

**MICRO-SOCIOLOGICAL ANALYSIS OF SOCIAL
SUPPORT FOLLOWING TRAUMATIC BEREAVEMENT:
UNHELPFUL AND AVOIDANT RESPONSES FROM
THE COMMUNITY***

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ABSTRACT

This article explores the reasons why parts of the social support to survivors of traumatic deaths fail. The data is based on in-depth interviews with 69 parents who lost their offspring due to suicide, SIDS, or accident between August 1, 1997 and December 31, 1998. Despite considerable positive support from their social network, the majority of the survivors also experienced some unhelpful encounters or lack of anticipated support. Network members often find it difficult to communicate support in a way that is helpful, and this is termed "social ineptitude." This ineptitude on the part of networks is explained by the lack of norms to guide this uncommon type of social encounter. The bereaved parents claim that "openness" and frankness about their situation is their best empowering strategy to meet this "social ineptitude." These concepts, as they are elaborated in survivors' accounts are discussed within a communicational and interactional perspective. A micro-sociological model of communication provides the frame of reference for the discussion.

INTRODUCTION

This article explores the communicative and interactional processes through which social support is solicited and conveyed in order to elucidate the failure of this form of support to survivors after sudden unexpected deaths. The research

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upon which this article is based was part of the study “Support and care for bereaved after suicide, SIDS (Sudden Infant Death), and accident: Evaluation of recipients and providers of care” (Abbreviated: “The Support and care study”) (Dyregrov, 2002; Dyregrov, Nordanger, & Dyregrov, 2003). An important finding from the study was that the survivors struggled with a diversity of problems, including difficulties in the encounters with members of their social network. Thus, the purpose of this article is threefold: 1) to present survivors’ accounts of unhelpful/lacking social support; 2) to describe the best strategy for survivors in coping with unhelpful/lacking support; and 3) to discuss the process of conveying support by focusing on the micro-dynamics of the unhelpful/lacking support and the self-help strategy. Before the method and results are presented, the theoretical frame is outlined.

Bereaved Populations Benefit from Social Support—A Myth?

A considerable body of literature indicates that the sudden, traumatic loss of a child may have serious psychological after-effects, such as an existential crisis, complicated grief reactions, and difficulties with social functioning (Cleiren & Diekstra, 1995; Dijkstra, 2000; Dyregrov & Dyregrov, 1999; Dyregrov et al., 2003; Janoff-Bulman & Berge, 1998; Range, 1998). Numerous researchers have stressed the important role of social support in reducing grief symptomatology and facilitating psychological adaptation (Dunne, McIntosh, & Dunne-Maxim, 1987; Johnson, 1991; Reed, 1998; Rönmark, 1999; Sherkat & Reed, 1992; Thuen, 1997a, 1997b). Social support usually refers to the emotional, economic, and practical help or information provided to the affected individual by significant others, such as family members, friends, neighbors, and co-workers (House & Kahn, 1985). Over the years, two main conclusions have emerged from this literature. First, social integration is directly and positively related to mental and physical health. Second, perceived emotional support is associated directly with better physical and mental health and usually acts as a buffer against the damaging impact of major life events and chronic strains on mental and physical health (Cohen, 1988; Cohen & Wills, 1985; Sarason, Sarason, & Pierce, 1990; Thoits, 1995). These conclusions imply that people with a good support network will not fall ill as easily and when they do, they will recover faster; in addition, the risk that they will die from their illness is reduced. This knowledge has provided the basis for social support programs for grieving populations (Gottlieb, 1992; Patton, 1996; Thuen, 1995).

Gradually, some less enthusiastic research reports began to emerge from researchers in more nuanced studies of social support. Thus, new directions in social support research included studies of the negative or unhelpful effects of social relationships, and the lack of support giving (Ingram, Betz, Mindes, Schmitt, & Smith, 2001; Rönmark, 1999; Sarason et al., 1990; Thoits, 1995;

Wortman & Lehman, 1985). Researchers pointed out that social support might even be experienced as negative and thus have an effect contrary to its purpose. Findings reveal that victims of life crisis are deeply offended or upset by an emphasis on rapid recovery, displays of over-protectiveness, or insensitive statements (Harris, 1992; Sarason, Sarason, & Shearin, 1986; Thompson & Range, 1992). Dakof and Taylor (1990) pointed out that a typical problematic interaction with friends, involved social avoidance. Brabant, Forsyth, and McFarlain (1995) found that, in order to reduce the pain, anger, and social isolation resulting from lack of support, bereaved parents tried to teach family and friends how to give support. Several authors concluded that the form and consequences of any strain vary according to the nature of the relationship between the receiver and provider of potential support (Dakof & Taylor, 1990; Lehman, Ellard, & Wortman, 1986; Sarason et al., 1990). However, despite the huge amount of research carried out on social support and physical and mental health, there are still major gaps in our knowledge of the processes involved, particularly how, when, and *why* social relationships and support processes sometimes have unfavorable consequences.

A New Key to the Exploration of Unfavorable Social Support?

Although social support is conceptualized as a set of processes involving social interaction, it is often measured in quantitative terms, focusing on the presumed mediators of the processes (how many helpers, who do you have contact with, how often, how long, how personal, etc.). Hence, increased research attention should be directed towards the interactive processes between the providers and recipients of the social support essential for theory development (Albrecht & Adelman, 1987; Baxter & Montgomery, 1997; Sarason, Sarason, & Gurung, 1997).

To examine the nature of these processes, it seems necessary to explore in depth the elements of the communicative relationship between the receiver and provider of support. It is important to pursue the line of some researchers who propose that the concepts of social support and communicative competence have much in common (Hansson, Jones, & Carpenter, 1984; Sarason et al., 1986). This perspective highlights the understanding that meaning does not reside in the messages exchanged but in the perceptual processes of each participant (Sarason et al., 1990; Sarason et al., 1997). Thus, accepting the perspective that social support is fundamentally a relational communication process implies that social support must be explored as an interpersonal phenomenon. To achieve this, attention should be paid to the determinants of the microstructures influencing the communicative relationship relating to the loss.

A Relational Communicational Perspective

Some of the early researchers who have contributed to relational theory are Bateson (1972) and Watzlawick (Watzlawick, Beavin, & Jackson, 1967). Basic to the concept of relational communication is the notion that a message has “relational” and “content” components. While the latter refers to the content of a message, the former alludes to the relationship between the communicants (Millar & Rogers, 1976; Reusch & Bateson, 1951). Watzlawick and his co-workers (1967) hypothesized that the relationship aspects of communication are less evident in “healthy” relationships, while “sick” relationships “. . . are characterized by a constant struggle about the nature of the relationship, with the content aspect of communication becoming less and less important“ (p. 232).

Especially important when it comes to the support and caring relationship is Watzlawick’s assumption that: “If it is accepted that all behavior has message value, i.e., is communication, it follows that no matter how one may try, one cannot not communicate” (Watzlawick et al., 1967, pp. 48-49). Furthermore, this assumption implies that all encounters between social networks and survivors function as communication and, depending on the meaning created by the survivor, may be interpreted as supportive or as non-supportive.

“Meta-communication,” i.e., communication about a communication,” is another central and widely adopted concept within this tradition (Watzlawick et al., 1967). Whenever we communicate about how we communicate, we communicate at this level, and express the implicit or explicit rules of human interaction. The concepts elaborated by Watzlawick form the basis of Jacobsen/Del Hymes’ micro-sociological model of communication (Briggs, 1986), and have been employed in analyzing the interviewees’ accounts in the present article. This model rests on a pragmatic perspective exploring the rules (or norms) which guide the formulation and interpretation of the messages that pass between human beings in a given socio-cultural context (Briggs, 1986).

As noted by Hymes (1971), the ability to communicate entails not only knowledge of syntax and semantics alone, but also communicative competence. Acquiring the latter involves knowing which expressions can be used in what circumstances to convey which meanings (Hymes, 1971). Being a relational concept, the term communicative competence also includes the ability to promote the communicative competence of others. The importance of the social roles, the social situation, and the type of communicative event pertaining to a given encounter are revealed in their joint role in defining the norms of interaction. In the encounter between the bereaved and the network, such norms will determine: Who is the helper supposed to support? What sort of support can/should be provided? How much can/should be said? What linguistic forms can/should be used? When and where is it expected or appropriate to give support? In a given situation, the network members, as well as the bereaved, will act according to their respective answers to these questions—if they have any clear answers.

METHOD

The following data is part of the larger quantitative and qualitative study entitled “the Support and Care study,” which explores: a) the psychosocial situation of bereaved parents; b) the experiences of social network support, professional help, and self-care as reported by bereaved parents; c) the professional provisions for bereaved families as reported by local authorities; and d) the bereaved parents’ experience of research participation. Mainly, the methodology underlying this article (one of the scopes of pt. b) is described in the following. For further details concerning methodology, see Dyregrov (2002) and Dyregrov et al. (2003).

Measurement

A qualitative research method was considered the most appropriate research method, and in-depth interviews the best technique to explore the inter-relational communicational processes that might facilitate or impede social network support (Kvale, 1996; Thoits, 1995). This method focuses on the generation or discovery of theory from systematically obtained and analyzed data. Ethnographic techniques were employed to explore recollections of the bereaved parents, tapping their “insiders’ perspectives” through their descriptions rather than focusing on their explanations. Thus, it was important to allow the interviewees to generate their own stories, words, and images.

A theme guide was used, based on four themes, aimed at illuminating the survivors’ experiences concerning: 1) quantitative dimensions of the support (sources of support, frequency, time perspective, etc.); 2) qualitative and relational dimensions of the support (particularly good or bad support, unhelpful support, lack of support, barriers for accepting support, etc.); 3) dimensions of ideal support (quantitatively and qualitatively); and 4) self-help strategies (“What has been the best self-help strategy to alleviate your situation?”). These themes were used as starting points for encouraging the survivors’ narrative activity.

Participants

The sample comprised a total of 69 parents from 40 families, who had lost a child/young adult due to suicide (20), accident (10), or SIDS (10). The sample varied significantly with regard to the age of the survivors, the suicide group being the eldest ($M = 52.0$, $SD = 8.0$) followed by the accident group ($M = 40.0$, $SD = 8.5$); the SIDS parents ($M = 30.0$, $SD = 5.7$) were the youngest. The female/male ratio for the interview sample was 37/32. The families represented both rural (36) and urban (33) populations. With regard to the parents, their educational backgrounds ranged from secondary school (14), to college (35), and university (19). Sixty-six of the parents were married, while three were single. Fifty of the parents were employed (full or part time), while 19 were unemployed.

The parents had lived between 1 year and 55 years at their present place of residence ($M = 21$).

The parents psychosocial health was measured 6 and 23 months post loss ($M = 14$ months), and a majority revealed severe disturbances. Sixty-two percent of the interview sample scored above the cut-off score for a high level of psychosocial complaints (General Health Questionnaire), 59% experienced a high level of posttraumatic distress (Impact of Event Scale), and 72% scored above the cut-off level for complicated grief reactions (Inventory of Complicated Grief) (for more details, see Dyregrov et al., 2003). The mean age of the deceased in the interview sample was 21 years for suicide (range 11-28 years), 10 years (range 2-17 years) for accidents, and 2.2 months for SIDS (range 0-1 year).

Procedure

After a 1½ -year process of application, the Ministry of Law and Justice in Norway granted permission to undertake “the Support and Care study.” They provided access to the names and addresses of bereaved families registered in the Norwegian police records (*Strasak*). The *Strasak* register contains all reported sudden deaths in Norway and is strictly confidential. Therefore, the Attorney General, the Council for Professional Secrecy and Research (UiO), the Medical Ethical Research Committee (UiB), and the Data Inspectorate of Norway all had to grant their permission for the study. This was the first time exemption had been granted to allow the use of this register for research.

The interviewees constitute a sub-sample selected from a larger sample of all the families bereaved due to suicide (162) and SIDS/child accidents (132) in Norway between August 1, 1997 and December 31, 1998. One hundred and fifty-five families (53%) participated in the first quantitative part of the study, and 95% of these families agreed to participate in in-depth interviews; 40 of these families were selected for in-depth interviews. The interview sample was defined as a theoretical sample; the criterion for selection was variety since the aim was to reveal the diversity of the survivors’ experiences. After having sorted the families according to all available background variables in a matrix, four families were selected from each of the 10 postal regions in the country, thereby ensuring diversity (see participants).

The families participating in the larger study were contacted by letter in April 1999 and the interviews took place in the autumn of 1999. Trained researchers (a sociologist and a psychologist) conducted the interviews in the homes of the survivors between 9 and 27 months after the deaths ($M = 19$). Every interview was conducted in a relaxed, informal atmosphere, accompanied by a light meal prepared spontaneously by the bereaved families. The in-depth interviews lasted approximately 2.5 hours per person/couple (range = 1.5 - 4 hours). Twenty-nine interviews were conducted with both parents together, while eleven interviews were conducted with a single parent present.

Every stage of the research process was carried out in a very sensitive and careful manner, showing deep respect for the very difficult period the families had been through. The families were thoroughly informed by letter about the purpose of the project, as well as the principles of anonymity and confidentiality involved; they were offered telephone contact with the researcher, and were informed of their right to withdraw from the study at any time. They replied to this inquiry in a stamped addressed envelope, giving their written consent or informing the project group that they were unable to participate.

Analysis

The analysis followed the five-step phenomenologically-based meaning condensation procedure suggested by Giorgi (1975) and later by Kvale (1996). The first step required that, after the interviews had been conducted, tape-recorded, and transcribed by the researchers, the whole interview was read through to get a sense of the whole. Then, phrases or sentences (“meaning units”) that directly pertained to the phenomenon under investigation were extracted from the transcribed interviews. Third, the themes that dominated the natural meaning units were stated as simply as possible, as these were understood by the researcher. The fourth step consisted of interrogating the meaning units in terms of the specific purpose of the study. Thus, the meanings expressed by the parents regarding their experiences with social network support were condensed into increasingly essential categories and meaningful themes. Repeated evidence of similar experiences across the interviews resulted in the identification of major concepts and themes. In the final step, the essential themes from all the interviews were linked together into descriptive statements of the core components of the phenomenon (Kvale, 1996). The condensed data was then analyzed employing meaning interpretation procedures in order to fulfill the third aim of this study. This allowed a deeper and more extensive interpretation of the data, in which the researcher sought the meanings behind or beneath what was said directly, in order to work out the structures and relations of meaning not immediately apparent in the text (Kvale, 1996).

Ecological Validity

In line with the notion that meaning is interactionally produced, this study has viewed the interviewee and the interviewer as being influenced by the same communicational components. Hence, some comments will be made on the ecological validity of the study, with regard to the effect of the researcher’s presence and procedures on the narratives of the research subjects (Silverman, 1987). In order to reduce the influence of the researcher’s way of thinking upon the interviewees, the decision was made to employ qualitative open interviews and the strategy of letting the interviewees direct the sequence of the

interview themes according to their own associations (Briggs, 1986). Being aware of the fact that the interview would constitute a significant channel through which the survivors could give meaning to their experiences, the researchers tried to develop an empathic listening mode which would catch the nuances and layers of meaning in what the interviewees told them (Kvale, 1996). The interview is a unique communicative event, involving negotiation between roles and frames of references. Efforts were therefore made to inform the survivors thoroughly about the type of interview, as well as about the researcher's role and background. The interviewees defined the social context themselves, by choosing to be interviewed in their own homes, while the interactional goal of the encounter was defined by both parties: a shared wish to throw light upon the situation of the survivors. A later study conducted in order to evaluate the interviews (Dyregrov, 2004) revealed that the survivors felt that they had benefited greatly from the experience, which they claimed had furthered their grief work. This feedback is valuable in the evaluation of the ecological validity of this study. Moreover, three survivors commented on the results and were strongly supportive of the conclusions that were drawn from the data.

RESULTS

The survivors appreciated most of the overwhelming support they received from their social networks, i.e., family, friends, acquaintances, work colleagues, and neighbors. Close friends and family came to comfort them at home; they brought food, wanted to help them with the housework, or took them out for a walk. Many survivors received warm letters, poems, or books. Most appreciated was the support provided by the network members who contacted them in their own homes. Here, the survivors felt freer to express whether they had the energy to see the visitors or not, and these encounters turned out better than when the survivors and network members met accidentally in public. It was noteworthy that the most appropriate and helpful responses were provided by network members who had themselves experienced a sudden unexpected death, or who had previously offered support to survivors.

However, despite all the positive experiences, they also had negative encounters with network members. Our findings were consistent with a study of Dakof and Taylor (1990) which indicated that what survivors defined as "ideal support" was a reiteration of what had been experienced as "helpful support," whereas "wished-for responses" were the mirror image of the "unhelpful/lacking support." Only the latter is focused in this article. The majority of the survivors in this study experienced what is termed "social ineptitude" from family, friends, neighbors, and co-workers. To cope with this social ineptitude, the survivors stressed the importance of what they called "openness."

Social Ineptitude

Social ineptitude refers to the difficulty a social network encounters in responding to and supporting those bereaved by sudden, traumatic deaths in a manner that is appreciated by the bereaved. A father expressed this as a bilateral problem after the suicide of his 14-year old son: “People learn to handle most situations in life, but when sudden and traumatic deaths occur, we ourselves, as well as the social networks, discover that we are completely inept at handling the situation.”

The survivors gave numerous examples of the negative impact certain acts or utterances on the part of people in their social networks had had on them. Three dimensions of social ineptitude emerged: 1) anticipated support fails to appear (non-communication); 2) people suddenly withdraw from the bereaved (abrupt communication); and 3) unhelpful advice and support is offered (unsuccessful communication). Although there were some differences between the groups of bereaved as to how and to what degree they experienced this social ineptitude, the similarities were far greater than the differences. Thus, mainly the similarities will be focused in this article.

Anticipated support that fails to appear was exemplified by many stories in which family members or good friends were expected to support the survivors, but did not do so. When the survivors finally managed to contact these network members, they often heard: “We have been thinking so much of you,” “We wanted so much to go and see you,” etc. However, as remarked by the survivors themselves: “It does not help the grieving person at all if someone sympathize with them, so long as they are not aware of it.” According to the survivors, it hurt even more when network members tried to excuse their absence by claiming to have been “so busy,” “having had to work so much lately,” etc. The absence of support from the workplace was noted by approximately one-third of the bereaved, as exemplified by a mother who lost her child in an accident: “None of the managers offered their condolences or mentioned the tragedy at all.”

When *people withdrew from the bereaved*, it was both physically and in conversation. Nearly all the survivors told stories about members in their inner or outer networks who had changed direction, crossed the street, or looked another way when they had caught sight of the bereaved person. A mother who had lost her 15-year-old son due to suicide, exemplified this by saying: “The first time I met a close colleague after the death of my child he was sitting right across the table but turned away from me and conversed intensely with the guy next to him. Then he left the room without even saying goodbye to me—that had never happened before.”

Another very common way for network members to withdraw social support was through conversational avoidance. Survivors gave a lot of examples in which network members had avoided talking about anything associated with death in

general or about that particular death, or they did not refer to the deceased by name in the conversation. One mother described this: "It really hurts my feelings when people seem to have burnt their lips and swallowed their tongue when they accidentally articulate his name." Some network members frenetically talked about anything but what had happened and the situation of the survivor. A father said: "It is so offensive when a person talks about everything except my dead boy, if I have expected to talk about him with that person. Such a conversation is completely meaningless to me." Survivors stressed that their wish to inform others about their present situation or to include the dead child in normal conversation did not imply that this was the only topic they were capable of talking about. However, they stated that a conversation about the tragedy seemed to them to be an important presupposition for the normalization of social interactions. A father said: "It is annoying to socialize with people who know what happened, and know that we know, without us being able to talk about it. By talking it over, we will establish a common basis, and then we can go on to everyday matters."

As reported by the survivors, this avoidance behavior on the part of network members was more frequent when the encounter took place outside the survivor's private home, e.g., in a shop, at a work place, at the funeral, or in a public place. They claimed that meeting network members at home facilitated closeness because there was more time and they themselves were in charge of the agenda.

There were numerous examples of *advice and support that was unhelpful* to the survivors, which had probably been thought helpful by network members. The survivors described a lot of "well-meant advice," thoughtless or even wicked remarks, and imprudent actions. A frequent comment made by the survivors regarding such well-intended advice from people, who had never experienced anything like this themselves, was: "They tried to help, but it went wrong." The advice offered was often not only poor, but also considered inappropriate, when given without any signs of empathy or respect. A mother, who had lost her 20-year-old son due to suicide, and who insisted on grieving in her own way and at her own pace, had the following comment to offer on the networks' tendency to give advice: "Immediately after his death I was at the graveyard every day, because it was important to me. Many people told me that I should not go there so often; it was not good for me. I think that advice mainly came up because it hurt them to see me there and they could not handle being confronted with their own death and grief." For this mother, the grave, the belongings, the mementos, and the memories of her son were important as a means to proceed with the grieving process. Parents stressed that nobody should give advice or proclaim himself to be an expert on the right or wrong ways of grieving. A mother who had lost her baby due to SIDS put this into words: "Nobody can ever get inside my mind and experience how dreadful this situation is. So, nobody can tell me what is right or wrong." A couple of survivors pointed out that it is important for the network to receive clear signals and messages from the bereaved in order to understand and respect that individual's way of grieving.

The survivors felt that although most network members wanted to be supportive, they often made thoughtless remarks such as: “Well, the grief will disappear after a while; There is a meaning in everything; As you had all the problems with your boy, this must also be a relief; Fortunately you have the other children left,” etc. Some of the utterances gave rise to long-term frustrations and could never be forgotten. One such example is the mother who had lost her 19-year-old son due to suicide and her old aunt tried to comfort her by saying: “I believe that Sam is with God too, because God does not discriminate between people.”

Inconsiderate and imprudent actions are the last form of unhelpful support included in the concept of social ineptitude. These were generally the actions of strangers who had experienced the loss of a child themselves and wanted to help. Although few survivors had actually had the privacy of their homes invaded by complete strangers, such episodes could be a great strain. Not all of those who have been bereaved managed the delicate balance between comforting and being comforted. One father who had lost his daughter in an accident described such an experience: “I was extremely angry. I felt that we were being burdened with her problems on top of our own.” The strangers who appeared at the door of a non-religious family who had lost their son due to suicide and wanted to read from the Bible, exemplifies another form of imprudent action.

Taking the Supporters' Point of View

Despite the pain experienced as a result of the social ineptitude of network members as well as strangers, most of the survivors spontaneously commented that they sympathized with many of the dilemmas and difficulties facing their social networks. They understood perfectly that it was difficult for others to contact them and to know what to say. The survivors realized, either at the time or later, that helpers' painful remarks were the result of an inability to offer helpful support, rather than indifference. So, although they were hurt, they excused the providers to a large degree. One father expressed this sympathy when he said: “Although it hurts badly, I can very well understand those who are avoiding us. People cross the street. I might have done it myself because—what could we talk about?”

Even though many survivors stated that they would probably have reacted in the same helpless way before their own experience, they had now learned a lesson they would remember for life. They had learned the importance of receiving support and care from those in their surroundings, and they had experienced the pain when people avoided them. Second, they insisted that they felt better able to support others who experienced a crisis than before their own tragedy. A father claimed that this competence was lacking in his generation, basing his arguments on his upbringing: “I remember that we, the children, were given money to go to the cinema when my grandparents died. We were not supposed

to talk about it. Of course, such an upbringing has a lasting effect.” This reflected the way of thinking at that time; that it was better to kill the problems by silence rather than let them grow by talking about them.

Finally, survivors stated that it seems as if network members have problems both with the form (how) and the content (what) when communicating with bereaved people. A father who had lost his son due to SIDS pointed out one way to reduce social ineptitude: “If they had simply said that they had not been able to face us in our difficult situation, I would have understood.” A couple of parents suggested that the public should be trained in how to support and interact with people who have experienced serious life-crises.

Survivors’ Openness

A lot of strategies were mentioned when the survivors answered the question “What has been the best self-help strategy to alleviate your situation?” Besides self-help strategies that fall into categories such as physical activity, good eating habits, reading, getting information, listening to music, working, etc., the number one category is “openness.” This term covered spontaneous statements from most of the survivors (81%) from all over the country who claimed that openness was their most important resource in dealing with unhelpful/lacking social support, hopelessness, and isolation. The term includes many linguistic nuances, such as frankness, honesty, and directness in interaction with others.

Three categories of openness emerged from the interviews, obviously covering the different needs of the survivors. The first category is labeled *telling the story*. The survivors described that the opportunity to tell network members about what had happened and about their personal experiences related to the event had an important therapeutic value. A mother who had lost her daughter in an accident said: “I have to articulate what I am thinking of all the time. If I can do that I feel much better afterwards. I have to talk, or else I will go crazy.”

The second category of openness is called *informing others*. The survivors stressed the importance of informing their social networks about the event, to signal to network members that they were allowed to talk to them about what had happened. Such behavior caused reactions of relief among many network members who, when facing the bereaved, did not have to pretend to be ignorant of what had happened.

Furthermore, the survivors had found that by speaking frankly about the loss, and by mentioning the deceased by name, they made it easier for the network who then felt that they were allowed to talk about the tragedy and would receive signals indicating how to behave. A mother who had lost her son due to SIDS confirmed this by saying: “It is important to talk about what happened. It is better if you start talking yourself, because most people do not know what to say or how to behave.” Another survivor stated: “When I pronounced his name and talked about him, my friends knew that I would not be embarrassed by them doing

the same.” In addition, the survivors strongly believed that this strategy helped them to avoid rumors, by informing larger groups of people at their schools, workplaces, etc. Three of the families bereaved due to suicide made the cause of death public through the obituary in the newspaper. One of the families announced: “He chose to end his life.”

The third category is labeled *clarifying own needs* and refers to survivors who explicitly told their network how to provide support. Although not always possible because of lack of energy, half of the interviewed families stressed the importance of being explicit regarding needs for support. They described active strategies of making contact with network members, initiating conversations about their loss, seeking support from others, inviting people to their homes, etc. A young mother who had lost a son due to SIDS stated: “I think it is very important to thank people for contacting us in a direct way. If this is impossible, signal in some way or other, that support is good for you.” When the survivors gave families, friends, co-workers, and neighbors direct and honest feedback on their support efforts, the network could then meet their demands for support. Thus, the openness helped the network members overcome their social ineptitude. Especially, the survivors following a suicide stressed this. Some very resourceful parents had gone straight up to people who avoided them. They told them that they wished to talk about their loss and explained what kind of support would be helpful. A mother who had lost her 21-year-old son due to suicide pointed out that this attitude was not easy: “It is not easy to take the initiative, because you may actually risk rejection and suffer another disappointment. Once I felt that a person was avoiding me out of fear and I decided that she had greater difficulties than me in dealing with the situation. Therefore, I made a detour just to meet her, and we were standing there talking for half an hour.”

However, despite all the positive attitudes towards openness, there were also important indications that survivors might lack the energy or power to take the initiative or meet others with openness. As reported elsewhere in the study, this was the case among those who refused to participate (Dyregrov, 2002; Dyregrov et al., 2003). Other survivors encountered the problem that their network was not ready for the openness, and refused to address the topic despite the efforts of the survivor. Conflicts within networks or communication problems within the bereaved family were pointed to as barriers to openness.

Finally, survivors of suicide advocated openness even more strongly than the parents bereaved by SIDS and accidents, often linking the need for openness with the stigmatization of suicide. Many survivors of suicide experienced controversies related to the question of openness and honesty, and many disagreed about this within the same family. However, survivors who had been skeptical, but had given in to their spouses’ belief in openness, were very positive when they realized the benefits of this strategy.

DISCUSSION

The data from the in-depth interviews confirms earlier research, which revealed that survivors felt that certain aspects of social network support was unhelpful or even harmful (Brabant et al., 1995; Dakof & Taylor, 1990; Lehman et al., 1986; Rönmark, 1999; Thoits, 1995). According to the accounts of the traumatic bereaved, the networks seem to be very insecure about how to express their empathy when facing the bereaved. Few norms exist that can serve as a guide to the social network regarding how to support parents in this difficult situation. Thus, the survivors seem to be right when assuming that “the social ineptitude” of network members seems to be caused by an inability to offer helpful support, and not by indifference. Resourceful survivors have found that expressions of “openness” are the best ways to reduce the social ineptitude as well as their own feeling of insecurity in the encounters. In this way, the receivers and the providers of social support influence each other in reducing the uncertainty about the situation, each other, and the relationship (Albrecht & Adelman, 1987). Being able to talk about what happened, how they feel, and how they want to be helped, means that the bereaved receive more appropriate support and the social networks learn to deal with grief and support the bereaved after tragic events. This pinpoints the importance of seeing social support as a joint accomplishment.

The “openness” of the survivors obviously promotes communicative competence among social network members. As also noted by Brabant et al. (1995), the survivors “teach” their insecure social network how to offer support through communication and meta-communication. In this way, the survivors create a common frame of reference by actively informing network members about what has happened, and allowing or inviting them to provide support. This study also supports earlier findings which indicate that when survivors communicate their appreciation of a particular action either explicitly or implicitly, network members will increase the frequency of such actions. The opposite is also true, and when they communicate that an action is very unhelpful, this will minimize the likelihood of a repeat occurrence (Dakof & Taylor, 1990). Therefore, the “openness” through which the survivors communicate the basic “rules” for communication in order to gain better support, must be seen as an empowering self-help strategy. However, the success of the strategy will always be related to social, situational, and cultural factors and premises.

Micro Dynamics of the Unhelpful or Lacking Responses

To grasp the dynamics at work in encounters between network supporters and bereaved on a micro-level, concepts introduced by Del Hymes’ (Briggs, 1986) have been adapted to a working model (see Figure 1).

Several of the basic components in the communication model play a dominant role in defining the major communicative function of these encounters. In the

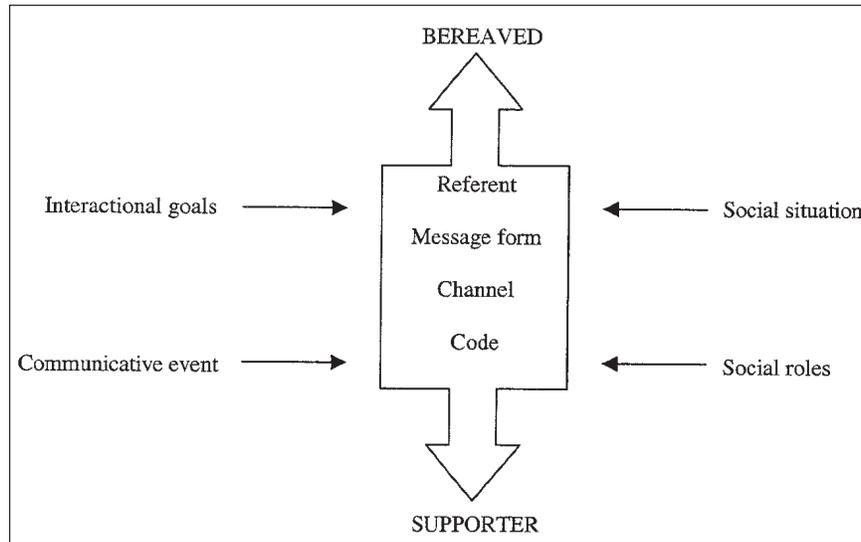


Figure 1. A micro-sociologic model of the communication of social support.
 (Social roles: assumed roles between the parts; Interactional goals: motivation for engaging in the encounter; Social situation: context for the encounter; Type of communicative event: category of social event; Message form: auditory and visual signals; Referent: semantic content; Channel: visual/acoustic or psychological circuits; Code: linguistic or nonverbal.)

following, each of the components is examined in terms of its role in shaping the meaning of what is said by both parties.

Supporting a bereaved person who has lost a child by traumatic death is an uncommon category of communicative events in any society. Since this kind of *communicative event* constitutes a critical, unusual, and uncertain situation for all parties concerned, common norms of interaction will be challenged. The parents' accounts indicate that network members and survivors often do not share a common interpretation of the "frame" for communicating following traumatic deaths. As pointed out by Bateson (1972), a frame constitutes the external conditions of the situation within which the context develops, and thus the frame will tell the interacting persons how to define the situation and thereby guide their production of meaning and actions. As also suggested by others, withdrawal and non-communication by the network members or the survivors is most likely due to the fact that they lack norms for interaction and canons for interpretation of that particular communicative event (Van Dongen, 1993). Since the child learns communicative forms within the socio-cultural contexts they live in (Bateson,

1972), and norms for supporting bereaved parents are seldom employed, this means that many network members will acquire this kind of competence for the first time through their interaction with the survivors. In line with Van Dongen's findings (1993), the survivors in this study affirmed that they would have been as helpless as their network if they had not experienced their own sad loss. According to many survivors, their experienced-based knowledge had made them far more competent in communicating about death and grief.

According to Bateson's perspective (1972), both survivors and network members will have internalized common-sense knowledge of how to act in a particular situation. Earlier studies have pointed out that following a suicide many survivors have tried to hide the cause of death and refused to talk about the deceased (Wertheimer, 1991). The belief that there is a danger of ripping open old wounds as time passes is another misconception that seems to lead to both non-communication and abrupt communication on the part of network members (Dyregrov & Dyregrov, 1999; Wertheimer, 1991). Thus, the norm of respectful silence has dominated, with the result that there are no rules governing supporting praxis. Although traumatic deaths, especially due to suicide, are still considered a highly private concern, there are signs that this is changing in Norway. As seen in other parts of this study, increased public knowledge of crisis psychology (Dyregrov, 2002) combined with trends towards openness about stigmatized topics, are gradually providing basic norms to regulate how to approach bereaved populations. At the same time as bereaved groups are increasingly turning to crisis psychology to fight their isolation and taking the initiative to change their adverse life-situations, there is also an official trend encouraging greater acceptance of psychological problems and diseases and placing these on the same footing as physical problems. These shifts are probably important steps in the redefinition of this particular communicative event.

The interactional goals, or the motivation of each of the participants for engaging in the encounter (Briggs, 1986), are evidently asymmetrical in this study. While most survivors express the need to talk about what has happened, many network members seem to want to flee the scene due to feelings of insecurity or fear of facing the grieving parents. The latter reaction is consistent with the findings of other studies, which show that social networks avoid confronting death in general and especially the death of a child (Lehman et al., 1986; Rönnmark, 1999).

Generally, when people are in familiar situations, they have clear implicit or explicit goals for the communication, and know what the encounter will lead to. This may explain why most of the network members who had experienced or supported others following a sudden unexpected death were more likely to offer support that matched the emotional and practical needs of the survivors (Thoits, 1995; Thuen, 1995; Van Dongen, 1993).

When the survivors made an effort to approach the network members, they were motivated by a strong wish to share and discuss their adverse life-situation with

their “significant others,” i.e., those network members who they themselves defined as the closest. Studies have shown that active support by network members may be motivated by an interactional goal of expressing concern or giving information, whereas withdrawal may be a result of a fear of confronting the pain of others, a desire to minimize one’s own anxiety, or a need to avoid a threat (Goldsmith, 1992; Lehman et al., 1986; Sarason et al., 1990). In line with earlier research, survivors of suicide in particular reported that they were concerned about the motives that caused some network members to approach them (Dunne et al., 1987; Van Dongen, 1993), and experienced more extreme responses from network members (Thompson & Range, 1992). Moreover, several survivors in the present study also express concern about how to approach the network. Finally, as social support is a joint accomplishment, it is of great importance that the interactional goals of the parties in the communicative event correspond.

The social roles that network members and survivors are assuming in the encounter have a profound effect on the sort of support that is signaled and how this is read. Consistent with earlier research, the role uncertainty of network members seems to account for much of the non-communication and abrupt communication seen in this study (Van Dongen, 1993; Wagner & Calhoun, 1991-1992). The survivors and the network members apparently defined their relationship in terms of different degrees of closeness. Thus, when the survivors in this study felt that they were not receiving support from a person they considered to be a close friend, the friend might define the relationship as less close, implying that the role would involve no obligations as a social supporter provider. The reason why close family members or friends also redefine the “rules” for providing support may reflect the fact that they are personally affected by the tragedy and the provision of support may threaten the survival of the system upon which their own social selves depends (Brabant et al., 1995; Lehman et al., 1986). This reveals the importance of seeing social roles as situational constructions and of bearing in mind that both survivors and network members are moving between a number of different social roles.

If the social roles of network members and bereaved have been characterized by an asymmetric (inferior-superior) relationship before the death, this may influence which partner takes the initiative following the loss. Thus, anticipated support that fails to appear, for example from employers, may sometimes be explained in terms of such mechanisms.

The social situation in which the interaction takes place may be crucial in determining how an encounter between survivors and network will proceed. As seen in the study, communication differs according to whether it takes place in a shop, in a work place, at the funeral, or in a public place, rather than in the survivor’s private home. As reported by the survivors, when a lot of time is available, and fewer outsiders and distractions are present, the interaction between themselves and network members improves. These factors, which define the social situation, seem to be closely linked to a general fear people experience when

they feel that they lack control of the message form, code, and channels for expressing support in adverse life situations (Dakof & Taylor, 1990).

The message form consists of the auditory and visual communication signals that serve as sign vehicles in the communication between the survivor and network supporter (Briggs, 1986). Insofar as network members had tried to support the survivors, they had many problems in deciding what signs to convey to the bereaved. The tone or manner in which the support was provided was not always understood by the survivors, not least because the semantic content was often subtle and followed by nonverbal markers. Lehman and his co-workers (1986) found that many potential caregivers knew what they would *want* to say, but feared that it would not come out the right way. The interaction may be complicated still further by the fact that many survivors felt that their message was vague, because they did not want to demand too much from the network or be too disappointed if they were avoided. On the other hand, as noted by Dakof and Taylor (1990), when survivors communicated their appreciation in an explicit or implicit form, the network members increased the frequency of actions that were helpful.

Generally, all forms of communication have to be conveyed through visual or acoustic (physical or psychological) *channels* between participants. Whereas some messages can only be transmitted nonverbally, others may combine a minimally essential nonverbal component with verbal elaboration (Briggs, 1986). In this study, social support was communicated via many channels, such as face-to-face, by letter or telephone, through a poem, or by a dinner brought to the survivors' front door. The survivors stressed that network members should prioritize the nonverbal channels by just listening, instead of trying to give "good advice" that often turned out to be unhelpful or harmful. As such, the verbal components in the communication between survivor and network member showed distinct inadequacies.

Finally, both parties in an encounter must share the necessary *codes* in order to permit the encoding and interpretation of messages (Briggs, 1986; Hymes, 1971). The network members displayed a basic lack of certainty with respect to what code to use in this encounter in order to convey empathy to the survivors of traumatic deaths. While the survivors expressed a wish for shared feelings and closeness, many were met with cognitive and intellectual communication codes. All the inappropriate advice meant to be supportive may serve to support the assumption that it is even more difficult to express emotions and feelings than words (Briggs, 1986). When the body language of a network member showed less proximity than expected by the survivors, the latter felt they were being avoided and abandoned. Finally, the survivors' negative reaction to anticipated support that failed to appear, confirms Watzlawick's (1967) notion that it is not possible *not* to communicate, because avoidance is also a code for communication.

Despite the relational perspective, the focus of this study has been more on the deficiencies of the social network than on those of the survivors. The argument for

this is that if supportive communication is to be a support, it must rest on the premises of the recipient and satisfy their needs. Moreover, we cannot discuss the experiences of the network members, since they have not been interviewed in the present study.

CONCLUSIONS

There seems to be few clear-cut norms guiding the social support-giving process between social networks and bereaved parents who have lost a child under tragic circumstances. Besides the norm of respectful silence (because some still believe that it is harmful to talk about death), there seem to be few rules governing the kinds of support to be given. Because suicide, accidents, and SIDS are fairly rare events, people are unsure of what to say and do to be supportive. Hence, it falls on the bereaved to tell their supporters what assistance they need and to signal that it is okay to talk about the deceased. This interplay has been analyzed through two main concepts, those of openness and social ineptitude, and micro-sociological communicational concepts have been employed in the discussion.

The concepts of “openness” and “social ineptitude” emerged from the bereaved parents’ accounts of their encounters with their social networks. While social ineptitude refers to the networks’ unhelpfulness or lack of support, openness relates to the survivors’ efforts to inform their network about their situation and how they wish to be supported. As has been pointed out, many problems in this encounter are rooted in an apparently heterogeneous interpretation of the various components, which have been discussed under the headings social situation, social roles, interactional goals, communicative event, message form, etc. The way in which survivors and network members interpret these components is based on previous personal experience. Thus, heightened communicative competence in the widest sense is an important prerequisite for improved social support for bereaved populations. Overall, the survivors claim that communication about these communicative components will make it easier for the network to provide helpful support and thereby improve their situation. Hence, it is necessary to improve people’s communicative competence in adverse life situations in order to improve social support for bereaved populations. Community based intervention programs for bereaved populations should include suggestions for improved network support. Future research could follow up on the accounts of the survivors in this study by approaching their social networks to obtain *their* accounts.

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