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How can we provide effective support for suicide survivors?

(First published in the Norwegian journal *Suicidologi* 2000, no.2)

Most activities for suicide prevention have, needless to say, focused on persons at risk of suicide. However, in recent years there has been an increasing recognition of the problems suicide survivors also may struggle with both in terms of the scope and type of problem.

All deaths involve painful loss. However, the loss that suicide survivors feel is more complex. Being actively left by a loved one is often experienced as extremely difficult. Moreover, suicide survivors often experience a number of secondary losses, for example the provider's income may disappear, causing more difficult financial conditions. Perhaps the family is forced to move away from the local community they are accustomed to, losing the support that might otherwise have been available. In some families the suicide leads to accusations and conflicts, which in turn may lead to a break down in communication and contact with important family members for children and adults. For some married couples the reactions and the grief process after the suicide of their son or daughter is so heavy that the family suffers a total breakdown. Family members left behind may feel that anxiety about a possible new suicide in the family, virtually like a curse is hanging over the family, is a heavy extra burden to bear. A surviving spouse may be overwhelmed by all the responsibilities that now must be shouldered alone, for day-to-day challenges that two coped with before, and for dealing with children's grief and reactions to their loss. Suicide has been a taboo and suppressed in many contexts. Many people continue to do all they can to hide the cause of death when a loved one takes his/her life, making it impossible to take part in the usual rites of passage. The burial is performed discreetly. In this way the bereaved distance themselves from any chance of receiving assistance and support from friends, neighbours or colleagues, who may not be able to solve any of the problems, but who will be able to listen and participate. Even more serious, however, may be the suppression that might dominate within the family itself, disabling any possibility of speaking openly about what has happened and the subsequent emotions.

All of the above factors increase the risk that suicide survivors might develop serious and long-term mental, family or social problems. The scope of this paper is not to provide a detailed description of these problems. Instead we shall point out preventive support measures that can be recommended to individuals, families and other groups of suicide survivors. Finally we shall examine some recent development features of preventive activities among survivors.

Professional or voluntary assistance?

During the days immediately following a death, survivors will most often need time and space to express their emotions and reactions, as well as support and assistance to

resolve problems large and small. They also need information that may help them to understand and accept their own reactions and well as those of others, and what can be done to cope with all the challenges facing them. *No special training is needed to satisfy most of these needs. What is needed is understanding and empathy.*

Professionals should help people gain confidence that they can contribute something more than mere stand-in services while waiting for professional assistance, but rather that what they do is vitally important. On the other hand, healthcare personnel and other professional assistants should be alert to the fact that there might be special needs or situations that require active efforts on their part. Perhaps the bereaved needs a compassionate dialogue aimed at relieving the natural and necessary grief process. In some cases pathological grief reactions may develop, with a grief that is more intense and lasts longer than normal. Grave depressive symptoms may develop, and in some cases even post-traumatic stress reactions. Such symptoms or reactions may easily reduce the quality of life to a great extent over extended periods of time, and for some people these may actually lead to suicide. Healthcare personnel have an important preventive role through early intervention with treatment and assistance.

Group intervention

Frequently whole groups of persons will be affected by a suicide. We are thinking particularly of the nuclear family, but also in some cases workplace colleagues or peer group friends. It is not uncommon that these will benefit from receiving assistance as a *group* during the initial days after a suicide. Such a group intervention, following the principles of group stress debriefing (Weisæth & Mehlum 1993), is typically undertaken 24-72 hours after the death, and may be most urgently required when the circumstances have been dramatic and the bereaved have been subjected to strong and agonizing impressions. Nowadays, many healthcare workers and other municipal assistance services have the necessary expertise to undertake group stress debriefing. Such group interventions with suicide survivors are thus realistically feasible in most districts, and should be given due consideration in many cases.

What about the children?

Sadly children are often forgotten when families are subjected to death and grief, and this applies in particular when the circumstances are so special and traumatic as they often are after suicides. However, children also need to grieve. Moreover, there are a number of reasons why we should include children in the grieving process and be alert to their needs in such cases (Mehlum 1999, Müller 1997). We have extensive documentation on how the loss of important persons during early childhood years may cause vulnerability that may later give rise to depression and other mental problems. Parents and other survivors with care responsibilities for children will often benefit from talking to a professional, but the amount of assistance required in each case will naturally vary widely, and it is essential that families themselves should be allowed to regulate this. Most families will benefit greatly from advice and guidance on how to tell a child about a suicide in a way the child may understand, but which does not mask the actual truth (Raundalen 2000, Mehlum 1999). In some cases a more active intervention strategy from professionals may be required when they are involved in the follow up of children who have experienced suicide close at hand. This applies

particularly when one of the parents has committed suicide or if the child has witnessed the suicide or found the deceased.

The support group

The process that is required for suicide survivors to get over their loss and the subsequent emotional reactions is called the grieving process. This process takes time – much more time than the first turbulent and event-packed days and weeks. The grieving process is a healthy and utterly necessary process. Grief may be postponed or suppressed for a while, but this will cost much energy that must be drained from more constructive processes. Many who suppress grief will be locked in a state of lasting shock, virtually paralysed, while the grief process will help the grieving person to restructure his or her thoughts and emotions from the life that **was** to the life that **is**. The resources the individual will adopt in his or her process and how each individual grieves may vary greatly, so we shall avoid prescribing any standard solutions. Many suicide survivors feel greatly comforted by meeting and speaking with people in the same situation – people who also have lost someone dear to them under similar circumstances. It is good to see that support groups and compassionate friend groups for suicide survivors have appeared in a number of areas in Norway, usually initiated by individuals with deep social involvement. (The Suicide Research and Prevention Unit has posted an up-to-date national overview of contact persons for support groups on this website, [Sett inn lenke her](#)) The programme and procedures may vary from place to place, but the aims of these groups are the same: to re-establish a satisfactory quality of life and prevent mental suffering (and suicides).

Do suicide survivors receive adequate assistance?

Kari Dyregrov, Norwegian sociologist, has recently published the findings from her study of the public assistance schemes for survivors after the suicide of young persons. Feedback from 321 Norwegian municipalities provides the basis for the following conclusions: In most cases the assistance system quickly contacted the bereaved, but the time and manner in which contact was established appeared haphazard, the follow-up period of time varied and the programme offered to children was lacking. Better care schemes and better access to them appeared to be most common in small municipalities and in municipalities with a permanent coordinator, crisis teams and written procedures for care (Dyregrov et al. 1999). Dyregrov recommends that a crisis action plan and grief contingency plan should be drawn up in all municipalities.

LEVE – (Norwegian abbreviation for the Norwegian Organization for Suicide Survivors – Landsforeningen for etterlatte ved selvmord)

The study cited above confirms the impression we have that care offered to suicide survivors is inadequately developed in this country. Efforts must be reinforced in many of the areas we have mentioned in this article. Suicide survivors themselves are a central resource group for these efforts, willing and able to contribute. Thus a milestone was reached when the Norwegian Organization for Suicide Survivors – LEVE – (the abbreviation spells the Norwegian word "live") was founded in

December 1999. The main aim of the association is to ensure that suicide survivors receive appropriate support and follow-up. Currently the organization structure is under development and strategies and central schemes are being designed. A number of prime movers are participating in this process, and support has been granted by the National Health Inspectorate and the Suicide Research and Prevention Unit.

Developments

The trend in other countries also shows that suicide survivors tend to form or join associations and foundations to provide better assistance and support for people who end up in their situation. In our neighbouring country of Sweden the SPES association (Swedish abbreviation for suicide prevention and survivor support – *spes* is Latin and means hope) has already been active for some years, and has been very active centrally and locally. The SPAN organization (Suicide Prevention Advocacy Network – span can mean bridge) is active in the USA. The founders of this organization have focused much of their energy on influencing politicians and other decision-makers to establish a national suicide prevention programme in the USA – and they have succeeded. We see that in a growing number of countries suicide survivors are playing active roles not only when it comes to providing care for themselves and others in their situation, but also concerning the prevention of suicides in a larger context. The international organization for suicide prevention - IASP – is also now focusing more on the situation of survivors, and it must be assumed that cooperation between professionals and volunteers thus will be bolstered.

All the constructive activities we have mentioned here have been made possible because the taboos and stigmas that have surrounded suicide are becoming less inhibiting. There is reason for optimism when we consider the involvement that might be generated for suicide prevention among the general population.

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