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Factors of Seeking Professional Help by the Bereaved by Suicide

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1. REVIEW OF LITERATURE

1.1 Definition and prevalence of the bereaved by suicide

Almost half a century ago, the pioneer in suicidology, Edwin Schneidman (1972), noted that the scientific and practical interest of this field cannot be limited to understanding only the suicidality of individuals, since every suicide can severely affect people who were close to the deceased (as cited in Dyregrov & Dyregrov, 2005). Traditionally, the closest family members have been considered to be bereaved by suicide (Dyregrov, 2011). However, it is argued that other people, regardless of their kinship with the deceased, can also feel the consequences of the loss. For example, Honeycutt and Praetorius (2016) found that there are many different relationships in which people can be bereaved: the participants of support groups mentioned 41 different type of the relationship to the deceased. According to the authors, the results reveal that the circle of people affected by a suicide is not limited only to members of the nuclear family. Very different people can identify themselves as suicide survivors, feel the impact of the loss on their well-being and seek help.

On the other hand, it is important to acknowledge that if a person has lost someone to suicide, it does not necessarily mean that he or she is grieving (Honeycutt & Praetorius, 2016). Berman (2011, p. 111) provides an abstract and broad definition of bereaved people: "those intimately and directly affected by a suicide; that is, those who would self-define as survivors after the suicide of another person". Andriessen (2009) claims that a person bereaved by suicide is someone who has lost an important person to suicide and whose life has changed after the loss. Therefore, the subjectively perceived closeness and quality of the relationship can be more important in the process of bereavement than simply the type of kinship to the deceased.

It was thought that every suicide affects six closest family members. Such estimation was suggested by Schneidman in 1969 (as cited in Andriessen, 2009). Unfortunately, the problems of describing suicide survivors discussed above also have an impact on a more accurate evaluation of the prevalence of the bereaved. According to Knieper (1999), suicide affects about 28 people. Other authors claim that every suicide has an impact on five family members (Chen, Choi, Mori, Sawada, & Sugano, 2009), about 14 other relatives, 20 friends and coworkers (Berman, 2011). Dyregrov (2009) points out that in Western culture one could count about 10-15 people bereaved after every suicide. So, based on this suggestion, one could estimate that in Lithuania in 2017, from 7480 to 11200 people were left grieving after suicide of a loved one. Whatever the estimation, it is obvious that many people are affected by suicides every year.

1.2 Bereavement after suicide

Bereavement after suicide can be defined as a period of grieving and adaptation to the loss which is experienced by a person who was close to or had a contact with the deceased and has been affected by the death (Pitman, Osborn, King, & Erlangsen, 2014). Losses following suicide are characterized by various, often intense physical, cognitive, emotional reactions and social changes (Begley & Quayle, 2007; Klimaitė, 2015). They can include shock, disbelief, fear, sadness, guilt, shame, anger, sense of relief, helplessness, feelings of emptiness, questioning why the loved one died of suicide, search for the meaning of the loss, lack of energy, concentration difficulties, disturbance of the daily life and others (Begley & Quayle, 2007; Fielden, 2003; Lindqvist, Johansson & Karlsson, 2008; McMenamy, Jordan, & Mitchell, 2008; Supiano, 2012). Loss due to suicide is seen as potentially traumatic as it is often sudden, unexpected, violent and may lead to symptoms of post-traumatic stress disorder (Green, 2000; Harrington-LaMorie, Jordan, Ruocco,

& Cerel, 2018). It has been noticed that after the suicide of an important person the bereaved themselves can have increased suicide risk (Harrington-LaMorie et al., 2018; Pitman et al. 2014; Supiano, 2012). Suicidal loss can also cause doubting the essential assumptions about the existence (lost sense of control, trust or security) (Begley & Quayle, 2007; Dyregrov & Dyregrov, 2005; Green, 2000). In addition, suicides might result in changes in family system and communicational disturbances in families (Cerel, Jordan, & Duberstein, 2008). In short, loss after suicide can often cause various intense intrapsychic and psychosocial changes and difficulties.

Bereavement is a natural reaction to a loss and many individuals adapt to changes caused by the death after some time. However, long-lasting and intense grief reactions can have particularly negative consequences for further adaptation of a bereaved person (Jordan & Litz, 2014; Prigerson et al., 2009). Such complicated and prolonged reactions are also defined as "complicated grief", "traumatic grief", "prolonged grief" or "chronic grief" in scientific literature (Kersting, Brahler, Glaesmer, & Wagner, 2011; Prigerson et al., 2009; Rando et al., 2012). Although the definitions may differ, they all involve grief process that is disturbed and not adaptive (Howarth, 2011). In order to maintain consistency in this paper, we are using the term of Prolonged Grief Disorder (PGD) proposed by Prigerson et al. (2009), which was also chosen for the latest version of the International Classification of Diseases (ICD-11). Unexpected traumatic losses, including suicide, are identified as risk factors for prolonged grief (Lobb et al., 2010).

Unlike grief without complications, prolonged grief tends to be "stuck" and intense reactions interfering with normal functioning of a daily life can last for a very long time if no measures are taken to cope with it. For example, Pivar and Field (2004) investigated the bereavement of war veterans and discovered that a person can still experience intense grief symptoms even after 30 years since the

event. Wago, Byrkjedal, Sinnes, Hystad and Dyregrov (2017) found that more intense prolonged grief symptoms 18 months after the loss were related to more intense symptoms after 28 and 40 months. Although this study showed that the intensity of the symptomatology of prolonged grief significantly decreases as time passes, even after 3.5 years since the death the level of PG remains high. Other studies showed that individuals who could be diagnosed with prolonged grief disorder have a higher suicide risk (Latham & Prigerson, 2004; Schaal, Elbert, & Neuner, 2009; Maciejewski, Maercker, Boelen, & Prigerson, 2016). Hence, unresolved grief may aggravate adaptation for a long time and become a chronic condition that does not end itself unless effective clinical interventions are implemented (Prigerson et al., 1995; Schaal et al., 2009).

One important question is whether bereavement after suicide is different from bereavement after other types of losses (natural, unexpected deaths, etc.). It is considered that losses due to natural causes do not provoke as many traumatic reactions as violent and unexpected deaths like suicide (Klimaitė, 2015). Qualitative studies show that bereavement after suicide can often be characterized by certain specific reactions: more frequent questions about reasons for suicide, increased feelings of guilt, blame, responsibility, rejection, and others (Clark & Goldney, 1995; Clark, 2001; Jordan, 2001; Harwood, Hawton, Hope, & Jacoby, 2002). Sveen and Walby (2007) conducted a meta-analysis of 41 bereavement studies and came to the conclusion that people bereaved by suicide experience stronger feelings of rejection, shame, guilt, stigma, and are more likely to search for reasons of death. According to the authors, the results may also depend on the instruments used. When data are collected by scales assessing common grief features differences are usually not found or they are small. If more specific instruments are chosen (in this case, assessing the essential aspects of suicidal loss), the differences are more evident.

1.3 Suicide bereavement peculiarities

1.3.1 Guilt in suicide bereavement

Guilt feelings are often experienced after a loved one has died of suicide. According to Li, Stroebe, Chan and Chow (2014, p. 166) guilt can be defined as "a remorseful emotional reaction in grieving with the recognition of having failed to live up to one's own inner standards and expectations in relationship to the deceased and/or the death". Intense and chronic feelings of guilt can have a strong negative effect on person's emotional well-being (Clark, 2012). Li et al. (2014) in their meta-analysis conclude that experience of guilt is related to distress, poorer adaptation, and prolonged grief symptoms. In order to redeem his or her guilt, a person can use various punishments against himself or herself hoping to restore the inner sense of justice (Fisher & Exline, 2010). Avoidance strategies, such as social isolation or use of psychoactive substances, can also be used to reduce emotional pain caused by guilt (Clark, 2012).

As mentioned before, feelings of guilt are often more intense in bereavement following suicide. Although guilt can occur after various losses, suicide usually reinforces these feelings as death is perceived as a choice of the deceased (Fielden, 2003). The bereaved might assume that they had contributed to the problems of the deceased (Clark, 2012) or were one of the reasons why the loved one died of suicide (Andriessen, Krysinska, Draper, Dudley, & Mitchell, 2018). Survivors often blame themselves for not noticing or not reacting to signs of suicide risk, not helping the deceased enough (Klimaitė, 2015). In addition, anger caused by feelings of rejection and betrayal can also lead to increased feelings of guilt (Lindqvist et al., 2008). Self-blame can escalate if the bereaved feel relief due to reduced suffering, either their own or that of the deceased after the suicide (Harrington-LaMorie et al., 2018). It has been observed that feelings of guilt may be greater if the relationship with the deceased was complicated, ambivalent (Fielden, 2003). On the other hand,

some studies show that distant relationship can also lead to more intense feelings of guilt, because the bereaved then believe that they paid too little attention to the loved one, did too little to make the relationship better (Klimaitė, 2015). Furthermore, survivors may blame themselves for their recovery, for example, that they feel better some time after the suicide (Fielden, 2003).

The analysis of the reasons for suicide is particularly characteristic to bereavement after suicidal death (Begley & Quayle, 2007; Fielden, 2003; Lindqvist et al., 2008). It has been noted that attribution of the reasons and constant reflections on the life of the deceased can serve not only as a way of giving meaning to this painful experience (Supiano, 2012) but also for reducing feelings of guilt and responsibility (Klimaitė, 2015) because finding another explanation of why the loved one died of suicide helps diminishing one's negative role in the suicidal crisis of the deceased.

1.3.2 Stigma and suicidal behavior

According to Reynders, Kerkhof, Molenbegh and Van Audenhove (2014), essential features of stigma are recognition and devaluation of differences. Stigma is defined as negative attitudes of a large part of the society towards certain groups of people that have particular characteristics (such as mental disorders) or behaviors (for example, seeking help). According to the authors, stigma includes negative beliefs or stereotypes, preconceived attitudes and behavior (discrimination, avoidance). Stigmatization can occur at different levels (Bos, Pryor, Reeder, & Sttuterheim, 2013). For example, public stigma comprises social and psychological reactions of the society towards the stigmatized group, whereas self-stigma reflects the impact of public stigma on the stigmatized person and includes understanding of the existing stigma and its internalisation.

Stigma can have a variety of negative consequences on the stigmatized person. Rejection, avoidance of social contacts, lack of self confidence, tension in social relationships, symptoms of

depression are mentioned among the effects of stigma (Frost, 2011). Bos et al. (2013) state that stigma increases social exclusion and is negatively related to compassion. As a result, people experiencing stigmatization can hide their stigmatized feature in order to protect themselves against negative emotions and social withdrawal (Reeder & Pryor, 2008). In addition, studies show that stigma can become a serious barrier to seeking help (Bartik, Maple, & McKay, 2015; Batterham, Calear, & Christensen, 2013; Knieper, 1999; Reynders et al., 2014; Skruibis, Dadašev, & Geležėlytė; 2015).

Suicidal behavior has been mystified for ages. Killing oneself contradicts natural course of human life, deviates from generally accepted norms (Maple, Edwards, Plummer, & Minichiello, 2010). Witte, Smith and Joiner (2010) note that the roots of suicide stigma come from religion and law. At the beginning of XIX century most countries still had laws describing sentences (including imprisonment) for people who attempted suicide (Mishara & Weisstub, 2016). Although condemnation of suicides can be considered to be the first attempts of prevention, such actions severely affected family members of the deceased. They were not only confronted with the loss but also faced various punishments, such as desecration of the body of the deceased, confiscation of property, fines, loss of status and reputation (Knieper, 1999). Suicides are considered unjustifiable and immoral in monotheistic religions (Galienė, 2015) which led to certain judgemental attitudes and behaviors towards suicidal deaths. Punishments to those who experienced suicide of a loved one have grown milder in religious, legal, and social systems since XVIII century. These days our knowledge is based on biopsychosocial view of suicides (Cvinar, 2005) but, though in more subtle ways, stigmatization of suicides and suicide survivors still exists (Feigelman, Gorman, & Jordan, 2009; Fielden, 2003). Previous studies have shown that negative attitudes towards suicidal people are prevalent in Lithuania (Gailienė, 2005; Knizek et al., 2008; Skruibis et al., 2010).

1.3.3 Stigmatization and shame in suicide bereavement

Unfortunately, the bereaved often feel the burden of suicide stigma. This has been shown by a number of studies. In a study by McNamy et al. (2008), 42% of respondents felt embarrassed and stigmatized after the suicide of a loved one, 40% felt social rejection and isolation. Dyregrov and Dyregrov (2005) analysed interviews with suicidally bereaved siblings and found that the themes of stigma, shame and guilt were common in their stories. Fielden (2003) revealed that it is difficult for bereaved people to admit that suicide was the cause of death, they choose to hide the fact or lie to others. De Groot, de Keyser and Neeleman (2006) found that suicide survivors feel more lonely than those who lost their relatives due to natural causes. Saarinen, Hintikka, Lehtonen, Lonnqvist and Viinamaki (2002) showed that people bereaved by suicide felt more socially isolated than populational sample even ten years after the event. One of the first Lithuanian studies of the experiences of suicidally bereaved people revealed that stigmatization also affects the person's ability to talk with others about the difficulties and feelings after suicide (Skruibis et al., 2015).

The significance of stigma in the process of grieving after suicide emerges in comparing the experiences of the bereaved after different kinds of losses. Harwood et al. (2002) studied the needs and experiences of relatives of seniors who died of suicide and compared the results with the control group – the bereaved after natural deaths. The results showed that feelings of stigma and shame in the group of suicide survivors were significantly higher. Chapple, Ziebland and Hawton (2015) conducted a qualitative study and found that guilt, stigma and shame after the loss were mentioned more often among people bereaved by suicide. Pitman, Osborn, Rantell and King (2016) discovered that the intensity of experienced stigma, shame and guilt levels was higher among suicide survivors compared with those who lost their relatives due to sudden natural or sudden

unnatural deaths. Cerel et al. (2008) noticed that people bereaved after natural deaths felt that they were receiving more social support than suicide survivors.

Shame in the aftermath of suicide is often defined as a consequence of internalized stigma (Hanschmidt, Lehnig, Riedel-Heller, & Kersting, 2016). If a person accepts and views stigmatization as truthful and identifies with the characteristics attributed to the stigmatized group, the experience of shame becomes stronger. It includes the belief that the person is bad (Fisher & Exline, 2010), inappropriate, unworthy (Wiklander, Samuelsson, & Asberg, 2003). According to Knieper (1999), shame after the suicide is associated with the loss of honor as if something was extremely wrong with the beareaved person or the deceased.

Stigmatization following suicide is accompanied by various problems that aggravate the bereavement. Previously we discussed some studies analysing possible consequences of stigmatization, but those who are left behind after suicide face a risk of stigmatization when they also have the difficult task of accepting the loss. It has been observed that negative attitudes towards suicide survivors can increase their feelings of guilt, affect their health and well-being (Geležėlytė, 2014; Maple et al., 2010). Studies where the needs of the suicidally bereaved are analysed underline the importance of help and support of the social network (Knieper, 1999), while social isolation and rejection are associated with greater psychological difficulties (Feigelman et al., 2009; McMenamy et al., 2008). Shame and stigma prevent the bereaved from expressing their pain openly (Chapple et al., 2015). Stigma also can become a barrier to receiving necessary help and support (Batterham et al., 2013; Fielden, 2003).

It has been confirmed that people with experiences related to suicide often feel ashamed: the bereaved by suicide (Drapeau, Cerel, & Moore, 2015; Pitman et al., 2016; Supiano, 2012) and the people who have attempted suicide (Wiklander et al., 2003) may feel intense embarrassment. Intense shame can increase feelings of anger

or self-hate (Fisher & Exline, 2010) so various defences (such as hiding, avoiding) can serve to reduce shame-induced pain (Fisher & Exline, 2010; Harrington-LaMorie et al., 2018; Wiklander et al., 2003). It has been hypothesized that failure to overcome stigma after suicide is related to passivity, helplessness and more negative attitudes towards seeking help (Drapeau et al., 2015). Therefore, perceived stigma and shame can aggravate the grieving process and discourage the bereaved from necessary resources and help possibilities.

1.4 Help after the suicide of a loved one

1.4.1 Help and support of social network

It has been noted that help of members of the social network is important while grieving. Emotional support – listening, caring, willingness to understand, and instrumental (or practical) help can both be useful (McNess, 2007; Miers, Abbott & Springer, 2012). Two main functions of social support while grieving can be buffering and recovery. Social support serves as a protective factor when social contacts that the person had maintained before the death of a loved one provide security and resources to facilitate reactions after the loss, so the impact of the death is not so strong (Anusic & Lucas, 2014). But even if the reaction to the loss is intense, social support can accelerate the recovery of the bereaved person, encourage more adaptive coping processes (Stroebe, Zech, Stroebe, & Abakoumkin, 2005). In a study of McMenamy et al. (2008), 86% of participants, and in a study of Wilson and Marshall (2010), 95% of respondents used social support and help after suicide. According to Lindqvist et al. (2008), the bereaved regard social support as highly valuable. However, social functioning of the bereaved can be disturbed due to emotional state of the survivors themselves (Dyregrov & Dyregrov, 2005; Gaffney & Hannigan, 2010; Maple et al., 2010), inappropriate behaviors and social ineptitude of the social

network (Dyregrov, 2004) or the stigmatization of suicidal behavior discussed before.

On the other hand, although the view that social support protects individuals from complications in bereavement is very common (Gaffney & Hannigan, 2010; Knieper, 1999), the results presented are often ambiguous (Stroebe et al., 2005). There are studies that do not suggest that social support is particularly important in reconciliation with the loss or avoiding grief complications. Stroebe et al. (2005) in their longitudinal study did not observe that social support had a buffering effect or accelerated recovery, i.e. those bereaved ones who had more social support did not show a better adaptation to changes after the loss. Anusic and Lucas (2014) also did not find that social support would have a buffering effect after the death of a loved one. In the longitudinal study of Wago et al. (2017) parents who lost their child after a terrorist attack and saw themselves as having more social support did not show less intense symptoms of prolonged grief. It was also found that the mitigation of these symptoms during the course of time was not related to social support received. Such results confirm once again that despite social support available, the bereaved may also need help from professionals.

1.4.2 Professional help following suicide

Schneidman (1969) was the first who drew attention to the importance of helping suicide survivors and introduced the term of *postvention* (as cited in Andriessen, 2009). Andriessen (2009) defines postvention as actions aimed at improving well-being of the bereaved by suicide and preventing them from experiencing negative consequences, in particular suicidal behavior. Postvention measures are intended to help the bereaved manage the crisis immediately after the loss and to prevent long-term negative consequences (Harrington-LaMorie et al., 2018). Studies show beneficial effects of professional psychological interventions (psychological counseling,

psychotherapy, psychotherapeutic and self-help groups) on the health of the bereaved (Lichtenthal et al., 2011; McDaid, Trowman, Golder, Hawton, & Sowden, 2008). According to Supiano (2012), self-help groups for suicide survivors can help them adapt to the loss through receiving and providing support to others with similar experiences, as well as through reduction of isolation and encouragement to reconsider false beliefs about the loss and grieving. Help and support from other specialists – policemen, doctors, clergy, teachers – can be significant too (McMenamy et al., 2008).

Studies show that the bereaved themselves often feel a strong need for professional help. As many as 95% of the Wilson and Marshall's (2010) study participants whose loved one has completed suicide expressed the need for help from professionals. 27% of the participants felt that professional support was needed for at least one year after the suicide, 19% – at least two years. 46% approached psychiatrists, psychologists and other counselors, 43% – family doctors, 41% participated in self-help groups. As many as 80% of participants in the study of McMenamy et al. (2008) reported accepting the assistance of mental health professionals after suicide of a loved one and rated it favorably (from moderately to very helpful). 85% of respondents participated in self-help groups, 85% were interested in literature on grief and suicidal processes, 78% had individual psychotherapy, 51% used psychotropic medications. Studies show that, for example, 3 months after the death the need for professional help of suicide survivors is significantly higher than of people who lost their relatives due to natural causes (de Groot et al., 2006).

1.5 Barriers of seeking professional help

1.5.1 Barriers of seeking professional help in suicide bereavement research

As professional interventions in the aftermath of suicide can significantly help a person to adapt to the loss, it is important to analyse why the numbers of the bereaved seeking professional help are often small and inadequate in terms of the need for it. For example, only 44% of the participants in Wilson and Marshall's (2010) study received help from specialists (although 95% expressed the need for it). According to Aguirre and Slater (2010), only one in four suicidally bereaved people seek help needed in the United States. Therefore, the discrepancy between the need for help and how often the bereaved actually approach the specialists may be particularly large.

In several studies analysing the peculiarities of seeking help after suicide a wide range of possible barriers were discussed. In the McMenamy et al. (2008) study depressed mood and energy shortage were identified as the main barriers to seeking help after suicide of a loved one (52%). Also, limited information about the availability of help (45%), lack of availability of professionals (34%), reluctance to ask for help (27%), lack of time (25%), mistrust in professionals (24%), financial issues (18%), disapproval of family members (17%), shame (14%), fear that help will be ineffective or even harmful (14%) were mentioned. In another study of suicide-bereaved people various barriers (desire to solve problems by oneself, lack of information, lack of trust in institutions and professionals, fear of being judged and others) and motivating factors to seek help (positive previous experiences, social support, encouragement and support from others, ensured confidentiality, trust in the specialist and others) were mentioned (Andriessen, Mowll et al., 2018). Skruibis et al. (2015) summarized the results of interviews of 44 participants (suicide survivors and attempters) and distinguished three main themes related to avoidance of sharing experiences with

others: self-reliance, distrust in others and stigma of suicidal behavior. Therefore, studies show that barriers of help-seeking in the aftermath of suicide can be related to attitudes as well as to practical issues. However, existing research reflects the diversity of these barriers rather than more general tendencies. There is a particular lack of data on the significance of specific obstacles in the process of professional help seeking after suicide of a loved one.

1.5.2 Other barriers of seeking professional help

Kushner and Sher (1989) note that the process of seeking psychological help is complex. So in order to better understand its peculiarities, it is important to evaluate the significance of various factors. Below we will discuss some of the most frequently mentioned barriers to seeking professional psychological help.

Attitudes towards seeking professional help is a factor that many studies find to be important to help-seeking behavior. Attitude can be defined as a tendency of a person to react (cognitive, emotional, intentional or behavioral responses) positively or negatively to an object, person, event or the like (Ajzen, 2005). It has been noticed that more positive attitudes towards mental health professionals were positively related to intention to seek help and to actual help-seeking behavior (Cramer, 1999; Elhai, Schweinle, & Anderson, 2008; Fischer & Farina, 1995; Picco et al., 2016; ten Have et al., 2010). Drapeau et al. (2015) claim that we have very little information about what attitudes people bereaved by suicide hold towards the seeking of professional help.

In order to predict the behavior of a person, it may also be important to assess anticipated **social norms** that reflect the predicted reactions of other people to certain behavior (Ajzen, 2002). In the meta-analysis of research about young people's professional psychological help-seeking behaviors it has been shown that one of the most commonly encountered obstacles was perceived stigma (Nam et al., 2013). The perception of negative social norms can

promote internalisation of stigma and experience of shame (Schomerus & Angermeyer, 2008; Vogel, Wade, & Hackler, 2007). It has been noticed that perceived stigmatization as well as self-stigma towards seeking psychological help diminish the probability of seeking it (Barney, Griffiths, Jorm, & Christensen, 2006; Komiya, Good, & Sherrod, 2000; Topkaya, 2014; Vogel, Wester, & Larson, 2007).

Another factor often associated with the pursuit of psychological help and support is the **tendency** of a person **to reveal (or conceal) personally relevant information** related to unpleasant emotions or distress that is independent of the time or different situations (Kahn & Hessling, 2001; Kahn, Hucke, Bradley, Glinski, & Malak, 2012). Disclosing personal experiences and feelings is one of the most important aspects in psychological interventions. Various studies confirmed the significance of the tendency to disclose distress to the attitudes and intentions to seek professional psychological counseling (Nam et al., 2013; Vogel et al., 2007; Vogel & Wester, 2003). The authors conclude that a person's decision to seek help from mental health professionals is linked to the extent to which he or she feels safe in disclosing emotionally important information to others.

Coping involves thoughts and behaviors that a person uses in order to satisfy internal and external requirements in situations that are regarded as stressful (Lazarus & Folkman, 1984). Although the process of coping is complex, people often tend to be more inclined to use particular coping strategies, in other words, ways to reduce emerging negative emotions, manage stressful situations or solve life problems (Tam & Lim, 2009). Seeking help and support from others or professionals can also be regarded as a coping strategy (Li et al., 2014). In addition, some coping strategies may be associated with a greater likelihood of seeking help from others when faced with difficulties. For example, in the study of Drapeau et al. (2015), the bereaved with higher openness to experience, agreeableness (the

model of the Big Five dimensions of personality (Costa & McCrae, 1989)) and active emotional coping style, had more positive attitudes towards seeking help. The need for autonomy (efforts to solve problems by oneself, with no help) in Pumpa and Martin's (2015) study were negatively related to the desire to seek professional help.

Although a person's tendency of coping with stress in certain ways can be revealed while grieving, in order to cope with such an intense stressor as a loss (Stroebe et al., 2005; Supiano, 2012), other coping mechanisms may also be used. Furthermore, it may be difficult to access commonly used ways of coping and resources due to a traumatic loss (Green, 2000). According to Stroebe and Schut (2001), adaptive grief management strategies are those that help a person to reduce negative physical and psychological consequences and distress after the loss. In order to understand the process of grieving Stroebe and Schut (1999) proposed a *dual process model of coping with bereavement*. It is claimed that the bereaved constantly experience oscillation between confronting the loss (for example, memories) and avoiding it (for example, engaging in other activities), which ensures successful further adaptation. Consequently, neither confronting the loss nor avoidance of it should be considered exclusively inappropriate.

The influence of **demographic factors** (age, gender, education, etc.) on help-seeking behaviors has also been mentioned in different studies, but the results are ambiguous (Elhai et al., 2008; Picco et al., 2016; Vogel et al., 2007). For example, in some studies it has been found that elderly people have more positive attitudes towards the seeking of professional psychological help (Elhai et al., 2008), however, some others show that younger people are more in favour of seeking professional care (Picco et al., 2016). In the study of three generations of adults in Lithuania no statistically significant differences comparing how often the youngest, middle and senior respondents approach mental health professionals when facing difficulties in life appeared (Skerytė-Kazlauskienė, Mažulytė, &

Eimontas, 2015). Analysing the role of socio-demographic variables in the process of seeking help is important as it could help identify the most appropriate means to encourage people with different characteristics to participate in clinical interventions.

1.6 Research question and relevance of the study

In the literature review we discussed the peculiarities of grieving after suicide and the psychosocial difficulties that arise after such loss. As a result, suicide survivors might be in need of help and support from members of their social network and from professionals. However, some research shows that social support may not be as helpful in adaptation to the loss as it had been commonly thought. Given the increased risk of grief complications and suicide attempts among the bereaved through suicide, appropriate professional psychological interventions can play a crucial role in preventing further development of psychopathology and ensuring healthy adaptation in the future. Unfortunately, there is a discrepancy between suicide survivors' need of professional help and actually receiving it (Aguirre & Slater, 2010; Wilson & Marshall, 2010). Therefore, the analysis of obstacles to seeking professional mental health care is important to better understand what measures could be taken to encourage the bereaved to seek help from specialists when they are in need of it.

Suicide bereavement peculiarities discussed before, such as guilt, stigma and shame, are often mentioned as potential barriers to seeking professional help. These factors are associated with avoidance, isolation, rejection, fear of disclosure, concern what others would think, reduced self confidence and self-esteem (Chapple et al., 2015; Fielden, 2003; Fisher & Exline, 2010; Frost, 2011; Wiklander et al., 2003) which can affect health condition of the bereaved and their decision to seek professional help. When dealing with guilt or shame a person may feel unworthy of help or

avoid any contact that could potentially prove his fears (for example, responsibility for suicide). However, to our knowledge, there is a great lack of quantitative research analysing the role of the suicide bereavement peculiarities regarding professional help-seeking mentioned above. The impact of suicide stigmatization on help-seeking behaviors has been described in several qualitative studies (Skruibis et al. 2015). However, most researchers provide only hypotheses or reflections that are supported by the results of studies from other fields, such as negative impact of stigma related to mental disorders on approaching mental health professionals (eg. Barney et al., 2006). It has been assumed that the role of suicide stigma in the process of seeking help after suicidal death should be similar, but these hypotheses have not been tested scientifically yet. According to Lester (2002), the combination of quantitative and qualitative research strategies is very important in suicidology, since only the integration of these two approaches can help us comprehend the phenomenon more universally. The results of quantitative studies can help researchers see more general tendencies, and qualitative data can provide us with a more detailed and deeper understanding of how they manifest in human experience. Taking all into account, it is important to conduct quantitative research analyzing the role of suicidal loss peculiarities to seeking help from professionals in the context of other potentially important factors, and qualitative data can help us better understand the results of quantitative analysis and provide insights on the multiplicity of experiences.

It is worth noting that a common limitation of studies in the field of bereavement after suicide is that samples often exceptionally involve persons actively seeking help (Lindqvist et al., 2008). Therefore, very high percentages reflecting high need for help after a loved one has completed suicide are presented. We get the impression from these studies that suicide survivors are almost always in need professional help. But on the other hand, grieving is a natural process with which people can often cope by themselves

without additional intervention. The results of research on people who are actively seeking help can distort the view of reality and encourage professionals to over-emphasize the suggestion of professional help to the bereaved or diagnose disorders too often (Maciejewski et al., 2016). According to Stroebe et al. (2005), if grief has no complications, individuals can cope with it by themselves, without clinical intervention at a pace and ways that are acceptable to them. Perhaps if external help is offered too quickly, it may actually prevent a person from looking for internal and social resources in his or her environment. Hence, better knowledge of the needs of the suicidally bereaved would help to understand how much and what kind of help the survivors really need.

Analysis of scientific research also reveals some paradoxes and discrepancies related to seeking professional help. For example, poor psychological condition is one of the most motivating factors to approach a professional. On the other hand, as discussed earlier, poor health, lack of energy are mentioned among help-seeking barriers. For example, in the study of McMenamy et al. (2008) depressed mood and lack of energy were identified as important obstacles to seeking help. Meanwhile, Wilson and Marshall (2010) found that the bereaved who were most in need of help received it, so those who experienced the most severe symptoms while grieving went to see specialists or accepted offers of help. Other studies indicate that the severity of the symptoms is not necessarily related to intention to seek help (Pumpa & Martin, 2015). So it is still unclear whether help from professionals is sought by the bereaved who feel worse, or maybe, on the contrary, those having more severe symptoms do not get necessary interventions. In that case the active stance of professionals themselves would be very important.

As we know very little about the peculiarities of help-seeking behaviors of people bereaved by suicide, this study is aimed to assess various aspects, including the specific features of grief following suicide, potentially relevant to the seeking of professional

psychological help. It is expected that the results will shed more light on the problematic areas that may deter the bereaved from using postvention measures. We hope to encourage further in-depth explorations of significant constructs identified after the analysis of the results of this study as well. Also, bereavement and coping with it are phenomena rooted in culture so the results of studies in other countries cannot be mechanically applied to make important suicide prevention decisions (Dyregrov, 2011; Hjelmeland & Knizek, 2010; Osafo, Hjelmeland, Akotia, & Knizek, 2011). As professional help resources for the bereaved are only developing in Lithuania, it is important to pay attention to the analysis of the factors that either motivate or hinder help-seeking behaviors so that scientifically-based practical recommendations that best fit the needs and interests of the bereaved could be provided.

1.7 Aim and objectives of the doctoral dissertation

Aim: To analyse and describe factors related to seeking professional psychological help after the suicide of a loved one.

Objectives:

1. To compare mental health condition, attitudes towards seeking professional help, coping strategies, suicide bereavement peculiarities (guilt, stigmatization, shame) as well as demographic and loss-related characteristics of persons who sought professional psychological help after the suicide of a loved one and those who did not.
2. To evaluate the prognostic value of suicide bereavement peculiarities and other factors to help-seeking behaviors of suicide-bereaved adults.
3. To describe the obstacles to seeking professional help and social changes after the suicide expressed by the respondents, and compare the differences of the social changes between

suicide survivors who sought professional psychological help and those who did not.

2. METHODS

2.1 Participants and procedure

82 people bereaved by suicide participated in the study: 64 women (78%) and 18 men. The average age of participants was 37.79 years (*SD* = 14.33, range = 19 to 70 years). 56 (68%) participants lived in a big city, 14 (17%) – in a city, 12 (15%) – in a town/village. Distribution of participants by education: 23 (28%) – primary/secondary, 18 (22%) – vocational, 41 (50%) – university degree; marital status: 14 (17%) – single, 45 (55%) – married/in a long term relationship, 5 (6%) – divorced, 17 (21%) – widow/widower, 1 (1%) – other. 53 (65%) participants stated that they were religious, 10 (12%) were non-religious and 19 (23%) were undecided.

The average time since suicide was 12.23 months (*SD* = 6.52; range from 5 to 36 months). Distribution of participants by the type of relation with the deceased: 55 (67%) lost a member of the nuclear family (10 – father/mother, 4 – sibling, 12 – spouse, 6 – child), 22 (27%) lost another relative, 5 (6%) lost a friend or acquaintance.

The Psychological Research Ethics Committee of the Vilnius University approved the research project (14/12/2016; Nr. 09). As suicide survivors are a vulnerable group, studies with these individuals often raise doubts about potentially negative impact of the participation in the study on the bereaved. In order to respond adequately to negative reactions of participants during the participation, it is important for researchers to be properly prepared to react in such situations, to ensure that the participant is provided with all the information, to emphasize that the participation is on voluntary basis and to assure the possibility to end the participation

in the study at any time (Andriessen, Krysinska et al., 2018). All of this was ensured in this study.

At first a pilot study was conducted in order to examine the psychometric characteristics of the questionnaires and the procedure for applying the form (N = 30). After the analysis of the results and comments of the participants of the pilot study some minor corrections were made. The final version of the questionnaire was prepared. Taking into account our previous experience in conducting research in this field, in order to assure better response rates it was decided to give the participants the opportunity to choose the way of filling in the questionnaire: paper or online version. Using both versions is not rare in the field of suicidology nowadays (for example, Honeycutt & Praetorius, 2016; Pitman et al., 2016). At the beginning the participants were informed about the purpose of the study, guaranteed confidentiality, data protection, ensured opportunity to end participation in the study at any time; contact information of the researchers was provided.

The results were collected by the author of the dissertation and four specially trained students from psychology (1) and clinical psychology (3) study programs. Participants of the study were invited through a convenience sampling and in collaboration with various organizations and specialists. Each participant who agreed to participate in the study was contacted individually by telephone or by e-mail. The participant was informed about the aims of the research, his or her questions were answered, the choice of online or paper version of the questionnaire was offered. To achieve a better response rate, each participant was assigned an identification code. If the participant did not complete the questionnaire within a certain period of time, he or she was contacted again (2 weeks and 1 month later) and reminded about the participation in the study. Data were collected from January, 2017 to July, 2018. In total, 22 (27%) paper and 60 online questionnaires were filled in.

Given the purpose of the study, in order to avoid additional anxiety, participants were not given specific contact information on psychological and emotional help resources after the participation. But at the beginning and at the end of the questionnaire respondents were encouraged to contact the researchers by e-mail or telephone if they had any questions or comments. Researchers who contacted the participants were also prepared to provide information on mental health resources if they felt that was needed.

2.2 Instruments

The Grief Experience Questionnaire (**GEQ**) (Barrett & Scott, 1989). Various aspects of grieving experience are evaluated using the GEQ. For the purposes of this study, the subscales of Stigmatization (total score ranges from 10 to 50), Shame (from seven to 35) and Guilt (from six to 30) were used (Bailley, Dunham, & Kral, 2000). Higher score indicates more prevalent stigmatization, shame or guilt while grieving after the loss. The Cronbach's alpha of Stigmatization scale in this study was .88, Shame .81 and Guilt .87.

The Inventory of Social Support (**ISS**) (Hogan & Schmidt, 2002). Social support is defined here as the availability of at least one person who will take the time to listen as the bereft express their open and honest feelings about grief. Higher ISS score indicates having more social support while grieving. The Cronbach's alpha of the ISS in this study was .79.

The Prolonged Grief Disorder-13 (**PG-13**) (Prigerson et al., 2009) instrument can be used for preliminary assessment of whether a person could be diagnosed with prolonged grief disorder or for a general evaluation of the intensity of prolonged grief symptoms. The Cronbach's alpha of PG-13 in this study was .88.

The World Health Organization Well-Being Index (**WHO-5**) is a 5-item scale that assesses various aspects (mood, activity, etc.) of

psychological well-being during the previous two weeks (World Health Organization, 1998). Total score of the scale varies from 0 to 100, reflecting 100% of possible well-being. WHO-5 can also be used as a screening instrument for the depression diagnosis using a threshold of ≤ 50 or a more rigorous ≤ 28. (Topp, Ostergaard, Sondergaard, & Bech, 2015). The Cronbach's alpha of WHO-5 in this study was .90. In order to compare the results of this study with the WHO-5 scores of the general population, we used the data from the study "Psychological Effects and Coping with Extreme Trauma and Social Transformations" (VP1-3.1-ŠMM-07-K-02-023 led by prof. Danutė Gailienė) (for more information about the study see: Grigutytė, 2015).

Subjective health in this study was evaluated by one item, asking participants to assess how they evaluate their health from 'terrible' (0) to 'excellent' (5).

The Brief COPE (Carver, 1997) includes 28 items which measure 14 different coping reactions. It was used to assess the person's usual tendencies of coping with difficulties in daily life in this study. The subscales of the Brief COPE are: Active coping (Cronbach's alpha was .68), Planning (α = .69), Positive reframing (α = .75), Acceptance (α = .44), Humor (α = .87), Religion (α = .85), Using emotional support (α = .79), Using instrumental support (α = .83), Self-distraction (α = .63), Denial (α = .75), Venting (α = .65), Substance use (α = .80), Behavioral disengagement (α = .73) and Self-blame (α = .78). Higher score of the subscale indicates that a particular strategy is used more often.

According to Pakalniškienė (2012), Cronbach's alpha higher than .60 is suitable for research so the estimate of the internal consistency of the Acceptance subscale could be considered too low for further analysis. However, according to Pallant (2005), scales containing a small number of items may have low Cronbach's alphas. Consequently, we checked the correlation between the items

constituting this subscale and found that it meets the requirements for satisfactory internal consistency (r = .32, p = .004), i. e. the coefficient is between .20 and .40 (Briggs & Cheek, 1986).

The Distress Disclosure Index (**DDI**) (Kahn & Hessling, 2001). The 12-item DDI measures the degree to which a person discloses (vs. conceals) emotionally distressing information. Higher scores indicate a higher tendency to disclose distress. Among the present data, coefficient alpha for scores from the DDI was .91.

The Attitudes Toward Seeking Professional Psychological Help – Short Form scale (**ATSPPH-SF**) (Fischer & Farina, 1995) was used for the assessment of help-seeking attitudes of the respondents. Total score ranges from zero to 30, with higher score indicating more positive attitudes towards seeking professional help. Due to varying factor structures of the scale proposed in literature (Elhai et al., 2008; Fischer & Farina, 1995; Picco et al., 2016) we conducted confirmatory factor analysis to find out which structure is best suited for this sample. Estimates of the three-factor model indicated a good fit: CFI = .99, TLI = .99, RMSEA = .01 (χ^2 = 32.55, df = 32, p = .44). Also, the items significantly correlated with the predicted factors ($p < .05$) and had sufficient weights. Therefore, in this study we will use the total estimate of the ATSPPH-SF and the scores of three factors as suggested by Picco et al. (2016). The Cronbach's alpha of total ATSPPH in this study was .83, factor of Openness to seeking professional help α = .64, factor of Value in seeking professional help α = .77 and factor of Preference to cope on one's own α = .64.

The Stigma Scale for Receiving Psychological Help (**SSRPH**) (Komiya et al., 2000) was used to assess individuals' perceptions of how stigmatizing it is to receive psychological treatment. Higher scores indicate greater perception of stigma associated with

receiving psychological treatment. Among the present data, coefficient alpha for scores from the SSRPH was .78.

Demographic questions, information about the deceased and help received. Since the disadvantage of scales with the proposed options is that they do not fully disclose experiences that are not described by the researchers' statements (Fielden, 2003), the participants were also asked some open-ended questions: what professional help-seeking barriers the participant had encountered and what social changes or unpleasant reactions from other people noticed after the loss. In addition, a question about what was of most help while grieving was included in the questionnaire.

2.3 Data analysis

Both quantitative and qualitative tools were used for the analysis of the research results.

Statistical data analysis was carried out using statistical software *IBM SPSS Statistics 25.0*. The comparison analyses of the study groups were carried out using a Student t test, ANOVA analysis and nonparametric criteria of Mann-Whitney U and Friedman Test. Confirmatory factor analysis was performed using a structural equation modeling software *IBM SPSS AMOS 25.0*. Model fit was evaluated by chi-square (χ^2), Root Mean Square Error of Approximation (RMSEA) index, Comparative fit index (CFI) and Tucker-Lewis (TLI) index. Good model fit was considered when $\chi^2 \geq 0.05$; RMSEA $\leq .05$; CFI $\geq .95$; TLI $\geq .95$ (Čekanavičius & Murauskas, 2009). A p value $< .05$ was used as a criterion for statistical significance evaluation.

A thematic analysis of the qualitative data was performed. Thematic analysis is a method for identifying, analysing and reporting patterns (themes) within data. Deductive (themes identified related to the specific questions, pre-selected aspects of the analysis)

and semantic (explicit level) approach to the analysis was chosen for the purposes of this study. The results were analysed based on the steps singled out by Braun and Clarke (2006):

- Familiarizing with the data.
- Generating initial themes (a theme is a meaningful description of the text which summarizes the information analysed in relation to the phenomenon under investigation).
- Defining, naming, creating a list of themes (title, description, typical examples, special conditions (description of exceptions)). A theme from the list can be assigned to a certain quotation, and if there are no relevant themes in the list, a new additional theme is included.
- Similar themes are joined into generalizing themes that will be used in the further analysis.
- All the answers by the participants are re-evaluated one more time, the accuracy of the original coding is evaluated, corrections of the themes and their definitions are made.

In qualitative research, the reliability of the results is the consensus of the experts, reducing the influence of the researcher's bias and projections on the results of the research. The double-coding procedure was chosen to ensure the reliability in this study. At first one researcher coded all the data and prepared a list of themes. Subsequently, the list was given to another researcher who, using the list, encoded the same data independently, at the same time reviewing and evaluating the list of themes. The overlap between the results of both encoders was reviewed. If discrepancies were found, they were discussed with the help of additional experts, final decisions were made. The shortcomings of the list of themes were removed and some corrections were made. The coding procedures were performed in a group of four researchers.

3. RESULTS

3.1 The type of the professional help used and the need for it in the research sample

In order to achieve the objectives of the study, participants were divided into **two groups**: those who took advantage of the help provided by mental health professionals after the suicide and those who did not. It was considered that a participant used professional psychological help if he or she had at least one consultation with a psychologist/psychotherapist, psychiatrist or participated in at least one self-help group for people bereaved by suicide led by a professional psychologist.

38 participants (46% of all respondents) used professional assistance due to psychological difficulties following suicide. 32 respondents (39% of all participants) consulted a psychologist/psychotherapist, 18 (22%) – a psychiatrist, 13 (16%) participated in a self-help group for people bereaved by suicide. 21 (26%) respondents used more than one of these three types of psychological care. 23 (28%) respondents consulted other medical doctors after the suicide, 14 (17%) – used help of a clergyman. Those who used help of mental health specialists, significantly more often consulted other medical doctors (16 (42%) respondents who consulted mental health specialists also approached other doctors, 7 (16%) of those who did not seek help from mental health specialists approached other doctors) ($\chi^2(1) = 5.70$, $p = .017$, $phi = .29$). There were no significant relations between seeking help from mental health professionals and contacting a clergyman after the suicide (in a group who sought help from mental help specialists 8 (22%) respondents contacted the clergy, in a group of non-help-seekers 6 (14%) contacted the clergyman) ($\chi^2(1) = 0.43$, $p = .515$).

Those respondents who used professional help after suicide were requested to evaluate its usefulness on a scale from ‘harmful’ (1) to

'very useful' (4). 3 (7%) participants indicated that help was useless, 18 (40%) – that it was partly useful and 24 (53%) – that it was very useful. The average rating was 3.47 (*SD* = 0.63).

93% of the participants of the study indicated that it is important for the specialists to actively offer professional help opportunities for the bereaved by suicide. 10 (15%) respondents who did not indicate having any experience participating in self-help groups after the suicide pointed out that they would like to participate in such groups, 28 (41%) claimed that they would not like to participate, 30 (44%) did not know if they would like to participate.

Respondents were also asked to evaluate the need for professional care immediately after the loss, one, six and 12 months after the loss on a scale from 'no help needed' (1) to 'high need for help' (5). Table 1 shows average evaluations of the need for help depending on time since loss. We can see that the highest need for help was felt one month after the loss. However, the average of the need for professional care changed only slightly during the whole year. The Friedman Test did not reveal statistically significant differences between all four evaluations (χ^2 = 7.4, *df* = 3, *p* = .060). We also compared the need for professional help of participants who sought it and those who did not consult specialists. The differences between the groups were statistically significant (except 6 months after the loss), however, the significance was threshold (close to $p \geq .05$).

Table 1. *Need for professional help depending on time since the loss*

Need for professional help	*N*; *M* (*SD*)	*M* (*SD*), *N* = 30	Help-seekers (*n* = 16) *M* (*SD*)	Non-help-seekers (*n* = 14) *M* (*SD*)	Differences between the groups *Z*; *p*
Immediately after the loss	*N* = 74; 3.16 (1.62)	2.83 (1.56)	3.38 (1.50)	2.21 (1.42)	−2.17; **.030**

Need for professional help	*N*; *M* (*SD*)	*M* (*SD*), *N* = 30	Help-seekers (*n* = 16) *M* (*SD*)	Non-help-seekers (*n* = 14) *M* (*SD*)	Differences between the groups *Z*; *p*
1 month after the loss	*N* = 66; 3.32 (1.61)	3.33 (1.58)	3.88 (1.36)	2.71 (1.64)	−2.00; **.046**
6 months after the loss	*N* = 65; 3.06 (1.52)	3.03 (1.47)	3.50 (1.41)	2.50 (1.40)	−1.91; .057
12 months after the loss	*N* = 30; 2.73 (1.31)	2.73 (1.31)	3.19 (1.33)	2.21 (1.12)	−1.98; **.048**

Notes. Help-seekers = the results of the participants who consulted mental health professionals after the loss; Non-help-seekers = the results of the participants who did not consult the professionals after the loss; Differences between the groups = the results of Mann-Whitney U test after comparison of the groups of help-seekers and non-help-seekers. Statistically significant differences are shown in bold.
All results of the participants who evaluated certain period of grieving are shown in the second column (*N* indicated); the results of the participants who evaluated all four periods of grieving are presented in the remaining columns (*N* = 30).

3.2 The comparison of demographic and loss-related characteristics between the groups

We also compared the main demographic and loss-related characteristics between the groups. Only the difference between subjective evaluations of how close the relationship with the deaceased reached statistical significance. Participants who sought help from mental health professionals considered that the relationship with the deceased had been closer (help-seeking group: *M* = 4.34, *SD* = 0.71, non-help-seeking group: *M* = 3.69, *SD* = 1.05; *Z* = −2.94, *p* = .003). There were no statistically significant differences between the groups regarding the following aspects: respondents' gender (help-seeking group = 87% female, non-seeking group = 70% female; $\chi^2(1, 82) = 2.31$, *p* = .128); age (help-seeking: *M* = 36.50, *SD* = 12.99, non-seeking: *M* = 38.91, *SD* = 15.46; *t*(80) =

0.76, p = .451); place of residence (χ^2(2, 82) = 1.47, p = .479); marital status (χ^2(2, 81) = 1.07, p = .586); education (χ^2(2, 82) = 0.05, p = .977); religiosity (χ^2(2, 82) = 0.91, p = .634); previous experience of seeking help from mental health professionals (help-seeking group = 41% had previous experience, non-seeking group = 30%; χ^2(1, 81) = 0.64, p = .423); type of the relationship with the deceased (help-seeking group = 71% first-degree relative, 29% second-degree relative, friend and others, non-seeking group = 64% first-degree relative, 36% second-degree relative, friend and others; χ^2(2, 82) = 1.42, p = .491); time since suicide (help-seeking: M = 11.93 months, SD = 5.28, non-seeking: M = 12.49, SD = 7.47; Z = −0.30, p = .762); age of the deceased (help-seeking: M = 43.95, SD = 17.64 , non-seeking: M = 43.34, SD = 20.94; t(79) = −0.14, p = .890) and experience of seeking help from mental health professionals of the deceased (help-seeking group = 37% reported that the deceased consulted a professional, non-seeking group = 27%; χ^2(1, 82) = 0.48, p = .490).

3.3 The comparison of peculiarities of bereavement after suicide between the groups

After comparing experiences of stigmatization, guilt and shame after the suicide (Table 2), statistically significant differences in perceived stigma and guilt evaluations were obtained. However, contrary to what had been anticipated, respondents who sought help from specialists expressed higher levels of experienced stigmatization and guilt after the loss. Differences between the evaluations of shame and subjective assessment of social support after the loss were small and statistically insignificant.

Table 2. *The comparison of stigmatization, shame, guilt and social support between the groups*

Group	Help-seekers (n = 38)	Non-help-seekers (n = 44)		
Characteristics compared	*M* (*SD*)		*t*	*p* value
Stigmatization	25.58 (9.23)	20.34 (7.32)	−2.86	**.005**
Shame	17.63 (6.05)	16.16 (6.07)	−1.10	.276
Guilt	21.18 (5.43)	17.68 (6.24)	−2.69	**.009**
Social support	19.21 (4.09)	19.57 (3.87)	0.41	.686

Notes. Help-seekers = the results of the participants who consulted mental health professionals after the loss; Non-help-seekers = the results of the participants who did not consult the professionals after the loss. The range of the score of the Stigmatization subscale: 10–50; Shame subscale: 7–35; Guilt subscale: 6–30; Social support scale: 5–25. Higher estimates show the assessed aspect experienced more often. Statistically significant differences are shown in bold.

In order to assess the impact of suicide on social changes in the life of the bereaved, the participants were asked whether they felt that the communication or behavior of other people after the suicide had changed. The summary of the results of the thematic data analysis are presented below. The brackets indicate the number of respondents mentioning certain theme. Some participants mentioned only positive (16), other only negative (18), some others positive and negative (5) changes. About half of the participants pointed out that they did not notice any changes. It was found that 12 (32%) of the respondents who sought help from specialists mentioned exceptionally negative changes, 3 (8%) pointed out only positive changes and 15 (40%) mentioned no changes. In a group of respondents who did not seek professional help 6 (14%) participants mentioned only negative changes, 13 (30%) only positive, and 24 (55%) expressed no social changes after the loss (χ^2 (3) = 15.42, p = .001, *Cramer's V* = .43). So individuals who sought help from mental health professionals mentioned 'only negative' social

changes more often and ‘only positive’ as well as ‘no changes at all’ less often than those who did not consult mental health specialists after the loss. The estimated effect size was medium (Cohen, 1988).

Themes on changes in communication with other people after the loss due to suicide:

• no changes (39);

• negative changes (47): inappropriate advice (5); exaggerated, inappropriate attention (6); other people at a loss in terms of how to behave with the bereaved (12); taking advantage of the state of the bereaved (1); accusation, shaming, condemnation (2); speculations and gossiping (1); relationships are no longer so close (5); termination of the relationships (6); avoidance of talking about the loss (7); increased protection of the bereaved (2);

• concealment of the bereaved (5): hiding suicidal loss (3); social withdrawal of the bereaved (2);

• positive changes (26): relationships with others became stronger (8); support and help from other people (18).

Respondents were also asked to answer the question of whether they had to deal with unpleasant reactions after the suicide which made them less willing to share their feelings and experiences. It is noteworthy that the themes on stigmatization and blaming were mentioned quite often. These results illustrate the results of the analysis of the GEQ subscales and gives a better notion of which negative reactions affected the bereaved by suicide the most.

Themes on unpleasant reactions from others after the loss:

• not mentioned (47);

• the stigma of suicide (24): unpleasant statements about suicides and people who died of suicide (10); search for reasons of the suicide (11); encouragement to lie about the cause of death (1); the topic of suicide in the media (1); refusal to give the usual ceremony for a person who died of suicide at church (1);

• death taboo/inappropriate reactions about grieving (11): avoidance of the topic of death (4); indifference (1) inappropriate advice or attempts to console (4); exaggerated attention to the loss (2);

• blame (9);

• concealment of the bereaved (4);

• poor health of the bereaved after the loss (2);

• other (1): others with experiences related to suicide (1).

3.4 The comparison of health status between the groups

The current health status of the participants was evaluated in several aspects (Table 3).

The WHO-5 scale measures how well the respondent feels in everyday life (Skerytė-Kazlauskienė et al., 2015). It was found that the well-being of participants who sought professional help was inferior, but this difference was not statistically significant. The participants were also asked to subjectively evaluate their health (from 'terrible' (0) to 'excellent' (5)) and respondents who sought help from specialists rated their health as worse. The WHO-5 scale can also be used as a tool for screening for clinical depression (the most commonly used thresholds are ≤ 50 or ≤ 28) (Topp et al., 2015). The differences of the percentages of cases with preliminary screening diagnosis for depression between the two groups were not statistically significant.

The prevalence of prolonged grief symptoms was also assessed in both groups. As prolonged grief disorder can be diagnosed after at least 6 months since the loss (Prigerson et al., 2009), the data of the participants who did not meet this criterion were not analysed (N = 74, sought professional help n = 36, did not seek n = 38). The analysis revealed that the symptoms of prolonged grief were more intense in the group of respondents who sought professional psychological help. In addition, based on the recommendations of the authors of the PG-13, it was assessed whether the respondent

could be diagnosed with the prolonged grief disorder. As many as 31% of participants who sought help could be diagnosed with this disorder (and only 5% of non-help-seekers). The obtained effect size was medium (*phi* = .33) (Cohen, 1988). Prolonged grief disorder could be diagnosed for 18% of the whole sample.

Table 3. *The comparison of the aspects of health status between the groups*

Group	Help-seekers (n = 38)	Non-help-seekers (n = 44)		
Characteristics compared	n (%) / M (SD)		χ^2 / t / Z	p value
WHO-5				
WHO-5 index	35.68 (20.55)	44.73 (23.66)	t = 1.83	.071
WHO-5 screening diagnosis of depression (≤ 50)	28 (74%)	24 (55%)	χ^2 = 2,45	.118
WHO-5 screening diagnosis of depression (≤ 28)	19 (50%)	15 (34%)	χ^2 = 1.52	.217
Subjective health	2.89 (1.29)	3.52 (1.30)	Z = –2.41	**.016**
PG-13 (N = 74)	(n = 36)	(n = 38)		
PG-13	33.39 (9.27)	28.55 (9.38)	t = –2.23	**.029**
Preliminary diagnosis of prolonged grief disorder	11 (31%)	2 (5%)	χ^2 = 6.51	**.011**

Notes. Help-seekers = the results of the participants who consulted mental health professionals after the loss; Non-help-seekers = the results of the participants who did not consult the professionals after the loss; WHO-5 = Well-Being Index (from 0 to 100), PG-13 = Prolonged Grief Disorder-13 (from 11 to 55). Statistically significant differences are shown in bold.

The WHO-5 index of the bereaved by suicide was compared with a population-based sample of Lithuania (for more information see *2.2. Instruments*). We wanted to analyse if there are some

considerable differences between the populational sample and the bereaved who sought professional help after the death as well as those respondents who did not consult professionals. ANOVA analysis revealed statistically significant differences F (2, 1060) = 18.70, $p < .000$. The average evaluation of the WHO-5 estimate for the populational sample was 55.02 (SD = 21.60). Post-hoc comparisons using the Bonferroni test indicated statistically significant differences between the populational sample and those participants of this study who sought professional psychological help ($p < .001$), as well as among the populational sample and those respondents who did not seek help from specialists ($p = .006$). Screening diagnosis for clinical depression was also compared among all three groups:

- **WHO-5 ≤ 50.** χ^2 (2, 1060) = 22.17, $p < .001$, *Cramer's V* = .15. A screening diagnosis of depression could be attributed to 39% of the cases in the populational sample (for comparison: suicide survivors who sought help: 74%, did not seek help: 55%);
- **WHO-5 ≤ 28.** χ^2 (2, 1060) = 43.39, $p < .001$, *Cramer's V* = .20. A screening diagnosis of depression could be attributed to 15% of the cases in the populational sample (for comparison: suicide survivors who sought help: 50%, did not seek help: 34%).

Thus, the results show that the bereaved after suicide show significantly lower levels of psychological well-being than representatives of the general population in Lithuania. Also, suicide survivors (both help-seekers and non-help-seekers) have higher chance to be diagnosed with clinical depression. However, the association is weak (Cohen, 1988).

3.5 Attitudes towards seeking help and coping strategies

We also compared attitudes towards seeking professional psychological help and subjective perceptions of the stigma of receiving professional help between the two groups. Participants

who sought help had more positive attitudes in all factors: were more open to seeking professional help, considered seeking professional help more valuable and were less prone to give preference to cope on one's own. The levels of perceived stigma of receiving psychological care were not significantly different. Although respondents who sought professional help after the suicide showed a greater tendency to disclose distress and emotionally relevant information to others, the difference was also not significant. However, individuals who approached specialists were more likely to use emotional support from others and blame themselves when faced with difficulties.

Table 4. *The comparison of attitudes towards seeking professional help, perceived stigma of receiving professional help, distress disclosure index and coping strategies between the groups*

Group	Help-seekers (n = 38)	Non-help-seekers (n = 44)		
Characteristics compared	M (SD)		t / Z	p value
ATSPPH				
Openness to seeking professional help	9.42 (2.01)	7.80 (2.50)	t = –3.21	**.002**
Value in seeking professional help	14.16 (1.75)	11.25 (3.25)	t = –5.14	**< .001**
Preference to cope on one's own	9.21 (2.30)	8.14 (2.50)	t = –2.01	**.048**
ATSPPH score	32.82 (4.39)	27.18 (6.99)	t = –4.43	**< .001**
SSRPH	7.86 (2.30)	7,79 (2.28)	t = 0.15	.884
DDI	42.13 (7.61)	38.43 (10.89)	t = –1.80	.076
COPE (N = 81)	(n = 38)	(n = 43)		
Active coping	5.87 (1.44)	6.19 (1.20)	t = 1.08	.282
Planning	5.34 (1.26)	5.74 (1.27)	t = 1.43	.158
Positive reframing	4.50 (1.77)	4.77 (1.31)	t = 0.77	.446
Acceptance	5.63 (1.75)	6.19 (1.26)	t = 1.62	.110
Humor	3.32 (1.68)	3.09 (1.67)	Z = –1.00	.317

Group	Help-seekers (n = 38)	Non-help-seekers (n = 44)		
Characteristics compared	M (SD)		t / Z	p value
Religion	4.08 (1.36)	4.02 (2.11)	t = –0.14	.887
Use of emotional support	5.18 (1.45)	4.26 (1.66)	t = –2.66	**.009**
Use of instrumental support	4.76 (1.46)	4.28 (1.55)	t = –1.44	.153
Self-distraction	5.58 (1.52)	5.67 (1.60)	t = 0.28	.784
Denial	3.89 (1.47)	3.63 (1.45)	t = –0.82	.413
Venting	4.66 (1.38)	4.19 (1.48)	t = –1.48	.144
Substance use	3.47 (1.87)	2.81 (1.16)	Z =–1.53	.127
Behavioral disengagement	3.76 (1.15)	3.26 (1.31)	t = –1.84	.069
Self-blame	5.39 (1.62)	4.21 (1.54)	t = –3.38	**.001**

Notes. Help-seekers = the results of the participants who consulted mental health professionals after the loss; Non-help-seekers = the results of the participants who did not consult the professionals after the loss. ATSPPH = Attitudes Toward Seeking Professional Psychological Help Scale (from 10 to 40); SSRPH = The Stigma Scale for Receiving Psychological Help (from 5 to 15); DDI = Distress Disclosure Index (from 12 to 60); COPE = The Brief COPE Inventory (from 2 to 8). Statistically significant differences are shown in bold.

Participants were also asked what was the most helpful to them while grieving. Results of the analysis:

- nothing helped (2);
- coping by oneself (5);
- isolation from others (2);
- emotional and instrumental support of the social network (93): other people (60); social support (17); others taking care of the household (3); communication with others (13);
- mental health specialists (21): psychologist/psychotherapist (13); self-help groups (4); medications (4);
- coping as orientation towards the loss (28): interest in the topic of suicide (2); analysis of the suicidal process of the deceased (3);

guilt reduction (3); other activities related to the loss and the deceased (3); similar experiences (3); anger at the deceased (1); crying (2); finding the meaning (1); recognition that death is inevitable (1); acceptance of the loss (2); talking about the loss (7);

- coping as orientation from the loss (37): avoiding things that remind the deceased (1); avoidance of loss-related thoughts (4); not talking about the loss (2); caring for others (4); other activities (24); change of the environment (2);
- faith/religion (7);
- guilt (1);
- other (7): professional experience (1); pets (1); time (2); fatigue (1); reduced activity (1); organizations (1).

Some of the themes were assigned to more general theme groups of coping as orientation towards the loss (emotions, thoughts, behaviors related to the loss), and coping as orientation from the loss (emotions, thoughts, behaviors related to avoiding the topic of the loss, efforts to distance oneself from it). We evaluated the differences between the manifestation rates of these themes among respondents who sought and did not seek professional help. There were no significant relations between seeking help from professionals and orientation towards the loss (12 (32%) respondents who sought help and 8 (18%) participants who did not seek help mentioned coping as an orientation towards the loss) ($\chi^2(1) = 1.33$, $p = .250$). Similar results were found when analysing orientation from the loss (14 (37 %) respondents who sought help and 13 (30 %) participants who did not seek it mentioned coping as an orientation from the loss) ($\chi^2(1) = 0.22$, $p = .642$). Therefore, the results did not confirm that suicide survivors who sought help from mental health professionals and the bereaved who did not seek it would be more inclined to use one or the other way of coping with the loss.

3.6 The prognostic role of the factors to seeking professional help

Summarizing the previous analysis, the following differences have emerged between the groups of the bereaved who sought professional psychological help after the loss and those who did not:

• relationship with the deceased (closer relationship with the deceased in the group of help-seekers);

• peculiarities of suicidal death (greater perceived stigmatization and guilt after the loss);

• well-being (more severe symptomatology of prolonged grief, poorer subjective evaluation of health);

• attitudes (more favorable attitudes towards seeking professional psychological help);

• coping with difficulties (more frequent use of emotional support and a tendency to blame oneself when faced with difficulties).

In order to assess the prognostic value of these factors in predicting suicide survivors' help-seeking behaviors, a logistic regression analysis was performed. The parameters demonstrated a good model fit (N = 73; the model correctly classified 80.6% of cases, χ^2 = 40.60, df = 10, p < .001; *Hosmer-Lemeshow chi-square* value was 2.11, p = .977; *Nagelkerke R squared* value was .575). The analysis revealed that the closer the relationship with the deceased, the more valuable seeking professional psychological help was perceived to be, and the more frequently emotional support was used when coping with difficulties, the greater the likelihood that the bereaved person sought help from mental health professionals.

Table 5. *Logistic regression predicting likelihood of seeking professional psychological help after the suicide of another person*

Variable	B	*SE*	Wald	OR	*p*	95% CI
Closeness of the relationship	1.15	0.49	5.58	3.15	**.018**	1.22–8.16

Variable	B	*SE*	Wald	OR	*p*	95% CI
Stigmatization	0.03	0.05	0.45	1.04	.503	0.94–1.14
Guilt	–0.03	0.08	0.11	0.98	.736	0.84–1.13
PG-13	–0.10	0.06	3.01	0.91	.083	0.81–1.01
Subjective health	–0.58	0.36	2.65	0.56	.104	0.28–1.13
COPE: Use of emotional support	0.52	0.25	4.32	1.67	**.038**	1.03–2.72
COPE: Self-blame	0.33	0.28	1.42	1.38	.233	0.81–2.39
ATSPPH: Openness to seeking prof. help	–0.03	0.22	0.02	0.97	.884	0.64–1.48
ATSPPH: Value in seeking prof. help	0.61	0.25	5.95	1.84	**.015**	1.13–3.00
ATSPPH: Preference to cope on one's own	–0.12	0.19	0.38	0.89	.539	0.62–1.29

Notes. PG-13 – Prolonged Grief Disorder-13; COPE – BriefCOPE Inventory; ATSPPH – Attitudes Toward Seeking Professional Psychological Help Scale. Statistically significant differences are shown in bold.

3.7 Help-seeking barriers indicated by the participants

The participants were also asked an open-ended question whether they had encountered barriers to seeking professional help after the loss. We wanted to investigate which obstacles to seeking professional help were perceived by the participants themselves. The results revealed that a significant part of respondents did not indicate any obstacles. Internal barriers related to the feelings or beliefs of respondents were mentioned less frequently. The most commonly reported obstacles were related to imperfections of the healthcare system. The health condition after the loss as an obstacle to seeking help was mentioned only once. Also one participant mentioned that guilty feelings were interfering with seeking help from professionals.

Themes on help-seeking barriers:

- no obstacles indicated (51): no obstacles (41); no need for help (8); did not seek professional help (2);
- health condition (1): shock (1);
- personal beliefs and feelings (11):

• stigma of seeking help: seeking help is a sign of weakness (1); stigma (1);

• disbelief that help can be effective (2);

• fear of speaking with a stranger about sensitive topics (1);

• preference to cope by oneself (1);

• guilt due to the loss (1);

• undefined internal barriers: hesitating to contact a professional (2); help was necessary, but did not seek it (2);

• negative experience (5): negative previous experience (2); inappropriate specialist (3);

• disappointment in specialists due to suicide (1);

• gaps in the health care system (33): too much effort needed to get an appointment (1); it takes a long time to get help (3); lack of help sources at the place of residence (4); received only short-term help (1); dissatisfaction with medical treatment (2); need for specialists working in private practice (5); financial difficulties (7);

• need for active approach from professionals (10): need for specialists' active role in offering help (2); lack of information on help available (8);

• other individual barriers (3): lack of time (2); other individual obstacles that impede access to help sources (1);

• use of other sources of help (4);

• factors motivating help-seeking (3): supportive and helping relatives (3);

• other (1): need for information on suicidal process (1).

4. DISCUSSION

4.1 Need for professional help after suicide

The analysis revealed that the highest need for professional help was indicated one month after the loss, but it did not change significantly during the whole year after the death. Other studies also show that

the need for professional care after a loss due to suicide can be felt for a long time. For example, 27% of the Wilson and Marshall's (2010) study participants bereaved by suicide claimed that professional care was needed for at least one year after the suicide, 19% thought it would be useful for at least two years. Begley and Quayle (2007) noticed that the most intense grief reactions occurred in the first year after the suicide. Therefore, the results of our study confirm that professional help after suicide of another person may be necessary and offered not only immediately after the death, but also later in the process of grieving.

At the beginning we raised the question whether those bereaved who are the most in need for help really receive it. The analysis revealed that participants who contacted mental health professionals also felt a higher (than average) need for professional help. Wilson and Marshall (2010) also found that suicide survivors who most needed professional help received it. On the other hand, it should be noted that the need for care from specialists (yet lower than average) was also expressed by those bereaved who did not approach the professionals.

Also, the analysis revealed that respondents who used help from mental health professionals after the loss contacted other medical doctors significantly more often. Such results confirm that the loss has an impact on both the psychological and physical condition of the bereaved. It is important that not only biomedical ways of coping with the bereavement but also psychological interventions are used.

4.2 The role of peculiarities of suicide bereavement in the process of seeking professional help

Contrary to what had been expected, we found that the bereaved who consulted mental health specialists after the suicide had higher levels of perceived stigmatization and guilt after the loss. Although these constructs did not have the prognostic value in predicting help-seeking behaviors, the fact that the bereaved who sought

professional care were more likely to feel guilty or stigmatized has a few implications: 1) these factors cannot be considered unambiguously as barriers of seeking professional help; 2) in some cases stigma and guilt can act as factors motivating to seek care from specialists. We give some possible interpretations of such results.

The results of some studies show that social support can be one of the factors influencing the decision to seek professional help. Maulik, Eaton and Bradshaw (2009) found that increased social support was associated with less frequent use of mental health services. The participants of our research often mentioned their social network as one of the most important sources of help: the presence and support of relatives and friends was one of the most important factors in helping to survive the loss. Other researchers also found that support of social network members was highly valued by the bereaved (Lindqvist et al., 2008). Therefore, the loss of support after the death can encourage the bereaved to look for other ways of getting it. Our research findings also revealed that individuals who sought care from specialists more often reported only negative, but less often only positive changes in their relationships with others after the death. The participants of the study expressed communication difficulties related to stigmatization, death taboo, blaming, reacting to the bereaved person and others. Dyregrov (2004) defined such negative social reactions experienced by suicide survivors as *social ineptitude*.

However, it is important to note that there were no differences between the groups in assessing social support while grieving. So it is likely that social support might be not enough: when faced with grief difficulties, professional interventions are needed. Other studies also could not find protective effect of social support in the aftermath of a loss (Stroebe et al., 2005; Anusic & Lucas, 2014; Wago et al., 2017). Therefore, the results indicate that the positive impact of social support may be not enough when faced with psychological or somatic problems after a loss, while negative social

experiences can become a motivating factor for approaching professionals. Wago et al. (2017) noticed that social support is not related to changes in prolonged grief symptomatology as time passes, and suggested that perhaps negative social reactions have even greater impact for the grieving process than positive ones. This is confirmed by the results of our study. On the other hand, it is important to note that the instrument we used in this study assesses the availability of at least one person who will take the time to listen as the bereft express their open and honest feelings about grief. We cannot guarantee that respondents did not have in mind, for example, their psychotherapists when filling in the questionnaire. It would be important to ensure that only the role of support of the social network after the loss is assessed in the future research.

Another explanation why the participants who consulted mental health professionals felt more stigmatized can be possibly related to the desire of an individual to manage negative effects of stigma. Different strategies can be used to control the consequences of stigma to maintain the well-being and relationships with others. We have already discussed that hiding, avoiding and social isolation are the ways that can be used to alleviate the effects of stigma (Frost, 2011; Hanschmidt et al., 2016). However, seeking professional help and support can also be used as means of reducing the negative impact of stigmatization on the well-being and getting the necessary support. It has been noticed that professional interventions can reduce feelings of anger, guilt, stigma and shame after a loved one has completed suicide (Harrington-LaMorie et al., 2018; McDaid et al., 2008;). One can find it useful to share negative emotions inflicted by stigmatization with a mental health specialist (Miller & Kaiser, 2001) and receive support to reduce negative effects of stigma on well-being (Frost, 2011). Supiano (2012) claims that support groups for suicide survivors provide a safe place to share difficulties in social relationships of the bereaved. According the participant of our research, the most helpful while grieving was "*the*

members/member of the support group. There <...> I found understanding, listening without judgement or remarks on what to do. <...> Others do not want to talk about it with me. Help is needed after such losses. Unambigiously" (136). Another participant wrote: "*Psychologist and support group. <...> I feel free. I feel that someone is listening to me attentively during psychological consultations. I understood some things due to very precise insights of the psychologist <....> And every time I come to the support group it is really easy to realize that I am not alone and that someone else feels like me, is facing similar problems like I do*" (154). Therefore, professional help can be sought by trying to compensate the lack of understanding, acceptance and support in the social network of the bereaved.

People bereaved by suicide often feel guilty after the death (Begley & Quayle, 2007; Fielden, 2003; Lindqvist et al., 2008). The results of this study revealed that individuals who sought help from specialists after the loss felt more guilt than those who did not approach professionals. Intense ruminations, search for reasons of suicide, analysis of the aspects of life of the deceased can help reduce feelings of guilt and responsibility for the death (Klimaitė, 2015). Consulting a professional can serve as a way to get more information about the suicidal process, analyse the circumstances of the life of the deceased and get more answers. As one of the goals of support groups in bereavement is to encourage reinterpretation of beliefs about grieving and loss, group members often have an opportunity to better understand suicidal and grief processes as well as to reduce the feelings of guilt for the death (Harrington-LaMorie et al., 2018; Supiano, 2012). Schneider, Grebner, Schnabel and Georgi (2011) found that survivors who received adequate professional support felt less guilt due to the death. The participants of our study wrote that the most helpful was "*time, prayer and information that I found on the internet about suicides*" (138); "*It was also work with myself: an attempt to rationally explain to myself*

what happened, that everyone will die sooner or later, and I am not guilty for the suicide." (150); "*My psychologist introduced me with the process of grieving (I needed to know that the event was not my responsibility)*" (158). One participant who did not consult professionals after the suicide wrote: "*There was no great need for professional help, I just wanted to know more why this happened, for what (psychological) reasons a person would do it, what led him to that step, maybe we did, maybe we paid too little attention, maybe it was the influence of alcohol*" (120). Therefore, suicide survivors can seek professional help or feel the need for it in order to better understand and integrate the experience of the suicide and at the same time to reduce the feelings of guilt as well as responsibility for the death.

It is also important that stigma and guilt can contribute to health problems of the bereaved. This has also been noticed in previous studies on bereavement after suicide (Feigelman et al., 2009; Maple et al., 2010; Mcmenamy et al., 2008). According to Li et al. (2014), the experience of guilt is related to distress, poorer adaptation and prolonged grief symptoms. Although we did not find that worse mental health could predict seeking help from specialists in our study, the level of prolonged grief symptoms was higher among the bereaved who consulted professionals. Therefore, it could be that stigmatization affects health of the bereaved, and the latter becomes a motivating factor to approach professionals. According to Cramer (1999), when social support is inadequate and people cannot share personally and emotionally relevant information with others, they experience more psychological difficulties, which can motivate to seek professional help. It is important to analyse the indirect role of stigma and guilt in the process of seeking help in the future research.

On the other hand, the question about the distinction between the constructs of stigma, guilt and prolonged grief may arise. Disturbances of social functioning and guilt feelings are mentioned among the symptoms of Prolonged Grief Disorder (ICD-11). Guilt is

also a characteristic of clinical depression episodes. Therefore, guilt can be seen as reflecting the complications of grief that motivate seeking professional help. The inclusion of the prolonged grief disorder into diagnostic categories is still very new. The symptoms are being questioned, the list of symptoms presented in the DSM and ICD classifications is not identical (Lenferink & Eisma, 2018; Maciejewski et al., 2016) so it is difficult to evaluate if some constructs are symptoms or correlates of prolonged grief. This requires further research. However, it is important to mention that guilty feelings after the loss are not evaluated with the instrument PG-13 we used in this study (Prigerson et al., 2009). In addition, ICD-11 describes a Prolonged Grief Disorder indicating that health disruption causes social difficulties, not vice versa.

As we already mentioned, differences between the groups were found, but stigmatization and guilt after the loss did not have any significant value in predicting the likelihood of seeking professional psychological help after the suicide. It is likely that the impact of such constructs on the behavior of seeking help is not unambiguously positive or negative. A better understanding of these results can be obtained through the analysis of qualitative data. For example, one participant responding to the question on obstacles to seeking help wrote: "*The hardest thing was to get over yourself, self-blame seemed very reasonable at the beginning*" (158). Therefore, it seems that guilt and stigmatization can act as factors encouraging as well as suppressing help-seeking, and the decision to consult a specialist may depend more on other factors. For example, the results of this study highlighted the value in seeking professional help or difficulties associated with the relationship with the deceased. Nevertheless, the results we found are contrary to the widespread belief that stigmatization following suicide is an obstacle to seeking professional help. Rather, the role of stigmatization is more complicated and diverse than it had been thought before. It is important to continue similar research in the future to better

understand the impact of stigmatization and guilt on the process of seeking help.

We did not find differences in shame evaluations between the groups. Although the participants who sought professional help experienced more shame after the loss, the difference was not statistically significant. Shame experienced after the suicide, defined as internalized stigma (Hanschmidt et al., 2016), reflects identification with the characteristics attributed to the stigmatized group. Therefore, a person devaluates himself or herself because having stigmatized qualities makes him or her feel worse. One explanation for such results may be that shame is a more complex construct that is more difficult to evaluate (Clark, 2012). However, according to some authors, external shame (in this case, perceived stigmatization) is more important to humans than the internal one because of our evolutionary-based need for belonging to a group (Kim, Thibodeau, & Jorgensen, 2011). This view would be consistent with the results of our study, but undoubtedly further research is needed.

Furthermore, we cannot exclude the assumption that the results of the research could have been influenced by defense mechanisms that, as adaptive unconscious psychological processes, help protect a person from anxiety, internal or external danger, maintain self-esteem (Larsen et al., 2010; McWilliams, 2014). For example, the defense mechanism of denial can act as an unconscious refusal to grieve when the pain of the loss is ignored (McWilliams, 2014). Perhaps the participants neglecting negative effects of grief simultaneously deny the pain or the feelings of guilt or shame analysed in this study. Due to the defense mechanism of projection internal phenomena can be misunderstood as arising from the outside (McWilliams, 2014). Therefore, it might be that the perceived stigmatization reflects unpleasant and unrecognized feelings of the bereaved themselves, already operacionalized as self-stigma (Bos et al., 2013). Deeper qualitative studies would help to

better disclose the role of these intrapsychic mechanisms in the process of seeking help.

4.3 Psychological well-being and professional help seeking

Adaptation to the changes after the loss was evaluated by analyzing the index of well-being and the intensity of symptoms of prolonged grief. No statistically significant differences were found between the subjective well-being (WHO-5) of the bereaved who sought professional help and those participants who did not seek it. Of course, the survivors had already received or had been receiving help before the moment of participation in the study. So it is likely that those bereaved who consulted specialists and got treatment were less depressed than before the intervention. However, after comparing the results of this study with the general population, we found that, regardless of help-seeking experiences, the bereaved by suicide had lower levels of well-being and were at greater risk of being diagnosed with clinical depression. Other studies show that people rarely approach mental health professionals when faced with difficulties in Lithuania (Skerytė-Kazlauskienė et al. 2015), so it is important to educate the society about the symptoms and treatment of depression. Certainly, we used the recommendations for screening diagnosis of depression measured with the WHO-5 in this study (Topp et al., 2015). More precise diagnostic tools should be used for more accurate results.

The results revealed that the bereaved who sought professional help had significantly more intense symptoms of prolonged grief; as well as more of them could be preliminary diagnosed with prolonged grief disorder. At the same time, they subjectively regarded their health as worse. Although the intensity of the symptomatology of prolonged grief could not help predict help-seeking behaviors, the value was close to the statistical significance. It is likely that the differences would be more obvious if we had a larger sample of participants. In addition, as previously mentioned, the positive

impact of interventions on the current health of the bereaved may also have affected the results. Likewise, only one participant of the study mentioned health condition as a barrier to seeking professional help. Therefore, the results of our research suggest that the symptoms of prolonged grief after the loss act more as motivating factors to help-seeking from professionals.

Although we found that most participants of the study who could be diagnosed with PGD had a contact with mental health professionals (31% sought help and 5% did not seek), other researchers do not get such an optimistic result. For example, in a study by Lichtenthal et al. (2011), only 43% of the bereaved who could be diagnosed with PGD participated in professional interventions. Perhaps the results of our study were also influenced by the type of the selection of participants. Those respondents who were involved in interventions might have been invited to participate by the specialists, and those bereaved with severe symptoms of PGD, but not involved in the interventions, might have refused to participate or did not get information about the study at all.

The fact that the bereaved who took advantage of psychological interventions following the suicide were still more likely to be diagnosed with prolonged grief during participation in the study affirmed that the symptoms of grief do not disappear suddenly (Murphy, 2000). According to Supiano (2012), grief process is not gradual and takes time. Although we cannot analyze causal relationships in this study, we reject the possibility that the bereaved who consulted specialists feel worse because of the intervention itself. And the assessment of the satisfaction with the help received was rather high in our study – the average was 3.58 (maximum was 4).

4.4 The importance of relationship with the deceased to help-seeking

We found that the relationship with the deceased was important in prognosticating help-seeking behaviors of the bereaved. The closer the relationship with the deceased was indicated, the greater the likelihood that the respondent sought help from mental health professionals or participated in support groups. Various studies show that the quality of the relationship between the survivor and the deceased is more important than the kinship (Andriessen, 2009; Cerel, Maple, Aldrich, & van de Venne, 2013; Honeycutt & Praetorius, 2016; Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004). Stroebe, Abakoumkin, Stroebe and Schut (2012) noticed that adaptation to the loss was more difficult by the bereaved who experienced an unexpected death and whose relationship with the deceased was closer. If the relationship was not so close, the factor that the death was unexpected was not so important. Continuing bonds is defined as a continuation of the relationship with the deceased after his or her death (Stroebe et al., 2012). The bereaved look for ways to move from physical attachment to psychological connection to the deceased. The loved person still does not lose the role and importance in the life of the bereaved, despite his or her physical absence (Begley & Quayle, 2007). As a result, professional help might be useful in processing various aspects of the relationship with the deceased. For example, the bereaved often feel intense feelings of rejection because of the loss due to suicide (Sveen & Walby, 2007), so one of the tasks of the grief process may be accepting that the deceased person left the bereaved behind. Stroebe et al. (2012) emphasize the importance of attachment style of the bereaved to the complications of the grieving process. According to the authors, the style of attachment affects the direction, intensity and way of grieving. So clinical intervention may be needed to deal

with the problems related to the lost relationship as well as personal issues that were triggered by the loss.

4.5 Attitudes, ways of coping and seeking professional help

The study revealed that an important factor in predicting whether a person sought help after the suicide was the value attributed to seeking professional psychological care. The role of attitudes towards seeking help was found to be important in previous research too (Picco et al., 2016; ten Have et al., 2010). Significant differences between the groups where found in all three factors of the ATSPPH scale: the bereaved who sought professional care were more open to seeking it, less often gave the priority to coping on one's own and considered professional psychological help as more valuable. However, only the latter factor had an important prognostic value, which indicates that perceived effectiveness of interventions is crucial for the decision to seek professional help. Komiti, Judd and Jackson (2006) also revealed that the belief in the effectiveness in help of a general practitioner was one of the most important predictors of approaching this source of help.

The fact that people who considered psychological help less valuable were less likely to seek it may be a consequence of lack of information. According to Nam et al. (2013), it is important to inform people about what is done during psychological interventions and provide information on their effectiveness (for example, statistics on positive outcomes). False belief that psychological counseling or psychotherapy is "just talking with another person" may hinder approaching specialists, because it becomes difficult for a person to tell the difference between clinical interventions and conversations with a supportive friend.

We also found that individuals who consulted mental health professionals use emotional support and blame themselves more often when faced with difficulties. No other differences were found

regarding the coping strategies most often used by the participants. The finding that the bereaved who approached specialists were more likely to use emotional support when faced with difficulties probably indicate willingness to use the same ways of coping with the loss of a loved one. In the study by Supiano (2012), suicide survivors participating in support groups also mentioned that seeking support from others is a very important way of coping with the loss.

Meanwhile, the differences of the tendency to blame oneself when in stressful situation may reflect the importance of personality characteristics to maladaptively respond to emerging stressors. For example, studies show the relationship between pathological self-blame and depressive symptomatology (Kim et al., 2011). The tendency to blame oneself may be related to guilt felt after the loss. Therefore, the desire to better understand and analyse the causes and processes of the suicide becomes a way of reducing the perceived responsibility for it. Of course, it is important to note that, since respondents have already participated in the study after the suicide, we cannot exclude the possibility that evaluation of coping strategies that should reflect general personal tendencies was still affected by the current state of the bereaved.

We found that individuals who contacted specialists were more inclined to disclose distress to others, but the difference was not statistically significant. While other studies show that a tendency to reveal emotionally important information to others is related to the attitudes or intentions of seeking help (Vogel & Wester, 2003; Vogel et al., 2007; Nam et al., 2013), it can be that in the face of severe emotional stress, as is in the case of a loss due to suicide, even those people who are not so open about their problems in their everyday life seek help and support from professionals. The fact that no significant differences in the frequency of use of other coping strategies were found probably reflects that coping is a complex dynamic process involving a person, his environment, and interactions between them (Folkman & Moskowitz, 2004).

Also the results did not confirm that those bereaved who sought care from professionals would be more inclined to use ways of coping when focusing on the loss (emotions, thoughts, behaviors related to the loss) or away from it (emotions, thoughts, behaviors related to avoiding the loss). Therefore, we did not find that avoidance of encountering the reality of the loss would be related to avoidance of seeking help from professionals or vice versa. The results are consistent with the *dual process model of grief* proposed by Stroebe and Schut (1999): the oscillation between the loss and avoidance of it ensures successful adaptation (Stroebe & Schut, 2010). Gaffney and Hannigan (2010) also found that movement between the emotions associated with the loss and the need to avoid them is natural in the first year of bereavement. According to Klimaitė (2015), though it is generally believed that avoiding the loss is a defensive and not adaptive reaction of the bereaved, a person can cope with the loss without speaking about it as well. Of course, we based our analysis on the data from answers to only one question in this study. A more detailed analysis on the ways of coping with grief reactions would be necessary to better understand their relations to help-seeking processes.

4.6 Demographic and loss-related characteristics in the process of seeking professional help

We did not find significant differences between the groups regarding the following demographic and loss-related aspects: respondents' gender, age, place of residence, marital status, education, religiosity, previous experiences of seeking help from mental health professionals, type of the relationship with the deceased, time since death, age of the deceased, and experience of seeking help from mental health professionals of the deceased. The results on the relations of demographic characteristics and help-seeking behaviors are ambiguous. For example, some studies show the link between age, gender or education and seeking help, while others do not show

such relations (Elhai et al., 2008; Grigienė, 2015; Picco et al., 2016; Skerytė-Kazlauskienė et al., 2015; Vogel et al., 2007).

Ward-Ciesielski, Wielgus and Jones (2015) compared the attitudes toward professionals of the bereaved whose relative used professional psychological interventions before the suicide and those whose relative did not receive professional care before the death. As in our study, there were no significant differences between the groups. Only one participant of our study mentioned disappointment in specialists due to the suicide of a loved one. It is a positive finding as, despite the fact that the significant person who had consulted specialists died of suicide, it does not discourage the bereaved from seeking professional help. Some studies show that previous experience of counseling may be related to more positive attitudes toward professional support (Pumpa & Martin, 2015; ten Have et al., 2010; Vogel & Wester, 2003). The groups that were compared in this study did not differ in the previous experiences of using professional psychological help. Probably, when it comes to coping with extreme stressors requiring extraordinary resources, such as suicide of another person (Stroebe et al., 2005; Supiano, 2012), the bereaved have to search for different help sources even though they had not been used before.

4.7 The barriers of seeking help from professionals related to the health care system

The vast majority of participants (93%), regardless of whether they sought help from mental health professionals, indicated that professional help sources should be actively offered by professionals themselves after the suicide. Other researchers also suggest focusing on active methods of contacting the bereaved in the aftermath of the suicide (Drapeau et al., 2015; Pitman et al., 2016). In addition, the participants of our study indicated lack of information on the availability of help as an obstacle to seeking it. It is worth noting that financial difficulties and the need for specialist who works in private

practice were mentioned quite often. The results reflect the importance of developing psychological help services that would be of high quality and free-of-charge. At the same time, it is important that this information about help would reach those in need. The development of help resources should not be limited only to big cities. It is also significant that the bereaved would have the possibility to choose different ways of help: individual, group therapy or psychiatric help. We found that 15% of the participants who have not participated in support groups would like to participate, 41% would not like to participate and as many as 44% of the participants could not decide if they would like to participate.

4.8 Limitations of the study and guidelines for further research

One of the main limitations of this study was the size of the sample and the distribution of participants by their demographic characteristics. More women than men participated in the study. Some research have found gender differences in grief process and help-seeking behaviors (Jordan & McMenamy, 2004; Komiti et al., 2006; Murphy, 2000; Vogel et al., 2007), some have not (Picco et al., 2016). Although we did not find differences in the seeking of help between men and women grieving after suicidal loss in this study, such results could be due to a small number of male participants in the study. Unfortunately, the significantly lower percentage of men participating in scientific studies is a very common problem of grief research (McDaid et al., 2008; Pitman et al., 2016). It is recommended to conduct studies of a broader range of participants covering a variety of demographic and loss-related characteristics in the future. It is also useful to analyse the results of larger samples as some results of this study, such as obtained by logistic regression analysis, could have been influenced by a small sample of participants and a large number of variables.

What is more, the selection of the participants was not random. So it is likely that the results have generalization limits. It may be that those bereaved who have the highest levels of stigma, shame, guilt, poorer health, and the most negative attitudes towards specialists were not included in the study. For example, Lichtenthal et al. (2011) noticed that those bereaved who refused to participate in the research had higher levels of distress. Such tendency to avoid participation in research was noticed by the researchers conducting bereavement after suicide studies in Lithuania before (Klimaitė, 2015). On the other hand, in studies with vulnerable groups, it is crucial to ensure that people who do not want to participate in the study were not forced to do so, or that individuals who are suffering from extreme distress would not participate in order to avoid adverse effects of participation on the health of the individual (Andriessen, Krysinska et al., 2018). However, not only those bereaved who are actively seeking help and support participated in this study, which can be considered as an advantage. The analysis of differences between the groups revealed that the results of studies, with data collected only from persons actively involved in interventions, cannot be easily generalized.

Due to a lack of knowledge in this field, in this study we aimed to analyze various potential barriers to seeking professional help after the suicide of another person. Therefore, we did not have room for a more detailed analysis of particular aspects. For example, it would be useful to evaluate how many times a person consulted a specialist, when was the time of the first consultation, etc. In addition, in this study, we did not analyse the differences between approaching various professionals (psychologists, psychiatrists, self-help groups). The sample of the study was too small, and part of the participants used several kinds of professional help.

Another shortcoming of the study was that the respondents had to retrospectively evaluate their past experiences. Current well-being and intervention experiences could have influenced the way previous

experiences were assessed. It would be important to conduct longitudinal studies to analyse health changes before and after professional interventions. The assessment of the constructs before receiving professional help would allow a more accurate analysis of factors influencing seeking help, with no impact of the intervention itself on the results. On the other hand, researchers often choose to study much longer time intervals since the death. In this study participants had lost someone due to suicide not longer than three years previously so the chance to remember the experiences more accurately is higher.

In this study the focus of the analysis was behavior of seeking help, not, for example, intentions that are often analysed in different studies. According to various authors, although intentions are often positively correlated with actions, they do not necessarily reflect how the individual will behave in the future (Vogel et al., 2007). However, the process of seeking help is complex, related to various factors. For example, according to Kushner and Sher (1989), the closer to the behavior the person gets, the more active avoidance factors are, fears become more intense as they are more likely to be encountered in reality. So the person's willingness to seek help can also depend on which stage of the decision-making process he or she is at. Given the complexity of the phenomenon, it is recommended to combine quantitative and qualitative research methods in order to understand general tendencies and individual trajectories of professional help seeking behaviors after suicidal loss. Also, since grief and social reactions to suicide are phenomena rooted in culture (Dyregrov, 2011; Osafo et al., 2011; Pitman et al., 2016) it is important to conduct similar studies in different cultural contexts and compare the results.

CONCLUSIONS

1. The bereaved by suicide who sought help from mental health professionals or participated in support groups after the loss had more intense symptoms of prolonged grief (they also could be preliminarily diagnosed with prolonged grief disorder more often), more favourable attitudes towards seeking professional psychological help and were more likely to use emotional support as well as self-blame coping strategies when faced with difficulties compared to those participants who did not get professional help.

2. The bereaved who sought professional help were characterized by stronger feelings of guilt, perceived stigmatization and more often experienced negative changes in their social relationships after the suicide.

3. The subjective closeness of the relationship with the deceased, the value attributed to seeking professional psychological help and the frequency of using the strategy of emotional support when faced with difficulties significantly predicted the likelihood of seeking professional psychological help after the suicide of another person.

4. The participants themselves most often identified the obstacles to seeking professional psychological care related to the gaps in the health care system. The need for active role of specialists in offering professional help emerged. Subjective beliefs and feelings as obstacles to seeking help from professionals were rarely mentioned by the participants.

5. The bereaved by suicide had worse estimates of psychological well-being and higher chance to be diagnosed with clinical depression than the general population of Lithuania.

IŠSAMI DISERTACIJOS REZIUMĖ

Odeta Geležėlytė

DĖL SAVIŽUDYBĖS ARTIMOJO NETEKUSIŲ ASMENŲ PROFESIONALIOS PAGALBOS SIEKIMO VEIKSNIAI

Gedulas po savižudybės – tai sielvartavimo ir bandymo prisitaikyti laikotarpis, patiriamas artimo žmogaus ar bet kurio asmens, turėjusio kontaktą su mirusiuoju ir paveikto jo savižudybės (Pitman et al., 2014). Gedintiesiems būdingos įvairios, neretai intensyvios fizinės, kognityvinės, emocinės reakcijos bei socialiniai pokyčiai (Begley & Quayle, 2007; Klimaitė, 2015). Pastebėta, kad gedului po savižudybės dažnai būdinga intensyviau patiriama stigmatizacija, gėda ir kaltė (Clark, 2001; Clark & Goldney, 1995; Harwood, Hawton, Hope, & Jacoby, 2002; Jordan, 2001; Sveen & Walby, 2007). Taigi išgyvenus svarbaus žmogaus savižudybę gali būti svarbi socialinio tinklo narių parama (McNess, 2007; Miers, Abbott, & Springer, 2012). Tačiau nepaisant to, kiek turi socialinio palaikymo artimoje aplinkoje, gedintiesiems gali būti reikalinga ir profesionalų pagalba (Jordan & McMenamy, 2004; Knieper, 1999). Turint omenyje padidėjusią gedulo komplikacijų bei suicidinę riziką tarp gedinčiųjų dėl savižudybės (Harrington-LaMorie et al., 2018; Lobb et al., 2010; Pitman et al., 2014), tinkama laiku suteikta profesionali psichologinė pagalba gali turėti itin svarbios reikšmės užkertant kelią tolimesnės psichopatologijos vystymuisi bei užtikrinant sveiką asmens adaptaciją ateityje.

Vis dėlto pastebimas neatitikimas tarp to, kokį sveikatos specialistų pagalbos poreikį jaučia gedintieji po savižudybės, bei kiek iš jų tos pagalbos kreipiasi ir jos gauna (Aguirre & Slater, 2010; Wilson & Marshall, 2010). Aptarti gedulo po savižudybės ypatumai – kaltė, stigmatizacija ir gėda – neretai minimi kaip potencialūs profesionalios pagalbos siekimo barjerai. Šie veiksniai siejami su

vengimu, izoliacija, atstūmimo, atsiskleidimo baime, susirūpinimu kitų nuomone, sumažėjusiu pasitikėjimu savimi ir savęs vertinimu (Chapple et al., 2015; Fielden, 2003; Fisher & Exline, 2010; Frost, 2011; Wiklander et al., 2003), kas gali turėti įtakos tiek suprastėjusiai savijautai, tiek sprendimui siekti profesionalų pagalbos. Tyrėjai pateikia hipotezes, paremtas kitų sričių studijų rezultatais, tikintis, jog ir savižudybės stigmos vaidmuo pagalbos siekimo procese turėtų būti panašus. Vis dėlto, tai yra prielaidos, kurios moksliškai iki šiol nebuvo tikrinamos.

Mokslinėje literatūroje išskiriamos ir kitos įvairios profesionalios pagalbos siekimo kliūtys, tokios kaip nuostatos pagalbos siekimo atžvilgiu (Elhai, Schweinle, & Anderson, 2008; Fischer & Farina, 1995; Picco et al., 2016), sunkumų įveikos būdai (Li et al., 2014), polinkis atskleisti (arba slėpti) asmeniškai svarbią informaciją, susijusią su nemaloniomis emocijomis ar psichologine kančia (Kahn & Hessling, 2001; Nam et al., 2013; Vogel et al., 2007), savijauta (McMenamy et al., 2008), demografinės ir su netektimi susijusios charakteristikos (Elhai et al., 2008; Picco et al., 2016; Vogel et al., 2007; Ward-Ciesielski et al., 2015).

Kushner ir Sher (1989) pastebi, kad psichologinės pagalbos siekimo procesas yra sudėtingas, tad tam, kad geriau suprastume pagalbos siekimo ypatumus, svarbu įvertinti įvairių faktorių reikšmę. Kadangi apie gedinčiųjų po artimojo savižudybės pagalbos siekimą žinoma itin nedaug, tyrime siekėme įvertinti įvarius mokslinėje literatūroje išskiriamus potencialiai pagalbos siekimui reikšmingus psichologinius bei socialinius aspektus dėl savižudybės artimojo netekusių asmenų profesionalios pagalbos siekimo elgsenai, įtraukiant ir būtent gedului po savižudybės būdingus ypatumus. Tikimasi, kad rezultatai suteiks daugiau aiškumo apie problemines sritis, kurios gedintiesiems gali trukdyti pasinaudoti postvencijos priemonėmis, bei paskatins tolimesnius gilesnius po šios studijos duomenų analizės išskirtų reikšmingų konstruktų tyrinėjimus.

Tyrimo **tikslas** – išanalizuoti bei aprašyti su dėl savižudybės artimojo netekusių asmenų profesionalios psichologinės pagalbos siekimo elgsena susijusius veiksnius. Tikslui pasiekti keliami **uždaviniai**:

1. Palyginti dėl savižudybės artimo netekusių asmenų, kurie kreipėsi profesionalios psichologinės pagalbos dėl netekties, ir tų, kurie nesikreipė, savijautą, nuostatas pagalbos siekimo atžvilgiu, sunkumų įveikos būdus, gedulo po savižudybės ypatumus (stigmatizacijos, gėdos, kaltės patyrimą) bei demografines ir su netektimi susijusias charakteristikas.
2. Įvertinti gedulo po savižudybės ypatumų ir kitų galimai pagalbos siekti motyvuojančių ar vengimą skatinančių faktorių prognostinę reikšmę profesionalios psichologinės pagalbos siekimo elgsenai.
3. Aprašyti dėl savižudybės artimo netekusių asmenų išskiriamas profesionalios pagalbos siekimo kliūtis bei socialinius pokyčius po netekties ir įvertinti pastarųjų pasireiškimo skirtumus tarp profesionalios psichologinės pagalbos po savižudybės siekusių ir nesiekusių respondentų grupių.

Tai vienas pirmųjų tyrimų, kuriame, derinant kiekybinius ir kokybinius metodus, buvo analizuojami įvairūs dėl savižudybės artimojo netekusių asmenų profesionalios pagalbos siekimo veiksniai, įskaitant ir gedulo po savižudybės ypatumus. Priešingai nei tikėtasi, lyginant po savižudybės gedinčių tyrimo dalyvių, kurie kreipėsi ir nesikreipė psichikos sveikatos profesionalų pagalbos grupes, gauta, kad tie, kurie lankėsi pas specialistus, pasižymėjo aukštesniais stigmatizacijos ir kaltės dėl netekties patyrimo rodikliais. Nors bendrame modelyje prognostinės reikšmės profesionalios pagalbos siekimo elgsenai šie gedulo po savižudybės ypatumai neturėjo, tai, jog gedintieji, kurie kreipėsi pagalbos, dažniau jautėsi kalti ir stigmatizuojami leidžia kelti prielaidas, kad pastarųjų poveikis pagalbos siekimui nėra tik vienareikšmiškai

teigiamas ar vienareikšmiškai neigiamas. Tokius rezultatus geriau suprasti padeda įžvalgos, gautos analizuojant kokybinius duomenis. Taip pat prognostiniame gedinčių po savižudybės pagalbos siekimo elgesio numatymo modelyje gauta ryšio su mirusiuoju artimumo svarba. Tokie rezultatai leidžia kelti prielaidas, kad darbas su specialistu gedinčiajam gali būti reikalingas sprendžiant tiek su prarastu santykiu, tiek su asmenybinėmis problemomis, kurias tas praradimas aktualizavo, susijusius išgyvenimus bei sunkumus. Be to tyrime gauta, jog sprendimui kreiptis profesionalų pagalbos, itin svarbu ir tai, ar ji suvokiama kaip veiksminga.

Pagrindinius tyrimo rezultatus galima apibendrinti tokiomis išvadomis:

1. Dėl savižudybės artimojo netekusiems asmenims, kurie po netekties kreipėsi į psichikos sveikatos specialistus arba dalyvavo savitarpio pagalbos grupėse, lyginant su tais, kurie į profesionalus nesikreipė, buvo būdingi stipriau išreikšti užsitęsusio gedulo simptomai, jiems dažniau galėjo būti priskiriama preliminari užsitęsusio gedulo sutrikimo diagnozė. Siekę specialistų pagalbos gedintieji pasižymėjo teigiamesnėmis nuostatomis profesionalios psichologinės pagalbos siekimo atžvilgiu. Susidūrę su sunkumais jie dažniau naudojosi emocinės paramos siekimo bei savęs kaltinimo įveikos strategijomis.
2. Asmenims, kurie kreipėsi į psichikos sveikatos specialistus po netekties, buvo būdinga stipriau jaučiama kaltė, stigmatizacija bei dažniau patiriami neigiami santykių su aplinkiniais pokyčiai po artimojo savižudybės.
3. Subjektyvus ryšio artimumo su mirusiuoju vertinimas, profesionaliai psichologinei pagalbai priskiriama vertė ir naudojimosi emocine parama įveikos strategijos vartojimo dažnumas reikšmingai teigiamai prognozavo, ar asmuo po netekties kreipėsi į psichikos sveikatos specialistus arba dalyvavo savitarpio pagalbos grupėje.

4. Tyrimo dalyviai patys dažniausiai išskyrė su sveikatos sistemos spragomis susijusias profesionalios psichologinės pagalbos siekimo kliūtis. Išryškėjo aktyvaus profesionalios pagalbos siūlymo dėl savižudybės artimojo netekusiems asmenims poreikis. Subjektyvūs įsitikinimai ir jausmai, kaip pagalbos siekimo trukdžiai, pačių dalyvių minėti retai.
5. Dėl savižudybės artimojo netekę asmenys pasižymėjo reikšmingai prastesniais psichologinės savijautos rodikliais, jiems buvo būdinga didesnė klinikinės depresijos pasireiškimo rizika nei bendrosios populiacijos atstovams.

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AUTHOR'S PUBLICATIONS ON THE DISSERTATION TOPIC / AUTORĖS PUBLIKACIJOS DISERTACIJOS TEMA

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MAIN PRESENTATIONS AT CONFERENCES ON THE DISSERTATION TOPIC / PAGRINDINIAI PRANEŠIMAI KONFERENCIJOSE DESERTACIJOS TEMA

Geležėlytė, O., Gailienė, D., Mažulytė-Rašytinė, E., Latakienė, J., Rimkevičienė, J., & Skruibis, P. Is stigmatization really a help-seeking barrier among suicide-bereaved? 17th European Symposium on Suicide and Suicidal Behaviour (Ghent, Belgium, 2018).

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