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Experiences of the bereaved in connection with the suicide of young men

ORIGINAL ARTICLE

METTE LYBERG RASMUSSEN

E-mail: mette.lyberg.rasmussen@fhi.no
Division of Mental Health and Suicide
Norwegian Institute of Public Health
She has contributed to the formulation of the research question, the collection, analysis and interpretation of data and the drafting of the actual manuscript.
Mette Lyberg Rasmussen PhD (born 1966) is a psychologist and postdoctoral researcher. She is also a clinical psychologist at Akershus University Hospital, Groruddalen Regional Psychiatric Service.
The author has completed the ICMJE form and reports no conflicts of interest.

GUDRUN DIESERUD

Division of Mental Health and Suicide
Norwegian Institute of Public Health
and
Bærum Municipality
She has contributed to the formulation of the research question, the collection, analysis and interpretation of data and the drafting of the actual manuscript.
Gudrun Dieserud PhD (born 1944) is a retired senior researcher and clinical psychologist.
The author has completed the ICMJE form and reports no conflicts of interest.

BACKGROUND

Each year, an average of 110 men under the age of 35 take their lives in Norway. Few receive health assistance in the period prior to the suicide. There is little existing research on contact with help services for those who take their lives, other than studies of the number of visits to doctors prior to death. The purpose of this study was to acquire information about the needs of family and friends for help from the health service, both to enable them to detect risk of suicide and to motivate those at risk to seek help in their life crises.

MATERIAL AND METHOD

A total of 61 in-depth interviews with close relatives and friends of young male suicides (aged 18–30 years) were analysed by means of interpretative phenomenological analysis.

RESULTS

The bereaved found the generally accepted assumption that suicide is due to mental illness an obstacle to identifying the risk of suicide. Most of the bereaved had not seen any signs of mental illness prior to the suicide. The suicide crisis was linked to relational factors. Bereaved individuals who had suspected a risk of suicide, found that urging the suicidal person to seek health assistance was not enough. Measures proposed included acquiring more knowledge about suicide and the provision of outreach health assistance.

INTERPRETATION

The findings challenge the current prevention model. Both healthcare personnel and the general public should be better informed that mental illness is neither a sufficient nor a necessary factor for explaining suicide, even though a higher risk of suicide is linked to some mental disorders.

Main points

The bereaved saw few signs of severe mental illness prior to the suicide

The bereaved lacked knowledge on suicide by high achievers

The bereaved felt that the Norwegian healthcare service lacked knowledge of suicide by high achievers

Life's burdens prior to the act of suicide were linked to relational problems and failures

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In recent decades, the Norwegian authorities have put a substantial amount of work into the prevention of suicide (1). Particular attention has been paid to measures in the specialist health service (2). Despite this work, figures from the

Norwegian Cause of Death Register show that the national suicide rates have not fallen for the past 15 years (3). In 2015, 590 people took their lives in Norway; 109 were men under the age of 35.

Our lack of success in reaching young men undergoing a mental crisis with existing help measures is a major problem. Only 13 % of them are in contact with the specialist health service, and only 23 % had sought help from the primary health service in the month prior to committing suicide (4). Some studies also show that few of those who seek health assistance before ending their lives mention their suicidal thoughts during the consultation (5).

The *Action plan for the prevention of suicide and self-harm 2014–2017* stresses that the responsibility for measures to prevent suicide rests with both the primary *and* the specialist health service, and that the development and implementation of measures that lead to more suicidal men seeking health assistance is an area to which particular effort should be devoted (1). Nevertheless, we have little research-based knowledge on which to base action.

Attention in previous research has been primarily focused on the number of visits to doctors in various periods prior to death (4). Little has been published about the experiences of family members, friends, girlfriends/partners and others close to young men who do not seek help from the healthcare service in the period before they take their lives. As our study shows, knowledge of the difficulties these people have in understanding the risk of suicide may be of great importance to both the healthcare service and people generally when it comes to detecting the risk of suicide and motivating the young men to seek help.

We have therefore conducted a research project to answer the questions: What experiences do bereaved persons have of detecting the risk of suicide and motivating young men in a mental crisis to seek health assistance?

Material and method

In the period 2007–2009, material was gathered through in-depth interviews with a total of 61 close friends and relatives of ten young male suicides aged 18–30. The material was extensive, and was collected for the purpose of use in several research projects. Each interview consists of 30–50 A4 pages and sheds light on many different topics associated with the deceased, the reasons for the suicide and the relations of the bereaved with the deceased.

The young men had not previously been in contact with mental health care, nor had they sought help from the primary health service prior to committing suicide. Six of the ten left farewell letters. Ten of the bereaved were mothers, eleven were fathers/step-fathers, ten were siblings, 24 were friends and six were girlfriends or partners. All the bereaved individuals were over 18 years old. The interviews took place 6–18 months after the suicide.

We contacted district medical officers in Southern Norway with written information about the study. They identified relevant suicides through death notices and autopsy reports and contacted the next of kin by phone to inform

them of the study. If the next of kin agreed to take part in the study, they received supplementary written information and a consent declaration. Only when the project manager received the consent declaration, were the interviewers given information about the bereaved person. The bereaved person was contacted by telephone, and the time and place of the interview agreed.

After the first interview, the bereaved persons were asked to mention others who had been close to the deceased. These people were sent information about the study, and the procedure of establishing contact after the consent declaration had been received by the project manager was maintained. The interviewers were the first and second authors and another experienced researcher, all with a high level of expertise in the field of suicide.

Our professional stance is rooted in psychological suicidology theory, where suicidal behaviour is perceived as a reaction to a great internal and external pressure, so that suicide is perceived by the suicidal person as the only way out of an insoluble crisis situation (6). This perception applies whether the deceased had a mental disorder or not.

In accordance with our professional methodology, the interviews started with an open question: "What are your thoughts about the circumstances that caused the deceased to take his life?" In this part we said as little as possible, and gave our informants free rein to recount their stories.

We then followed up with a problem-oriented part, based on Shneidman's method for carrying out in-depth interviews with those bereaved by a suicide, called psychological autopsies (6). In this part, the focus was on topics associated with the deceased's mental state prior to the suicide, negative events in the period prior to the suicide, general personality traits, the quality of interpersonal relations, substance abuse and life histories.

Finally, the bereaved were asked whether they had any thoughts as to what might possibly have averted the suicide. The interviews (1.5–3 hours) were recorded, transcribed and de-identified in accordance with the approval of the Ethics Committee.

The interviews were analysed using a flexible interpretative phenomenological method (7). In previous analyses of the material, we reported how the bereaved see the deceased and the suicide (8–10). We saw then that most of the bereaved persons went over the last conversations they had had with the deceased for answers to the questions "Why didn't I see the suicide coming?" and "Could I have done more to get hold of health assistance?"

In order to examine these questions, the entire material was reviewed again, and analysed with this as the principal theme. This meant that both authors individually reviewed all the interviews in each of the ten suicide cases, firstly in order to get a grasp of the whole picture, then to identify problems and needs associated with understanding the risk of suicide and motivating at-risk individuals to seek help. By reading through the transcribed material, we arrived at numerous different topics, which were then discussed and challenged at many author meetings. The analytical results were condensed into three main themes.

To strengthen the validity, we have tried to be clear as to how we have drawn conclusions on topics from the concrete material, to enable the reader to follow the analytical path as a basis for interpretation and conclusions. We also present many quotations from the material.

Research on qualitative data demands a high degree of reflectiveness with respect to our own preconceptions and our own engagement. Both authors are clinical psychologists, with long experience of working with persons in suicidal crises under both the municipal and the specialist health service. We have also worked for many years with the bereaved following suicides. Both authors also have long experience as suicide researchers.

The survey has been approved by the Regional Committee for Medical Research Ethics.

Results

Using text analysis, it was possible to break down into three themes the bereaved individuals' experience of problems and needs in the work of identifying suicide risk and motivating potential suicides to seek help: First, the assumption that suicide is due to mental illness was an obstacle. Second, the fact that the suicidal crisis was linked to relational factors. Third, that urging those at risk to seek help is not enough.

The assumption that suicide is due to mental illness was an obstacle.

Most bereaved persons started by saying that the suicide had come as a shock. They had seen no signs of mental illness, but found the deceased to be "normal" and "good at" work and school right up to the time when he took his life.

A friend who had recently been on holiday with the deceased and had attended a lecture at the university the day before the suicide said, for example: "It came as a shock. No signs of any depression. He was quite simply a very smart guy."

The bereaved consistently criticised what they felt was the prevailing view, based on the statements of health personnel, that suicide is due to depression and/or happens to people who are severely mentally ill. They rejected this theory because it seemed "wrong" or "misleading" with respect to how they experienced the deceased in the period prior to the suicide.

In another suicide case, a close family member who worked in the healthcare service, described how the medical model falls short:

He had a job in which he functioned well. He was at school the same day, he was with mates the same day, did all the usual things .... He was the kind who had to be involved in everything, very clever, top marks ... But then what we have seen of irregularities, that he slept badly, broke up with his girlfriend. These little things .... You feel in a way that you should maybe have seen things, psychiatric diagnoses and such, but which did he have?

Most striking was the fact that many of the bereaved spoke about how precisely the assumption that suicide is related to mental illness, coupled with the deceased's facade of being in full control, might have contributed to their overlooking signs of suicide risk (such as sleeping problems, aggressive outbursts, utterances about own death/suicide) that actually were there in the period before the suicide. One mother put it like this:

I haven't thought of him as sick ... he was a clever boy, career ... good salary, nice apartment, car, new partner... He isn't the type ... One thing that I did not take him up on, he said "I'm going to die soon". And I have thought about that a lot and can't understand myself why I didn't take it up ... and I can't make sense of it, either ... he just wasn't sick.

In another suicide case a family member said: "What was strange, was that *he* did it ... he was a resourceful person, stood on his own two feet at an early age, got an education ... he was a together sort of person through and through." The family member went on to say that there was an episode in which the deceased had behaved very badly in public the week before the suicide - "it just wasn't *him* at all .... that's when a lot of alarm bells should have rung".

A lack of knowledge of suicide by high achievers was singled out by many of the bereaved as a key factor in terms of both their own and healthcare personnel's ability to identify a suicidal crisis. One mother said "There is inadequate knowledge, even among primary doctors." In another case, a friend who was at a party with the deceased the same night as he took his life said: "The doctor maintained that this was one of those psychotic cases, that he didn't know what he was doing when he did it, but no. He was never so out of it that he didn't know what he was doing."

On the subject of the need for knowledge about suicide not attributable to mental illness, the best friend of another suicide said:

There are many things I can point to, that if I'd known more about suicide then, maybe I'd have been able to see certain things ... What happens is that it was a real downer when he didn't get that job ... that was a real slap in the face ... he took it very hard personally ... Because there, at work, he has always been very good ... and I don't see this until after things have happened.

The suicide was linked to relational factors.

Another problem a number of bereaved persons mentioned with respect to their possibility of picking up and/or handling the risk of suicide was due to the fact that the suicidal crisis did not arise in a vacuum, but in an interaction between the deceased and some of them. They had therefore not been in a position to understand the seriousness of the threats of suicide and react appropriately to them.

This is illustrated by the following statement from a father about the conversation that took place between him and the deceased just hours before the suicide, when he refused his son's wish to avoid taking responsibility for a normal, but awkward situation that the young man himself had caused:

*And then he said, angrily, then he said, f***, I should have killed myself, he said actually. Then I said, for God's sake, what are you talking about, I said, because it's like, I didn't react when he said it, because often that's the sort of*

thing you say when you're ... But of course, I've thought about it since. But at the time I said what will you achieve by that, you'll just create more problems for us.

This father described how in a conflict situation he experienced his son's threats of taking his own life as totally out of proportion. He went on to say that his project was to make a man out of his immature son, by getting him to do something he expected that a young man should be able to do: "I did what I did because I thought he would learn something from it." In retrospect, he sees that he failed to hear the seriousness of the threat or to respond appropriately. He interpreted the statement about suicide as a sign of weakness.

In connection with another suicide, a former partner described how she too had failed to understand the seriousness of the threats that he couldn't take any more. He had phoned her a week before committing suicide and been despairing. She had experienced very turbulent periods in the relationship and did not want to start up again.

He tried to come closer and closer, but I just couldn't do it. I actually just wanted him further out of my life .... And a week before he took his life, he rang me and said like that he couldn't take it any more: I can't take it any more ... But I didn't interpret it as meaning, I can't take anything anymore...

As these two examples demonstrate, many bereaved persons speak of how they only in retrospect interpret direct threats of suicide and statements about not being able to take any more as expressions of a real risk of suicide. In particular the fact that they were a party to a conflict with the deceased when they received threats of suicide, and thus were themselves agents in the suicide crisis, was singled out by many as key to the possibility of realising that there was a risk of suicide and then acting.

Urging a person to seek help is not enough

In connection with various suicides, some bereaved persons related that they had understood the risk of suicide and urged the deceased person to seek health assistance, but that this in itself had not been enough.

One father had been seriously concerned about his son for weeks before the suicide, after the young man had been stopped from an assumed suicide attempt after a humiliating failure and had then isolated himself at home. The father had therefore made several doctor's appointments for his son. But his son had failed to keep any of them.

In a conversation with the father following the suicide, the primary doctor said that he doubted whether it would have been a good alternative to get the police to come home to his son to help in having him sectioned. This would probably only have exacerbated the shame and the whole problem. At the time of the interview, the father still agreed with the doctor in this assessment. But several times during the interview he mentioned that it should have been possible to arrive at a solution whereby the doctor could have made a house call.

In another suicide case, where all the informants described the deceased as very successful, a former partner related that she had been seriously concerned about the deceased a few days before the suicide. She related the following

about the contents of the conversation she had had with him when he unexpectedly rang her at night:

... Then he said that his job was going to hell and that everything was crap, like ... And then he says that he should just go and shoot himself ... I got really scared, and I asked him, pleaded with him to go and get help, then. Said, you must do it.

The young man took his life a few days after this conversation. He did not seek health assistance, but presented himself as in control and successful in all other relations right up to the time when he took his life. He left a letter in which he wrote that he had been thinking about suicide for a long time.

Why seeking and accepting health assistance does not appear to have been an option for the young men undergoing a suicidal crisis was attributed by many of the bereaved to the sense of having suffered an irreparable failure. They stated that events that are usually viewed as normal for young men (not getting the job one wants, breaking up with a girlfriend, outbursts of aggression), were not tolerated by the deceased. Suicide was viewed as a solution to an "impossible" situation.

Many of the bereaved rejected superficial explanations – such as that the suicide was the result of an impulsive action and/or inadequate knowledge on the part of the healthcare service. One father put it like this: "Why he didn't seek professional help? He knew there was a healthcare service, but decided that this was the solution."

Some bereaved persons attributed the failure to seek help to the deceased's having grown up in a family where facade was important and/or weakness was rejected. One bereaved person said: "Status is important, things have to look *very* good from the outside... he was part of a family where mental problems are taboo ... we don't accept that sort of thing in our family."

Discussion

Inadequate knowledge

A recurring finding in this study is that risk of suicide was not attached to these young men because of their high level of achievement and absence of symptoms of serious mental illness.

The bereaved indicated that mental health professionals generally stress the link between suicide and mental illness when they speak to the media. This has led to a general belief, as they expressed it, that there is no suicide where there is no mental illness.

The bereaved in our study pointed to the need for general information, both to the public and to health personnel, about the complexity surrounding suicide. In other words, mental health professionals must also convey that high achievers may commit suicide, particularly when there is a change in their behaviour.

This finding is consistent with the findings in a study from the UK, where the informants' assumption that suicide is primarily committed by people who are mentally ill or severely depressed, was an obstacle to detecting a risk of suicide in young, high-achieving men (11). This finding is also consistent with both a national and several international studies that have shown that over 40 % of suicides cannot reasonably be attributed to severe mental illness (5, 12, 13).

It may be threatening to acknowledge one's own children's mental problems, not least if they are experienced as having a bearing on one's identity as parent/family. The fact that interviews have also been conducted in this study with individuals who knew the deceased person well, but were not a close family member, is therefore very important. Also these informants do not regard mental illness as an explanation for the suicide.

If we take the experience of the bereaved persons seriously, it appears as though what the general public has been taught about the reasons for suicide has been concentrated too narrowly on mental illness. Moreover, to protect themselves from a sense of guilt, some bereaved persons may attribute the grounds for the suicide to external factors.

This is demonstrated in a British study of parents' interpretation of their sons' suicide (14).

View of the suicide crisis and how it should be handled

The other main finding in our study, that the deceased found himself in a situation of conflict, is interpreted by the bereaved as crucial to the suicide. The young men's experience of rejection in close relationships and/or unmanageable shame due to a failure at work/school was regarded as more important than severe depression/mental illness (9).

This is consistent with the findings of a Norwegian thesis on suicides among the elderly, where analyses of interview material from both the bereaved and healthcare personnel showed that suicide among elderly people was related to loss of self-esteem, not primarily to depression (15). Our findings are also consistent with those of a Norwegian thesis on suicides among young people, in which interviews with parents who have lost children to suicide revealed that some suicides among children and young people were related to relational conflicts rather than mental illness (12).

Overall, these findings indicate that prevention is a matter for both the primary and the specialist health services - and for people in general. The bereaved perceived the conflict situations the deceased experienced before taking his life as well within his ability to deal with. The situation is made more difficult by the fact that some families shrank from seeking health assistance, even where symptoms such as sleeping problems, outbursts of aggression, withdrawal or substance abuse indicated mental stress of some kind. In a couple of the cases the family sought health assistance, and some bereaved individuals expressed a wish that the family doctor should pay a house call when the family are concerned for the person's life.

In Norway, the primary doctor and the accident and emergency department are the first agencies to which people in life crises turn for health assistance. The bereaved in our study indicated that those who are experiencing a crisis and seek health assistance should receive acknowledgement of – and be assisted with – the various problems that triggered their life crisis. They also pointed out that health assistance should be something more than symptom-related in the narrow sense.

This view is also supported by an authority in the field of suicide, Øivind Ekeberg, who says that "action in the event of suicidal behaviour must nonetheless go further than making a psychiatric diagnosis and treating it, as it is a matter not least of interpersonal, social, professional and existential problems" (16).

The bereaved in our study believed that if family or close friends are the prime movers in getting young men in a crisis situation an opportunity for a talk with their primary doctor, the doctor must have a knowledge of the risk of suicide in people who apparently function well, but whose facade is developing cracks. Primary doctors should also engage in active outreach if a young man of this kind does not keep an appointment. This view is supported by studies showing that seeking medical help at the urging of close family and friends is not in itself enough to prevent suicide (17).

Another important implication of our findings is that information campaigns about suicide must be designed to give sufficient space to the knowledge we have about suicide outside the bounds of mental health care. We should continue to establish low-threshold options for people suffering life crises, as a number of municipalities have already done. In particular, we should customise some of these options for young men. For example, there could be separate evenings at the health clinics for young people that target boys/young men. As there are more suicides among men than among women, there is a need for measures like this.

Limitations and strengths of the study

The findings from the interviews with the bereaved cannot be generalised to apply to all young men, but provide insight into the suicides of young high-achieving men. The bereaved family and friends of other young men, other researchers and other qualitative methods may yield different findings. This does not make our findings any less important.

One methodological strength is that we have based the study on open, in-depth interviews with many informants, and that the analysis is linked to knowledge of the specific relationship each informant had with the deceased. For reasons of anonymity some changes have naturally been made, but the proximity to the deceased is correctly described.

Another strength of our study is that the classification by topic and interpretation of the data was conducted individually and then compared and discussed at many author meetings. The fact that the authors have long

experience of working clinically with suicide researchers and those bereaved by suicides, and have scientific expertise, enhances the validity of the findings.

Conclusion

Our findings are not consistent with the established belief that suicide is primarily a symptom of mental disorder. Our study shows how difficult it may be to prevent suicide. At the same time, our findings point to an area of general applicability – namely, the pressure on young people to be successful in most areas of life. That this may lead to suicide is certainly not a new observation for most people.

Future action plans for the prevention of suicide should include a broader perspective of suicide than the illness model.

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