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Methodological Insights from a Psychosocial Autopsy Study of Adult Suicide*

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Conducting a psychosocial autopsy after a suicide is a well-known method in the world for a deeper understanding of suicide, but it still raises a lot of debates over how this method could be applied better to avoid questionable reliability of the research. This study represents methodological insights from a psychosocial autopsy study of adult suicide. 145 people, who lost a close relative or friend due to a suicide, participated in the study. The results revealed that it is particularly important to complete a pilot study and a test of the protocol in a specific sample. Insights to organize face to face meetings due to the sensitivity of the experience, the ability to observe and respond to the risk of suicide of respondents, and to require researchers with practical experience in suicide prevention and psychological assistance is emphasized. This study is an attempt to give methodological insights for future research of suicide and facilitate significant progress in our understanding of suicide.

Keywords: suicide, psychosocial autopsy, methodological insights

Highlights:

- The methodological insights of the study showed the importance aspects of suicide research and facilitated significant progress in our understanding of suicide.
- To prevent suicide more effectively and for a better understanding of the context of help seeking behaviour of the deceased a psychosocial autopsy study should be carried out.
- The psychosocial autopsy studies will allow the development of schemes for trauma resolution and a healthy mourning process for family members or friends.

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Suicide is identified as a serious global public health issue since about 800,000 people worldwide commit suicide per year (WHO, 2019). As the World Health Organization (WHO) prioritized the reduction of suicide mortality, there is a need to better understand the suicide process and to focus on the countries with the highest suicide rates (WHO, 2019). Although actions are taken to solve this problem and the suicide rate in Lithuania is consistently declining, the overall number of people taking their own lives remains rather high, which highlights the problems in the mental health system (Benošis et al., 2016; WHO, 2017). Lithuania ranks fourth in the world's suicide rate, while it has the second rank for the male suicide rate among all countries in the world (WHO, 2016). According to the data provided by the Institute of Hygiene in Lithuania, 683 people died by suicide in 2018, down from 748 in 2017, 823 in 2016, and 891 in 2015. The suicide rate has also declined over the past few years from 30.8 suicides per 100,000 residents in 2015 to 28.7 in 2016, 26.4 in 2017, and 24.4 in 2018. The most vulnerable groups include middle-aged (45–59 years) and over-75-years-old males living in a rural and socially isolated environment. Men are five times more likely to commit suicide than women (Health Information Centre Institute of Hygiene, 2017).

Despite a high suicide rate among these groups, there is a significant lack of empirical evidence on their help-seeking behaviour (Ko, 2018). It is known that suicide rates are influenced by many factors like the accessibility of healthcare services, stigmatization of mental health issues, easy access to lethal objects, and flawed reporting on suicide in the media (Lang, 2013; Rajkumar et al., 2013; Sisask & Varnik, 2012). The support from other people during a suicidal crisis is one of the strongest suicide deterrents (Goldsmith et al., 2002). Unfortunately, individuals with suicidal behaviour often avoid seeking help from others (Wen et al., 2013). This is why most of suicide prevention programs are based on proactive strategies. Nevertheless, it is particularly important to better understand the reasons for such avoidance.

These findings and unanswered questions illustrate that suicide is a multidimensional and multi-causal phenomenon that can be described from different approaches and perspectives. The psychological autopsy is a well-known and established method in suicide research, assessing potential risk factors, that still need to be considered with caution, and analysing the personality, the behaviour, and the motives of the person before committing a suicide (Conner et al., 2011; Knoll & Hatters-Friedman, 2015; Khan et al., 2005; Pouliot & De Leo, 2006). This strategy is widely used in many countries, but it is still minimally used and not analysed methodologically in Lithuania. From the methodological point of view, psychosocial autopsy appears to be a complex strategy. One of the biggest discussions has been on 'the diagnostic process' in psychological studies and the more widely criticized statement that mental disorders play a significant role in at least 90% of suicides (Hjelmeland & Knizek, 2017). Yet, supposedly, a better analysis of socioenvironmental contributors to suicide needs to be prioritized instead of psychiatric diagnoses (Pouliot & De Leo, 2006). The methodological challenges also include timing of the interviews after suicide, designing the structure or standard protocol, defining and reaching proxy respondents, training and supervising interviewers, carrying case-control studies, critically analysing

the medical illness, help-seeking behaviour, and other personal information of suicide decedents named by the respondents (Conner et al., 2011; Conner et al., 2012; Pouliot & De Leo, 2006). In general, there is a lack of defined guidelines for performing this type of method (Pouliot & De Leo, 2006).

The aim of this article is to discuss the experience-based insights into the application of psychosocial autopsy method for the research into help seeking behaviour and accessibility of help in a suicide victim's environment.

Method

The research was conducted from March 2018 to January 2020 as part of the psychosocial autopsy research project 'Psychosocial suicide risk factors and accessibility of help in the environment of persons who died by suicide', which was carried out in Lithuania and was funded by the Research Council of Lithuania. The study protocol was approved by the Kaunas Regional Biomedical Research Ethics Committee. Inclusion criteria for this study were that participants are over 18 years of age, who had experienced a loss of an adult to suicide during last three years, agreed to participate in the study and to sign an informed consent form of the study. The research was implemented throughout Lithuania. A number of steps were undertaken in the psychosocial autopsy study, as shown in (Table 1).

Table 1
Steps of the psychosocial autopsy study of suicide

Step 1. Prior development review	To review the literature associated with the methodology of psychosocial autopsy studies.
Step 2. Generalization of research questions and preparation of the research protocol	To adopt some questionnaires by considering findings from previous studies and characteristics
Step 3. Research protocol testing and discussions with experts	To collect discussions and feedbacks from researchers, interviewers-psychologists, and other experts who used similar methods in their research
Step 4. Sample selection criteria and description of the research procedure	To invite close family members or friends to participate in the psychosocial autopsy study
Step 5. Pilot study	To gather interviews and observations from researchers
Step 6. Development or preparation of the final study protocol	To analyse data and develop study protocol and methodology

The review of literature allowed to specify and present operative guiding criteria for a psychosocial autopsy as well as to define basic items for the semi-structured interview. Key-themes associated with suicide were covered by using closed, open and echo questions (the questioner repeats the part of the answer of the interviewee to find out more or to refine the information). Some questions which can be applied to suicide completers or suicide survivors were developed by considering findings from previous studies and specific characteristics of the Lithuanian health care system in our population (Dadasev et al., 2016; Gailienė, 2015). The result of this step was the first draft of a study protocol. First of all, we established parameters for data collection and organization with detailed instructions. The study was led by a senior researcher. The research group and 4 psychologists carefully reviewed each item of the semi-structured interview and adopted some items to make it more suitable for adults and to meet the characteristics of our population. In addition, considering the findings and measurements used in the previous studies, some new questions were developed.

After these steps, in the beginning, we identified suicide cases with the help of the municipal administration. We sent letters with the invitation to the municipalities by email. After two weeks we made phone calls to social workers or other workers in municipalities and repeated the information about the study. Social workers from municipalities were asked for help to contact possible informants. Informants were family members or friends who had close relationships and had lived with or had a close contact with the one who died by suicide, or someone who knew the subject well and was in contact with the subject in the period before death. Initially, social workers contacted by telephone or face to face possible informants of suicide cases, and invited them to participate in the study. However, this strategy did not help to collect the entire sample planned. Implicit reasons could be the lack of information about suicides in the municipality or contacts to next of kin, low motivation of municipal employees, stigmatization that suicides do not need to be discussed with relatives. Due to poor response rate, the search was expanded and people were invited through a variety of sources: inviting mental health professionals, crisis centres to share invitations, creating a page to share useful information on suicide prevention, going to radio broadcasts, promoting messages from famous people talking about the importance of the study. Family members or friends submitting a request to participate in the study had to complete an informed consent form. In the case of an agreement, we arranged the day, time, and place for the interview. Participants were invited to give information on the same set of questions as in the psychosocial autopsy protocol (Table 2).

Table 2
The structure and main of psychosocial suicide autopsy study protocol

1. The information about suicide case and decedent	– History of suicide case; – Sociodemographic characteristics (age, gender, education, marital status, region (rural/urban); – Suicidal behaviour and information about death (details of the death; a brief outline of the victim's history; previous suicide attempts); – Cases of suicide in the victim's family; – Recent stressors, tensions; – Experienced difficulties (financial problems, work-related problems, interpersonal relationships, other life routines); – Alcohol and drug use; – Information related to physical and mental health and health care history; – Help-seeking efforts and contacts for help before death; – Psychological and social support needs and availability barriers.
2. The information about the participant of the study	– Sociodemographic characteristics; – Relationship with decedent; – The reaction of a participant to the victim's death; – Seeking help at health care facilities after the death of family members; – The role of health care professionals or other services stating the fact of death, providing help to relatives, institutional care or help; – Observations and recommendations for suicide prevention; – Any comments or special features of the case.
3. The information from the interviewer	– Comments or special features of the case from the interviewer's perspective.

The protocol consisted of 57 open-ended and close-ended questions covering main groups of questions: a) socio-demographic information about people who died by suicide and their family members (age, sex, place of residence, method of suicide, etc.); b) short prehistory of suicide and circumstances of the death, such as past attempts to commit suicide, physical and mental health problems and other potential difficulties (interpersonal, financial, work, survival, law enforcement, etc.); c) the attitude of the family members about their and the suicide victim's needs, availability and experience of the help; d) the insights into how to improve suicide prevention based on experiences of suicide case from both, interview respondents and interviewers, were recorded. The interviews took place at either private rooms of district municipalities, crisis centres, or community mental health centres. The duration of the interview was, on average, nearly two hours. Considering this is a semi-structured interview, we started every interview with a short narrative of suicide. This question allows telling a story without interruption even though sometimes the story goes away from the prehistory of the event to details that are important for the respondent. It was noticed that interruption usually creates preconditions for the loss of important information. In addition, at the beginning of the interview, researchers observed and inquired about the psychological and emotional states of participants. It can lead to the formation of a therapeutic alliance between interviewers and participants as it conveys a meaning that the interviewer is taking care of the psychological well-being of participants. In the pilot study, 8 interviews were conducted with family members of suicide victims. 7 women and 1 man participated in the pilot study, 5 subjects lived in the village and 3 in the city, the age of subjects ranged from 26 to 59 years and the average age was 48 years. The mean of time interval passed between the death by suicide and the interview was 22.50±10.50 months (range 7–35) in the pilot study.

In the study, 145 interviews were conducted with family members or friends of suicide victims. 123 (84.8%) women and 22 (15.2%) men participated in the study; 34 (23.4%) subjects lived in the country-side or village and 103 (71%) in the city, 8 (5.6%) lived elsewhere. The age of subjects ranged from 19 to 80 years, the average age was 40±13 years; the mean age of men was 38±11 (range 20–58), of women – 41±13 (range 19–80). 77% of cases were of men suicide and 23% cases of women. The age of suicide completers ranged from 17 to 87 years with an average of 43.5±18.5. The mean of time interval passed between the death by suicide and the interview was 23.01±14.9 months, range (2–42).

The Main Methodological Insights

Primarily, the research was planned by selecting the main targets. In undertaking the psychosocial autopsy study, we were seeking to explore in the deep psychosocial context of help-seeking behaviour and accessibility of help in a suicide victim's environment. Based on these targets the literature review was made for constructing the protocol. Methodological insights of psychosocial autopsy study are presented and discussed below.

Researchers with Practical Experience

As every country may have its uniqueness, practicing psychologists and researchers in Lithuania were invited to share the experience and to discuss the protocol. In other studies, experts were also invited to develop the protocol (Cavalcante et al., 2012). This inclusion of practicing psychologists was useful in this study not only for gaining useful insights and preparing the protocol but also for preparing potential researchers to collect interviews. Based on our experience, there are several inclusion criteria for conducting autopsy: a) practical experience in suicide prevention, b) an ability to identify suicide risk, and c) to provide psychological assistance in case of a suicide threat. Previous research experts also recommended inviting interviewers with clinical experience (Conner et al., 2012). Moreover, our experience has shown that regardless of the time after the suicide, some participants

in this research, especially if they did not receive help during the period after the loss, had suicidal intentions. The practical experience of researchers helped these people and directed them to further psychological help when needed.

The Relevance of the Pilot Study in the Development of the Final Protocol

With reference to our experience, there is a need to evaluate the suitability of the study protocol for data collection, to perform an analysis of its completeness, to observe the well-being of subjects and their reactions to questions of the research. Several significant insights were gained from the pilot study with relatives. Following the pilot study, the protocol was supplemented with some questions, and the order of questions was adjusted according to the consistency of the story. The main observation was made about the inclusion of a question about the cause of death in official documents because several individuals mentioned that the cause of death was not named as suicide in the certificate of death. Reliability of suicide certification and reporting is an issue in great need of improvement. Especially by focusing on the cause of death, this must be made reliable, because in few cases in our study the cause of death in the death certificate was incorrect and the investigation by police seemed to cause a lot of uncertainty for family members. Suicides are most commonly found misclassified according to the codes of the 10th edition of the International Classification of Diseases and Related Health Conditions (ICD–10) (WHO, 2011). In addition, the stigma associated with suicide (and suicide attempts) has profound psychological and behavioural effects on individuals and families – who may avoid seeking help, and may conceal or deny suicide – and also affects false death registration and coding practice (Angermeyer et al., 2017; Brooks & Reed, 2015; De Leo, Cerin et al., 2005). Considerations may include the victims' age (especially children and young people), social standing, families' or communities' distress and emotional wellbeing, cultural and religious interests, financial impact (insurance claims), and legislation. Providing case registration information to policymakers, researchers and health care professionals allows greater exposure to the problem of suicide and can be a way of raising awareness, initiating research, and developing prevention campaigns, monitoring the effectiveness of suicide prevention and intervention strategies.

Also, after the pilot study the new section 'Other interviewer observations' was included in the protocol. This helped to capture as much information as possible from the subject, which has not been included in the main part of the questionnaire but could have been useful for suicide prevention. Moreover, it was decided to interrupt the natural narrative process as little as possible during the inquiry by asking a question after question, and to write answers to the questions in the protocol by listening to the research story. Corrective questions were submitted only after the end of the story. However, some participants wanted questions to be asked immediately one after another and that means that the process of the interview was moderated both by the informant and the researcher. Depending on the individual convenience to gather information, interviewers chose to add additional sheets to the pages of protocol, lay out all pages of the protocol on a table or to record exact quotes. After completing the pilot study, the draft of the questionnaire was developed and modified simultaneously by considering the opinions of interviewers and participants. It is significant that the final semi-structured protocol of the psychosocial autopsy was well received by the participants of the study.

Time Interval between Suicide and Interview

Another difficult issue that needs to be addressed when planning a psychosocial suicide autopsy study is to decide when is the best time to include into the study the relatives or friends after suicides experienced in the immediate environment. Finding an optimal time for an interview after a suicide is not an easy task. The first barrier in participant recruitment for a

psychosocial autopsy study is the stigma of family members and beliefs about suicide. Suicide can be a tragic experience for family members or friends as they might feel guilty of not preventing suicide and more likely to cause trauma and psychological problems (Lindqvist et al., 2008). During the acute phase of grief immediately after a suicide, the request to complete a long interview with questions in a protocol may seem insensitive and cause more harm than benefits. On the other hand, if too much time elapses between the death and the interview, recall of events may be insufficient because of aging-related deteriorating memory (Schroeder & Salthouse, 2004). Moreover, the family's motivation for completing such an interview may no longer be as high as in the previous time (Brent, 1989). There is a sensitive selection of the time interval that probably influences the quality of the information obtained (Beskow et al., 1990). Some authors recommend conducting the psychosocial autopsy study at least six months after the death, however, previous studies contacted the bereaved family at least 3–4 weeks after the death (Kodaka et al., 2017; Portzky et al., 2009).

On the basis of these previous practices, we decided to invite participants for interviews not earlier than 6 months after the suicide. The chosen period seemed to prevent unpreparedness to speak and at the same time to allow more accurate recovery of last months before the suicide and events after suicide, but partly complicated the search for respondents. Firstly, it was noticed that readiness to talk about experiencing the suicide of loved ones and circumstances of their life was very individual in terms of time after the suicide. There were family members who found it harder to talk about that situation after more than three years and they provided less information than those who experienced that a few months ago. The same insight is about the remembrance of events and circumstances. Opportunities to remember events and to retell situations varied more from the connection with a loved one and the participation in his or her life than from time after the suicide. After the first interview, it was noticed that the relatives of the suicide victim were sensitive and could hardly talk about it half a year after losing their loved one. The material that has been committed to suicide prior to the intended trial period is also informative because, according to the data available, the problems and problems of family members after suicide often persist after many years. Though we recommend conducting interviews not earlier than 6 months due to the sensitivity of the information and not later than three years to prevent impairments of memory.

The Respondents' Profile: Setting the Sample Selection Criteria

Based on scientific and practical experience inclusion criteria was identified as: a) adults (older than 18 years old), b) at least 6 months have elapsed since the suicide, but not longer than 36 months, c) close communication with the person in the last year, and especially one month, before suicide, d) voluntary consent to participate in the study. Hence people who participated in the study were adults who had lost a member of their family member (a parent, spouse or partner, brother, sister, child) or a close friend at least six months ago, but no more than three years ago. The circle of potential subjects was expanded based on the methodological insights of previous studies about inviting to participate in the study of psychosocial autopsy not only family members but also close friends, who sometimes knew more and spoke more boldly about the difficulties experienced in the family (Conner et al., 2012; Phillips et al., 2002). Moreover, closeness to the deceased and knowledge of this person's way of living from the last six to one month before suicide becomes even a more important advantage to fulfill the aim of this study and to name as important selection criteria for future psychosocial autopsy studies. However, time frames after suicide made it difficult to find participants for a study as some cases happened later than three years ago. Coordinators of the research noticed that people applied regardless of the period after the suicide. The time of possible participants for the research ranged from a few weeks to more than twenty years after the experience of suicide. As a result, it was necessary for research coordinators to contact the appealing people firstly about circumstances of them experiencing

the loss, to allow applicants to speak out, to target possible assistance options if they needed help for themselves or their relatives in suicide risk, and only then to select suitable people according to the selection criteria for the study. Due to stigma and high insecurity potential, research participants were informed more about the study and were able to withdraw from the study at any time.

The confidentiality of the information supplied by the research participants was guaranteed. Participation in the study was voluntary, and the research participants provided a written consent. Another limitation was a voluntary application for this study as these people are motivated to share their painful stories but may lack to cover all trends. However, 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 et al., 2018). The previous studies reported that only 47–83% of bereaved families agreed to take part in the psychological autopsy interview (Portzky et al., 2009; Renaud et al., 2008). Researchers noticed that those bereaved who refused to participate in the research had higher levels of distress (Lichtenthal et al., 2011). Such a tendency to avoid participation in research had been previously noticed by the researchers conducting studies on bereavement after suicide in Lithuania (Klimaitė, 2015). Studies with these participants often raise doubts about the potentially negative impact of participation in the study on the bereaved (Andriessen et al., 2018). In order to respond adequately to negative reactions of participants during participation, it is important to emphasize that participation is on a voluntary basis and to assure the possibility to end the participation in the study at any time.

More and Less Effective Ways to Collect the Study Sample

Our experience has showed that less effective ways to invite people to psychosocial autopsy study after suicide were the communication with the administration of municipal institutions or institutions offering psychosocial help, like health institutions, crisis centres, and mental health centres, inviting mental health professionals personally to share the invitation with the clients. For example, 501 emails have been sent to employees in 51 Lithuanian district or city municipalities, an exceedingly small proportion was responded to and even fewer individuals were referred to the research. Differences between personal and environment-driven participation were also highlighted as more an open contact was achieved through personal motivation to participate in the study. Moreover, it has been observed that the distribution of information leaflets about the research or going to radio broadcasts was not as effective as publications analysing the problem of suicide or interviews with researchers in dailies and information portals. From the experience of study coordinators and researchers, most people responded to the invitation of this study after published psychoeducational articles and shared invitations to speak more openly of a famous person, who also experienced suicide in their environment. For example, about 2,800 people shared, 2,500 reacted and about 130 commented on a post of one famous Lithuanian actor and TV host, which attracted a large proportion of study participants who met all criteria. Another rather effective way to find and attract respondents was a voluntarily shared experience about the research by respondents who have already participated. This means that all possible ways of reaching participants for interviews need to be considered, as this group is very difficult to reach. Respondents usually responded spontaneously to an invitation to participate in an interview, but then later postponed the meeting and dropped out at any stage of the preparation for the meeting. Moreover, it is also important to find ways of informing the people living in remote areas, and especially older people with limited access to the internet or social networks. Focusing on these groups, advertisements near churches, authorities in rural areas were placed and social workers, visiting socially isolated people at home, were informed.

Advantages and Limitations of Face-to-Face Interviews

Before face-to-face interviews, we used several primary methods to make initial contact with potential informants, mostly by email or phone. During this phase coordinators of this research provided all the information about the research and clarified opportunities for a live meeting. Some people responding to invitations no longer answered after informing about a live meeting for a more detailed interview, but overall a large proportion of people did not meet selection criteria when suicide had occurred many years ago, referred people who tried to commit a suicide and survived. Nevertheless, such a contact was time consuming, we would recommend not to ignore the desire of these relatives to meet live and participate in the study. Often, these are individuals who need help, who are 'trapped in mourning' or are so severely affected by trauma that their own lives and functioning are disrupted. For many people, it would be easier to refuse participation after only a letter in which details of the procedure are outlined, but some of them may feel that their integrity has been violated without any way of understanding the situation better (Beskow et al., 1990). In such cases, we responded quite flexibly, meeting and talking to these subjects about their experiences, and also capturing their insights into what should be done to reduce the number of suicides in the country. As an advantage of these face-to-face interviews, we have gathered a lot of additional valuable information. Opportunities to collect interviews were further complicated by the drop-out of potential participants. There have been occasions that several respondents did not come to the meeting with the interviewer, so going to live meetings with respondents across the country is time-consuming and may not produce the expected results.

However, interviewers stated the importance of face-to-face meetings due to the sensitivity of the experience, the ability to observe and respond to non-verbal expressions or the risk of suicide of respondents, the need for their psychological support and the opportunity to provide more safety by seeing the real person in front. In the pilot study, we conducted several interviews by telephone, and they were less open and profound, especially when subjects talked about their personal experiences and help needs. Therefore, the assessment of the suicidal risk of respondents becomes exceedingly difficult, as these topics are likely to be avoided without the researcher seeing them. All these conditions are important as the interview can become a moment for clarification with a positive affirmation and response from researchers (Cavalcante et al., 2012). Facing this conflict between scientific inquiry and human subject protection, today's researchers have to be creative, because a high refusal rate may also affect the quality of the project.

The Need of Teamwork and Supervisions for Researchers

Following a structured interview, the protocol for collecting data requires researchers to listen to painful stories one after the other. As the research progresses, every researcher is getting more and more into people's problems. It has been observed that interviews conducted by direct contact are emotionally difficult and deeply touching for interviewers, therefore supervisions must be organized, case discussions, and analysis carried out. To prevent burnout, researchers periodically organized special discussions to express their experiences and emotions. Based on the experience of this research, regular discussions and supervisions are recommended at least twice a month, with the possibility of having individual supervision at any time when needed. Also, we recommend conducting no more than one interview per day and 1 to 3 interviews per week.

Another major problem was the need to be a case manager for people seeking help. In some cases, this study attracted people who asked for help to their loved ones with suicidal risk or after a suicide attempt. Therefore, coordinators of this research had to provide emotional support and search for help depending on the location and situation of the caller. In other cases, interviewers also had to provide social support and respond to a need for psychosocial

help in live meetings or look for colleagues who can provide counselling for respondents after meetings. In summary, researchers must have basic skills to provide emergency assistance and create a network of psychosocial help.

Subjectivity Dilemmas and the Importance of Refinement

The information provided about circumstances before suicide may be influenced by education, memory, health literacy, relationship closeness, and other aspects of the informant. In some of the cases, informants could not provide information about visits to specialists, health problems, or the use of psychoactive substances. Moreover, their provided information could be wrongly interpreted or remembered. The informants can only offer a personal view of events and conditions as iprevious researchers were stated (Hjelmeland & Knizek, 2017; Hjelmeland et al., 2012). Nevertheless, the participants must be accepted as 'close informants' who knew the people who died by suicide, often intimately. Importantly, we have attempted a systematic and comprehensive depiction of the experiences, issues, and processes as presented by families or friends without overlaying these accounts with too much intrusive interpretation. Researchers noticed difficulties of informants to distinguish between a psychologist, a psychiatrist, and a psychotherapist, to recognize the use of psychoactive substances or to name experienced difficulties of a person before attempted suicide. For more objectivity, there is a need for medical records or several informants on the same case, but these requirements can make researches into the process of suicide more complicated. In this research, it was noted that these uncertainties can be better controlled by asking more clarifying questions about the provided information. With regard to the protection of personal data, it was decided to collect information about the health status of suicidal persons before suicide only on the basis of information provided by respondents during a semi-structured interview. This information must be seen as of limited objectivity, but it is particularly important to collect it for a better understanding of the context of help seeking behaviour of the deceased. This means that researchers pursued the aim focused on learning more about the difficulties of seeking help and not on diagnosing disorders.

Questions to be Considered in Future Research

This study is the first step to recognize in the details the suicidal tendencies of people with psychological and social support needs and its availability barriers and uncover additional resources that could be more effectively used for the prevention of suicide. It will provide for more accurate strategic suicide prevention tasks, choose appropriate tools, and targeted use of resources allocated to the prevention of suicide, developing a tailored action-plan specifically to Lithuania and Lithuanian communities. This study should carefully explore not only the suicide risk factors at the individual level but also the availability and acceptability of mental health services should reveal more personal and socioeconomic details of suicide risk factors and gaps in the availability of help in the environment of the people that commit a suicide.

In suicide studies, there may be no better autopsy method for understanding the social, psychological, and physical circumstances of the victim than the psychological and psychosocial autopsy (Cavalcante et al., 2012). Psychosocial autopsies can be used both for single-case investigations to know the individual situation and for epidemiological studies to know the characteristics and risk factors of suicide among various populations (Beskow et al., 1990). Regarding the prevention, the results of psychosocial autopsy studies will allow the development of schemes for trauma resolution and a healthy mourning process for family members or friends of the deceased by considering their current mourning stages and psychological or emotional states. Through this, their feeling of guilt and negative thinking can be resolved. So, to prevent suicide more effectively, a psychosocial autopsy study should be carried out.

Conclusion

This study is an attempt to give methodological insights for future studies of suicide. The results revealed that the pilot study and testing the protocol in a specific sample are especially important. Insights to organize face-to-face meetings due to the sensitivity of the experience, the ability to observe and respond to the risk of suicide of respondents, and to require researchers with practical experience in suicide prevention and psychological assistance is emphasized. Although, some of the insights made in this study require further research, or may involve extensive resources, the experience from this study showed the importance of these aspects for future studies of suicide and facilitated significant progress in our understanding of suicide.

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Metodološki uvidi iz istraživanja koje je uključivalo psihosocijalnu autopsiju samoubistva odraslih

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Sprovođenje psihosocijalne autopsije nakon samoubistva je dobro poznata metoda u svetu namenjena dubljem razumevanju suicida, ali i dalje se za nju vezuju brojne debate u smislu bolje primene, a u cilju poboljšanja pouzdanosti istraživanja. U ovom radu predstavljamo metodološke uvide do kojih smo došli sprovodeći istraživanje koje je uključivalo psihosocijalnu autopsiju samoubistava odraslih. U istraživanju je učestvovalo 145 osoba čiji je bliski rođak ili prijatelj izvršio samoubistvo. Rezultati ukazuju da je važno sprovesti pilot istraživanje i proveriti istraživački protokol na određenom uzorku. Nalazi ukazuju na važnost sprovođenja intervjua licem u lice imajući u vidu da se radi o osetljivom iskustvu, ali i mogućnost da se na taj način posmatra i odgovori na suicidalni rizik učesnika. Takođe je važno da tokom realizacije studije na raspolaganju bude pomoć istraživača sa praktičnim iskustvom u prevenciji suicida i pružanju psihološke podrške. Ovaj rad je pokušaj da se podele metodološki uvidi koji mogu biti korisni u budućim istraživanjima suicida, kao i da se olakša njegovo razumevanje.

Ključne reči: suicid, psihosocijalna autopsija, metodološki uvidi

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