What Do We Know About Needs for Help After Suicide in Different Parts of the World?

A Phenomenological Perspective

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Abstract. *Background:* "A person's death is not only an ending: it is also a beginning – for the survivors. Indeed, in the case of suicide, the largest public health problem is neither the prevention of suicide (. . .), nor the management of attempts (. . .), but the alleviation of the effects of stress in the survivor-victims of suicidal deaths, whose lives are forever changed and who, over a period of years, numbers in the millions . . ." (Edwin S. Shneidman, 1973). *Aims:* As there is no doubt that suicide postvention should be given a more prominent position on the agenda than is presently the case, this paper explores what we now know about perceived needs for help on the part of suicide bereaved in different parts of the world. *Methods:* A search of related literature in the field was undertaken using the PubMed/PsychInfo databases. In addition, professionals throughout the world working in the field of suicide postvention were invited to submit reports about suicide postvention measures or literature. *Results:* Very little research was found that reflected the perceived needs for help on the part of the bereaved – and all the studies stemmed from countries in the Western world. However, the bereaved in these studies agreed about a common need for peer and social support, and that professional help must be adapted to and offered with respect for individual needs. Thus, it seems that in societies in which the stigma about suicide has diminished, the bereaved experience very similar needs for help, whereas in other societies it is difficult to talk about their need for help because of the sanctions and taboos connected to suicide. *Conclusions:* We need far more culturally sensitive research in order to explore and clarify how each community understands suicide and reacts to families who have lost someone by suicide.

Keywords: suicide postvention, needs for help, suicide stigma, culture and suicide, suicide bereaved/survivors

Introduction

During the last 15 years, there has been a positive development regarding postvention and individuals bereaved by suicide. This is important, as politicians, professionals, and the public need to devote greater attention to both suicide pre- and postvention. Still, research is lacking and support services must be improved in order for life to go on for the millions of people throughout the world who are bereaved by suicide every year. We are especially lacking knowledge about the needs of the suicide bereaved as they personally perceive these, and how this perception may vary in different societies. At a more profound level, the claim has been made that researchers worldwide must learn from the bereaved, acknowledging the bereaved as the experts they unfortunately are.

After having defined some key concepts, and reviewed what we know about the perceived needs of persons bereaved by suicide for support worldwide, the paper discusses what may govern the experience of suicidal loss and perceived needs for postvention. It concludes with some suggestions regarding what may be done to improve suicide postvention globally.

Some Key Concepts

Suicide survivors is a term widely used in the South and North American context and is synonymous with the concept *suicide bereaved*, which is applied in other parts of the world as well as in this paper. In line with Andriessen (Farberow, personal communication, cited in Andriessen, 2009) the term suicide survivor (a bereaved individual) integrates three aspects: It refers to the behavior of someone else (and not to one's own suicide attempt), to the death and absence of that person, and to the subsequent impact on the surviving persons (Andriessen, 2009, p. 43). Traditionally, the concept has been reserved for the immediate

Crisis 2011; Vol. 32(6):310–318
DOI: 10.1027/0227-5910/a000098

family, which in Western societies consists of approximately five individuals after each suicide. However, recently it has become more common to extend it to include others who are strongly affected by a suicide, such as friends, sweethearts, fellow students, work colleagues, and neighbors (Andriessen, 2005; Dyregrov & Dyregrov, 2008). This suggests that in Western countries 10 to 15 persons could be defined as suicide bereaved per suicide – and probably many more in non-Western societies. This latter, rather phenomenological concept of the bereaved person is important, as it could entail more people receiving the help and support they need after a suicide.

Suicide Bereavement

Although suicide is an individual act, it has widespread consequences for the bereaved. Decades ago the late and great suicidologist Professor Edwin Shneidman put a focus on those bereaved by suicide and paved the way for the field of suicide postvention when he wrote:

> A person's death is not only an ending: it is also a beginning – for the survivors. Indeed, in the case of suicide, the largest public health problem is neither the prevention of suicide (. . .), nor the management of attempts (. . .), but the alleviation of the effects of stress in the survivor-victims of suicidal deaths, whose lives are forever changed and who, over a period of years, numbers in the millions . . . (Shneidman, 1973, p. 33)

Chow from Hong Kong (2006, p. 293), elaborates on this by stating:

> A suicide seems to end the pain of the completer, yet commences a lengthy agony of those who love him or her.

Although the bereaved (and most suicidologists) may possess this knowledge, there has been a general lack of understanding in society about the degree to which the suicide bereaved may be at risk of psychological stress, existential crisis, social difficulties, and elevated rates of complicated grief – as well as an increased life risk of suicide themselves (Dyregrov, Nordanger, & Dyregrov, 2003; Farberow, 2001; Jordan, 2001; Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004; Qin, Agerbo, & Mortensen, 2002). There has also been an increasing focus on the traumatic impact that accompanies a sudden and violent death such as a suicide (Li, Precht, Mortensen, & Olsen, 2003). As suicide bereavement can have such wide-reaching consequences, it should be considered a public health issue.

The Meaning of Suicide and Suicidal Loss Across Cultures

As Valsiner (2003) emphasized, culture is neither a static variable nor a measurable concept; nor can it be understood as a linear, casual construct explained in a linear, causal manner. Rather, culture is part of the interaction between human beings and their surroundings.

Several authors have shown how grief reactions are molded by the culture; they are formed by one's societal belief systems, expectations, values, and norms for relationships (Cvinar, 2005; Dyregrov, 2010). This influences both the expression and duration of grief reactions across different cultural settings. Therefore, both within and between societies, the suicide bereaved define their needs for help in connection with the meaning they attribute to suicide in general as well as to their personal loss. One may expect that the bereaved in different societies attribute different meanings to a suicide, and consequently have different perceptions of the help they need.

Postvention

As mentioned, Shneidman was one of the very first to alert the public to the needs of bereaved family members or friends after suicidal deaths. Already back in 1969, he defined postvention as primarily aimed at mollifying the psychological sequel of a suicidal death, by alleviating the effects of stress in the "survivor-victims" (as he called them). He also introduced the term "postvention," a combination of "prevention" and "intervention" (Shneidman, 1969). Based on the work of Edwin Shneidman and Norman Farberow, Karl Andriessen (2009, p. 43) offers a more pragmatic definition, stating that:

> Postvention is those activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behavior.

Combined, the definitions above point to the necessity of facilitating the recovery from suicide, by mollifying the effects and preventing adverse outcomes, through different activities. What kinds of activities or support should this be? Is social support/informal support sufficient for most bereaved – or do some also want professional/formal support? Jordan and McMenamy (2004) conducted a review, which showed that formal interventions after a loss might be especially effective for people who are at an elevated risk of developing a complicated grief response. In addition, a review paper of controlled studies from 2008 concluded that there is evidence of some benefit from interventions for people bereaved by suicide, although the findings are not conclusive (McDaid, Trowman, Golder, Hawton, & Sowden, 2008). Several other papers also state that the question of how the bereaved can be helped is an important one (Dyregrov, 2002; Jordan & Neimeyer, 2003; Wilson & Clark, 2005), not only for secondary prevention of complicated grief for an at-risk population (Mitchell et al., 2004), but also for primary prevention of suicide (Qin et al., 2002). However, our knowledge about effective postvention strategies is currently rudimentary at best. To secure knowledge that will make a difference, this must

include the perceived needs for help from the target group – which is the focus of this paper.

Method

Inclusion Criteria and Search Strategy

In order to acquire an overview of what we know about the perceived needs, we undertook a search of relevant literature in the field. We included studies if they met the following criteria: (1) research studies where the bereaved themselves expressed their perceived needs for help after suicide (i.e., a phenomenological perspective); (2) quantitative and/or qualitative studies; (3) publications in Norwegian, Swedish, Danish, and English; (4) publications in peer-reviewed journals and books.

The PubMed and PsychINFO databases were used for the following keywords: suicide and bereaved/survivors, suicide and postvention, postvention and needs, suicide and bereaved/survivors and needs, suicide and postvention and needs, suicide and postvention and needs and perception, suicide and bereaved/survivor and culture. Note that only research studies based on the perceived needs of the suicide bereaved are presented in this paper.

In addition, professionals throughout the world working in the field of suicide postvention were contacted by e-mail through the International Postvention Taskforce network (33 professionals) in order to secure information about unpublished or non-English publications from studies from different parts of the world. A high response rate, great enthusiasm, and a willingness to help were displayed. Professionals forwarded the e-mail to their own networks so that many suicide bereaved, clinicians, and researchers submitted e-mails, references, papers, etc. However, few actually contained research results about the self-reported needs of suicide bereaved, and none yielded information beyond the literature search.

The papers that met the inclusion criteria were analyzed by comparing differences and similarities of perceived needs, and presented as an ad-hoc structure for a narrative presentation.

Results

Research Mapping Needs for Help

The review showed that only five studies had been carried out and published in English asking directly the suicide bereaved about their perceived needs. These studies represented bereaved in United States from the Family Loss Project run by McMenemy, Jordan, and Mitchell (2008), and another by Provini and her group (Provini, Everett, & Pfeffer, 2000). Wilson and Clark (2005) carried out The South Australian Suicide Postvention Project in Australia (Wilson, 2010). In Europe, de Groot, Keijser, and Neeleman (2006) conducted the Survivors at Risk Project in The Netherlands, and a research group in Norway completed the project Support and Care After Suicide in 1999 (Dyregrov, 2002; Dyregrov et al., 2003). In addition, a nationwide study from Belgium from the year 2000 had been published in English in an abridged form (Grad, Clark, Dyregrov, & Andriessen, 2004; for a full report, see Andriessen, Delhaise, & Forceville, 2001). The latter study explored the perceived needs for help of 171 suicide bereaved. So far, all the studies only represent populations in Western societies, with no studies having adequately investigated the perceived needs for postvention in non-Western societies, among indigenous people, rural and remote populations, and non-white populations, etc. However, exciting studies have been initiated and results will soon be emerging from hitherto understudied cultures or subcultures around the world.

Peter Lee at the Hong Kong Centre for Suicide Research and Prevention has initiated an important 3-year multidisciplinary project aimed at understanding the needs and identifying the best practice to help the suicide bereaved in Hong Kong (Wong, 2008). Another study is a Ugandan/Norwegian psychological autopsy study presently being conducted by Dorothy Kizza (Kizza, Hjelmeland, Kinyanda, & Knizek, 2010), one goals of which is to explore what the bereaved in northern Uganda need following a suicide. Under challenging circumstances (such as conducting outdoor interviews in noisy surroundings), Kizza interviewed two to five bereaved individuals for each of twenty suicides. Finally, the indigenous Sami population of Norway is currently being studied both quantitatively and qualitatively by Dr. Anne Silviken, who is leading an interdisciplinary group of professionals and will not only explore the needs of the suicide bereaved for help, but also their resilience from a cultural perspective. Hopefully, we will learn more about the diversity of the needs of the bereaved for support, and potential similarities in the years to come.

What Do We Know About Perceived Needs for Help?

Despite some minor differences in findings, the existing postvention research shows astonishing similarities – both regarding the impact on the psychosocial situation of the bereaved and their coping resources as well as their needs for support. Overall, the suicide bereaved experience a great need for help (Andriessen et al., 2001; Dyregrov, 2002; Farberow, 1991; McMenamy et al., 2008; Provini et al., 2000; Wilson & Clark, 2005). Moreover, they state that it is not a matter of *either* professional help and public assistance *or* informal support from social networks and peers. Rather, each source of help can address different needs (Dyregrov, 2002; Wilson & Clark, 2005). Sadly

enough, another commonality found in the studies is the discrepancy between their wishes and needs for help and how these are actually met.

Peer Support Is Wanted

Peer support may come about when a bereaved individual meets with other bereaved people in support groups, peer organizations, or when those who have experienced the same kind of loss meet one-on-one through private initiatives or connections (McMenamy et al., 2008). Support groups, helplines, weekend retreats, and conferences for bereaved are also considered very valuable: They offer a safe and confidential environment in which bereaved people can share their experiences and feelings as well as gain and give support mutually. Many bereaved, though not all, wish to meet others who have experienced losing someone through suicide (Dyregrov, 2002; Feigelman, Gorman, Beal Chastain, & Jordan, 2008; Provini et al., 2000; Wertheimer, 2001).

"We need not say very much when we meet, because we already know" is what one often hears regarding such encounters. The suicide bereaved may cry and receive acceptance and understanding and be comfortable telling their story to somebody who is able to really listen and understand. It is also easier for people bereaved by suicide to allow themselves to laugh and enjoy themselves in the presence of other bereaved, without the risk of being misunderstood. Time spent together is experienced as a "timeout," because they can be wholly and fully themselves and need not hide their sadness and continually pull themselves together or pretend. Through the community of peers, the bereaved receive confirmation that their reactions and thoughts are normal and natural. They may also express thoughts and feelings on their own terms and need not hide "the very worst" – as other bereaved "can stand to hear it" (Dyregrov & Dyregrov, 2008).

Many bereaved people receive (and give) valuable information and good advice from peers. Advice that comes from others in the same situation is considered extremely credible. This can be a matter of advice concerning coping strategies, assistance programs that are available or that have worked for them, or useful literature. The fact that both parties give and take contributes to feelings of equal worth and increased self-respect at a time when many bereaved otherwise experience crushing blows to their self-esteem. In particular, they will be able to share and receive support on a long-term perspective, when the time comes that others appear to have forgotten the deceased and what has happened. This type of community may also give hope for the future in that one meets others who have advanced further in the grieving process than oneself. Over time, many of the bereaved also feel it is extremely meaningful to be able to provide support for other bereaved persons. It helps to instill a meaningless event with a kind of meaning (Dyregrov & Dyregrov, 2008; Neimeyer, 2001; Neimeyer, Baldwin & Gillies, 2006).

Social Network Support Is Wanted

The extensive support many bereaved receive from family, friends, colleagues, and neighbors is greatly appreciated and needed (Dyregrov & Dyregrov, 2008). Of greatest importance, however, is the experience that the network "cares" – that they make contact, are available when needed, and that they listen, showing empathy and willingness to talk about the deceased. Support in the form of flowers, visits, telephone calls, and letters is appreciated, as is stepping in to help with children and practical matters in everyday life. The bereaved appreciate when networks gradually help them to return to a more normal daily life through work and social activities. Family and friends become an important part of daily life at a time when the world has fallen apart and everything has been turned upside down. Therefore, one often hears the bereaved say that "without family and friends I would have never managed," or that the social support is the "alpha and omega" (Dyregrov, 2008; Feigelman et al., 2008; McMenamy et al., 2008; Wilson & Clark, 2005).

It is of significance to note that the bereaved ask their social network to take the initiative and do not expect the type of 50–50 reciprocality that is commonly the norm among friends. The bereaved need friends that are present and available, and who listen with sincerity and in earnest. Moreover, they appreciate empathy, respect, and patience for the individual's way of grieving. Finally, many bereaved need practical help when everyday life returns and strongly appreciate support that is given over time (Dyregrov & Dyregrov, 2008).

Professional Help Is Wanted

Although support from peers and networks is considered to be of the great importance, the bereaved also stress that professionals should be included to some extent. In 2002, Provini et al. (2000) reported on self-perceived concerns about bereavement, needs for assistance, and help-seeking behavior of 227 next-of-kin adults bereaved by suicide. They found that professional intervention was the most frequently reported need and type of desired help. Although some bereaved people had not sought help because they felt able to cope without assistance, others encountered barriers to receiving the desired help. The researchers suggested that increased and sustained community outreach would help this population. In another study, de Groot and her group (2006) documented that psychosocial health was significantly worse among first-degree suicide-bereaved relatives than among relatives who were survivors of natural deaths. Additionally, the perceived need for professional help was nine times higher among the suicide bereaved

compared to other bereaved individuals, even after adjustments for relevant variables. In the late 1990s, 198 Norwegian parents and siblings bereaved by suicide were asked about their wishes for help. The results showed that 80% asked for contact with professionals. The bereaved wanted more, or other types of, professional help than they actually had received. However, they also stressed that they were not seeking to become lifetime clients of a treatment system, but rather that they would like guidance toward self-help, which would eventually enable them to get on with their lives in the best way possible (Dyregrov, 2002; McMenamy et al., 2008; Wilson & Clark, 2005).

The bereaved ask for *early and outreach assistance*, where they need not take the first initiative for contact (Andriessen et al., 2001; Dyregrov, 2002). Although assistance workers may tell the bereaved to contact them if they need help, many of them stress that they are not capable of asking for such help, even though they really need it. The bereaved give different explanations for this. First, a loss of energy and exhaustion disables many from contacting the assistance scheme (Dyregrov, 2002), so that, paradoxically, one of the most important reasons for the need for help thus becomes a barrier to its acquisition. Feelings of shame or guilt, or prejudices on the part of those in the surroundings can also contribute to the bereaved hesitating to seek out professional help. In a pilot study, McMenamy et al. (2008) found that many bereaved do not get the professional help they need because depression or a lack of information acts as a barrier.

Information

After a suicide, the bereaved have a great need for different types of information. They want information about the medical aspects of the suicide, the grief process, and about how the death can affect family members and the family as a unit. In particular, adults often ask for advice in helping bereaved children and young people, and for handling communication problems in the family. They request both written and oral information (Andriessen et al., 2001; Dyregrov, 2002; Murphy, 2000; Wilson & Clark, 2005).

Varied Help

Many grieving families have a need for various types of help. Beyond information, help is also required with regard to the existential, practical, economic, and legal questions, as well as therapeutic help and advice. Wilson and Clark (2005) reported that while 94% of the Australians bereaved by suicide asked for a broad spectrum of needs-targeted help outside the family, only 44% had actually received such help. In particular, the need for more specific psychological assistance and advice on self-mastery to reduce stress reactions, nightmares, and flashbacks is emphasized. As shown by a meta-analysis by Schut, Stroebe, Van den Bout, and Terheggen (2001), the more complicated the grief process, the better specific therapeutic interventions appear to work.

Help for Bereaved Children

Parents are often unsure as to whether or not they are "doing the right thing," and whether their children might need more help than they personally are able to provide. In the Norwegian study mentioned earlier, two-thirds of the parents wanted this type of advice and almost 45% felt that they needed a psychologist's help for their children. Parents also sought family counseling to improve the family dynamics, resolve conflicts in parent-child relationships, and receive support and discuss their own thoughts about the best possible way to provide care for their children (Dyregrov, 2002; McMenamy et al., 2008; Wertheimer, 2001; Wilson & Clark, 2005). The younger people in the Norwegian study specified the need for more professional support that directly addressed their needs as independent individuals and on their own terms. They communicated to support services that it was important for them that their parents receive help in coping. This was so that they themselves could be spared having to do so or being burdened with caregiving tasks, such as responsibility for the well-being of younger siblings (Dyregrov & Dyregrov, 2005).

Long-Term Follow-Up

The duration of follow-up is a key topic among the bereaved in the postvention research studies. The bereaved maintain that professional help measures must be of a longer duration than is usually the case. The Norwegian study showed that 73% of the sample wanted contact with the assistance scheme for a minimum of 1 year (Dyregrov, 2002). This is not unlike the requests of bereaved people in other countries (Clark, 2001; de Groot et al., 2006; McMenamy et al., 2008; Murphy, 2000; Provini et al., 2000; Wertheimer, 2001). This provides a striking contrast to the actual experiences of the bereaved, who usually receive help only during the first week(s) while they are still in shock or busy planning the funeral, but are subsequently left to their own devices.

What Can Be Done to Achieve Advances in the Field?

The selected studies conclude that those who are close to the deceased constitute a group of mourners who need to be offered help more proactively than is usually the case in most healthcare systems and communities, although the public guidelines for help measures may require further refinement. It is of significance that the recommendations

include public education regarding destigmatization of suicide and more research about the needs of the bereaved.

Avoiding Ethnocentrism

The research clearly demonstrates that we are still lacking the voices of the bereaved from many parts of the world. There may be some minor or even large similarities between the needs of the bereaved for postvention in other countries and in Western societies – but perhaps not. However, we in the Western world must be extremely cautious in exporting our findings and beliefs about postvention to all parts of the world. This would be ethnocentrism and should be avoided. Instead, we need to include a strong cultural and cross-cultural consciousness in the suicide postvention research. What may be right in Norway, Belgium, the United States, or South Australia may be quite wrong for a population in Ghana, among the Sámi of Norway, or for the Australian Aborigines. In the latter cases, these are subcultures within the majority population, subcultures that could require specifically adapted postvention programs.

Contextualizing Postvention Strategies

We ought to promote a postvention policy in all societies which identifies and recognizes suicide postvention as a suicide-prevention strategy. This policy should guide best practice procedures and guidelines that address issues regarding the provision of culturally appropriate services. The studies cited in this paper have all concluded by giving advice to their respective societies about what actions to take. Although there may be some principles that are common among the majority of bereaved individuals, it is of the utmost importance that postvention plans and strategies be adapted to individuals and their families for each unique cultural context. There are many reasons why politicians, researchers, and communities have historically neglected the situation of the suicide bereaved – and in many societies still do. The most important is the huge variations in the ascribed meaning of suicide and suicidal loss from culture to culture. Therefore, the role of postvention must be situated within and connected to its cultural context.

Attending to the Ascribed Meaning of Suicide and Suicidal Loss

In line with Donna H. Barnes (2006), in order to understand a person's reaction to a suicide and his/her perceived needs for support, one should consider some important questions:

- How do the bereaved actually respond to the suicide?
- What attitude does the society have toward suicide?
- What knowledge of suicidal processes and the situation of the bereaved do professionals have? Does the public have this knowledge?
- Are bereaved people willing to accept help?
- Are peers, networks, and professionals willing, or do they have the opportunity, to offer help?
- Is there any economic basis for welfare programs for public postvention?
- What rituals does the given society have when crisis strikes?

One common denominator that has a strong impact on most of these factors is the magnitude of the taboo connected to suicide (Barnes, 2006). If suicide is heavily stigmatized in a society, the bereaved will conceal their loss and their responses to it and will consequently not receive help or support for their actual struggles. Public and professional knowledge as well as economic funding are then not given priority, and joint services for support in time of crisis, such as religious societies, may avoid involvement in the taboo-ridden field.

Recognizing the Effect of Stigma on Postvention

In a literature review concerning suicide and stigma, Jacqueline Cvinar (2005) concluded that one of the distinguishing features found in suicide bereavement versus normal bereavement is the stigma the bereaved experienced. Therefore, the stigma of suicide will have a major impact on whether or not, and to what extent, help is available in a given society – and thus, of course, the extent to which it is sought out and used by the bereaved. Moreover, with stigma comes shame, guilt, and feelings of rejection (Begley & Quayle, 2007). Therefore, many bereaved feel that their friends and local community reject them. Often this becomes a two-way process in that the bereaved wish to be cut off from the pain of the past and may well misinterpret the extent of the rejection. Consequently, the bereaved may explain the death by statements such as *he died of an illness* or *she died by accident*. In addition to disclosing the cause of death, self-attribution for the death is also a source of stress, and those who experience it are generally ashamed about discussing this openly. Thus, the stigmatization can be painful for individuals whose guilt, shame, and blame can be intensified and reinforced by the lack of discussion about suicide in society in general (Dyregrov, 2010). In addition, this may be reinforced due to the lack of opportunity they have to talk about their experience of being bereaved. Instead, they may be expected to "get on with their lives," which leaves little room for grieving.

Therefore, in societies in which stigma about suicide remains prevalent, the bereaved will try to conceal the cause of death – a concealment that is rooted in a sense of insecurity and fear of discrimination. It will consequently be unusual to receive information and support from professionals and social networks. As such, when discussing postvention, we must always look at the stigmatization to

understand how the bereaved may be best supported and helped. Only when stigma is reduced or removed – and combined with empathetic understanding – will the bereaved feel that it is safe for them to share their feelings with each other, professionals and their local communities.

Culturally Sensitive Research

The one-size-fits-all approach is not useful for the development of postvention services. Rather, we need far more culturally sensitive research to explore and clarify how each community understands suicide and reacts to families who have lost someone by suicide. There is still a need to address the healing process, and we should study the situation as experienced by the bereaved, in addition to scrutinizing the context of their bereavement. To learn from and about the suicide bereaved from a cross-national perspective, varied research methods are needed. In addition to quantitative methods, we need a greater focus on qualitative methods that explore phenomena or processes. We should apply explorative methods such as phenomenological and ethnographic research that rely on indepth interviews, personal narratives, and stories, and we should participate in settings together with the bereaved. Researchers need to be creative and well-schooled in all kinds of research methods in order to include the great variety of bereavement processes and stigma, as well as to develop postvention strategies adapted to different societies and bereaved individuals around the world.

In line with leading grief researchers (Stroebe et al., 2008), we need to develop primary preventive interventions that will be open to those experiencing uncomplicated bereavement, secondary preventive interventions for the more vulnerable, and a tertiary level for those who are experiencing prolonged or complicated grief.

Listening to the Bereaved

This must be done in different societies around the world to learn about *their* needs for help and support. To enable interventions to build on the natural coping strategies of bereaved in their unique context, we need to know what these strategies are. To succeed in creating true insider knowledge, researchers must work more closely with bereaved, for example by including them as coresearchers. Certainly, research has shown that most participating individuals appreciate the opportunity to take part (Dyregrov, 2004; Hawton, Houston, Malmberg & Simkin, 2003). As stated by a suicide survivor "Survivors are not delicate flowers that need to be handled with extreme care" (Peters, 2009, p. 1). By stressing the importance of user/consumer participation, we may ensure final recommendations that are more realistic, applicable and appropriate for the suicide bereaved and that suicide postvention is relevant for every society.

Conclusion

Taking the words of Shneidman, "the father of suicidology," seriously implies that IASP, clinicians, researchers, bureaucrats, and the bereaved should strive to give suicide postvention a more prominent position on the agenda in the future. The stigma in any given society acts as an important backdrop for the perceived need of the bereaved for help, and for how they are supported. Therefore, when discussing postvention, we must also look at the stigma in a given society so we can understand if and how the bereaved may be better supported after a suicide (Cvinar, 2005). The word "suicide" has to become part of the communities of all bereaved. There is an entire healing process that needs to be addressed, and the situation as experienced by the bereaved needs to be studied further. The context of the bereavement also needs to be scrutinized: We should explore what the cultural understandings of suicide are and how the particular community reacts to families who lose someone to suicide. Finally, the bereaved in many societies must be asked about their views regarding how their communities respond so we can understand which types of pre-, inter- and postvention programs need to be developed and tested for effectiveness in that particular community. We need public education regarding destigmatization of suicide and the perceived needs of the bereaved. Moreover, we need a reinforcement of internal and external coping support, facilitation of access to both professional and community help, and better and more coordinated culturally appropriate services. Still, we should always remember that, although the bereaved experience crisis, they have many constructive competencies and a large pool of resources.

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Received April 21, 2010
Revision received March 16, 2011
Accepted March 22, 2011
Published online July 8, 2011

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