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Public support for suicide survivors in Norwegian municipalities

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In Norway in 1998, 24 women and 75 men under 30 years of age committed suicide (my statistics – based on information from the Police Crime Register and the population register). Even if no statistics are available for the number of suicide survivors, several thousand persons will suffer each year in Norway as the result of a suicide. This article will examine the services offered by the various municipalities in Norway after a young person has committed suicide.

Struggle for survivors

It has been documented that many suicide survivors are struggling to cope with major personal problems (McIntosh 1990; Müller 1992). A number of studies have shown that sudden deaths cause greater health-related consequences for survivors than expected deaths (Parkes & Weiss 1983; Figley 1989). For survivors this means that not only do they experience grief over the loss of a close family member, but also a trauma. While the core of grief is loss and longing, the manner in which it happens causes specific, often long-term after-effects. Feelings of unrest and general restlessness are usually higher than after an expected death, and intrusive memories/fantasies about what happened are common consequences, in addition to avoiding things that remind one of the death (Dyregrov 1993). After a suicide many people also struggle with a sense of guilt, shame and anger. Many people may also encounter social difficulties either because of self-imposed isolation or due to a decline in social intercourse, as friends and acquaintances may be hesitant. Professional care workers engaged in activities for suicide survivors have called for systematic help and assistance, particularly for children (Svenberg 1987; Müller 1992).

Presentation of the project

"Care for suicide survivors" is one of two comparative research projects. The other project focuses on care for survivors after crib deaths (sudden infant death syndrome – SIDS), and child accidents. Each of the projects in turn consists of two sub-studies. The aim of *Kommunestudien* (The Municipal Study) (Dyregrov, Nordanger & Dyregrov 1998) was to survey the content and structure of care given by the public assistance services. A total of 321 of 481 Norwegian towns/boroughs responded to a national questionnaire. Of these, 156 municipalities believed they followed up suicide survivors with specific programmes (the suicide sample), and 110 municipalities defined themselves as having general follow-up programmes for sudden deaths (the sudden death sample). The findings from this study are presented in this article. The questionnaires were collated from February 1998 until the middle of August 1998. The second and on-going sub-study (the Survivor study) examines the situation of survivors, their needs for assistance, and their perception of the care programme

offered after a suicide. The findings will be published in a report around the middle of 2000. The aim of the project is to draw up proposals for measures and/or guidelines for care for survivors.

Main findings from the Municipal Study

There are great differences in the care schemes in Norwegian municipalities, spanning from little assistance to planned follow-up with specially targeted measures. The variations are particularly focused on whether the municipalities have crisis teams, a permanent coordinator, written procedures for assistance schemes and written procedures between first- and second-line services. Having one or more of these organized structures together with the better general overview small municipalities will have appear to make the care schemes for suicide survivors best in small and medium-sized municipalities with clear lines of responsibility. Strategies for establishing contact appear haphazard, however, follow-up times vary and assistance to children appears to be less than perfect. Norwegian municipalities generally have (but not necessarily take) contact with survivors relatively quickly after the death. This is generally due to the fact that other family members and friends of the survivor approach these services rather than the public agencies contacting them.

Haphazard contact and follow-up schemes

The risk that suicide survivors cannot manage to take the first contact with the assistance services is particularly great during the initial period. Knowing the state of helplessness and shock survivors are in after a suicide and the common extent of subsequent social withdrawal, the point in time and the manner in which contact is established may be a critical issue if survivors are to receive the assistance they need. Literature on grief shows that assistance must come quickly and it must come to the person in crisis (Worden 1983; Figley 1989; Dyregrov & Dyregrov 1999). Bearing this in mind, the findings indicate that there is a decisive barrier blocking a good care scheme in municipalities. The assistance services, whether psychological, medical or practical/financial, must seek out the person in question and be respectfully "persuasive", and survivors must be contacted again even if they reject assistance the first time. A study of survivors 12-15 years after losing a child through crib death found that parents urged the assistance services to "be a good sales person" (Dyregrov & Dyregrov 1999).

There are most likely several reasons why only one third of the municipalities in the suicide sample (and only 17% of the sudden death sample) regularly call on survivors to offer assistance. Municipalities themselves point out that considerations of time and capacity cause some municipal executives to handle only those tasks that "must" be addressed. They have neither the resources nor surplus capacity to think about prevention and to offer assistance to those who need it before they seek help. Other municipalities suffer from inadequate organization and plans for crisis operations, or existing plans are not sufficiently detailed and precise. Other reasons include inadequate expertise and uncertainty as to how the assistance services should deal with suicide survivors.

Brief follow-up period

Even if there will be individual variations and gender differences with respect to the intensity of reactions, we do know that grief and trauma reactions are typical features of a survivor's life for many years, and many will need outside help (Parkes 1983; Svenberg 1987). The fact that only one third of the municipalities that believe they have specific schemes for suicide survivors follow up survivors for up to one year confirms the trends found by previous studies that survivors are offered most assistance during the first months, only to be left to their own devices when they are ready to start the real grieving process. The reason may often be linked to the fact that the assistance services etc. underestimate the intensity and duration of grief and traumas. When so many municipal executives tick the category "varies", this indicates the great individual differences that necessarily will be present, based on the different needs for follow-up over time. Thus it is to be hoped that more municipalities will still have contact with suicide survivors one year after the death than suggested by the findings.

Inadequate care for children

Knowing how much young children understand of death and grief, and knowing their need to be able to grieve (Müller 1992; Dyregrov 1989), it is not satisfactory that one half of the municipalities do not mention schemes for children who experience a suicide in their close family. While adults, for example, are offered support in professional therapy groups in three out of four municipalities, children receive offers of such help in only 20% of the municipalities. This suggests that children are not taken seriously as survivors, which has also been claimed by and addressed in research literature. When the local authorities describe areas they are considering improving, care for children is one area that is strikingly absent. However, supplements from 29 municipalities with written procedures for care programmes mention and deal with children to a certain extent. There are many explanations for this apparently inadequate care for children.

Uncertainty when it comes to understanding the grief of children has been rife, because, for example, children do not grieve in the same way adults do. Inadequate assistance for children may thus be caused by a sense of not feeling capable of communicating with children about grief, trusting that children will be helped by their parents. Other explanations may include the absence of a focus on or willingness to give priority to care for children. The most frequently mentioned assistance schemes for children are conversations with the public health nurse and measures in schools and day-care centres, and this reflects how these are arenas where children are, and how school has undertaken a growing responsibility for the mental functions and well-being of children.

Municipalities in early contact

Half of the municipalities state that a representative will contact the survivors on the first day, and 74% say that contact is established within three days. A clergyman, doctor or the police generally give the bad news about a sudden death, medical first

aid or police information. Frequently this is also the end of the contact. As the assistance services routinely have contact with so many survivors, there is here a potential for further follow-up.

Action plan for crises and grief

On the basis of the main findings outlined above, a comprehensive action plan for crisis and grief is recommended for all municipalities.

The plan must be adapted to each municipality's demography and geography and should contain an organization structure and detailed plans for implementing and carrying out the care scheme. Increased knowledge about grief and crisis assistance is essential for the understanding of survivor reactions after the suicide. An "outreached hand" from the assistance services is needed, a hand that perhaps must be there for an extended period of time. Moreover, the care services should have a general responsibility for stimulating the incorporation of care within the social structure, based on interpersonal relationships and local conditions in each municipality.

Conclusion

As only the findings of the Municipal Study have been described here the important and good support from social networks and NGOs has not been described. The report "The Survivor Study", to be completed in July 2000 describes how survivors experience such assistance.

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A more detailed presentation of the Municipal Study in the Norwegian language can be found in *Tidsskrift for Den norske lægeforening* 1999; 119 (27): 4010-15.

The author:

Kari Dyregrov is a sociologist and works as a researcher at the Centre for Crisis Psychology in Bergen. She has managed the project "Omsorg ved brå, uventet død" [Care when there is a sudden unexpected death], which will be continued as a three-year doctoral thesis study from 1 July 2000. This research aims at increasing the total understanding of the problem area and to contribute recommendations for supplementing the grief assistance service for survivors, particularly after a suicide.