagement or exhaustion, while job resources have a buffering effect and maintain a good level of commitment and job satisfaction (Bakker & Demerouti, 2014). Recently, the JD-R has been extended to include more factors related to crisis management in the framework, making it more suitable for the current pandemic context. Specifically, more factors were considered, namely the characteristics of the work context, the organisational procedures implemented, the interactions with people inside and outside the organisation and the social and personal sphere (Demerouti and Bakker 2023).

Applying the JD-R approach to the death care can therefore be an effective key to identifying and mapping the specific demands and resources that characterise this particular professional context and bring to light all the risk factors to which these workers are exposed.

Outcomes

According to the literature, the constant confrontation with suffering, pain and death can lead to the development of physical, psychological and behavioural disorders. The syndromes most associated with the characteristics described above are compassion fatigue, secondary traumatic stress disorder, vicarious trauma and burnout syndrome (Cieslak et al., 2014). The first three constructs are

similar to each other and are often used interchangeably. Compassion fatigue highlights the cost to the caring professions: professionals who listen to their clients' stories of pain and suffering may experience the same emotions themselves. This situation of being overwhelmed can lead to secondary traumatic stress disorder, which is described as an acute reaction that develops suddenly and displays the classic symptoms of posttraumatic stress disorder. Vicarious trauma is caused by the operator being exposed to existential experiences of deep suffering and pain through the stories of their clients (Cieslak et al., 2014). Burnout syndrome (Schaufeli et al., 1996), on the other hand, develops when the workers realise that they have exhausted their cognitive, mental and physical resources for performing their work. On a behavioural level, this leads to an emotional detachment from their clients, a lack of responsibility for their professional role and cynicism towards their suffering. Compared to the previous three symptomatologies, this symptom picture is not necessarily related to the client's trauma exposure.

Demands

The profession of death care involves a daily basis in which the operator is constantly confronted with the vision of the deceased and has to manage relationships with the deceased's relatives that are not always clear and relaxed: indeed, it is not uncommon for negative feelings such as aggression and anger to be vented on the operators. These feelings are channelled towards external objects, such as the staff responsible for caring for the deceased. Sometimes they are used as scapegoats against whom to direct anger in order to avoid feeling the pain that would otherwise be difficult to bear (Boschetti, 2003). The role of the death care professionals also concerns providing support to the bereaved who are facing a potential highly traumatic event – such as the loss of a loved one – and who are in a state of greater fragility and limited resources to cope with the situation. The most

emotionally distressing moments when the presence of death care workers is required are the first sight of the body in the coffin by the relatives, the closing of the coffin, its positioning in the grave or – in the case of cremation – the handing over of the coffin to the crematorium and the receipt of the urn. Each of them represents a further estrangement from the loved one. The situations perceived as most dramatic are the death of children and death from sudden causes (accident, heart attack, etc.), in which the professionals themselves report major difficulties (Gary Benfield & Nichols, 1984; Kalkofen, 1989). It is clear that the operators are exposed to a pressure of suffering that causes deep discomfort, which can lead to symptoms of a certain relevance in the long term (Messina, 2004). Scientific findings, although still limited, have shown that emotional load is a very relevant factor in this professional field, contributing to the risk of emotional dissonance (L. Colombo et al., 2019; Guidetti et al., 2022; Smith et al., 2009), burnout (Cüneyt et al., 2013; Guidetti et al., 2021; Kömür et al., 2017; Smith et al., 2009) and secondary traumatic stress (L. Colombo et al., 2019; Guidetti et al., 2022).

Although, as we have just seen, this professional activity is emotionally risky and plays an important role in the final part of the personal care process, it is not always regarded with respect and gratitude. The social image of the death care worker is sometimes associated with embarrassment or disgust, if not hilarity. Working closely with death and the dead is seen by many as "dirty work" (Thompson, 1991) and therefore cast in a poor light by society, which tends to stigmatise rather than acknowledge the essential support that this category of workers provide (Carden, 2001). The public is highly unaware of the role of the death care and due to the existing stigmatisation, many people are not interested in getting to know them better (Carden, 2001).

Exposure to the suffering of bereaved and the constant sight of corpses – even in various states of decomposition – can be factors of strong physical and psychological impact. Workers engaged in

these day-to-day tasks may sometimes resort to dysfunctional strategies, such as alcohol abuse. It has been highlighted that, among the mortuary staff, some operators resort to alcohol to cope with the stress related to the daily performance of work, as "asking for help" through psychological support would be seen as a sign of weakness (Brysiewicz, 2007). In a study of mortuary workers in developing countries, however, it emerged that the use of alcohol can be a way of dealing with the stigma linked to work: in these countries, in fact, work in contact with death is entrusted to people with precarious socio-economic conditions, who belong to the lowest social castes (Patwary et al., 2010). A recent study also investigated this phenomenon among funeral directors, reporting that a small part of them (specifically, 20% of the sample) said they used alcohol consistently (Cegelka et al., 2020). There are though currently few studies on this issue, probably due to the sensitivity of the topic.

Resources

Factors have also been identified that play a protective role and can offset the effects of challenging job demands. Among the personal resources that have proven functional in death care, we find, for example, spirituality, understood as the attribution of meaning and purpose to life, not linked to a particular religious belief. Individuals who work in occupations with high exposure to death and who feel that their lives really have purpose and are meaningful are less anxious about their own death than those who do not possess these beliefs (Harrawood, 2010). In particular, in Harrawood's (2010) study on a sample of U.S. funeral directors and embalmers, it emerged that spirituality (which seems to grow with age) is one of the main predictors of death anxiety, facilitating the acceptance of death and reducing the anxiety it can generate. In research involving workers in the helping professions, including workers employed in funeral homes, it was found that participants with higher levels of

spirituality tend to feel less stress in the workplace and feel that the organizations they work for are healthier than colleagues who are less spiritually inclined (Csiernik & Adams, 2002). It was also highlighted how a good level of spirituality helps to decrease the perception of stress in the workplace and how this can contribute to a greater sense of well-being (Csiernik & Adams, 2002). It seems that exposure to an atavistic theme such as death generates anxieties and questions that push individuals towards a deeper elaboration of their condition. This "spiritual" elaboration of the theme seems to be able to lead towards a more conscious conception of oneself and more open to life.

Another resource that plays a very important role in these professions is the use of humour. Humour appears in fact to promote a positive attitude towards the unpleasantness of death and is reportedly a useful way of strengthening cohesion among employees (Vivona 2013; Scott 2007; McCarroll et al. 1993; Grandi et al. 2021). This strategy also seems to be helpful in dealing with anxiety, reducing stress and emotional upset and keeping the fear of death at bay (Carden 2001; Pringle and Alley 1995; Thompson 1991).

Although the scientific evidence in this regard is still limited, it should be noted that other factors may play an important protective role for death care professionals, namely secondary trauma self-efficacy (Guidetti et al., 2022), the gratitude of the bereaved (Guidetti et al., 2022), the support of supervisors (Guidetti et al., 2021), the work ability (Cotrim et al., 2020) and the meaning these professionals give to their work (Guidetti et al., 2021).

Finally, it is important to remember that among the outcomes related to the characteristics of death care work, there are also positive effects. Indeed, it seems that by constantly dealing with death, people develop thinking strategies that are useful to them in their lives. Understanding death as a natural and inevitable event helps to develop a positive attitude towards life, to give less importance

to superfluous details and to see death itself as a salvific event, especially in cases of illness and pain (Natsikou et al., 2016).

COVID-19 and death care

The recent COVID-19 pandemic has taken a toll on people's psycho-physical health (S. K. Brooks et al., 2020; Fabbri et al., 2022) and led to negative mental health impacts in various occupational settings (Grandi et al., 2022; Grandi, Sist, et al., 2021), particularly in the healthcare sector (Vizheh et al., 2020). Nevertheless, very little attention has been paid to those occupational groups that have had the most to do with the calamitous consequences of the pandemic. Death care workers in fact were involved in front-line – as healthcare and emergency workers – in order to guarantee the disposal of the bodies and the burials, and therefore helping to rule the chaos that the staggering number of deaths was engendering. During the recent pandemic, the exponential increase in mortality made the working conditions of these professionals critical, as a greater number of bodies (and funerals) had to be handled.

During the pandemic, the work of the death care underwent several changes. First, stricter hygiene and safety practises were introduced for handling the bodies that were – or could have been – contaminated with the virus. As there was no scientific evidence of the actual infectivity of Covid corpses (Mahajan et al., 2020; Suwalowska et al., 2021), precautionary measures were introduced in the handling of potentially infectious corpses. This change had a particularly strong impact on the work of funeral directors and mortuary staff, who could no longer come into contact with the corpse and thus lost the opportunity to dress and care for it in an appropriate and dignified manner (Clavandier et al., 2021). The high number of deaths also made the management and storage of the bodies more difficult. In the funeral ceremony, the number of people present was reduced and new

forms of "virtual" participation were introduced to maintain a kind of continuity in relation to the funeral process and thus allow the bereaved to process their grief (Turner & Caswell, 2020). Finally, the high number of deaths has led to an exponential increase in workload and increased pressure related to the management of services, as queues in cemeteries and crematoria have increased the time required. All these new working conditions have increased the risk factors for death care workers.

The impact of the pandemic on the death care sector has so far been analysed in terms of the biological risks to which they have been exposed (Mahajan et al., 2020; Van Overmeire & Bilsen, 2020). Few studies to date have examined the psychosocial conditions of death care workers during the pandemic (Clavandier et al., 2021; Durand-Moreau & Galarneau, 2021; Hicks et al., 2022; Van Overmeire et al., 2021; Van Overmeire & Bilsen, 2020).

This doctoral thesis presents an investigation of this phenomenon in a sample of Italian death care workers during COVID-19.

The Ph.D. project… in brief

The Ph.D. research project aimed to broaden and deepen knowledge of death care professions, which remain under-researched in the literature, by specifically examining the impact of the Covid-19 pandemic on professionals in the local death care sector. The aim was to identify the psychosocial risk factors and coping strategies used by death care professionals – based on the JD-R theory (Bakker & Demerouti, 2014; Demerouti & Bakker, 2023) – especially during the time of the pandemic.

The research project was divided into three phases:

1) a qualitative study aimed at exploring peculiar psychosocial demands in death care workers during the recent pandemic;

2) a quantitative study aimed at investigating the relationship between a specific job demand (secondary traumatic stress) and two particular resources (work ability and vicarious posttraumatic growth) in death care professionals;

3) a rapid ethnography in a reality of the death care sector to understand the underlying dynamics.

The first phase of the project involved analysing the scientific literature on issues related to the death care context, its legal framework and the identification of structures in the local area (Turin). Interviews were conducted with various professionals in the death care (mortuaries, funeral agencies, cremation services) from August 2021 to August 2022, to obtain information on the working context and gather their experiences during the pandemic. The interviews were audio-recorded with informed consent, transcribed and analysed using template analysis.

In the second phase (from September 2022 to December 2022), based on the qualitative data and the literature review, a self-report questionnaire on quality of work life was created and administered to death care workers in the provincial capital and some neighbouring municipalities. The data was analysed using multivariate and structural equation statistical models.

In the third phase (from December 2022 to June 2023), an ethnographic observation was carried out during the working hours of a group of workers employed in a mortuary in Turin. Keeping a logbook and ethnographic protocols were used as helpful tools to address the issue of reflexivity (Berger, 2015). The interviews were conducted during observation and were audio-recorded and transcribed with informed consent.

The following chapters present some of the results of the Ph.D. research project. Regarding the qualitative data collected through the interviews, the main demands that death care professionals faced during the pandemics will be presented in the first study. The second study focuses on the quantitative relationship between a specific job demand (secondary traumatic stress) and two particular resources (work ability and vicarious posttraumatic growth) in death care professionals. The final study reports on the researcher's personal experience of the ethnographic study she carried out in a mortuary, from an autoethnographic perspective. This is followed by some concluding remarks on the main findings and some indications for practice.

STUDY 1.

Psychosocial Demands in Death Care During Covid-19: a Qualitative Study on Italian Workers*

The outbreak of COVID-19 was a major shock to the world's population, bringing with it a range of governmental, societal and individual challenges. Unpreparedness for this unforeseen event made it difficult to manage the pandemic, especially the policy of containing the virus. There were several abrupt changes in the social environment: the lockdowns imposed in many cities led many people to stay at home, which radically changed lifestyles, and many activities shifted to remote work (Grandi, Sist, et al., 2021). However, some professions were still "in presence" to ensure the continuation of services defined as "essential". In the field of care services, healthcare professionals were on the front line to respond to the ongoing emergency, facing a situation full of uncertainty, a high workload and a high risk of contagion. The interest in the working conditions and health of these workers has been remarkable, both from the media and the point of view of research (Vizheh et al., 2020). Surprisingly, another professional group that continued to perform an activity considered essential on a social level, namely the death care workers, has received little attention regarding the physical, biological and psychosocial risks they were exposed to during the pandemic. In fact, professionals in this sector have also been on the front line – as healthcare and emergency

* Grandi, A., King, N. and Colombo, L. (*in review*). "Psychosocial Demands in Death Care During Covid-19: a Qualitative Study on Italian Workers", *Journal of Health Psychology*.

service workers – as they are responsible for the preparation, disposal and burial of bodies at a historical moment when mortality has been very high and when funeral practices have undergone profound changes. To date, few studies have examined the critical situation experienced by death care workers during the COVID pandemic (Clavandier et al., 2021; Durand-Moreau & Galarneau, 2021; Van Overmeire et al., 2021; Van Overmeire & Bilsen, 2020); further research is therefore needed to gain deeper knowledge about this particular professional context.

Background

The funeral industry sector, better known as death care, includes professionals who work in mortuaries, crematoria, cemeteries and funeral directing services. Their work includes all tasks ranging from receiving the body of the deceased to burial or scattering of the ashes, and therefore involves constant exposure to death. An important part of their job is also to support the relatives of the deceased, who need guidance and support in organising the funeral at a time of potentially great suffering. The role of the death care professional therefore involves a high degree of responsibility and organisational, technical and relational skills.

Death care work can be physically, mentally and psychologically demanding. The psychosocial risks to which these workers are exposed due to the work context in which they are employed have been studied for several years, albeit only scarcely. From a mental and physical health perspective, anxiety and depression (Cegelka et al., 2020; Goldenhar et al., 2001; Guidetti et al., 2022; Keith, 1997), work-related stress (Bailey, 2010; Bartlett & Riches, 2007; Goldenhar et al., 2001; Kroshus et al., 1995) and occupational burnout (Guidetti et al., 2021; Smith et al., 2009; Tetrick et al., 2000) have been identified. Results of recent studies have also examined the negative consequences of over-exposure of these professionals to death and suffering, recognising the risk of secondary traumatic stress and

vicarious traumatisation (Colombo, Emanuel, and Zito 2019; Grandi, Rizzo, and Colombo 2023; Guidetti et al. 2022) and emotional dissonance (Guidetti et al., 2022). Death care has also been studied in particular with regard to its relationship with occupational stigma, a phenomenon that is still current among those who work with death and can have a serious impact on the private, social and professional lives of these people (Guidetti et al., 2021; Soria Batista & Codo, 2018; Thompson, 1991).

According to the literature, death care professionals can turn to several resources to compensate for the negative consequences of their work. Among professional resources, for example, organisational support was found to be an important element (Cegelka, Wagner-Greene, and Newquist 2020; Guidetti et al. 2021; Tetrick et al. 2000; Grandi, Rizzo, and Colombo *in press*), along with professional identity (Emke, 2002; McCarthy, 2016; Szkil, 2016; Thompson, 1991) and the use of coping strategies, such as humour (Grandi, Guidetti, et al., 2021). From a personal perspective, the attribution of value and meaning to work has been shown to be a valuable resource against the occurrence of occupational burnout (Guidetti et al., 2021). In addition, the opportunity for personal growth following direct and vicarious work-related traumatic experiences was found to be another important resource for these professionals (Grandi et al., 2023).

During the COVID-19 pandemic, death care work fundamentally changed due to the restrictions and new regulations imposed by the government to ensure public health and safety. As there was no scientific evidence of the actual infectivity of Covid corpses (Mahajan et al., 2020; Suwalowska et al., 2021), precautionary measures were introduced in the handling of potentially infectious corpses. This change had a particularly strong impact on the work of funeral directors and mortuary staff, who could no longer come into direct contact with the corpse and thus lost the opportunity to dress and care for it in an appropriate and dignified manner (Clavandier et al., 2021). Together with the

suspension of funeral ceremonies, this state of affairs had a major impact at the social level, preventing a healthy ritual process of farewell, which is essential for the elaboration of grief (Turner & Caswell, 2020). The high mortality rate also led to serious difficulties in managing spaces to accommodate bodies and coffins (Clavandier et al., 2021) and has significantly increased the daily workload that must be managed to ensure the continuity of funeral services. The impact of the pandemic on the death care sector has so far been analysed in terms of the biological risks to which they have been exposed (Mahajan et al., 2020; Van Overmeire & Bilsen, 2020) and mental health outcomes (Durand-Moreau & Galarneau, 2021; Hicks et al., 2022; Van Overmeire et al., 2021). On the other hand, little research has been done on the difficulties encountered in complying with the new ways of working (Clavandier et al., 2021; Mas'amah et al., 2023; Moreras, 2023).

This study therefore seeks to understand, through the lived experience of death care workers, the main critical problems they faced during the first wave of the pandemic, the most difficult phase to manage due to the general unpreparedness of governments and the health system. The study focuses in particular on the experience in Northern Italy, which was the first area in Europe to be significantly affected by the pandemic.

Theoretical framework

The Job Demands-Resources Theory–JD-R (Bakker & Demerouti, 2014; Demerouti & Bakker, 2023) was used as a theoretical framework. JD-R states that each occupation is characterised by specific job demands and specific resources, whether occupational, personal or social. Job demands (e.g. workload, emotional strain, role conflicts, unfavourable work environment, etc.) refer to physical, psychological, social and organisational aspects that require adaptive efforts and an expenditure of psychophysical energy from the person. On the other hand, resources include the physical,

psychological, social and organisational aspects that enable work goals to be achieved and that can mitigate the impact of job demands on psychophysical discomfort outcomes. The JD-R theory also predicts outcomes in terms of indicators of malaise, but also in terms of well-being at work. It is therefore designed to identify both the risk factors that can increase discomfort and decrease well-being and health, and the protective factors that can promote motivation, engagement and well-being at work. Recently, the JD-R has been extended to include more factors related to crisis management in the framework, making it more suitable for the current pandemic context. Specifically, more factors were considered, namely the characteristics of the work context, the organisational procedures implemented, the interactions with people inside and outside the organisation and the social and personal sphere (Demerouti & Bakker, 2023).

MATERIALS AND METHODS

Data Collection

The participants were selected from the funeral agencies, mortuaries and crematoria of the provincial capital and some neighbouring municipalities of Piedmont (Northern Italy). The study included a convenience sample of 29 death care workers, 19 women and 10 men, aged 26-58 years and with 1-32 years of service in the sector. The employees worked in various areas of death care: funeral directing (6), crematoria (9), mortuaries (14).

In order to try to better understand the experiences of the professionals, a qualitative research design was chosen, involving semi-structured interviews. All sessions were held at the participants' place of work, on the days and at the times that they themselves described as most convenient. The

research is in line with the Declaration of Helsinki (with the Edinburgh revisions of 2000). The project has been approved by the Bioethics Committee of the University of Turin (Prot. no. 0598340).

The interviews were conducted between 2021 and 2022 and were audio-recorded with the consent of the participants; they ranged from 18 to 119 minutes in duration (mean length 55.6 minutes). During the sessions, the safety protocol in force under Italian law (wearing a mask and sanitising hands) was followed. The interviews were fully transcribed, and anonymised with the use of alphanumeric codes.

The interviews were conducted by the first researcher who was assisted by one Work and Organizational Psychology student, and one intern, who in turn took on the role of observer.

In order to explore the participants' professional experience, some more general questions were asked first, aimed at obtaining information about the respondent's professional background. Subsequently, the questions became more specific and aimed to delve into the difficulties encountered in the daily performance of the job and the strategies or resources used to cope with the most critical situations at work during the pandemic period. At the end of each session, space was left for respondents to provide further information/comments.

Data Analysis

The transcripts were read several times by the researchers in order to familiarise with the data. The analysis technique chosen is Template Analysis–TeA (Brooks et al. 2015), a particularly flexible thematic analysis approach appropriate to organisational contexts, as already demonstrated in other studies in different work contexts, including in the death care (Grandi, Guidetti, et al., 2021). A special aspect of TeA is that it offers the possibility to include some themes defined in advance – so

called *a priori* themes – in the analysis process that might be relevant. However, these themes must be considered provisional, as they can be changed or eliminated if they are not conducive to the analysis (J. Brooks et al., 2015). The first version of the template was created based on the coding of the data from the first three transcripts. The identified categories were grouped into significant clusters in a hierarchical manner, creating an initial template. The preliminary coding of the first transcripts was then applied to all the transcribed material and changes were made where necessary. An iterative process was followed until the final version of the template that could be applied to all transcribed data was achieved (see Table 1). The researchers coded the data independently. They then came together to discuss similarities and differences and to define and redefine themes accordingly. The method of analysis used was paper and pencil.

During the research, attention was paid to the issue of reflexivity (Berger, 2015), by writing field notes, which were useful to improve self-awareness in relation to the emotions that could arise during the interviews and any prejudices and/or bias.

Since TeA allows the use of theoretically-derived *a priori* themes, the Job Demands-Resources Theory–JD-R (Bakker & Demerouti, 2014; Demerouti & Bakker, 2023) was used as a theoretical framework.

Results

The analyses identified five main themes related to the critical issues faced by death care professionals during the pandemic, with varying numbers of subthemes; these are presented in detail below.

1. CHANGES IN FUNERAL PRACTICES	**2. WORKLOAD**
1.1. Treatment/Disposal of the body	**2.1. "Huge numbers" to deal with**
1.1.1. New procedures in death care work	2.1.1. Shifts, overtime and increased on-call work
1.1.1.1. Problems with the procedures	2.1.2. Increased pressure
1.1.1.2. Lack of knowledge about the funeral sector	2.1.3. Greater responsibility on supervisors
1.1.2. COVID vs non COVID deaths	
1.1.3. No sight of the body	**3. OVEREXPOSURE**
1.1.3.1. Problems with the recognition	**3.1. Deaths at home (Covid/non Covid)**
1.1.3.2. Bodies not well groomed	**3.2. Bereaved not respecting the regulations**
1.1.3.3. Inability to provide part of the "psychological support	
1.2. Relationships with the bereaved	**4. STIGMA**
1.2.1. Changes in "taking" the funeral service	**4.1. "Making money with death"**
1.2.1.1. Losing the meaning of the work	**4.2. Seen as corpse carriers/plague spreaders**
1.2.2. Difficulty in explaining the new regulations	
1.2.2.1. Scepticism of the funeral professionals	**5. LACK OF SUPPORT**
1.2.2.2. Bereaved reactions	**5.1. Practical**
1.3. Funeral ceremonies	5.1. General practitioners and Civil Status Registrars
1.3.1. Ceremonies with no relatives	5.2. No inclusion in the vaccination plan
1.3.2. Restricted numbers	5.3. No inclusion in PPE delivery
	5.2. Psychological

Table 1. Final template.

THEME 1. CHANGES IN FUNERAL PRACTICES

This theme captures the most important changes that have occurred in the performance of death care work, as experienced by our participants. In particular, it covers the way in which the bodies were handled, the relationship with the bereaved and the management of funeral ceremonies.

1.1. Treatment/Disposal of the body

Like many other professions, the death care industry had to change the way work was done to adapt to government regulations put in place at the beginning of the COVID-19 epidemic to contain the virus and protect public health and safety.

New pathways were established for mortuaries to follow when recovering bodies from hospital wards, to ensure a clear separation between "clean" and "dirty" pathways (with higher risk of virus infection). Specifically, this meant that the operator was dressed in PPE, arrived outside the ward, placed the body on a stretcher and returned to the mortuary. The new route was longer, went through the basement to avoid the gaze of staff from other departments/offices and, according to the operators, was much more strenuous, partly because the recovery was sometimes carried out by a single member of staff and the body could be excessively heavy. The body was already disinfected by the ward (wrapped in a sheet soaked in a chlorine solution) and delivered sealed in a bag. The task of the morgue worker was therefore to retrieve the body and bring it to the morgue premises, where it was absolutely forbidden to touch it in any way. The Covid deceased were placed in special areas to separate them from the deceased from other causes. This new procedure was a precautionary measure with regard to the possible infectivity of the corpses, a topic that was still being discussed scientifically during the first wave of the pandemic. The funeral chambers (chapels of rest) were no longer set up, as mourners were not allowed to visit the body and keep watch near it.

Funeral directors had to adapt to the regulations of the healthcare facilities – which were not always the same and differed depending on the hospital – and were no longer allowed to enter the mortuaries. They only had to deliver the coffin – the bottom of which had to be covered with a protective layer to contain any leaks, a so-called "barrier", – collect the deceased (already in a bag) and close the coffin as quickly as possible. The same applied to the nursing homes.

In the crematoria, the work was limited to disposing of the coffins, as the funeral ceremonies were suspended; the cemeteries instead were closed.

In the experience of the participants, the general unpreparedness for the pandemic and the lack of knowledge of the funeral sector on the part of the bodies in charge of drafting the new regulations led to the creation of new rules and procedures that were not always appropriate. For example, the Civil Protection Department had required that an additional external zinc coffin be used when transferring a Covid deceased person from home to the cemetery. According to the funeral directors, this procedure was not justified, as transporting the same type of deceased from home to the crematorium did not require this measure, although the dynamics of the transport were the same. In addition, the outer zinc was very heavy to carry and had no handles, so there was a risk of operators dropping it (and injuring themselves) during handling due to its heavy weight and slippery surface. A funeral director adds:

> *"...they are not prepared, that is, at the government level, our rulers do not know what happens to people when they die, regulations, things... they do not care" [4FC, Funeral director]*

It was initially impossible for some mortuary staff to identify the bodies, as the bracelet of the deceased had been left in the sealed bag. It was only after some staff reported this that ward staff were asked to also attach a copy of the bracelet to the outside of the bag.

The extreme confusion that prevailed in the early days of the pandemic and the hectic pace with which the work was carried out cast doubt on the correct diagnosis given to the deceased. According to some employees, deaths from causes other than Covid were also misdiagnosed as "Covid". This is evident from several interviewees, such as a mortuary worker explained:

> *"Huh... some yes, but because there... … maybe the nurse or the doctor on the early shift who left something, there was the one who was handed over,*

maybe they didn't speak to each other, and then one thing was another. So yes, that happened...” [3CO, Mortuary worker]

A fundamental change that has taken place at a professional level is the fact that funeral directors and mortuary staff could no longer see the deceased. Dealing with "faceless corpses" had a major impact on operators:

"...You don't even see the faces of the people you bring down, and… the fact that you don't even know who you're taking down was devastating because it dehumanises everything." [20MR, Mortuary worker]

"...they came in bags and there was practically nothing left of the human side." [13AL, Mortuary worker]

In practice, this led to problems with the identification of bodies with the result that there was a risk of confusion between the deceased. The issue of professional responsibility was also repeatedly raised by professionals: funeral directors, for example, had to sign a form stating that they recognised the body, which was objectively impossible as they could only see a sealed bag. In addition, this new regulation meant that funeral directors and mortuaries could no longer take care of the body – one of their main tasks – so the bodies could no longer be dressed and cared for. This task has always been very important, as seeing the loved one well-groomed and in a relaxed, almost sleeping position is seen as a relieving element in the grieving process, a kind of "psychological support" for the bereaved.

1.2. Relationships with the bereaved

The need to comply with the new health and safety provisions, as we have seen, lead death care workers to change their usual – and entrenched – way of working, which also led to significant changes in their relationship with bereaved clients. Funeral directors, for example, had to minimise contact with their clients and tried to receive them in their offices where possible to avoid the risk of entering their homes. If this was not possible, they tried to limit their presence in the home by finding alternative ways to get them to leave or hand over documents (e.g. these were left on the doormat and then sanitised, or were sent by email). The most important consequence of this new way of working was the loss of direct contact with the bereaved. Physical presence and the ability to be there for the bereaved in times of great suffering is an essential part of the work of death care professionals. This lack, evident in all interviews, undermined the value and importance that professionals placed on their work. An employee of a crematorium recounts:

> *"... We realised that... We cannot give what we have to give, that is, what are we doing? We load and unload and in this matter there was a bit of alienation, there was a bit of imbalance for us emotionally as well... So you lingered from time to time, maybe went into the furnace room, put your hand on a coffin and wanted to, I don't know, say hello to him/her, somehow [...] [we lost] the human part that we have... We were missing a piece." [27ZC, Crematorium worker]*

Even from the words of the funeral directors and mortuary workers emerged the sense of "emptiness" experienced in a time that required "aseptic" methods of contact:

> *"... The impact, that is, the biggest one was to stop going to the families, to stop having the management of the funeral as a ceremony, because in any*

case it was no longer a ceremony, it was basically just transport, doing everything online, in the sense that we were kind of used to getting in touch with people... instead you sent them the photos, explained the numbers and did everything over the phone, then you sent the documents, they signed them and then you came to collect them..." [4FC, Funeral director]

"That period there left me with a bit of sadness, an emptiness, also the different way of working, no longer having contact with the families. [...] I missed that, yes, I really missed the human relationship with the people, because it was all very aseptic." [13AL, Mortuary worker]

It was a daunting task for death care workers to communicate the new regulations to the bereaved. Explaining to the bereaved – most of whom had seen their loved ones being taken away in an ambulance – that they would never see the body again was said to be one of the most difficult tasks, especially as the operators themselves were sceptical about the implementation of this ban:

“I tried to do my best, because it was difficult for me too... to make people understand something that I could not imagine either, because frankly... it was also difficult for me to have to explain to them: «You can't see your relative because... is contagious», also because we were told that it was no longer contagious at the time of death, so you had to explain to them something that you were not even convinced was so…. it was not easy.” [3CO, Mortuary worker]

Although some of the bereaved gradually understood and accepted this new reality, others reacted aggressively to this imposed deprivation and vented their resentment against the operators, who were merely executors of the procedures decided from above. The morgue staff said that they had

to send some bereaved people to the Health Directorate because they could not control their anger and they threatened to call the police to enable them to see their loved ones. There were also reports of bereaved people who were not sure if it was really their relative lying in the closed coffin because they could not identify him/her.

1.3. Funeral ceremonies

The nationwide lockdown was accompanied by government decrees that suspended funeral ceremonies. This took place in both churches and crematoria and was seen as a major social problem: in fact, the funeral ceremony is a fundamental step in the process of coping with grief. Only a limited number of people could be present to accompany the coffin to the crematorium. There were situations in which more people wanted to attend and the death care workers had to explain with difficulty that the rules had to be followed; others in which the people who wanted to be present were quarantined so that no one was present except the funeral director in charge of the funeral service.

> *"No farewell, no relatives, nothing... Zero. Zero. Ten people at the first lockdown, ten people just relatives, so if there was a friend, they already couldn't attend. [...] I did funerals without anyone I filmed live with Whatsapp the funeral for relatives who were maybe either in quarantine or in isolation or in another region." [1MF, Funeral director]*

THEME 2. WORKLOAD

During the outbreak of the pandemic, the workload of death care workers increased exponentially, as the high mortality rate led to "huge numbers" that had to be dealt with. In the crematoria, work had to be organised in shifts to ensure that the facilities could operate around the clock, and on-call duty increased considerably for the funeral directors. In addition, both funeral directors and mortuaries were under constant pressure from hospitals to "close the coffins as quickly as possible", so that the former had to constantly "race" to deliver the coffins in the shortest possible time and facilitate the latter's encasement of the body and then closing them. In general, an increase in overtime was reported across all professions to cope with the heavy workload.

The exponential increase in mortality has caused serious problems in the management of the spaces, as the facilities were not prepared to receive such a large number of bodies and coffins: from 25 funerals per day in the main city, peaks of around 70 were reached during Covid.

Special rooms were used in the mortuaries to accommodate all the Covid bodies. The funeral chambers (chapels of rest) and in some cases even the chapels within the hospitals were used as storage rooms for the sealed coffins.

> *"So there were rooms where there were coffins on the floor at the time, because maybe there were 20 closed coffins in one room of the [name of hospital]. They used the funeral chambers. Sometimes the chapels were also used: there are often chapels in the mortuary, the chapels were used for Covid coffins. So that's what it looked like" [4FC, Funeral director]*

The crematoria had to hire external refrigerated containers to accommodate the large number of coffins and store them in appropriate and dignified conditions.

Although the suspension of funeral ceremonies has partially reduced the management time of the funeral service and attempts have been made to better organise arrival and departure times to facilitate the work of the operators, the high number of bodies to be managed has led to an increase in the time required to carry out the activity in the crematoria. If the average time from the arrival of the coffin to the delivery of the ashes used to be 1/2 day, it had increased to 7/10 days at the beginning of the pandemic. In fact, the average daily number of cremations in the main city had increased from 24 to 50.

The high number of bodies and sealed coffins and the hectic pace with which the work was carried out on a daily basis also required more time from the operators to carry out all the necessary checks and ensure that they "didn't make any mistakes".

> *"...In the quiet moments I took it all back in and checked everything again, because during the day there was a lot of movement, the phone kept ringing, a lot of people, and so maybe there was a typo and a date, I don't know: 11 instead of 12, let's fix it. That's taking each other, saying «Okay, everybody stop, let's get on with it, cross-check, look». We do that on a daily basis, but of course in less time and also with a fresher mind… instead there, with the fiftieth document I see today, I squint, I write nonsense, let's wait a moment."*
> *[15CL, Crematorium worker]*

Finally, another element that led to an increase in workload was the greater responsibility placed on the shoulders of supervisors. Not only did they have to keep up to date and orientate themselves in the applicable regulations, but they also had to bear the burden of implementing and constantly monitoring the safety procedures that had to be applied in their work environment to ensure the

protection of workers. They also had to be able to answer workers' many questions about the current situation and make decisions about major changes in working practices.

> *"…It was coordinating, just learning how to manage and make the right decision, with everyone asking you the question «but now this, the other, how do we do that...», so it was one question that you had to give an answer to... It was intense, really intense..." [27ZC, Crematorium worker]*

THEME 3. OVEREXPOSURE

Although efforts were made to reduce contact with the bereaved, some funeral services were held in the mourners' homes for the funeral directors. This led to an increased risk of exposure to the virus, especially if the cause of death was not communicated to professionals in time.

Another factor reported was the failure of the bereaved present at home to comply with the regulations and the failure to report their possible positivity to the virus. Some funeral directors have reported several cases of going into homes and finding people without masks there to welcome them. Some of them had Covid and had not thought to communicate this to the professionals.

> *"... right at the beginning, a lady called me one day and said, «Huh listen, I wanted to tell you that my aunt did the swab, but I forgot to ask the doctor, she was [Covid] positive», I told her, «Huh well, madam, we dressed her, encased her!», [...] Or people who told you, «Listen, three days ago, I accompanied my [deceased] uncle on the hearse... I just wanted to tell you that I'm [Covid] positive», so even on the hearse, at a certain point, we didn't let anyone on because it was a risk..." [18PR, Funeral director]*

THEME 4. STIGMA

An important theme that emerged in the interviews is the aura of stigmatisation that these professionals felt during the pandemic. Some workers reported incidents in which they were treated by customers or laypeople as if they were spreading the virus.

> *"They were afraid to see us, I think they thought we were a bit of plague spreaders. We sensed it, that is, I sensed it, in the sense of «No, no, I will stay at home, we can solve this differently»." [5VG, Funeral director]*

> *"I came [home], I came back from work, there were all the neighbours on the balcony sunbathing quietly and someone who was also making jokes because my wife also works in a hospital, saying, «Huh, but you are from the healthcare service, then we have to stay away from you», idiotic jokes… really" [20MR, Mortuary workers]*

Workers employed in crematoria or funeral directing also had to deal with the widespread opinion at the time that they were "making money from death".

> *“... I mean, they were all heroes, and the funeral directors were the bitchy arseholes who got rich off people's deaths." [15CL, Crematorium worker]*

> *"«It went well for you, huh!» so... Okay, if you say so... It's always, «Of course you make money from death, it went well for you last year!»” [1MF, Funeral director]*

This issue is a source of discomfort, if not annoyance, for the participants, who pointed out that although they had a greater economic return than in previous years (which, however, was not as high), it is necessary to consider the context. Indeed, requested funeral services were much cheaper

than traditional ones, as there were no more ceremonies, customers chose simpler (and cheaper) options; moreover, many customers opted for cremation, which requires less money than burial. In this context, some death care professionals still argue that mortality has demographic trends, so they assume that they will work less in the coming years.

> *"...and now we know instead that [work] will decrease a lot because it is natural. And therefore also at the level of investments that may be made, or simply in the taxes that we will pay... now this year we are paying last year's high taxes [smiles] and maybe this year we are working less. So you are always there, even from an economic point of view, to travel on sight. That's another problem in our job, that you do not know what's going to happen until the end of the year... that means you can make predictions, but only up to a certain point." [1MF, Funeral director]*

THEME 5. LACK OF SUPPORT

During the pandemic, while death care professionals tried to reach out to each other to provide funeral services, they also encountered a lack of support on several fronts. Difficulties were reported with the general practitioners, some of whom did not want to enter patients' homes to determine the causes of death (and therefore possible Covid infection).

> *"Yes, I understand, but if you're afraid, I'm afraid too... that is, the [Hippocratic] oath... you did it, I have not done it [smiles], that is, I am working, you have taken the oath... Yes, and then in any case, the Prime Minister's decree said that I must know beforehand in order to intervene,*

because when I have a Covid [body], I bring a certain type of coffin and the deceased is also cared for differently…" [4FC, Funeral director]

Further difficulties arose from the lack of co-operation from Civil Status Registrars, especially in the first period, which was the most critical. Despite the high mortality rate in the hospitals, the offices did not extend their opening hours to facilitate the completion of the paperwork related to the death and did not allow the electronic transmission of the documents until a later date.

Other situations in which workers perceived a lack of support were, in their view, related to the lack of recognition of their professional category. In particular, they had great difficulty in obtaining the PPE required by the regulations, as they did not belong to the "risk groups" to which the equipment had been distributed. Furthermore, although they belonged to the few categories working "in presence" and in possible contact with the virus, they had not been included in the vaccination plan. This omission was described as very serious and as a symptom of a lack of knowledge and recognition of the professional sector. In fact, only mortuary staff, who are recognised as part of the healthcare sector, were subjected to the first vaccinations. Funeral directors and crematorium workers had to "join the queue" and wait their turn, like the rest of the non-healthcare population.

"...it made me angry, I wrote to the Ministry of Health, to the President of the Republic, I did not know where to write anymore, that the guy who does the maintenance of the hospital boiler was... [vaccinated]. We who went to the mortuary were not a protected category, we went into the houses... [...] We were also at the frontline, but nobody paid any attention to us" [18PR, Funeral director]

"Right during the first lockdown, the first wave, we obviously spent many hours at work, like healthcare workers, because... But nobody, really nobody

– neither the media, nor the newspapers, the radio, nobody – paid any attention to the work of the death care..." [12GG, Crematorium worker]

Of course, working in the death care sector involves being constantly confronted with death. During the pandemic, the very high number of bodies to be managed, the hectic pace with which the work had to be carried out and the impact that the loss of contact with the bereaved had on the staff, as well as the experience of empathising with their suffering, left its mark. They lacked psychological support to share and process their experiences during a traumatic time.

"...neither at the level of the hospital nor at the level of the company. There was no psychological support... No, we had to come to terms with it, as we always have. In the moment of the pandemic, at the height of the pandemic, you do not want that, but as soon as it subsides: «Okay, let's stop for a moment, let's sit down, let's see how you are doing guys. Are you all right?» Then it hits you after a while, huh... [...] I think we needed some psychological support." [14AS, Mortuary worker]

Discussion

The aim of this study was to understand, through the lived experience of death care workers, the main critical problems they faced during the first wave of the pandemic. Therefore, the narratives of several professionals from the mortuary, crematorium and funeral directing sector were collected to understand their experience in depth and five particularly relevant themes were identified in relation to the critical issues they faced.

The first issue addressed the impact that changing funeral practices have had on death care workers. Like all other professions, the death care sector had to adapt to the new health and safety regulations to contain the virus. One important element that emerged from the narratives is the lack of knowledge about the funeral sector on the part of the institutions. The regulations were issued without factual knowledge of the context in which they were to be implemented and without the involvement of the professionals concerned. Unfortunately, this situation is not limited to the local/national context, but has also been highlighted at the international level (Clavandier et al., 2021). The new regulations for the treatment of the body provide for disinfection, isolation and immediate closure, thus excluding any type of contact by staff. On the one hand, this procedure should meet the need for prevention and protection, as there was no scientific evidence of the possible infectiousness of the bodies. Indeed, the treatment of the bodies of those who have died in epidemics is an issue whose practical, socio-cultural and ethical implications remain to be clarified (Mahajan et al., 2020; Suwalowska et al., 2021). On the other hand, one of the main impacts that the change in work activity had since the introduction of this new procedure was the loss of a central aspect of the role of funeral directors and mortuary staff. One of their main tasks is to take care of the body and hand it over to the bereaved well cared for and well placed in the coffins as a dormant. This is in fact an important element in facilitating the final farewell to a loved one and thus easing the grieving process (Colombo, 2022; Thompson, 1991). In the absence of this fundamental part of the work, the professionals experienced "emptiness" and a sense of dehumanisation in the face of all these "faceless bodies". Furthermore, the lack of the usual contact with the bereaved called into question the meaning of their work: if they could no longer offer (psychological and practical) support to families at the loss of a loved one, "what were they doing?". To compensate for this negative feeling, all professions tried to dignify somehow the deceased despite the strict regulations: from mortuary workers and funeral directors who placed their clothes over the body bag before

closing the coffin, to crematoria, who found dignified solutions for storing the coffins. The suspension of funeral ceremonies was another restriction related to the containment of the virus, which unfortunately had far-reaching consequences on a social level (Carr et al., 2020; Mas'amah et al., 2023; Zavattaro et al., 2021), which funeral directors tried to compensate for by taking the place of absentees and/or filming the event to allow people to attend remotely (Clavandier et al., 2021).

As a result of the exponential increase in mortality, the daily workload has increased considerably, which has led to several difficulties. First and foremost was the need to provide funeral services which required a considerable commitment from the staff. Work shifts were organised and increased, a lot of overtime was worked and constant availability was required. Another problem which the staff were not prepared for was the storage of bodies and coffins, which arrived in considerable numbers compared to the maximum capacity of the premises. To deal with this new situation, it was necessary to utilise the existing rooms differently and, as in the case of the crematoria, to rent containers that could hold all the coffins. The latter solution in particular is due to the professionalism with which funeral work is carried out, i.e. the desire to preserve the dignity of the deceased, who would otherwise have been roughly "piled up" outside, at the mercy of climatic conditions that were not always favourable. As they had to guarantee a public service, these professionals always worked during the pandemic, taking a serious risk of contracting the virus (Van Overmeire & Bilsen, 2020). Funeral directors in particular took a considerable risk, as they had to visit the homes of the bereaved, albeit to a lesser extent than before. Failure to comply with current regulations, such as not wearing a mask or not reporting the infectiousness of corpses or bystanders in a timely manner, created a state of overexposure to biological risk. These behaviours were attributed by the interviewees to a lack of consideration for death care work.

Another important topic that emerged from the participants' stories is related to stigma. Death care work has always been associated with stigmatisation (Thompson, 1991) and still is due to the denial of death in contemporary society: those working in this sector are in fact “a living symbol of a dreaded subject” (Stephenson 1985, p.223). One of the main factors why these professionals are surrounded by stigmatisation is that they earn their living from activities that are still considered taboo and are seen as those who make money from the death and suffering of others (Thompson, 1991). Although death care workers have attempted to combat this aura of stigma over time by emphasising and reinforcing their professionalism and the importance of their work (Guidetti et al., 2021; Thompson, 1991) it appears that their efforts were thwarted during the pandemic in favour of a return to stereotypical views. They are people who get rich from death and even become spreaders of the virus. Although these professionals are used to living with a certain aura of stigma associated with their profession, this feedback from public opinion was perceived negatively and as a lack of recognition of the value of their profession and the active contribution they have made during the global crisis.

A final theme that emerged in the interviews related to the lack of support perceived by the death care sector. In particular, a lack of co-operation between general practitioners and Civil Status Registrars was reported, which made it difficult to carry out the work. The decision not to include the death care sector in the vaccination plan caused disappointment – if not anger – and was perceived as a further lack of recognition of their professionalism and commitment "on the frontline" during the pandemic. In addition, the lack of psychological support to deal with the traumatic experiences during the pandemic was perceived as showing a disregard for the risk that their profession entails.

These results are also consistent with the theoretical framework of the JD-R (Demerouti & Bakker, 2023). It has been shown how the pandemic has profoundly changed the working context of death care. The psychosocial demands identified are closely related to the introduction of new procedures that brought new challenges, such as the absence of important parts of their professional role, a high workload and responsibility, and stigmatisation, all conditions that had a significant impact on their professionalism and the meaning of their work.

Notwithstanding the new insights that this study contributes to knowledge about the field of death care during the recent pandemic, its limitations should also be pointed out. Firstly, due to the qualitative nature of the study, the findings correspond to the perceptions of a limited number of participants and should therefore not be generalised to a wider national context. Furthermore, as the focus of the study was on understanding the main critical issues faced by death care professionals during the pandemic, protective factors were not investigated.

Further research is needed to understand also what resources had an impact on offsetting the negative effects of these demands and to promote a possible motivational process during these difficult times.

Conclusions and Practical Implications

From the results of this study, it is clear that most of the challenges faced by the death care professionals during the COVID-19 pandemic were largely due to a lack of knowledge about the professional sector, both on the part of the government and public opinion. Surprisingly, while much attention was paid to the healthcare sector – which tried to "save lives" – little was paid to those who cared for the dead (…a failure of the healthcare system, some may say). In this context, the

question arises: what would have happened if the death care sector had not guaranteed the funeral services? Based on the findings of this study and this final question, it is hoped that a greater awareness of the role of these professionals can arise. While research in this area is slowly expanding, particularly with quantitative studies that aim to measure and understand the relationships between certain factors which death care workers have faced during the pandemic (Grandi, Rizzo, and Colombo 2023; Van Overmeire et al. 2021; Durand-Moreau and Galarneau 2021; Grandi, Rizzo, and Colombo *in press*) it is important to remember the role that qualitative research can play in this area. Precisely because, as we have seen, the death care sector is little known, capturing the lived experience of these professionals can help to better understand the underlying – or hidden – dynamics that they deal with on a daily basis and that would be difficult to measure. Furthermore, by overcoming the taboos of engaging in "dirty work" and the fear of their own personal resonance in relation to death and bereavement, researchers could engage in immersive ethnographic experiences that allow them to see the challenges that death care workers deal with on a daily basis “with their own eyes".

STUDY 2.

Secondary traumatic stress and work ability in death care workers: The moderating role of vicarious posttraumatic growth*

Introduction

Death is a fundamental and inevitable aspect of life, yet dealing with it is a difficult task for many. Dealing with death means confronting our finitude as human beings, the uncertainty of how much time we have left, and the awareness of what will happen to the body we have inhabited when we have left it. Professionals in the field of death care are those who, despite the difficulty of the task, take charge of the entire process of caring for the body – from the moment of death to burial/ash scattering – and relieve the bereaved of some of the burden of loss; in this sense, they could be placed under the category of the helping professions.

Death care encompasses several services, including cremation services, funeral services (such as funeral directors, pallbearers), mortuary services (and forensic work) and cemetery services. Workers in all these areas are constantly exposed to the sight of coffins and/or corpses (in various states of decomposition) and the suffering of the bereaved due to the specific nature of their work (Cotrim et al., 2020; Goldenhar et al., 2001; Guidetti et al., 2022; Keith, 1997; Pinheiro et al., 2012; Roche et al., 2022; Sehgal & Sethi, 2016). Overexposure to trauma and narratives of traumatic

* Grandi, A., Rizzo, M. and Colombo, L. (2023). Secondary traumatic stress and work ability in death care workers: The moderating role of vicarious posttraumatic growth. *PLoS ONE*, 18(7), e0289180. https://doi.org/10.1371/journal.pone.0289180

experiences can lead to secondary traumatic stress in workers. This type of exposure is considered a serious occupational risk, as trauma in the work context can lead to significant negative effects on psychophysical health, such as anxiety and depression (Bock et al., 2020). Trauma work can also significantly affect workers' job performance (Bock et al., 2020) and reduce workers' perceptions of their ability to meet the mental and physical demands of the job (Cotrim et al., 2020). It is important to note that individuals exposed to traumatizing situations at work can also experience positive outcomes. Vicarious posttraumatic growth is possible when the worker is able to find new meanings and develop personal growth after experiencing trauma.

The aim of this study is to examine the relationship between occupational trauma exposure, the capacity of death care workers to overcome traumatic events, and their perceptions of work ability in a currently under-researched work context, such as death care. The theoretical framework used is based on the Job Demands-Resources Theory, JD-R (Bakker & Demerouti, 2014) and the Conservation of Resources Theory, COR (Halbesleben et al., 2014; Hobfoll, 1985, 1989). The first model assumes that a balance between job demands and job and personal resources can reduce negative consequences (not only from a work perspective, such as disengagement, but also in terms of psychophysical health, such as exhaustion) and can have positive effects, e.g. in terms of employees' health, commitment and job satisfaction (Bakker & Demerouti, 2014). The importance of resources was widely studied and valued by Hobfoll, who argued that people tend to protect their resources and develop new ones, also because they can be useful protective factors during stressful events (Halbesleben et al., 2014). In this framework, it is also claimed that resources can mitigate the relationship between demands (threats) and negative outcomes, which is consistent with the assumptions of JD-R theory (Xanthopoulou et al., 2007). According to the JD-R and the theoretical framework of COR, exposure to trauma is a feature of death care and can therefore be considered a

job demand. Vicarious posttraumatic growth is the result of a process of living through trauma that leads to the acquisition of a new and deeper view of the world. In this sense, it can be considered a very important resource in the death care, which can help to balance the job demands. Finally, workers' perception of their own ability to work is another resource that can be undermined by exposure to trauma at work, but at the same time can be enhanced if other resources such as vicarious posttraumatic growth are present.

Secondary Traumatic Stress

The literature on trauma and its effects – both short- and long-term – is extensive, but indirect exposure to trauma has only recently been studied. The term secondary traumatic stress (STS) was introduced to describe the negative effects experienced by those in close contact with trauma victims (Figley, 1995). This category includes workers who are indirectly exposed to trauma because of the specific characteristics of their jobs, such as providing assistance to people who have been physically or psychologically abused, to victims of road, domestic or workplace accidents, and people grieving the loss of a loved one. Emergency workers (Argentero & Setti, 2011), police officers (Acquadro Maran et al., 2020), firefighters (Bastug et al., 2019; Serrano-Ibáñez et al., 2022), social workers (Bride, 2007; Wagaman et al., 2015), mental health professionals (Buchanan et al., 2006; Robinson-Keilig, 2014) and death care workers (Colombo et al., 2019; Guidetti et al., 2022), because of their constant exposure to trauma, are among the occupational groups at highest risk for secondary traumatic stress, which is considered a serious occupational risk. The symptomatology to which secondary traumatic stress is attributed is that of post-traumatic stress disorder (PTSD), the main features of which are intrusion – re-experiencing the traumatic material in an unwanted way –

avoidance – avoiding emotions or stimuli related to the traumatic event – and arousal, i.e. increased physical excitement/tension (Figley, 1999).

It should be noted that the term secondary traumatic stress is used interchangeably with the term of vicarious traumatization (Bourke & Craun, 2014). Although they share some similar features, secondary traumatic stress refers more to "socio-emotional symptoms" (Craig & Sprang, 2010) and it is associated with PTSD symptoms (Bride et al., 2004), while vicarious traumatization is considered more of a change in mental patterns due to empathic work with trauma victims (Pearlman & Saakvitne, 1995).

Several studies have shown that STS is related to negative psychophysical outcomes (Greinacher et al., 2019), such as anxiety, and depression (Bock et al., 2020). Also, some sociodemographic characteristics seem to be related to STS, such as female gender, older age, and seniority (Greinacher et al., 2019). Factors that play a protective role include social support, affective commitment and role clarity, and personal resources such as mindfulness and resilience (Greinacher et al., 2019). Non-functional coping strategies for dealing with STS include instead denial, alcohol and tobacco use, and negative humour (Greinacher et al., 2019).

In one of the few studies of death care work STS scores were found to be higher in workers who had less frequent exposure to corpses (Guidetti et al., 2022); STS scores were also higher in workers involved with bereaved families, along with higher scores for secondary traumatic self-efficacy and perceived gratitude, suggesting that these workers may have developed personal resources that can protect them from the negative effects of secondary trauma (Guidetti et al., 2022). Another study of a sample of cemetery workers found that those workers most exposed to traumatic events at work (gravediggers and front office workers) had higher STS scores (Colombo et al., 2019).

Work Ability

The interest in work ability (WA) stems from occupational health research to "predict" work capacity in the aging population. One of the most commonly used definitions of the construct is that of Tuomi and colleagues, namely "How good is the worker at present, in the near future, and how able is he or she to do his or her work with respect to work demands, health, and mental resources?" (Tuomi et al., 1991, p.67). In over 30 years of research on this construct, it has been widely demonstrated that WA is able to predict important aspects of occupational health, such as early retirement (Tuomi et al., 1997), disability, and mortality (Von Bonsdorff et al., 2011). Recently, efforts have been made to promote WA to improve the quality of life of aging workers. Indeed, a good level of WA is associated with good psychophysical functioning in workers upon retirement (Tuomi et al., 2001). It is important to note that work ability is not a personal characteristic of the worker, but is given by the interaction between job demands and the worker's personal resources (Tuomi et al., 1997). Research on work ability has focused on various occupational groups, such as teachers (Guidetti et al., 2018; Viotti et al., 2017, 2019), administrative employees (Sottimano et al., 2019), healthcare professionals (Knezevic et al., 2011; Marina Fischer et al., 2006), construction workers (Alavinia et al., 2009), bus drivers (Kloimüller et al., 2000), and petrochemical industry employees (Mazloumi et al., 2012). Although work in the death care sector is both physically and emotionally demanding, only one study has been conducted. Cotrim and colleagues (Cotrim et al., 2020) investigated the psychosocial factors influencing WA in a sample of Portuguese cemetery workers. Compared to other occupational groups in the same country, such as municipal employees, WA scores were lower. The study also showed that burnout, temporary impairment, job satisfaction, and quality of leadership were predictors of WA along with age and general health. In general, few studies have focused on workers exposed to different types of trauma. Results showed lower scores for WA and

PTSD symptoms compared to unexposed workers (Fichera et al., 2009; Klasan et al., 2013; Tehrani, 2018a) and also a negative association between WA and fatigue, workload, and frustration (Rostamabadi et al., 2017).

Vicarious Posttraumatic Growth

The term “posttraumatic growth” (PTG) appeared for the first time in the mid-1990s in two works by Tedeschi and Calhoun (Tedeschi & Calhoun, 1995, 1996). Posttraumatic growth refers to the positive changes an individual experiences after an event *lived as* traumatic (Calhoun & Tedeschi, 2004; Tedeschi et al., 2018). The emphasis on individual perception is a characteristic aspect of PTG. According to the definitions of the psychiatric classification systems, “trauma” is associated with life-threatening events and PTSD symptoms (see APA, 2013; 1980; 1994), that is more focused on objective characteristics. Calhoun and Tedeschi (Tedeschi et al., 2018), on the other hand, also consider the subjective component and define trauma as “a highly stressful and challenging *life-altering event*” for a particular person (Tedeschi et al., 2018 p.8), thus contributing to a broader definition. This extended view is more appropriate as the definition of a traumatic experience can change over time and vary according to culture (Tedeschi et al., 2018). Posttraumatic growth can thus occur after a trauma – a crisis or very stressful event – that causes individuals to break their mental patterns, their known world, and create new patterns. The phenomenon consists of five areas: 1) a greater appreciation of life and a changed sense of priorities, 2) warmer relationships, 3) a greater sense of personal strength, 4) recognising new possibilities or paths for one's life, and 5) spiritual development (for those who are not religious, greater existential questions) (Tedeschi & Calhoun, 2004). The authors proposed an instrument, the Posttraumatic Growth Inventory (PTGI), to measure and quantify this type of personal growth (Tedeschi & Calhoun, 1996), and more recently

developed a short form (PTGI-SF) (Cann et al., 2010). To date, this instrument, which has been translated and validated in many languages, is the most widely used to assess posttraumatic growth (Tedeschi et al., 2018).

While many studies on PTG have been conducted on the general population in the context of the experience of various traumas, such as vehicle accidents survivors (Nishi et al., 2010; Wu et al., 2016), cancer patients (Danhauer et al., 2013; Marziliano et al., 2020), bereaved parents (Engelkemeyer & Marwit, 2008), disaster survivors (Holgersen et al., 2010), refugees (Powell et al., 2003), prisoners of war (Erbes et al., 2005; Feder et al., 2008), this phenomenon has also been studied in workers for some years. Certain work contexts are indeed characterized by a strong and frequent – sometimes daily – exposure to traumatic events, such as healthcare, emergency services, social work, death care or the police sector. When the experience of posttraumatic growth is associated with exposure to direct and indirect trauma, it is referred to as vicarious posttraumatic growth (VPTG). Professionals in the above fields work with people who have suffered trauma and are simultaneously affected by the same traumatic events (Tedeschi et al., 2018). As emerged from the systematic review by Manning-Jones and colleagues, some features of PTG are recognizable in VPTG, such as changes in life priorities and values, spiritual growth, increased personal growth and improved social relationships. Although VPTG falls under PTG – understood as an umbrella term – it should be noted that it has some distinctive features. The domain into which these unique changes fall is professional identity. In contexts where vicarious posttraumatic growth occurs, significant associations have been observed with higher job value (Lonergan et al., 2004), improved occupational skills (Shamai & Ron, 2009) and, generally, a greater sense of professional competence (Manning-Jones et al., 2015). Some factors that facilitate VPTG have also been identified. Empathy in the relationship with traumatized clients, for example, appears to help professionals feel the

traumatic experience as if it were their own, which facilitates VPTG (Cohen & Collens, 2013; Manning-Jones et al., 2015). Positive affect and optimism also promote VPTG. An optimistic and positive outlook on life may more readily lead to recognition of positive outcomes after a vicarious trauma experience, as demonstrated in Linley and Joseph's study of a sample of funeral directors (Linley & Joseph, 2005). Interestingly, in the same study, the authors found that negative affect was also closely associated with VPTG, confirming that it is necessary *to go through* the traumatic experience in order to develop VPTG (Linley & Joseph, 2005). Another important factor is self-care, understood as coping strategies to maintain psychophysical wellbeing. Several studies have shown a positive association between VPTG and self-care activities such as exercise, healthy eating habits, hobbies and spiritual practices (Manning-Jones et al., 2015). Regarding factors affecting the interpersonal domain, social support seems to promote coping and adaptation after trauma and reduce isolation and feelings of loneliness (Manning-Jones et al., 2015). A final factor that may promote VPTG is time. It seems that the distress experienced by professionals working with trauma decreases over time, in favour of the development of greater personal growth, as if time allows the traumatic event to be integrated and new meanings to be found, thus favouring VPTG (Manning-Jones et al., 2015).

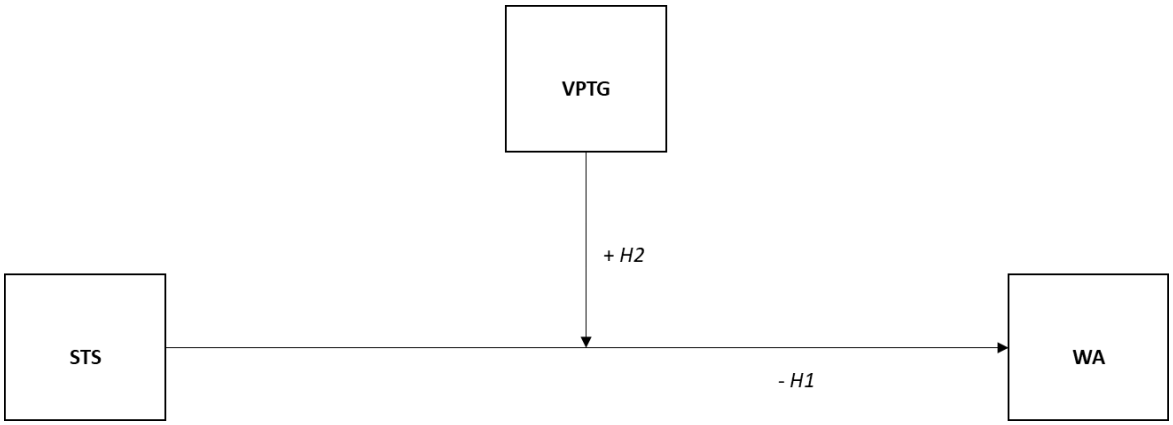
While VPTG has been studied in the context of helping professions, such as healthcare and emergency workers, there are currently few studies conducted in the death care work. The study by Linley and Joseph (Linley & Joseph, 2005) found that positive changes following contact with death in funeral directors were associated with positive attitudes towards life and social support. Another study looking at funeral work found a higher quality of family relationships, greater understanding of clients' grief, an approach to death as a natural and inevitable event, and a greater appreciation of life (Natsikou et al., 2016). The positive impact of dealing with death and trauma at work was also

found in military mortuary workers, who reported personal growth and improved coping skills as positive outcomes of mortuary experience (Flynn et al., 2015).

Given the results found in the literature, it is of particular interest to delve deeper into the relationship between trauma exposure outcomes, work ability and vicarious posttraumatic growth in a neglected field such as the death care sector. According to the literature discussed so far and the theoretical framework of Job Demands-Resources Theory, JD-R (Bakker & Demerouti, 2014) and Conservation of Resources Theory, COR (Halbesleben et al., 2014; Hobfoll, 1985, 1989), our model (see Figure 1) supports the following hypotheses:

Hypothesis 1 (H1): *Secondary traumatic stress (STS) is negatively associated with work ability (WA).*

Hypothesis 2 (H2): *Vicarious posttraumatic growth (VPTG) has a moderating role in the relationship between secondary traumatic stress (STS) and work ability (WA).*



Note. STS = Secondary Traumatic Stress; VPTG = Vicarious Posttraumatic Growth; WA = Work Ability

Figure 1. Conceptual model.

Method

Participants and Procedure

The present study was conducted in accordance with the guidelines of the Declaration of Helsinki (and subsequent revisions) and the ethical requirements of Italian legislation and approved by the Bioethics Committee of the University of Turin (protocol code no. 0598340).

The professional reference sector is complex in terms of organization and accessibility compared to other sectors, therefore a convenience sampling method was chosen and the sample size was not estimated in advance. The funeral agencies of the provincial capital and some neighbouring municipalities, the mortuaries of the main provincial hospitals and the municipal mortuary, the provincial offices of the cemeteries and the provincial crematoria were contacted.

A self-report questionnaire was prepared and distributed in hard copy to participants at times and dates agreed with employers/managers who agreed to participate in the study. The questionnaire was accompanied by a sheet explaining the aims of the study and how the data would be processed (in accordance with EU Regulation 2016/679). To participate in the study, workers had to read and sign the consent form. The researcher attended the meetings and presented the research project and the objectives of the survey to clarify any doubts the participants might have. The response rate was 90% of the distributed questionnaires. The questionnaire did not provide for the collection of personal data and participants did not receive any compensation; in addition, the consent form signed by the participants was collected separately from the questionnaire so that it was not possible to trace it back to the individual participant.

A total of 259 participants completed the questionnaire. Five participants were excluded because they had not completed at least one item of the scales under study. Eighteen participants were

excluded because they could not answer the items on secondary traumatic stress because they did not interact with other people during their work. A multivariate test for outliers using the Mahalanobis distance also revealed five participants as outliers, who were then excluded from the analyses.

The final sample to test our hypotheses included 231 participants (70.1% males) aged 20 to 74 years (M = 45.3, SD = 12.2; one case was missing for this variable). The socio-demographic characteristics of the respondents are shown in Table 1. In terms of the profession reported by the participants, the majority worked in funeral services (132; 57.1%), followed by mortuary services (57; 24.0%), cremation services (37; 16.0%), and cemetery services (13; 5.1%). Since six participants worked in more than one service, the sum of these four areas of work exceeds the total number of the sample (cf. Table 1).

Measures

The measurement scales used in the study are all validated instruments with good consistency and reliability in the literature. The STS and WA have been used in previous research on death care (Colombo et al., 2019; Cotrim et al., 2020; Guidetti et al., 2022). The PTGI was selected because it has been used in samples of helping professions, such as emergency workers (Shakespeare-Finch et al., 2003), that share similar characteristics (e.g. exposure to death and contact with the bereaved).

Secondary traumatic stress was measured with the 17 items of the Secondary Traumatic Stress Scale (STSS) developed by Bride and colleagues (Bride et al., 2004). The instrument is composed of three subscales, intrusion, avoidance and arousal, but for the purposes of this study only the total score was used. Responses were on a 5-point Likert scale (1 = never; 5 = very often); an example item is “I

avoided people, places, or things that reminded me of my work with clients". The total score ranges from 17 to 85. A low or no STS is indicated by a score ≤ 28, a mild level by scores between 28 and 37, a moderate level by scores between 38 and 43, a high level of STS by scores between 44 and 48, and a severe STS by scores ≥ 49 (Bride, Radey, et al., 2007). In the original validation study, the Cronbach's α was .93, while in this study was .90.

Work ability was measured using the Work Ability Index-2 (WAI2) (Ebener & Hasselhorn, 2019), a 2-item scale that asks workers to rate their perceived current work ability in relation to the physical and mental demands of their job on a 5-point Likert scale (1 = very poor; 5 = very good); the total score ranges from 1 to 10.

Vicarious posttraumatic growth was measured with the 10 items of the Posttraumatic Growth Inventory-Short Form (Cann et al., 2010; Prati & Pietrantoni, 2014) on a 6-point Likert scale (0 = not at all; 5 = very much); the total score ranges from 0 to 50; an example item is "I changed my priorities about what is important in life". As there is currently no specific measure to assess VPTG, most studies use the same measure developed for direct trauma survivors (Manning-Jones et al., 2015). When using the scale, reference is not made to personal specific trauma, but to traumatic exposure related to the person's occupation. The Cronbach's α was .89 in the original validation study, while in this study was .92.

	N	*%*
Sex		
Female	69	29.9
Male	162	70.1
Marital status[a]		
Single	85	36.8
Married/Cohabiting	112	48.5
Separated/Divorced or Widowed	33	14.3
Children[b]		
Yes	131	56.7
No	96	41.6
Educational level[c]		
Middle school diploma	93	40.3
High school diploma	109	47.2
Associate degree or higher	28	12.1
Professional sector		
Funeral Services[d]	132	57.1
Cremation Services[d]	37	16.0
Mortuary Services[d]	57	24.7
Cemetery Services[d]	13	5.1

Note. N = 231. [a] 1 missing value; [b] 4 missing values; [c] 1 missing value. [d] 3 participants are both in funeral and cemetery services; 1 participant is both in mortuary and cemetery services; 2 participants are in both funeral, mortuary, and cemetery services.

Table 1. **Characteristics of the sample.**

Data Analysis

Statistical analyses were performed using Statistical Package for the Social Sciences (SPSS 28.0), and a regression model with moderation was tested using Hayes (2019) PROCESS (version 4.1, model 1).

In a preliminary phase, multiple imputation (MI) was performed after we determined that the data were not missing completely at random. The percentage of missing values for each scale studied ranged from 0.4% to 0.8%. To test our hypotheses, secondary traumatic stress (STS) was the independent variable, vicarious posttraumatic growth (VPTG) was the moderating variable and work ability (WA) was the dependent variable. Having children or not, job tenure, and exposure to bereaved clients (recoded as a dummy according to the median value of the ordinal variable) were used as control variables in the model, as they had been identified in previous studies (Bride, Jones, et al., 2007; Thieleman & Cacciatore, 2014) as possible confounders of the relationships under study.

To assess power for moderation analysis with a sample size of 231 and an alpha of 0.05, a post-hoc power analysis was performed using Gpower 3 software (Faul et al., 2007), with linear multiple regression, fixed model and R^2 deviation from zero. As recommended, a power of at least 0.80 is acceptable for social science (J. Cohen, 2013).

Frequencies, means and standard deviations were calculated to summarize the variables included in this study. Pearson correlation (r) was used to test the relationship between variables and results were interpreted according to Cohen's conventions (Cohen, 1988). Standardized coefficients (ß) and 95% confidence interval (CI) were calculated. The reliability of each scale was determined using the Cronbach's alpha coefficient with at least three items per scale.

The Johnson-Neyman technique was used to test for statistically significant interactions in the relationship between secondary traumatic stress and work ability. This technique was used to identify areas of significance in the moderator variable (vicarious posttraumatic growth).

Results

Before testing the hypotheses under investigation, some preliminary analyses were performed. The normality assumptions of the regression model were tested. A graphical inspection of the residuals using the Q-Q plot and a scatterplot of the residuals to test homoscedasticity showed no relevant violations of the assumptions. In addition, the Durbin-Watson score (2.09) confirmed the independence of the residuals of the multiple regression models. A test for multicollinearity was performed and the VIF values were all below 5. To test for common method bias, Harman's single factor test method was used in an exploratory factor analysis. One factor, which included all variables examined, confirmed that the first factor extracted (eigenvalue > 1.0) explained 25.3% of the total variance, less than 40%, which could indicate method bias (Podsakoff et al., 2003).

The bivariate correlation and descriptive statistics are shown in Table 2.

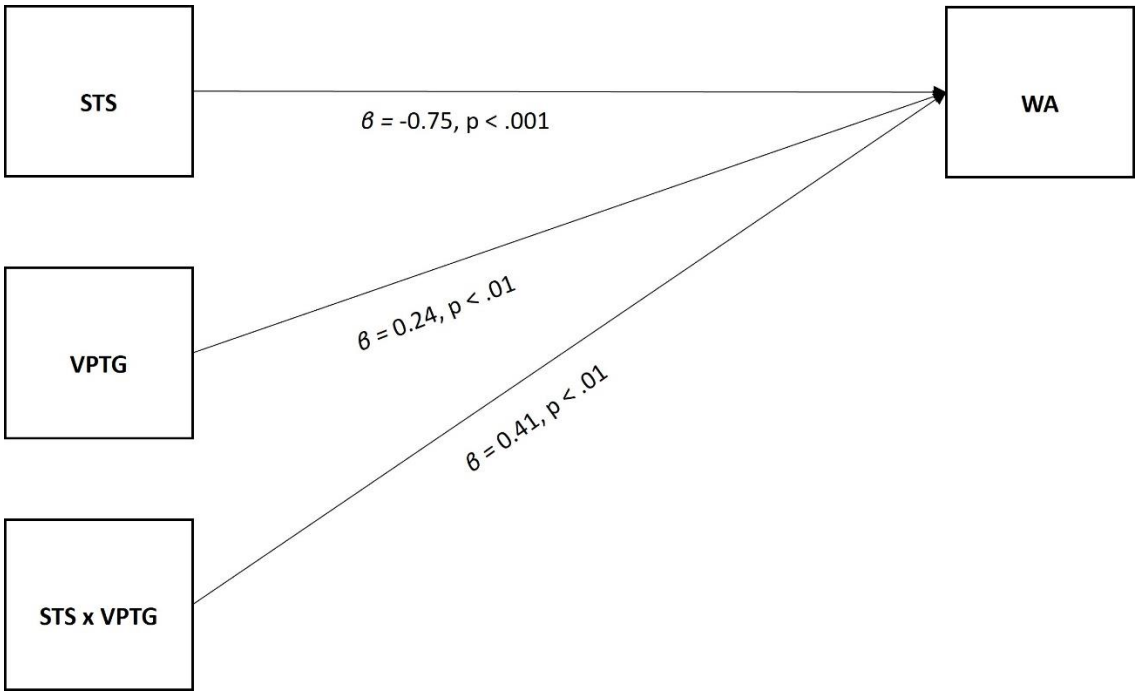
	M	*SD*	1	2	3	4	5	6
1. STS	0.70	0.59	—	-0.06	-0.36***	0.09	0.08	-0.11
2. VPTG	2.80	1.24		—	0.19**	0.17**	0.02	-0.19**
3. WA	6.23	1.39			—	0.01	-0.05	0.06
4. Job tenure	12.38	10.84				—	—	—
5. Children	—	—					—	—
6. Exposure to bereaved clients	—	—						—

Note. N = 231. STS = Secondary Traumatic Stress; VPTG = Vicarious Posttraumatic Growth; WA= Work Ability. ***p < 0.001; **p < 0.01; *p < 0.05

Table 2. Mean, standard deviation, and bivariate correlations between scale study variables.

STS was not correlated with VPTG, while a negative correlation was found between STS and WA, VPTG was positively correlated with WA. Among the control variables, a significant negative correlation was found only between VPTG and exposure to bereaved clients (0 = exposure).

Regarding the results of the moderation model (see Figure 2), the hypotheses were partially confirmed.



Note. STS = Secondary Traumatic Stress; VPTG = Vicarious Posttraumatic Growth; WA = Work Ability.

Figure 2. Results of the regression model with interaction effect.

The direct association between STS and WA was negative and statistically significant (B = -.75, S.E. = .15, 95% C.I. (-1.03, -.46), p < .001), confirming H1. The association between VPTG and WA was positive and statistically significant (B = .24., S.E. = .07, 95% C.I. (.10, .39), p <. 01). The interaction between STS and VPTG was positive and statistically significant (B = .41., S.E. = .12, 95% C.I. (.17, .65), p < .01). Together, the variables accounted for approximately 20% of the variance, R2 = .20, F (6,219) = 9.3, p < .001. A non-significant association emerged between the control variables and WA.

Regarding the conditional effect of the interaction term, the Johnson-Neyman (see Figure 3), the technique showed that the effect of STS on WA was significant for values of VPTG below 0.90, which partially confirms H2. This implies that the effect of STS on WA is strongly negative when the moderator (VPTG) is low. When the moderator (VPTG) is high, the effect of STS on WA towards 0.

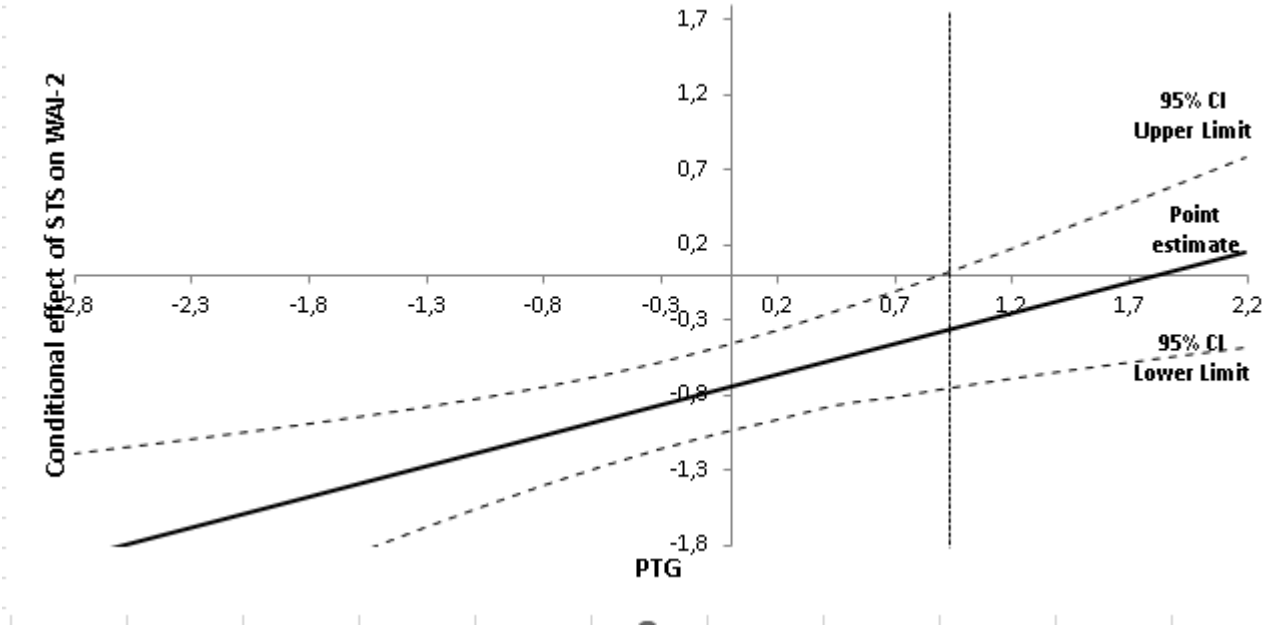


Figure 3. Results of Johnson-Neyman technique.

Discussion

The aim of the present study was to examine the role of vicarious posttraumatic growth in workers who are continuously exposed to trauma at work. Given the lack of studies in the literature, the results obtained are particularly interesting and contribute to new knowledge about this occupational field.

The first hypothesis of the study (H1) states a negative relationship between secondary traumatic stress and work ability. As we have seen, secondary traumatic stress corresponds to the

symptomatological framework of PTSD and is experienced by people who live traumatic situations indirectly, for example through their work. Higher levels of activation, intrusive thoughts of traumatic memories and avoidance behaviours towards emotions or stimuli that remind people of traumatic events are symptoms that can make workers more vulnerable and affect their ability to work in the long term. This hypothesis was confirmed by the analyses, and although the association between STS and WA has not been examined in previous studies in the field of death care work, this finding is consistent with other studies in other professions that deal with trauma. For example, in the study by Bock and colleagues (Bock et al., 2020, 2022), nurses who reported more severe STS symptoms reported higher levels of depression, anxiety and work stress, and lower work ability; and in another study of police officers working in child protection, work ability was a good predictor of secondary trauma (Tehrani, 2018b).

Regarding the second hypothesis (H2), we have argued that vicarious posttraumatic growth plays a moderating role in the relationship between STS and WA. VPTG describes the set of positive changes that can occur as a result of experiencing traumatic events directly and indirectly. A distinguishing feature of the construct is the necessity of *living through* the traumatic experience: it is not possible to avoid it. With this in mind, it was necessary to consider symptoms related to working with trauma in the model. The results of the analysis partially confirmed the second hypothesis (H2). VPTG indeed seems to have a significant moderator role in the relationship between STS and WA when VPTG scores are low or moderate; its role as a moderator loses statistical significance when VPTG scores are higher. This result is interesting because it suggests the protective role of VPTG against STS. It underscores that stress related to traumatic experience loses significance when individuals have experienced growth. This finding is consistent with previous research on workplace trauma, which found that VPTG moderated the effects of STS in therapists who worked with trauma survivors

(Samios et al., 2012). The study highlights the stress-buffering effect of VPTG and suggests that higher VPTG may have helped therapists reinterpret challenging and threatening aspects of their work, leading to a lower experience of secondary traumatic stress (Samios et al., 2012). Moreover, this result seems to be consistent with the definition of the VPTG construct; the kind of growth that VPTG leads to indeed includes a greater appreciation of life, a changed sense of priorities, and warmer relationships; all of these new achievements can contribute to living difficult work environments, such as those of trauma-work, in a more balanced way and consequently experiencing lower levels of stress. A greater sense of personal strength, typical of post-traumatic vicarious growth, may be another element that improves workers' perceptions of their ability to do their work in terms of available physical energy and required mental energies.

These results are also in line with the proposed theoretical framework. We have seen that occupational exposure to trauma is one of the typical work demands in death care. This psychosocial risk factor may lead to an increase in perceived work ability where there is growth of the individual. This confirms the protective role of resources in relation to job demands as supported by the JD-R model, as well as the gain spiral created by acquiring new resource, as postulated by the COR model.

These findings highlight the importance of supporting personal growth processes in a work environment where individuals are constantly exposed to traumatic events.

Conclusions

Death care is a professional sector that has received little research attention, making it essential to better understand the protective factors that can maintain employee wellbeing.

The findings of the present study provide new insights into the role of vicarious posttraumatic growth in work environments with daily trauma exposure and suggest that workers who develop these positive changes may improve their wellbeing and their work ability.

These results are particularly interesting in light of recent events related to the COVID-19 situation, where workload and trauma exposure have increased exponentially, severely scarring all workers involved in the frontline management of the emergency, including death care workers (Van Overmeire et al., 2021; Van Overmeire & Bilsen, 2020). Identifying the determinants of wellbeing in the workplace may allow targeted interventions to be designed, even at job induction, to provide workers with useful resources to cope with the negative consequences of the traumatic experience (Grandi, Guidetti, et al., 2021; Guidetti et al., 2021). For example, supporting the vicarious posttraumatic growth process and raising awareness of the importance of personal and professional self-care practices may be useful interventions to enhance wellbeing in the workplace.

Although the present study has brought new insights to the field of death care research, it is also important to note its limitations. Firstly, the sample size is not very large and a convenience sample was used. In addition, due to of the cross-sectional design, it was not possible to test causal relationships between variables.

Some other information, such as socioeconomic status, health status, access to psychological, social, medical and structural resources, perceived severity of working with trauma survivors and personal trauma history, was not collected; future studies could also include these variables, which could play an interesting role in the proposed model. Furthermore, because the sample was not evenly distributed across professional groups, it was not possible to examine differences in the association between the model variables in the death care professional groups. Future studies could examine these differences. Another limitation is that the instrument used to measure secondary traumatic

stress, namely the STSS, is based on the DSM-4 PTSD symptomatology. However, it is also important to note, that the literature argues that the DSM-4 symptoms can still approximately measure the DSM-5 diagnosis (Rosellini et al., 2015).

Finally, in the future it would be interesting to use samples from different countries to also investigate cross-cultural differences and to think about longitudinal models to also explore the dimensions of causality.

STUDY 3.

Six Months in the Morgue… *and Still I Rise*. An Autoethnographic Essay[*]

Introduction

Talking about death is not easy. Dealing with it can be an even more daunting task. Confronting death means facing the fact that the time we have left to live is limited and may end sooner than expected. This awareness can open the door to deep fears about our own finiteness and that of our loved ones. Death has always been a natural event that characterises life, but over time the way it is treated in society has changed. In the past, death was an event in which the whole community participated. The dying, who were aware of their imminent end and accepted it, were cared for in their homes by their relatives (Ariès, 1974). Nowadays, the relationship to death in Western society has changed profoundly. Partly as a result of the hospitalisation of care, death occurs much more frequently in hospitals or nursing homes, far away from home and the care of loved ones (Arfini et al., 2022; Ariès, 1974). In addition, today's society's drive to overcome its limitations has made it much more difficult to accept the precariousness of health and illness, leading to a constant search for new curative or life-prolonging treatments. These elements have turned death into something to be feared and defeated, almost as if the laws of nature themselves were to be defied.

[*] Grandi, A. (*in review*). Six Months in the Morgue… *and Still I Rise*. An Autoethnographic Essay. In Tripathi, K. and Lamond, I. (Eds), *Listening to Death's Echo: International Critical Autoethnographic Discussions on Death*. Palgrave Macmillan: London.

I have been involved in research into death care for several years, focussing on the quality of working life in this particular area. The existing literature shows how little this area of work has been researched over the years, despite being fertile ground for the study of phenomena of great interest, such as burnout, vicarious trauma, vicarious posttraumatic growth, to name but a few. This paucity of knowledge on death care could be related to the fact that these professions are rather "niche" and general knowledge about how they work is scarce. Another factor could be the difficulty for researchers to enter contexts in which it is impossible to avoid experiencing and processing strong resonances of a personal nature. Indeed, work and organizational psychology is largely concerned with organisational contexts, which we might call more "sheltered" from the point of view of the personal impact on the researcher, and ethnographic and autoethnographic research is very limited in this area of study.

Death care encompasses all professions involved in dealing with the death of a person, from the moment of death to the disposal of the human remains. In Italy, these are mortuary services (who are primarily responsible for the care of the body), funeral directing services (who are responsible for the organisation and management of funeral services), crematoria services (who are responsible for the "transformation" of the body and the performance of secular farewell ceremonies) and cemetery services (who are responsible for the burial and exhumation practices). An important role is also played by the coroners, who carry out the post-mortem examination in cases where the cause of death is unclear or the conditions that led to death are considered suspicious.

From 2017 to date, my work has mainly consisted of trying to fully understand these particular professional contexts by exploring the characteristics of the work and its underlying dynamics. To this end, I have carried out many visits in the different realities of the aforementioned work settings and interviewed many professionals to collect their professional history and their experiences in a

sector that is as fundamental to society as it is "almost completely unknown" and often stigmatised (Guidetti et al., 2021; Soria Batista & Codo, 2018; Thompson, 1991). Although my research path has led me to get to know and better understand this professional field, I felt the need to deepen my knowledge and try to "see with their eyes" the same reality that until then I had only known as an external observer. So, I began to consider the possibility of carrying out fieldwork where I could really experience first-hand what these professionals experience on a daily basis.

The choice of setting was clear from the outset: among the various sectors I could have chosen, the mortuary service was the one that most appealed to my professional curiosity and at the same time gave me the opportunity to face my fears of what happens "when we die". The mortuary is in fact the first place where the body of someone who has died in hospital is taken, and the staff of the service are responsible for the entire process of caring for and displaying the body. However, it took me a long time from conceiving the idea to putting the project into motion. One of the main reasons for this postponement was certainly the fear of "not being able to do it", of not being able to "stay" in such an emotionally charged and potentially traumatic environment: what would have happened if I had fainted on the very first day of work? What if I had felt sick in front of certain "ugly corpses"? From the many interviews I had collected, I had been told – without being stingy with details! – that certain corpses may already be in a state of decomposition or have various leaks, all conditions that make it more difficult even for the operators to deal with them. I was worried that, if something went wrong, I might perceive this experience as a personal failure... Thus, the limitations and difficulties were apparent from the start and contributed to my desire to take more time to decide if this was really the right path for me.

I firmly believe that research must be transformative; it must change the way the researcher sees the world. The experience I would likely face in the proposed ethnographic study certainly had the

potential to contribute to such a goal. At the same time, I believe that it is healthy to carefully assess the risks that the researcher can take in order to protect themselves from possible overexposure.

The factor that facilitated my decision making was that I also started to consider the resources that could support me. In my professional background, I have training in psychotherapy, which has led me to know myself well enough. Indeed, one of the foundations of the Gestalt approach – the approach I've be trained in and I still follow – is the idea that the therapist is one of the most important tools through which the therapeutic process takes place: it is therefore necessary to know this tool (oneself) well in order to manage important dynamics that may arise in therapy (e.g. projections, resonances, etc.). This awareness brought me a kind of serenity, because I realised that I would be able to listen to myself and recognise what was going to happen. My previous experience in death care also helped to give me the confidence that I would be able to somehow bear that environment. In addition to the detailed accounts of professional activity I had gathered, I also had opportunities to "test" myself in challenging situations, such as interviews in the vicinity of dead bodies. Finally, the realisation that it would be a "gradual" process of approaching the daily activity was another important element: I knew that I could say "no" if I felt certain situations were "over the top" (such as immediately attending autopsies).

This careful weighing up of the pros and cons was very useful. It helped me to feel more confident in my decision making, which ended with the decision in favour of this experience.

Context and Methods

The place I chose for the ethnographic project is the morgue of one of the most important hospitals in Turin, in the north-west of Italy. In recent years I have had the opportunity to visit various

mortuaries, and thanks to this opportunity I was able to make a prudent choice regarding the characteristics of the environment in which I could have this experience. Most mortuaries in Turin are contracted out to external cooperatives, so the staff are not "internal" employees of the hospital. Larger hospitals tend to have bigger complements of mortuary staff, who may even belong to two different cooperatives, a situation that makes the work dynamics even more complex. In addition, these cooperatives often also take care of job placement, so the decision to work in the death care context can be forced rather than deliberate. The organisation I chose is one of the few that has its own staff. The team seemed to stick together from the first meetings and the internal climate was serene. Also, most of the staff had years of experience in the field and were helpful and open to the research I was conducting with the research group of the Department of Psychology[†]. The path I would have taken with an ethnography would have been very difficult, so I thought that also relying on feelings that arose during the meetings and interviews might be helpful: I had perceived welcome and sensitivity from the people in this mortuary.

Having identified the setting and the working group after these considerations, I contacted the hospital management to see if this was a viable path for them. To my surprise, the medical director was positive from our first phone contact. A formal meeting followed where I was able to explain to her in detail what my research project would consist of, and where I was able to dispel her doubts about the processing of the data I would be collecting. Once I had received formal authorisation from the hospital, a meeting was arranged with the mortuary staff to determine together what my role would be. To avoid situations where I would have found myself in a "dual role", we decided that they would not introduce me to clients – if they asked – as a "psychologist". The risk would have been to create an expectation of my potential role as providing psychological support for the

[†] The project I am referring to is called "*Psycho-Social Risks and Quality of Working Life in Funeral Operators*" co-financed by Fondazione San Paolo and the University of Turin (P.I. prof. Lara Colombo).

bereaved. My badge was therefore labelled "Ph.D. student" and I was introduced as a researcher who wanted to better understand the work of mortuary operators. Once these details were finalised, I could officially begin my experience in the field.

The research approach I used was phenomenologically-informed ethnography and during the fieldwork I kept a diary in which I collected all my reflections and field notes. The period in which I conducted the ethnographic observation is approximately six months, from the end of December 2022 to the end of June 2023, so my work can be described as a rapid ethnography (Vindrola-Padros, 2021).

The mortuary opening hours are from 8.30am to 3.30pm, so my schedule was from 8.00am to 3.45pm to be present during the opening and closing periods. The staff usually arrive well in advance (sometimes even before 8.00 am) to start preparations, and before the official opening there is usually a social moment, a "coffee break", where they all go to the bar together, catch up on each other's personal fortunes and begin thinking about how to organise the day's work. I found this moment very important, so that I also wanted to take part in it. During the first weeks, I was present every day, then every other day.

In fact, for the first few weeks after I completed the entire work shift with them, I went home and started writing my observations (and took care of other work related to my Ph.D.) and did not finish until late in the evening. I remember one morning when we were preparing a body, Raul[‡] stopped for a moment, looked at me and said, "You must be very tired, of course... You work the whole shift with us, then you come home and start working again!" It was true. It was strange to hear someone say that. It was as if it was a recognition of a tiredness I did not want to feel: there was this idea in me that I *had* to be able to keep up with that pace. So I allowed myself to listen to my tiredness, and

[‡] The names in this chapter are fictitious names chosen by the workers themselves.

after thinking it over with them a bit, we agreed that it would be better not to overextend myself and try to go every other day, and indeed that turned out to be the better solution for me.

In the beginning, I simply observed the activity carried out and asked for information to better understand the practises used. Gradually, I began to participate more actively, first helping to prepare the body's clothes – they are taken out of the bag in which the relatives leave them and laid out on a table so that it is immediately clear in which order they must be worn and it is easier to take them – and then helping to put on the socks and shoes. Over time, thanks to job shadowing, I learnt to carry out all the tasks associated with the work: moving, cleaning and dressing the body, placing the body in the coffin, setting up the chapel of rest, giving information to the relatives and carrying out the necessary bureaucratic procedures.

During my ethnography, I collected data from documents reporting on official morgue procedures, direct observation, informal interviews, semi-structured interviews (conducted at the end of the ethnography) and field notes. An autoethnographic approach was chosen as it allows the researcher's personal experiences to be used to describe cultural beliefs, practices and experiences, to recognise and value the researcher's relationships with others and also to use reflexivity to explore the intersections between the self and society (Adams et al., 2015).

The experience was very rich and for the purposes of this chapter I have chosen to focus on just two main themes, the transformative side of working with death and one of the strategies that helped me work with death.

The transformative side of working with death

What struck me first, at the beginning of this important professional – and personal – experience was the ordinariness of death: if death is indeed an extraordinary phenomenon for laypeople, for those who work in the mortuary it is a constant, something you are confronted with every day, that you cannot "avoid" thinking about. This awareness leads to a different way of looking at reality and often to new resolutions regarding the way you live your life. In the interviews I have conducted over the years, this shift in perspective was often reported, and I always thought it was understandable. During the field experience, the visions and constant contact with death also led *me* to rethink the meaning of life and I realised how difficult it is to describe this process.

In the mortuary, most of the deceased arriving are elderly people, often with multiple illnesses, who had been long-term patients in the wards. Somehow, when dealing with these corpses, I was often helped by the thought – even after talking my colleagues who had more experience – that they had had a long life and, in the case of severe chronic and painful illnesses, that their suffering had finally come to an end. This last consideration was also supported by the fact that I often saw a "relaxed" expression on their faces and I liked the idea that they were "now" serene. This view helped me a lot in my practice as it gave me a sense of greater serenity. However, I know that death affects everyone, regardless of how long they have lived. The death of young people – especially those "younger than me" – has left a deep mark.

One day I learnt from my colleagues that the body of a young man had arrived. I went to room 10 (where the bodies are brought from the wards) and lifted the sheets on the stretchers there, but I could not find him. Later I entered the dressing room and saw my colleagues around a stretcher with the body of an older man on it (one of the ones I'd seen under the sheets earlier); they were preparing it, so I went over to help. It was the young man. He was 28/29 years old and had just

graduated. He had been diagnosed with fulminant cancer that had stripped him to the bone in a matter of months. I could not believe that that was the body of a young man... I had to check the bracelet on his wrist[§]. While dressing, the air was different, it was stuffy. None of us could speak. The parents had brought the clothes the young man had worn at his graduation...

Contact with the bereaved was something I had become accustomed to, and I had realised that there are different ways of experiencing grief. However, some people carry such a large field of suffering with them that it is impossible not to feel it and to feel compassion for them immediately. This was true of the young man's parents: they were devastated, and there were no words that could be said or even thought to alleviate that suffering.

I took that young man home with me. I remember seeing him again in the faces of strangers in the days that followed and the feeling I had felt at work was reactivated. This had never happened to me before. This feeling was a mixture of sorrow, sadness and anguish. Deep down, there was also the feeling that something wrong had happened: he was too young (...much younger than me!). Those were days of deep personal suffering, when what I had previously only heard and thought was "understandable" had become "true". A truth that I felt in my whole body and that brought fear and anguish with it: tomorrow everything could be over. And the questions I asked myself were: "What am I doing with *my life*?", "What is really important to me *now*?", "What do I *really* need?". Gradually, I realised that many things were no longer important and that it was easier for me "to let go" of things that I might have clung to in the past. The time I spent with my loved ones had changed in value, it had become much more precious and I was living it more intensely. "My time", or rather the feeling of having little time, had become "urgent" instead: I began to welcome or create opportunities without postponing them or putting them in periods that I thought would have been

[§] All bodies arriving at the mortuary wear an identification bracelet.

"better" (...to name a few, this year I have been to Scotland twice, a country I have always wanted to visit).

Another change that took place was my attitude to death, or rather to the dead body. The main task of the mortuary workers is to bring the deceased to their relatives in the most dignified way possible. The body is prepared so that it is cared for down to the smallest detail (men are shaved and women are made up and their hair combed if desired). All of this grooming seeks to facilitate the grieving process and convey a sense of "serenity": in fact, the body seems to "rest" at the end of the process.

The work in the mortuary makes clear how the body is "naturally" when it dies. The dead person is the one who comes directly from the ward: a body dishevelled in posture, half naked, sometimes dirty. Without dignity. This awareness had a strong impact on me. We die without dignity. I began to wonder how people would react if they could see the true picture of death. While I recognise the process that has led to our society needing these tools to make death "less scary", I wonder if a reality check can lead to a reappraisal of the true nature of death and a consequent awareness of what it entails.

Dealing with death work

Working with death can undoubtedly be hard work. According to the literature on this subject, one of the strategies that can prove useful in dealing with death is the use of humour. Humour appears in fact to promote a positive attitude towards the unpleasantness of death and is reportedly a useful way of strengthening cohesion among employees (Grandi, Guidetti, et al., 2021; McCarroll et al., 1993; Scott, 2007; Vivona, 2013). This strategy also seems to be helpful in dealing with anxiety,

reducing stress and emotional upset and keeping the fear of death at bay (Carden, 2001; Pringle & Alley, 1995; Thompson, 1991).

During the many interviews I had conducted as part of the previous research project, I found that professionals did indeed report this strategy and used it during the same interviews. This mode seemed to me to be a functional way to "lighten up" the topics we were talking about. However, laughing about topics related to death is not looked upon favourably from the outside, so the professionals stated that this is usually done in the backstage in order not to offend the sensitivity of the bereaved and also not to be judged as "insensitive" (Grandi, Guidetti, et al., 2021).

Working in the mortuary gave me the opportunity to experience first-hand how humour is used in death care. I remember saying several times when friends asked me about my experience that I had never laughed so much at work in my life! I laughed so much that I sometimes had tears in my eyes. And as I write this, it seems absurd: how can you laugh when you are dealing with dead bodies and mourners? You can. First of all, the place where this happens is really a private room, a behind-the-scenes place: the office when there are no clients, the changing room, the dressing room or other spaces in the back. The tasks of mortuary operators, although they would be extraordinary to many, are – as mentioned earlier – commonplace to them. Dressing the body, for example, is a series of activities that are carried out methodically and in one day you can dress up to 4/5 corpses: each phase is perfectly known and is carried out with gestures that are sometimes almost automatic. In other words, it is a series of "ordinary" daily activities. This ordinariness allows staff, for example, to talk while dressing and often tell funny anecdotes that happened to someone in the group. Sometimes you can also laugh about things that happen while dressing the body.

Leo and Raul made fun of me or joked every time I took the solution to sanitise the corpses because they thought I was using too much of it (... and they would soon run out of supplies because of me!): sometimes I only had to look into their eyes as soon as I picked up the bottle to start laughing.

One of the most important parts of humour is the ability to see the funny part of a situation. Once, after receiving the body of a woman, we noticed that she had marks on her neck, so we decided to cover them with a cloth. As the relatives hadn't brought one, we decided to take one from the closets[**] and Leo offered to get it. A small remark must be made in this regard: Leo is known to take very good care of male corpses, but less good care of the details of female corpses. He came back with a grey men's scarf that he thought was perfect. Brenda and I looked at the scarf and burst out laughing, because it looked very similar to the scarf Leo wore in the morning when he came to work... Clearly not an accessory for a woman!

There was no shortage of jokes in downtime either. In the first few weeks of work, I was in the office with Raul one afternoon. It was a quiet time, we'd already done the day's work and there were no clients in the office. At some point the phone rings. Raul answers it and greets the hospital director, then listens for a while with a worried expression. After a while he says that *I* am actually with him at that moment and continues with "do you want to speak to her?". He hands me the cordless phone, looks at me and tells me that the director wants to speak to me. I remember turning pale and being very worried (...had I done something wrong?). When I picked up the phone, a pre-recorded advertisement was still talking. Raul burst out laughing at the look on my face and after an initial reaction of annoyance, I burst out laughing too.

[**] Relatives sometimes bring additional clothing, and unused clothing is often left in the mortuary. These clothes are used in case of need or if the deceased have no one to take care of their burial.

In my experience, humour at work was a healthy component that helped to make the working day easier to live and also to normalise what we were doing. I recognize that humour was also sometimes used to help manage anxiety when the days were more emotionally challenging.

Humour also helped to create a bonding. Some jokes – such as the last anecdote I mentioned – I think also served as a kind of initiation, testing whether I was "one of them" and whether I was suitable to become part of the group.

Conclusion

In this chapter I have reported on some of my ethnographic experiences in a mortuary. The aspects I have focussed on, namely the "burden" of the work and the impact it had on me, and the humorous component, seem very distant from each other. Actually, they were a constant in my experience. Sometimes the transition from one moment to the next was so quick that it seemed like moving between different realities. Both helped to gain a deeper understanding of the experience of working in death care and also to "survive" it.

Feeling accompanied in this experience, thanks to the support of my wonderful colleagues, was undoubtedly a fundamental element. But it also required a lot of commitment and personal strength. The title I wanted to give to this chapter is a line from one of my favourite poems, by Maya Angelou. Although it goes back to a specific experience of the author, its verses are dedicated to resilience and determination in the face of life's adversities. Looking back, I realise that the journey was difficult, with strong resonance from a personal point of view, but it allowed me to confront my personal limitations and deep fears… *and still I rise.*

Ethics Approval

The ethnographic project was conducted according to the guidelines of the Declaration of Helsinki, approved by the hospital where the mortuary is located and by the Bioethics Committee of the University of Turin (Prot. no. 0630062). Informed consent was obtained from all subjects involved in the study, according to EU Regulation 2016/679.

Acknowledgments

At the end of this journey, I would like to pause for a few moments to honour the people who have accompanied and supported me.

Firstly, I would like to thank my supervisor, prof. Lara Colombo, for believing in the project and facilitating all the bureaucratic procedures so that I could have this experience on the field.

Brenda, Leo and Raul, *my colleagues* at the mortuary, for their welcome and support; through the many shared experiences I have grown personally and professionally.

A special thanks to prof. Nigel King for his constant guidance throughout my ethnographic journey and for his valuable comments on the first draft of this chapter.

Conclusions

The aim of the doctoral project was to better understand and explain the role of psychosocial demands and resources in Italian death care workers during the COVID-19 pandemic through a multi-method research approach. Given the lack of studies in the literature, the results contribute to new knowledge about this professional field. Indeed, the studies presented offer new insights into the factors contributing to the wellbeing of death care workers, who are among the professions struggling most with the effects of the pandemic.

Death care workers fall into the categories of work considered essential to society, which is why they are always on duty, even in times of crisis. The recent pandemic has emphasised the importance of their work and at the same time exacerbated their working conditions, increasing the risk factors for their occupational health.

The first study made it possible to understand in depth the experiences of a sample of Italian death care workers, through a qualitative research approach involving semi-structured interviews. The analysis of the results revealed several psychosocial factors that had a negative impact on the death care sector during the COVID-19 pandemic. It has been shown that the exponential increase in mortality has significantly increased the workload, requiring great effort and commitment from all professionals in death care to ensure the continuity of funeral services for citizens.

The results of this study also highlighted an important issue, namely the lack of knowledge about the funeral sector on the part of the institutions. This situation led to the adoption of regulations

that were not always practicable, as they were issued without factual knowledge of the context in which they were to be implemented and without the involvement of the professionals concerned. This topic is particularly relevant because it makes it clear that even today, working with death is still associated with little interest and a taboo. Despite the fact that – as we have seen – death care involves a whole range of tasks to support the bereaved, so that from this point of view it can be counted among the so-called "helping professions", it is still considered by many to be "dirty work", both because it involves contact with corpses and because it brings economic gains.

Although death care workers have attempted to combat this aura of stigmatisation over time by emphasising and reinforcing their professionalism and the importance of their work (Guidetti et al., 2021; Thompson, 1991), it seems that their efforts were thwarted during the pandemic in favour of a return to stereotypical views. They were seen as people enriching themselves from death and even becoming spreaders of the virus. Although these professionals are used to living with a certain aura of stigma associated with their profession, this feedback from public opinion has been perceived negatively and as a lack of recognition of the value of their profession and the active contribution they have made during the global crisis.

A lack of support on a practical and psychological level was also noted. A lack of co-operation from general practitioners and Civil Status Registrars was reported, which made it difficult to carry out the work. The fact that they were not included in the vaccination plan was a source of disappointment and was perceived as a further lack of recognition of their professionalism and commitment "on the front line" during the pandemic. Furthermore, the lack of psychological support to cope with the traumatic experiences during the pandemic was perceived as a disregard for the risk that their profession entails.

Finally, it was found that the significant changes that have taken place in relation to the performance of daily activities have had a strong impact on death care workers, causing them to lose a central aspect of their work, namely the support of the bereaved. Indeed, the impossibility of caring for the body, the limited possibilities of contact with the bereaved and the suspension of funeral ceremonies have cast doubt on the meaning and value that these professionals attached to their work.

These findings are also consistent with the theoretical framework of the JD-R (Demerouti & Bakker, 2023): it has been shown how the pandemic has profoundly changed the working context of death care and led to challenging psychosocial demands. In view of the findings, it should be noted that the Job-Demand-Control-Support Model (Johnson & Hall, 1988; Karasek, 1979) would also have been a suitable theoretical framework for the present study.

The second study focussed on the psychosocial demands and resources in Italian death care in order to explain the relationship between them and to gain further insights into dynamics that have been little explored in the literature to date. Particular attention was paid to the role of vicarious posttraumatic growth, i.e. positive changes that can be experienced by workers who are continuously exposed to trauma at work (Calhoun & Tedeschi, 2004; Tedeschi & Calhoun, 1996). Using a structural equation model, it was shown that secondary traumatic stress – understood as higher levels of activation, intrusive thoughts of traumatic memories and avoidance behaviour towards emotions or stimuli reminiscent of traumatic events – can make workers more vulnerable and impair their ability to work in the long term. This finding is particularly interesting as the relationship between secondary traumatic stress and work ability has only been studied in other trauma-related occupations, namely nurses and police officers (Bock et al., 2020, 2022; Tehrani, 2018b), but not in death care. The results of this study also emphasised the role of vicarious posttraumatic growth in this relationship. They pointed to the protective role of vicarious

posttraumatic growth from secondary traumatic stress and emphasised that stress related to traumatic experiences becomes less important when individuals have experienced growth.

In line with the JD-R model, this study reinforces the protective role of resources in relation to psychosocial demands and emphasises the importance of supporting personal growth processes in a work environment where people are constantly exposed to traumatic events, such as death care during the COVID-19 pandemic.

The third study was about the lived experience of an organisational ethnography in a mortuary. The decision to carry out this fieldwork arose from the need to deepen the knowledge of this particular work context and to "see with their eyes" the reality that I had previously only known as an external observer. Phenomenology was useful to understand the everyday experiences and to explore the meaning that the participants gave to their experiences while the researcher was an observer but also a participant herself (van Manen, 1997). A phenomenological, autoethnographic approach was used to explore the researcher's experiences by combining detailed field notes with reflexive accounts of engagement with the research process (Allen-Collinson & Hockey, 2008). The themes explored in the study concerned the transformative side of death care for those who undertake this activity and a deeper understanding of a resource widely used in this professional context, namely humour.

An innovative element of the Ph.D. project was the investigation of psychosocial risks through a multi-method approach that combined qualitative and quantitative data collection methods. Indeed, triangulation made it possible to gain a deeper understanding of the main critical issues death care professionals dealt with during the pandemic by valuing their opinions and personal lived experiences. Moreover, it allowed to explain, through a quantitative approach, the relationships between particular constructs essential to the professional context. Finally, the use of an

ethnographic methodology, still little used in the organisational context, allowed the collection of data also from a phenomenological perspective, which made it possible to interpret the meaning of human behaviour by capturing the cognitions, emotions and interpersonal interactions of the people observed and also the lived experience of the researcher herself.

The findings of the studies may be useful in improving the quality of working life of death care professionals. Greater involvement of funeral professionals by the Italian governing parties could be a useful strategy to increase knowledge of this particular context, implement adequate procedures and protect the well-being of workers in this sector. In addition, a deeper awareness among the urban population of the death care system and the role of its professionals is needed. This could be developed through town hall projects in collaboration with associations and institutions involved in Death Studies.

Although death care workers have been working in the frontline, there are few studies of this professional context, unlike other categories of essential workers. The findings of the present Ph.D. research project help to fill the gap in the literature on these particular professions, but much more research needs to be done.

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