

ASSISTANCE FROM LOCAL AUTHORITIES VERSUS  
SURVIVORS' NEEDS FOR SUPPORT AFTER SUICIDE

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*As part of a larger study, this article describes the local authorities in Norway as providers of help and survivors as recipients of help after the suicide of a young person (<30 years) in 83 families. A questionnaire developed for this study maps the extent of professional community support as reported by parent survivors (N = 128). Additionally, 41 survivors described the quality of the assistance through in-depth interviews. Another questionnaire assesses the provisions and the organization of intervention strategies in local communities. Personnel in 321 of Norway's 481 municipalities responded. Although survivors' wishes for ideal support coincide with recommendations by experts in the field, local authorities lack the organization to fulfill such expectations. The discussion highlights issues relating to content, organization, and ideology of the assistance.*

Even though Norway is a large, sparsely populated country with a population of only 4.7 million people, there are thousands of people bereaved by suicide each year. Slowly decreasing from 1988, the suicide rate (per 100,000) has been approximately 13 over the last five years; 19 for men and 7 for women (Statistics Norway, 2001). In 1998, the number of suicides was 548 (399 men and 149 women). Of these, 145 were young people below the age of 30: 114 men and 31 women. These young

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suicides represent 15% of all deaths in the age group this year (CSB, 2001).

Several authors stress that suicide results in grief reactions different from those following other forms of death (Jordan, 2001; Reed, 1998; Silverman, Range, & Overholser, 1994). When young persons commit suicide, their parents will suddenly have their lives overturned. Deaths of young people are often unanticipated and out of the developmental order, and the bereaved feel stigmatized. In correspondence with varying degrees of stigma, different cultures have applied (or still apply) legal, religious, or other sanctions against survivors of suicide. Although the last legal and religious sanctions in Norway ended in 1902, feelings of shame, guilt, anger and distress are still very common reactions, as reported in other studies (Clark & Goldney, 2000; Silverman et al., 1994; Wertheimer, 1999). The traumatic experience might lead to serious psychological after-reactions, an existential crisis, and complicated grief reactions (Dyregrov, Nordanger, & Dyregrov, *in press*; Murray, Terry, Vance, Battistutta, & Connolly, 2000). The survivors may also experience long-lasting difficulties with social functioning at school, at work, among friends, and within marriage (Amaya-Jackson et al., 1999; Dijkstra, 2000; Murphy et al., 1999). Some withdraw emotionally and socially and have difficulties accepting offers of assistance (Murray et al., 2000; Wertheimer, 1999). Hence, there is a huge body of research indicating that survivors of suicide might need help after the tragedy. Social network support is often considered the most appropriate postvention strategy (Patton, 1996).

Little research has focused on the self-reported needs for assistance following suicide, which probably reflects the difficult task of carrying out research on this vulnerable group. However, a few recent studies focus on the user's perspective and point out that survivors ask for both formal (professional/community-based) and informal (social network) assistance in dealing with their loss (Clark, 2001; Murphy, 2000; Provini, Everett, & Pfeffer, 2000). Provini et al. found that professional intervention was the most frequently reported type of help desired by survivors of suicide. Studies also point to the need for more professional or community-based bereavement services because of the failure of social networks to provide adequate support during the lengthy bereavement period (Murphy, 2000). There is little evidence of how these needs correspond with available services for the bereaved. In spite of the fact that there are a variety of suicide postvention programs developed for use in schools

(i.e., Leenaars & Wenckstern, 1998), few local authorities describe postvention strategies for use in the communities (Clark, 2001). The existing knowledge of postvention for survivors of suicide mainly results from projects evaluating limited bereavement programs showing that such help is more effective than simply normal healing. However, these programs are not current public provisions (Amaya-Jackson et al., 1999; Murphy, et al., 1998; Murray et al., 2000; Patton, 1996; Provini et al., 2000). Probably, this reflects the fact that most communities do not have a postvention strategy for those bereaved by suicide, but instead expect them to make use of existing local health care facilities.

As a welfare state, central authorities in Norway have designated the responsibility for free general healthcare and welfare of all inhabitants in 481 municipalities of varying size. The law requires local authorities in each of these communities to provide a wide range of health welfare, including psychosocial support. A chief general practitioner in every community is responsible for implementing the services. Professional crisis teams have been organized in some local communities to act upon sudden traumatic incidents with information, counseling, and therapeutic help. These teams have proved fairly effective in implementing intervention strategies when large-scale disasters strike. In the wake of media reports, which often misleadingly produce a picture of a general support system, individuals representing groups of people in need of psychosocial help have started to claim their rights. These claims indicate huge deficiencies concerning appropriate help for survivors when personal catastrophes, such as suicides, happen one at a time. Against this background, it seemed vital to gain more knowledge about what local community services offer and what the survivors' subjective needs for professional help are.

The purpose of this paper is five-fold: (a) to describe what help first degree bereaved by suicide (survivors) say they are given; (b) to investigate what help the survivors would have liked to receive; (c) to describe what the communities say they offer; (d) to see how the publicly administered help matches the expectations of the survivors; and (e) to make recommendations for improving bereavement care.

## **Method**

Although the following data are part of a larger study (Dyregrov et al., in press), only the methodology underlying this article is described.

Data are presented from two samples, “the survivor sample” and “the community sample.”

### *Participants*

The survivor sample comprises 128 parents who had lost a child by suicide. These survivors represent 83 deceased out of the total population of 162 adolescents and young adults. They all committed suicide in the period between July 1, 1997 and December 31, 1998. The mean age of the deceased was 22 years (range 11–29 years), and the women:men ratio was 17:64. The age of the parents varied between 23–73 years ( $M = 51$  years), and the women:men ratio was 77:51. They represented all parts of the country, rural as well as urban areas, and a range of educational and occupational backgrounds. A majority of the parents evinced severe reactions on measures of psychosocial health. Sixty-two percent scored above the cut-off score for high level of psychosocial complaints on the General Health Questionnaire (GHQ), 52% experienced a high level of posttraumatic distress on the Impact of Event Scale (IES), and 78% scored above the cut-off level for complicated grief reactions on the Inventory of Complicated Grief (ICG) (for more details, see Dyregrov et al., in press).

To explore qualities of the research questions, I selected a sub-sample of 20 families, represented by 32 parents, from the total survivor sample for in-depth interviews. The criteria for this sample were variation concerning (a) rural and urban citizenship, (b) educational background, (c) time elapsed since the loss, (d) age of the deceased, and (e) gender distribution of half women and men.

The community sample consisted of health care professionals from 321 Norwegian communities. The professionals who reported on what their communities provided consisted of chief general practitioners (50%) and public health nurses and crisis teams (50%). Half of them had more than 10 years of community work experience, 34% had 3–10 years, while only 16% had been employed in their local community for less than 2 years. Fifty-three percent of the responders were women and 47% men. Seventeen percent represented large communities (>18,000 inhabitants), 36% represented middle-sized (5,000–18,000 inhabitants), and 47% represented small (<5,000 inhabitants) communities. Twelve percent of the communities were urban and 88% represented rural districts, which mirrored the distribution of the types of communities in Norway.

*Instruments*

1. An “assistance questionnaire” developed for the study was administered to all the survivors of suicide, mapping their experience of public assistance and social network support (229 variables). They were asked to describe what professionals had actually assisted them, what types of help they received, and their levels of satisfaction with and suggestions for such assistance. Five open questions addressed possible barriers for accepting help, what had been the best help, what would be the ideal help, and if life values had been changed after the suicide.
2. In-depth interviews with survivors addressed the quality of the assistance received both from professionals and social networks, as well as their own self-help strategies.
3. Psychopathology in the responders was assessed by means of three self-completed questionnaires: GHQ, IES, and ICG. The latter instruments are however only reported on as descriptions of the sample in this article (see above).
4. A “community questionnaire” was developed to survey the services provided by each of the administrative districts (local authorities) in charge of the chief general practitioner. The informants were asked to describe what services are routinely provided to survivors of suicide, that is, in general. Hence, the questions (178 variables) explored the kind of assistance that is usually provided, groups of helpers involved, coordination strategies, and whether the help is outreach (i.e., offered by the professionals) or whether it is up to the survivors to make contact for help. Other variables that were covered included point of time for contact with the survivor, length of usual follow-up, the contents of possible help programs for children, and if the local authorities cooperate with other institutions (i.e., hospitals [second line of helpers] or Non Governmental Organizations (NGOs)) in this work. The local authorities (first line of helpers) were also asked if they had written plans for a follow-up strategy. As the latter, as well as any necessary transference between the lines is the responsibility of the helpers, they were asked whether these plans included formalized procedures between the first and second line of helpers. In addition, they were asked to evaluate their follow-up strategies, if any. Finally, three qualitative questions asked for descriptions of plans for improvement of existing help, possible barriers in the process of providing help, and solicited their opinions of what might improve help for bereaved populations.

*Procedure*

After a 1½-year process of application, the Ministry of Law and Justice in Norway allowed permission to undertake the study and provided access to the names and addresses of bereaved families through the Norwegian police records (Strasak). The Strasak register contains all reported suicides in Norway and is strictly confidential. Therefore the Attorney General, the Council for Professional Secrecy and Research (UiO), the Medical Ethical Research Committee (UiB), and the Data Inspectorate of Norway had to give permission for the study. This was the first time exemption to use this register had been granted for research. In April 1999, the researcher contacted by letter all the families (157) bereaved by suicide between 1 July 1997 and 31 December 1998. All family members (age >15) were invited to fill in questionnaires and asked whether they would participate in an interview later. It was important to carry out every part of the research in a sensitive and careful way, showing deep respect for the very difficult period of time the families experienced. The families were thoroughly informed about the purpose of the project, anonymity, and confidentiality, and at the same time offered telephone contact with the researcher. They were also informed about their right to withdraw from the study at any time. Families were invited to participate in the research between 6 and 23 months after the deaths ( $M = 15$  months). They replied to this inquiry in a stamped addressed envelope, giving written consent or informing that they were unable to participate.

Although 58% of the contacted families initially agreed to participate, only 50% completed and returned the questionnaires by August 1999. Thus, 8% withdrew after receiving the questionnaire, mainly, as stated by them, because of "lack of energy." An additional 10% responded that they refused to participate, while the researcher had telephone contact with a further 12% who for different reasons wanted to stay in touch but not to participate. The non-contact rate was 20%. On the basis of Strasak-register, participating and non-participating parents were compared regarding place of residence, gender, and age of the deceased, suicide method, and time from the death until the parents were asked to participate in the study. There were no statistically significant differences between the groups on any of these variables. The participation rate for the interviews was 95% (drawn from the questionnaire sample). The mean time between the suicide and interview was

14.5 months ( $SD = 5.48$ ). The interviews were conducted by the researcher in the homes of the survivors and lasted approximately 2.5 hours per person/couple (range = 1.5– 4 hours).

The chief general practitioners responsible for the provision of bereavement services in each of the 481 communities in Norway were contacted through a national record of health personnel in the communities. They were asked to participate by filling in a questionnaire or pass it on to such coworkers as health nurses, crisis teams, priests, and so on, who possibly had better knowledge of community support strategies. The response rate was 71%, although only 67% of the surveys were analyzed because of incomplete answers from 4%. Data were collected from February 1998 until August 1998.

### *Data Analysis*

Frequency, bivariate distribution, and correlation analysis were conducted on the standardized questions. Chi-square and  $t$  tests were performed on all available background variables to investigate group differences between responders and non-responders. The interviews were conducted, taperecorded, and transcribed by the researcher. The open questions in the questionnaire and the in-depth interviews were analyzed using Steinar Kvale's qualitative mode of analysis (Kvale, 1996). The method involved a condensation of the expressed meanings into more and more essential meanings of the structure and style of the different research topics. Thereafter the condensations were categorized on dimensions in line with the quantification tradition of facts in the social sciences (Kvale, 1996).

## **Results**

### *Provisions as Evaluated by Survivors and Local Authorities*

Eighty-five percent of the parent survivors reported that they had experienced some kind of contact with community professionals.

The communities report far more often that the medical doctor, the psychiatric nurse, and the public health nurse are common helpers than

**TABLE 1** Help as Received by Parents and as Provided by Local Authorities After Youth Suicide (%)

Received and provided help	Survivors of suicide (n = 128)	Local authorities (n = 320)
Professional helpers		
Parish priest	79	83
Undertaker	69	32
Medical doctor	55	78
Police	47	50
Psychologist	21	18
Psychiatric nurse	18	63
Public Health nurse	8	63
Family counselor	3	8
Types of help		
Counseling	80	86
Information	66	23 (written)
Medical	33	82
Practical/financial	48	42
Support groups	26	40

what is experienced by the survivors (Table 1). However, the survivors report the undertaker to be a significant helper, much more so than what is reported by the local authorities. Supportive counseling was the type of help most often received and provided for, as reported by 80% of the survivors and 86% of the local authorities. It is also worth noticing that only 26% of the parent survivors had participated in support groups, whereas 40% of the local authorities reported to have such groups (Table 1).

Table 2 shows that the duration of professional help is short as reported by both groups.

Half of the survivors were contacted by professionals and offered some kind of help. Priests, undertakers, or the police contacted most of these survivors, usually offering assistance during the first week. The communities had a varied practice, but only 38% reported that they always contacted survivors to offer help. Less than half of the siblings aged 18 or under living with their parents had received some kind of support from community helpers (individual counseling, school support programs, etc.), whereas 56% of the parents had been given advice on how to care for the bereaved siblings. The figures correspond to the answers from local authorities.



**TABLE 2** Aspects of Help as Received and Ideally Wanted by Parents and as Provided by Local Authorities After Youth Suicide (%)

Aspects of received, provided, and ideal help	Survivors of suicide (n = 128)	Local authorities (n = 320)
Received help		
Duration of professional follow-up	15%: 1 year 18%: 6 months 67%: less than 6 months	14%: 1 year 4%: 6 months 24%: less than 6 months 58%: "varying"
Ideal duration of follow-up		
Who initiated contact	73%: wished 1 year or more 56%: professionals 44%: parents or social network	38%: always contact survivors 21%: always let survivors contact 41%: "varying"
Specific help for younger siblings	40%: received direct help 56%: advice received by parents 65%: wanted (more) help	36%: support programs for children 50%: advising parents
Ideal help for siblings		
Satisfaction with help provisions	11%: very satisfied 47%: fairly satisfied 42%: satisfied to a limited extent	16%: very satisfied 61%: fairly satisfied 23%: satisfied to a limited extent

*Ideal Help as Seen by Survivors*

Ideal help was described through the quantitative questionnaire data (Table 2), by the open questions in the questionnaire (Table 3), and through the in-depth interviews (citations). When looking into the results from the open questions in the survey, it is worth emphasizing that percentages resulting from categorized material of written statements must be considered as even "stronger" than data gathered by a standardized survey selected through a multiple-choice system. The answer from open questions is probably the most important answer to the individual, and not one of many given possibilities as seen by the

**TABLE 3** Parent Survivors of Suicide Answering the Open Question, "What Would be Ideal Help from Local Authorities?"

Ideal help	Survivors of suicide ( $n = 128$ )
Routine professional help	45
Active outreach help	47
Long term follow-up	11
Peer group help	22
Information	13

researcher. The in-depth interviews give valuable support when interpreting the results from the open questions.

First, 88% of the parent survivors stated that they are in need of professional help. There is also a significant correlation ( $p < .01$ ) between parents' evaluation of need of help and psychosocial complaints ( $-.40$ ), traumatic after-reactions ( $-.35$ ), and complicated grief reactions ( $-.39$ ). The mother of a 13-year-old boy who hung himself expressed the desperate need of help by saying, "When you experience such a disaster, you are not capable of asking anyone for anything. You are completely lost in the world and feel like you are drowning, and you need to be held up by someone." A large proportion of the bereaved claimed that they wanted more or other types of help than they had received, and the psychologist was the most frequent missing helper (Table 2).

It is a strong signal when 45% of the parents expressed the wish for psychosocial care to be routinely offered (Table 3). Many survivors felt that the present distribution of psychosocial crisis intervention was really unfair, even insulting and provoking. A mother posed the question, "Why do clear procedures and routines exist when sixteen persons are killed in a boat accident, but nothing happens when we lose our child to suicide? Are these children and families worth more than us, or is their pain greater?" The routines should secure automatic contact by a professional team with knowledge about their situation and the capability of yielding support.

Ideally, a professional from the local community should contact the bereaved family to see if they need help, as reflected in answers of 47% of the parents (Table 3) and 100% of the interviewed survivors. An important reason for their strong wishes was that they were not in a position to take initiatives because of their shock and trauma after the suicide. A mother stated the necessity of active outreach: "I don't think

anyone in profound grief has the initiative to contact someone for help. The local authorities should have a system where they automatically enter the scene to help, without us having to ask for it." Even if helpers during the first days had told them to "contact us if you need help," many were unable to do so. Another basis for the mother's assertion was that survivors did not know what kind of help they needed or what was recommended or available. Well aware of their changing needs for help during the bereavement process, survivors emphasized that, in addition to the immediate crisis intervention, contact should be initiated several times. A father proposed this solution: "If the community health service had contacted us and offered some regular help after the suicide, I could have treated this contact as a life buoy, knowing that it was there and grabbing it if necessary."

The duration of the follow-up was a central issue for survivors. The questionnaire data showed that 73% wished they had been offered contact with authorities and, if necessary, help from professionals for at least 1 year. In the interviews, a high proportion also pleaded for support and help over "at least 2 years," "as long as it is needed," or "the rest of our lives." Through the open questions (Table 3), 11% of the parents described that an ideal follow-up would need to encompass a lengthy time perspective. Most of the interviewed survivors had experienced being supported during the first weeks while they were in shock or busy with the funeral, and then being left alone to face the harsh reality after the first month. In addition, most of the network support also stopped after some months.

One fourth (22%) of the parents considered peer-support to be important and ideal help (Table 3). They thought that they could learn much from the unique experiences of other bereaved persons concerning what to expect in the weeks to come and "how to survive the pain," issues explicitly affirmed in the interviews. A mother said "Those who have lost someone in the same way give a special kind of support. You don't need so many words, because they know what to say and not to say." Some survivors proposed that local authorities could organize a link between survivors who have been bereaved.

Parents (13%) asked for different kinds of advice on how to help and deal with surviving siblings, how to meet different grief reactions in the family, and how to deal with social networks (Table 3). They emphasized the importance of written information, because of their disturbed memory functioning after the tragedy.

*Improvements as Seen by Local Authorities*

When the community responders described their opinions on the need for professional help after suicides, they answered that it depends on “the actual situation,” “the actual needs,” “how much social support is given,” and “the resources of the family,” and so on. Problems of initially lacking information about the suicide or shortage of health care providers were mentioned as reasons for not being able to help. Also, two general practitioners asserted that “Grief should not be treated by health care personnel, but is a normal part of life, and social network support is the best resource.”

Half of the communities (50%) maintained that it was necessary to clarify responsibility and improve coordination and cooperation to improve existing provisions after a crisis like suicide (Table 4). One psychiatric nurse gave a common explanation why assistance could fail: “Presently one group of professionals is hoping that the other group is doing something, and as a result a family might not be helped.” Insufficient coordination was an even greater problem when considering long-term follow-up. Large communities proposed crisis teams, whereas smaller communities stressed that a coordinator should have the responsibility and take the necessary steps to solve the problem.

Thirty-five percent pointed to the necessity of making written plans for support programs both to secure assistance for everybody who needs it, as well as to make clear “which personnel is doing what and when.” Many of the communities claimed to fail because they only had

**TABLE 4** Local Authorities Answering the Open Question, “What Should be Changed to Improve Help for Suicide Survivors?”

Improvements	Local authorities ( <i>n</i> = 197)
Clarified responsibility, and improved co-ordination and co-operation	50
Written routines and plans for support programs	35
More personnel, decreased “turnover”	19
Improved contact between health agencies or services	18
Increased knowledge and competence	11
Heightened priority and commitment to the field	11
More money	8
More time	3

unwritten routines that were much more liable to fade away with rapid turnover of personnel. A chief general practitioner of a community described how vacancies affect efforts to meet psychosocial needs: "The amount of work is already too great for an 8–10 hour working day and vacancies imply even more work which results in lack of surplus energy for psychosocial tasks."

Better contact between hospital services and community health services would improve community services as pointed out by this physician: "Sometimes the local services do not know about a suicide because it is been handled by the hospital and slow or lacking routines have precluded transfer of necessary information to the community health service". Finally, increased knowledge about bereavement processes, more money, more time and heightened commitment and priority of the bereavement field would improve assistance.

Bivariate distribution and analysis of correlation showed that communities with organizing initiatives, such as a coordinator, a crisis team, and written routines, offered the best support in terms of what the survivors regarded as ideal help. With the existence of a crisis team there was more often a coordinator (.29), written routines for provisions (.32), and written routines for cooperation (.27) between the first and second line of health services ( $p < .01$ ).

## Discussion

### *Discrepancy Concerning Received and Provided Help*

Overall, there seems to be a good correspondence between the types of help survivors report to receive and the help professionals usually provide. This probably reflects a good validity, showing that receivers and providers are referring to the same phenomena.

However, there seems to be some discrepancy concerning the extent of involvement of certain professional helpers. To use the psychiatric nurse and public health nurse as helpers is obviously much more an ideal set up by the communities than a reality as reported by the survivors. The undertaker gives more support for survivors than noted by the authorities, whereas survivors participate less often in bereavement groups than what is generally reported by local authorities. Both are probably due to local authorities lacking information about the work of

non-health professionals or NGOs, as most communities have little formal cooperation between such agencies. Obviously, local authorities could profit from improving their contact and cooperation with non-health professionals who presently are assisting survivors following a suicide.

Despite the reasonable correspondence between received and provided help, neither the survivors nor the local authorities are satisfied with the situation. Through the interviews, the survivors elaborated on their dissatisfaction with the existing help. As suggested by other findings, traumatized and bereaved populations do not seem to be prioritized and are not sufficiently helped by health services in local communities (Amaya-Jackson et al., 1999; Clark, 2001; Murray et al., 2000). When the huge majority (88%) of our bereaved parents claimed to need professional help, this might reflect different reasons. First, it reflects that this research is probably carried out on one of the most vulnerable survivor groups. To lose a child or sibling by suicide represents a tremendous impact of trauma and loss (Dyregrov et al., in press), as does the young age of the deceased. In a similar study (Provini et al., 2000), only 26% of next-of-kin identified specific needs for professional assistance. However, in that study only 17% of the bereaved were parents. The registration point of time might reflect another explanation. While the average length of time from death to initial contact was about 14 months for the present study, it was only 5 months for the first study (Provini et al., 2000). As expressed by many of the survivors, needs for assistance increase rather than decrease during the first year. During the first month, a majority was satisfied with the initial (obligatory) services from priests, undertakers, doctors, the police, and social network support. Expectations from the Norwegian welfare state are probably another important reason why so many survivors express needs for help and are disappointed by the existing services.

### *Survivors' Wishes Correspond with Specialists' Recommendations*

Ideal assistance as outlined by the survivors is on level with results from the scarce, prevailing research literature (Amaya-Jackson et al., 1999; Clark, 2001; Murphy, 2000; Murray et al., 2000; Provini et al., 2000), as well as the general advice from clinicians working in the field of crisis psychology (Bryant, Harvey, Dang, & Sackville, 1998; Dyregrov, 1990; Wertheimer, 1999). The survivors ask for professional public help and

desire a range of kinds of assistance. Murray et al. (2000) reported that parents bereaved by infant deaths who participated in an intervention program benefited in terms of more rapid improvement scores on personal disturbance than parents who did not. They suggested that early and qualified help would enhance the progress of mourning. A crucial point concerning follow-up seems to be when and how contact with the helpers is established. The survivors strongly want an early community outreach without having to take the first initiative. Two important reasons might explain why the survivors do not seek help to the degree that they deem necessary. First, as also reported by Provini et al. (2000), exhaustion and loss of energy make many survivors incapable of initiating contact with community services. Thus, one of the reasons why they need help becomes an important barrier to receiving help (Dyregrov et al., in press). Amaya-Jackson et al. (1999) found that people who had experienced a traumatic event were two to three times more likely than a control group to perceive barriers to ask for medical health services and even higher barriers for mental health services. A second reason why survivors want to be contacted and offered help is probably due to remaining stigma. Internalizations of shame and guilt, or acts from the networks showing disrespect, might account for less help-seeking behavior than needed (Provini et al., 2000). Survivors' wish for follow-up contact is consistent with Provini et al. (2000) who also recommended that assistance be repeatedly offered to meet the changing needs of this bereaved population. The devastating loss and the draining of energy make it impossible for many bereaved to continually evaluate their own and their children's changing needs for help. Neither do survivors perceive that they possess the knowledge about how and where they could get appropriate help.

Survivors also desire professional contact over time. Close family members are often struggling with serious problems for a much longer period of time than realized both by the health service and social networks (Dyregrov & Dyregrov, 1999; Murphy, 2000; Wertheimer, 1999). Short-term contacts with professionals were common in the present study. However, survivors did not consider this sufficient. When Murray et al. (2000) reported that 88% of survivor contacts with grief workers were initiated during the first 6 months, and significantly less needed to talk about the loss with others after 15 months; they claimed that this might reflect the success of a sufficient and effective early intervention program. Thus, the survivors of the present study might have

experienced less need for a long-time follow-up if they had systematically been offered an early professional intervention program aimed at meeting their specific needs. However, Murphy (2000) found that nearly 40% of parents experienced most progress being made during the third and fourth year of bereavement after violent deaths of their children. The study concluded that a 6-month duration of victim assistance counseling was far too short and recommended that referrals to support groups, bereavement counselors, and other services may need to continue even up to 5 years after the death of a child. Long-term follow-up is also found to be especially important in reducing the risk of complicated bereavement (Dyregrov, 1990; Murray et al., 2000). Hence, survivors' desire for contact over time to meet new and changing needs for help should be taken into account. Local authorities should make an effort to aim for a standard duration, at least covering the first year. As proposed by survivors of the present study, the follow-up does not have to be particularly time-consuming but might consist of a telephone contact to assess whether more or other kinds of help are necessary over time.

The survivors clearly confirm that the focus of help has not been adequately tailored to all their surviving concerns. More help that is psychological specific was the parents' most frequently reported need. This included therapeutic help for themselves, but more particularly for their children. The high incidence of parents at risk of developing complicated grief, post-traumatic stress disorder (PTSD), and general health problems in this sample probably indicates that the parents would have profited from more specific help than they received. As found by Murray et al. (2000), bereaved populations who are identified prior to intervention as being at the highest risk of developing complicated grief benefit the most from a postvention program. However, as also related by the survivors, the intervention must be aimed at treating specific needs caused by traumatic reminders that appear as nightmares, flashbacks, and so on. The superiority of cognitive behavioral therapy over non-specific therapies in preventing chronic PTSD has previously been demonstrated (Bryant et al., 1998). Bryant et al. proved that only 17% of those in a traumatized sample who were treated by cognitive behavioral therapy (CBT) developed PTSD, whereas in a group who received information and supportive counseling as many as 76% met the criteria for PTSD.

In accordance with the wishes of bereaved families, Murray et al. (2000) recommended that these families should be offered information



on medical aspects of the death, the progress of mourning, effects of the death on family members and family systems and on future decision making. The survivors ask for written information, as reported by survivors in other studies (Clark, 2001; Murphy, 2000; Murray et al., 2000). The importance of helping survivors with practical, economic, and legal issues, in addition to providing information and therapeutic intervention, has also been found to be important in other studies (Dyregrov, 2001; Provini et al., 2000).

When two thirds of the parents desire more help for their children, and 45% want psychological help for their children, it strongly signals the necessity of focusing more on this vulnerable group. This is supported by studies showing significant correlations between the degree of psychopathology of the caretaker, and social difficulties and poor psychosocial adaptation of child survivors of suicide (Pfeffer et al., 1997). Parents also report perceptions of less harmony and more unresolved conflict in the parent–child relationship in the wake of suicide, than parents bereaved by other modes of death (Murphy, 2000). Additionally, families with surviving children also experience more complicated bereavement (Provini et al., 2000).

Although support from one's social network is not the focus for this article, survivors asserted the importance of such support, but in combination with professional help. As found in other studies (Murphy, 2000; Provini et al., 2000), they claim that professional assistance cannot replace social network support, and vice versa, because the two forms of help meet quite different needs.

#### *Communities Want to Improve Psychosocial Assistance*

Survivors and local authorities have a different focus when proposing how to improve support and care after suicide. Whereas survivors describe the ideal content of help on a micro level, local authorities are mainly focusing on organizational improvements. The latter identify many deficiencies in their support programs because of a lack of written routines concerning organization and responsibility.

Several conditions must be present for a strategy to function. One is that there is contact between the receiver and provider of support. Both groups may be responsible for a lack of contact. The results of this study show that although the communities may not take the first initiative because of a lack of routines, personnel, or tradition, survivors might

lack the energy to ask for help after a suicide (Brownstein, 1992). These factors, also known from previous studies (Murray et al., 2000), can be handled by reorganizing existing resources and personnel. Lack of personnel, money, time, and priority of the bereavement field must be dealt with at a higher political level. As pointed out both by the survivors and the communities, heightened competence by caretakers is also necessary to improve services. Educational campaigns based on comprehensive knowledge in the field should be initiated. A national plan for psychosocial support after major individual traumas is necessary for the communities to arrange and give priority to this important work. The Norwegian Board of Health has just recently taken the first steps in this direction.

#### *Possible Explanations for the Insufficient Help*

Considering the existing knowledge of the psychosocial impact of trauma and bereavement in the family, and the fact that the study is carried out in a highly developed welfare state, the lack of help is rather surprising. As pointed out by local authorities, many of the shortcomings are likely to result from a lack of organization of services for the vulnerable population of survivors of suicide. Probably the discrepancy is a remnant—not worthy of a welfare state—of somatic difficulties taking priority over psychosocial issues. It is also probably a sign of curative services taking precedence over prophylactic intervention. Traditional ideologies are probably important reasons why the organization of psychosocial welfare is not at the same level as for somatic services. However, when studying the national Law of Health Services for the Communities from 1982, there is little doubt that survivors of suicide are entitled to necessary public help. Pursuant to this law, local authorities are responsible for meeting the needs of the bereaved population both by curative and prophylactic means. Hence, political strategies based on a willingness to take responsibility for the psychosocial well being of all inhabitants of local communities should be implemented. Desperate utterances, like the one from this woman who lost her ex-husband and her son by suicide, should be unnecessary in the future: “I thought of how I could break both legs, so that I might be taken care of by someone in the health services.”

*Recommendations for Postvention Services*

Acute and long-term provisions should be secured through written routines (Nordanger, Dyregrov, & Dyregrov, in press), so that every close family member who loses someone to suicide should automatically be offered assistance through a standard procedure. Crisis teams and/or coordinators should assist survivors on an active outreach basis, used immediately and continuing over time. Siblings should be prioritized and given age-related support and help. Initial advice and written information for the family are of outmost importance to contribute to the initiation of the grief process and to reduce the traumatic after reactions. Personnel must be trained to meet and assist survivors with their special needs, stressing that grief is normal, individual, lasts for life, and affects the whole family. Local authorities should be proactive and offer specific assistance to prevent or treat complicated grief, PTSD, or depression.

*Limitations and Strengths of the Study*

Although it is uncommon that the participation rate for samples of survivors of suicide is high (cf. Paykel, 1983), the response rate was only 50% of the total population. This makes it necessary to discuss the generalizations of the findings. First, it is of importance that no group differences were found when comparing participant and non-participant survivors on available basic background variables. However, the researcher's contact with 30% of the non-participants (see *Procedure*) left the impression that the latter were even worse off, concerning psychosocial health and lack of help, than the participants. Hence, the need for assistance among those bereaved by youth suicide might be even greater, and the provisions even poorer, than data from this study reflect.

Unlike findings from other studies (Provini et al., 2000), the suicide survivors in this study had few difficulties in discussing their concerns and needs of help. Possibly, this might be because of the researcher interviewing the bereaved face-to-face in their homes, rather than by telephone or other methods. Hence, the extremely challenging and time-consuming task of locating and contacting this vulnerable group seems worthwhile. Another motivating factor was that the researcher often spent a day or two traveling to interview each family, because of great distances and sometimes poor communications in Norway. As expressed by survivors, the strong effort to reach them was taken by

survivors as a way of “honoring” the deceased. A close and confidential contact between interviewee and interviewer was established.

There is a possibility of under- or overreporting of help through the self-report method used. However, the good correspondence between what was reported in the interviews and the questionnaire report indicates that this has not been a significant problem in this case.

However, as the survivor sample is based on a total population (1.5 years) of bereaved families of youth suicide, with a relatively good response rate and a good demographic spread, the possibility of generalization to the total population is considered satisfactory, within the discussed limits. The possibilities of generalization from the communities are also considered satisfactory, being based on a sample of 71% of the total population of communities. The degree of consciousness concerning the necessity of psychosocial help, current knowledge in the field of bereavement and trauma intervention, general economy, cultural expectations and priorities within health services, and so on, will influence to what extent results of the present study will be replicated in other countries.

Further research should also include some information on personality traits and correlate such profiles with measures of psychosocial health, and acceptance and desire for help.

## **Conclusion**

Parents clearly indicate that support from their social network is crucial, but insufficient to accommodate the horrifying experience of losing a child by suicide. They want and need more assistance from the local authorities than is provided at present. Local community providers are aware of the shortcomings by comparison with the needs of the survivors and as specified under national law. Hence, the communities are not satisfied with their own services and many improvements are in progress. Most of the deficiencies are accounted for by a lack of clear responsibility regimes and organization, and differing health ideologies. The professional help that the survivors want is more or less identical to what specialists recommend for crisis intervention programs. They ask for outreach and immediate assistance from trained personnel, long-term follow up, information, and care for surviving children. To be able to fulfill these basic “needs” for all survivors of suicide, local authorities have to

make organizational efforts through clearly stated guidelines of assistance. Directives from the director-general of health services are necessary to give psychosocial assistance the same priority as the somatic field.

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