This two-part report examines important aspects of survivor of suicide support groups: some of the motivating factors attracting survivors to join these groups and why many withdraw as time after a loss passes. In this second part we analyze the support group departures issue, drawing primarily upon participant observation data collected over a 7-year period from more than 300 suicide survivors observed at monthly group meetings and from follow-up interviews with 24 respondents who withdrew from groups. Findings suggest that support group affiliation is a time-limited activity for most of those bereaved by suicide. This very preliminary data suggests that most survivors feel that two things were especially indispensable to them in their efforts to advance after a suicide loss: 1) affiliation to a support group (or to several groups); and 2) the help received from friendships established with other survivors along their healing journeys.

Key Words: suicide bereavement, suicide survivors, support groups, support group departures

INTRODUCTION

Though widely used by thousands of bereaved families losing loved ones to suicide yearly, researchers have devoted scant attention to survivor of suicide peer...
support groups (Cerel, Padgett, Conwell, & Reed, 2009). In an earlier publication, we probed the more enduring features of support groups as they address the healing needs of survivors (Feigelman & Feigelman, 2008), who struggle with the upending effects of a suicide: guilt, depression, a sense of meaninglessness, isolation, and stigmatization (Jordan, 2001). The present two-part report builds on the previous work, now investigating the more dynamic features of support groups and addressing the comings and goings of members. In the first of this two-part article, we discussed some of the motivating factors that attract survivors to support groups. Here we focus on why many discontinue their participation as time after a loss passes.

Most survivors begin early grieving feeling they have reached an all-time low point in their lives. Many desperately reach out, often times concurrently, for help from a wide variety of sources: mental health professionals, peer support groups, general bereavement groups like The Compassionate Friends, pastoral counselors, psychics, and/or spiritualists (Feigelman, Jordan, Gorman, & Feigelman, forthcoming). In contrast to the near insatiable need for grief support experienced by newly bereaved, many longer-term survivors feel that the support group addresses issues they have long since resolved and some even feel that the group “brings them down,” as some of our follow-up respondents stated. Since most peer support groups are open-ended, enabling members to join or depart as they please, support group leadership faces a dilemma: how to address the diverging needs of the newly bereaved as well as those of the longer-term survivors, one of several fundamental cleavage points in support groups that leadership must effectively resolve.

As some survivors depart from support groups, leaders may question whether they have failed to serve some of their members’ important needs, recognizing that it may be impossible for them to satisfy the diversity of all membership needs. Leadership is often mentioned as critical in affecting whether some survivors decide to stay or leave their groups. In this report we document, from survivors’ comments, their expectations of good group facilitation skill and leadership.

Yet, even with the most skillful support group leadership, there are still likely to be many comings and goings of members. Many pursue differing healing pathways with the passage of time. Survivors’ healing needs evolve in different ways over their usually life-long course of healing. Some leave groups feeling that the group has given them all that it could to help them manage their grief. Others gravitate to different groups with the passage of time because they perceive that their group has failed to meet their expectations. In some cases, disappointments arise because their group has undergone some important changes. The group may have grown, shrunk, or its membership composition may have changed. In still other cases, people leave group because they feel ready to co-lead or start their own peer support groups. We call this last adaptation an example of post-traumatic growth. Still other reasons explain members’ comings and goings.
This article examines survivors’ needs and poses questions about their support group departures: are these “unplanned endings” (Walsh, 2003) or “early terminations” (Northen & Kurland, 2001) a result of dissatisfaction with the group, the facilitator, or environmental constraints or are these departures actually a reflection of the differing healing pathways that survivors pursue with the passage of time? Clinicians and support group facilitators serving the suicide bereaved, as well as survivors themselves, can benefit from better understanding the healing trajectories of survivors and how they use support groups in this process. It is in promoting this aim that we offer the following presentation.

**METHOD**

In this second article we draw our data primarily from participant observations with others bereaved by suicide at peer support group meetings and at healing conferences. The group meetings yielded information on more than 200 suicide survivors. Both authors regularly attended monthly meetings of one, peer-led, survivor of suicide support group for more than 5 years. Because both authors experienced the suicide loss of their son, they were permitted membership into this group. In a previous publication (Feigelman & Feigelman, 2008) we described in detail this group’s participation format and interaction patterns. The group studied was located in a suburban community in one of the country’s largest cities. Additional participant observations were also collected over a 2-year period from close to 100 more suicide bereaved when the authors co-led their own support group at a different location, situated close to a large metropolitan center. The meeting format for the second support group followed much the same structure as that of the first group’s. For this report, all names and personally identifying information about respondents were changed to protect respondent confidentiality. Wherever necessary, throughout this report, non-essential details about observations and persons were changed to safeguard each participant’s privacy and confidentiality.

Support group members were never explicitly asked for their consent to participate in this research unless they were asked to complete the surveys (described in Part I of this report) or to be respondents in the follow-up interviews. From both support groups, we selected a sample of 26 names of respondents who had withdrawn from their respective groups. Unlike the survey sample, who were exclusively parents, this follow-up population consisted of a diverse group of suicide survivors. Some had lost children, others, spouses or partners, and others had lost parents, siblings, other relatives, or friends. The follow-up population also ranged greatly in the time since their loss. Approximately a third were newly bereaved respondents, having sustained their losses less than 2 years earlier. The majority were longer-term bereaved, having suffered losses 5 or more years beforehand. One person refused to be interviewed for the follow-up research.
and another could not be reached at her last known phone number. A total of 24 others were interviewed.

In our usually hour-long telephone interviews, we asked respondents to reflect back on all the healing aids they had employed—support groups, bereavement counselors, other mental health care givers, clergy, psychics—and evaluate the importance of each in advancing their healing efforts. We probed support group utilization in particular, asked why respondents had affiliated and withdrawn from their groups and their activities and interests directed at promoting various suicide prevention causes. As far as we know, this is one of only a few research efforts asking American suicide bereaved to make assessments of their healing efforts (McMenamy, Jordan, & Mitchell, 2008; Provini, Everett, & Pfeffer, 2000). The only other analogous research like this—where bereaved were asked to make an overall assessment of their healing—was conducted among Norwegian suicide bereaved by Kari and Atle Dyregrov (Dyregrov, 2004; Dyregrov & Dyregrov, 2008). Too often in the past, researchers have avoided investigating the suicide bereaved, assuming that any research on their grief will only serve to further traumatize these “very fragile survivors.” Yet, the research record challenges this view: most survivors are engaged in a deeply felt, sense making experience of their loss (Currier, Holland, & Niemeyer, 2006) and warmly welcome the interest and response from others who show caring interests in them (Dyregrov, 2004).

It may seem unwarranted and speculative to be offering assertions about how suicide survivors view their healing from such meager numbers of survivors as we now present. We are, indeed, keenly aware of the limited numbers in our sample and the potential for bias. Yet, if we had drawn our sample of support group withdrawals from a larger sample of support group enrollees, we would have needed a sample of some several hundred to find a smaller group of withdrawing members. However, by using a base of some 300 participant affiliates from the two support groups who we had ties to over a 7-year period, we were able to swiftly find our population of research interest: this never-before-studied group of suicide bereaved withdrawing from their support groups.

RESULTS AND ANALYSIS

Clarifying the Synergistic Association between Seeing Bereavement Counselors and Going to Support Groups

In Part I we claimed that an association exists between going to counselors and attending support groups, with each one facilitating the other. While the cross-sectional survey data demonstrates this, only by looking at survivors over a period of time can we begin to better understand the complex association between seeing counselors and going to support groups. Betty Hargrave (pseudonym...
When my husband Donny died by shooting himself, I couldn’t stop blaming myself for his death. We had been childhood sweethearts and were supposed to always be there for each other till the very end. Then, he went on active duty in Iraq and never was the same afterwards. He came back like a zombie. I guess he was a classic case of post-traumatic stress. After serving three months in a combat-zone, he came home and shot himself with a handgun.

I was literally shaking with shock, sadness and self-blame for nearly the whole first year after Donny died. I went to two support groups, saw a therapist, and a psychic; I tried everything. But, I couldn’t take the first therapist seriously. She hadn’t lost anyone to suicide; what could she know and tell me that would be of help—she was completely wasted on me. But the support group. That was wonderful! It felt so good to know others in the same boat as me. I was not the only one losing a husband to a suicide. In the group I learned to stop blaming myself. There was another widow in our group whose husband shot himself right in front of her in their living room. If she could stop blaming herself for her husband’s death, then there was every incentive for me to do the same. The support group showed me that I was not the only one with my problems and I absolutely must stop torturing myself. Later on, I went back to another counselor and in the second round—after having been in the group—it didn’t bother me at all that my counselor wasn’t a survivor. If she could help me learn more things about myself and my imperfections, then it was OK. Now, my second counselor is helping me get to a better place. I’m convinced that managing my grief will be a lifelong project, but at least for now, three years after Donny’s death, I can begin to think about taking on a new job (which was recently offered to me) to serve as a counselor for bereaved military families. I never thought I’d ever come this far, two and a half years ago.

Betty’s experience clearly shows the interplay between support group participation and being amenable to clinical treatment. Each feeds into the other, helping the survivor use both treatment modalities synergistically. Yet, it should be understood that the interplay between support groups and therapists is far from a simplistic one.

In another case, Helen James (a pseudonym) at a support group meeting shared her experience of being at a dinner party with a group of strangers and being asked the question many child loss survivors stumble over: “how many children do you have?” Helen had lost her only daughter to suicide about 5 years earlier. At first, she was tempted to pass on the question and simply respond that she had no children. But then, before she spoke, she pondered, and as a former teacher, thought this might be a good teachable moment and she should be honest about her daughter’s life, death, and suicide. Helen briefly shared her story and felt relief afterwards. At the support group, she received an enthusiastic burst of approval from most members present, who praised her courage. Later, she
shared this same story with her psychiatrist. By contrast, her psychiatrist questioned Helen’s placing any emphasis on this personal revelation and subsequently expressed some puzzlement why her daughter’s suicide should have been regarded as different from any other death. Later on, Helen decided there was little value in remaining under the care of this obtuse treatment professional and sought a referral elsewhere.

In some cases, like Helen’s, the lack of compassionate caring by a treatment professional—and the contrast of this against the responsiveness of one’s surviving peers—makes a clinician’s deficiencies seem all the more apparent to the suicide bereaved individual. Probably, it makes most sense to think of the interplay between peer support group and professional caregivers taking place on a case by case basis.

Overall, there appears to be a trend toward a pooling together of treatments, of people who seek one modality being encouraged to pursue another. Of course, in many cases, the gravity of an individual’s grief problems and other mental health difficulties may lead a survivor along a pathway toward seeking more treatments. In some cases, opening the door to probe one’s grief difficulties and personalities may encourage one to pursue parallel treatments, fully exploring interpersonal and intra-psychic issues that may have emerged. And, at the other end of the spectrum, as some bereaved individuals keep the lid on themselves, shying away from joining a support group and denying the idea that counseling help could ever be of any value, they may encounter experiences reinforcing their decisions to avoid treatment and therapeutic opportunities. In another phase of this work (Feigelman et al., forthcoming), we also found that the parents who did not have any support group experiences nor any counseling help, tended to be parents who had sustained natural death losses of a child. It is probable that in some of these cases parents may have received hospice counseling prior to the death and felt that this satisfactorily addressed many, if not all, of their bereavement needs. Also, in cases of natural deaths of loved ones, socially significant others readily offer more caring responses to bereaved persons. In contrast, in cases of traumatic deaths, parents are much more likely to be drawn to support groups and to other mental health professionals as they cope with the sudden and unexpected nature of their losses and as they also cope with the silence and lack of apparent support from socially significant others. In these cases, significant others often are stunned into silence (Feigelman, Gorman, & Jordan, 2009).

### Why Survivors Leave Support Groups during Early Grieving Years

#### Facilitator Skill Issues

In the course of this discussion and with illustrative case material, we identify and recommend several facilitator practices to avoid premature attrition in groups.
Good leadership prevents monopolization—If there is any one important quality associated with good facilitation in peer support groups it is the facilitator’s ability to control the group so that no one member or a small group of members monopolizes the discussion time at meetings. We repeatedly heard this comment made when survivors reported switching from one group to another or leaving groups altogether. Here’s an example from our field notes from Mary Ann Vitaglio (a pseudonym):

I had to leave Bob and Marta’s CF (group name changed) group because it became a colossal waste. It started out OK. My husband and I were in it for over a year and it was helping us. But then two mothers who lost young children in swimming pool drowning accidents joined, and after that, that was all we ever talked about. No one else could get a word in edgewise. I was surprised Bob and Marta didn’t intervene to give the floor to someone else. But, they just let these two mothers go on and on. And they should have known better. Bob is a school social worker and Marta an RN; they must have run groups before. After waiting three or four meetings for them to do something, finally, we had to pick ourselves up and look for a new support group.

Good facilitators gently encourage support group members to participate by regularly scanning the room and responding to the nonverbal cues that attendees show—Linda Horowitz (pseudonym) went up to her facilitator after one of her first SOS meetings and said,

Thanks for calling on me and getting me into the discussion of how to deal with relatives who avoid mentioning our lost loved ones. I’m glad I got into it, even though you said new members didn’t have to say anything. I was about to take the easy way out, but I’m glad you called on me to offer something and I put my two-cents in. Now I feel more comfortable here. Thanks for helping to get me started.

Sometimes the best leadership involves keeping silent and letting other members respond first to help each other—Support group facilitator Tom Garrity (pseudonym) remarked to his wife Susan after a support group meeting how glad he was that he had paused before saying anything in response to one member’s query about how survivors should talk about the suicide deaths of relatives to young children. He said,

I’m so glad I waited, because several group members offered helpful advice, based on their own experiences, about providing truthful age-appropriate information to kids. It was much better for it to come from them, rather than from us. We can always offer more information if something said is incorrect or incomplete.

As a corollary to this principle, facilitators should try to avoid doing it all, and should engage other support group members, wherever possible, to share facilitation tasks. Here is a good example: an especially distressed newly bereaved
A survivor who lost her husband called a group facilitator asking for information about the support group and for grief help. After offering advice on the bereavement issues of concern to this survivor, the facilitator (himself a survivor of child loss) suggested that another member of the group (who had also lost a spouse) could call and support this person until the group’s next meeting. The newly bereaved survivor appreciated this demonstration of concern about her welfare and an opportunity was created where a more experienced survivor rendered aid to someone newly bereaved. The more experienced survivor, in turn, felt respected for the acknowledgment of her healing progress. This example follows the model of “sponsorship” applied in Alcoholics Anonymous.

We cannot emphasize enough the facilitator’s role in encouraging empowerment among fellow survivors. As we mentioned in our earlier article (Feigelman & Feigelman, 2008), survivors often feel greatly diminished and personally shattered in the aftermath of a suicide. Their self-confidence has often plummeted to an all-time low. Therefore, opportunities to provide caring responses to other survivors often become important stepping stones along the pathway toward reestablishing a sense of self worth and self confidence.

**Learning facilitation**—There are few if any “natural leaders” of support groups. Most peer survivors need training to develop leadership skills.

Annette Petry (pseudonym for one of our follow-up interviewees) said:

> I had to leave the Terrace Gardens support group (pseudonym). After a few months of going to meetings, it was painfully apparent that the group facilitator didn’t know what she was doing. She let the same people talk at every meeting and she rarely paid much attention to helping the new people who came to meetings. Our meetings kept going over the same few issues, from one meeting to the next. She never had an agenda, or ever changed the topic from the few subjects her “regulars” were interested in discussing. That’s why I had to find a new group.

Peer facilitators interested in improving their leadership skills can find very helpful peer facilitator manuals, including the following sources: Department of Mental Health and Substance Abuse, 2008; Flatt, 2007; and Jordan, 2008. In addition, in the United States the American Foundation of Suicide Prevention (AFSP) periodically offers 2-day peer facilitator training courses monthly in different U.S. metropolitan areas. AFSP also runs a monthly toll-free, professionally facilitated, help line where peer facilitators can gain advice and share information with other facilitators. Interested parties can check the AFSP.ORG website for details on the call-in and training course schedules.

It should be understood that mutual-aid within a support group doesn’t just happen spontaneously or naturally. It has to be cultivated, and it requires hard work. But, group work techniques can be taught. Good leadership takes compassion and commitment. Leaders should also be mindful to expand their knowledge.
of the bereavement process, take advantage of learning opportunities and try to update their listings of available referral resources in their communities.

As facilitators strive to address the compelling needs for grief support among their newly bereaved members, we offer a summary list of best group facilitator practices:

1. Be a good listener.
2. Scan the group regularly to read and respond to nonverbal cues.
3. Rather than present yourself as the only expert, promote sharing and helping among members whenever.
4. Be comfortable with group silence, expressions of pain and verbal expressions of anger.
5. Gently guide others, especially newcomers, to openly express their grief issues, if they feel ready to do so.
6. Lead discussions along relevant and meaningful lines to address survivors’ grief problems.
7. Swiftly address potential conflict issues before they escalate, resolving issues so that each person’s point of view gains respect and legitimacy.
8. Monitor and respond to other potential group problems: monopolizing, proselytizing, or expressions of intense distress.

Departures among the Newly Bereaved
(not associated with leadership deficiencies)

Support groups are not for everyone suffering a suicide loss. Although many peer facilitators may be inclined to perceive the departure of a new member as due to their own leadership shortcomings, this can often be a mistaken conclusion. The largest number of member withdrawals are usually due to a wide variety of circumstances. To promote the most realistic assessment of the group, it is good advice to suggest that newer members give the group at least two or three trial visits before deciding whether to remain or to withdraw.

Survivors come to meetings with many diverging needs and what may satisfy one survivor may be perceived as unhelpful to another. Support group meetings necessarily involve all members sharing their discussion time together as equitably as possible. More needy individuals that persistently take over meetings, to the exclusion of other members, may need to be referred elsewhere for more one-on-one support.

It is sometimes suggested that survivors should not begin attending support groups until a certain amount of time has passed since the loss. Yet, there appears to be no hard and fast rule on this. We have seen some survivors benefit from participation as recently as 1 week after the death of a loved one. And we have seen others, starting their participation more than a year after a loss, who are still not entirely comfortable and question the value of support group participation. The time interval depends entirely upon the individual survivor and his
capacity to feel sufficiently safe, supported, and in a comfortable place and ready to share and exchange loss stories with other survivors.

Some support group features perceived as essential for most survivors may be experienced as too shocking or horrific for others. One cornerstone of the support groups’ success is the permission it offers survivors to talk about ALL facets of their loss, including some themes viewed as taboo by non-survivors. Some survivors will need to share their first-hand traumatic experiences of encountering a loss, such as finding a loved one’s body after a gun shot death. Other survivors, like the couple described below, may be overwhelmed by hearing such graphic death details and feel unable to continue.

Bob and Betty Jones (pseudonyms) came to their first support group meeting 3 weeks after their daughter’s violent death. Their daughter Carol died by jumping from their apartment’s eighth-story balcony. The next day after their first group meeting Betty called her facilitator to thank her for running a very orderly meeting but said,

Maybe I made a mistake by starting here too soon after my daughter’s death. Maybe we should have waited longer before we started. I just couldn’t sit still during the meeting, hearing about others’ tragic losses. It was too much for me and it brought me right back to the scene of my daughter’s death. Every time I walk into my apartment building I see visions of my Carol’s body, lying under a blanket, with the police, EMS people and all those bystanders milling about in front of our building. Then I go upstairs and look at that stupid balcony barrier. I couldn’t take it here last night. It was much too distressing. I think my husband and I will try going to a general bereavement support group where it might be easier for us now.

Betty Jones’ comments point to a serious problem for a minority of survivors in support groups: the possibility of being re-traumatized by hearing other survivors’ loss stories. As these stories are shared, some more fragile survivors may become overwhelmed by the similarities to their own death loss circumstances and to the intensity of emotions expressed by others in the room. Occasionally, a new member may quickly exit from the meeting room, in an attempt to escape their discomfort. Facilitators need to be prepared for such occurrences and, if possible, provide extra support before, during, and after the meetings. Participation in a support group requires a certain amount of courage and ego strength and may not be a useful healing aid for some survivors or at some points during a survivor’s healing process. Referring these individuals to professional bereavement counselors who are known as compassionate and familiar with suicide bereavement may be a more appropriate venue for these survivors.

Another somewhat common reason why survivors leave groups relates to the changing composition of the support group. Marion Richards (pseudonym) was a member of a support group for over a year. This young woman lost her father to suicide a couple of months before she began attending the group. She was a regular member for over a year and felt the group was very important to her,
especially since all her family lived far away. After she abruptly stopped attending meetings, the facilitator called to find out if everything was OK. In the conversation, Marion said that the group had changed and was no longer helping her. When she first began, the group had been very good for her with about 8 to 10 survivors coming to monthly meetings. But, in recent months, with about 15 to 20 people generally attending, the group had lost its feeling of closeness. Also, when she started, the membership was very diverse, with most every relationship loss represented. Now it seemed parents who lost children were the dominant ones and took up most of the discussion time, leaving her feeling less supported. Marion said she would probably try to find another smaller group if possible, and if not, would probably seek occasional sessions with a bereavement counselor.

Still another common reason to explain support group shifts pertains to the informal social relations and shared norms between members. This can cut two ways. On the one hand it can lead some members to withdraw from a group because it seems too “cliqueish.” This is precisely what Renata Garafolo (pseudonym) reported.

I was put off by some other members who usually dominated discussions. If I could get a comment in between these five big talkers I was very lucky. After meetings, this same little group and the facilitator usually went out to a diner for coffee.

For Renata, who had little interest (and time available) to join the others at the diner afterwards, other members’ strong social ties created a barrier for her to use the group in a personally meaningful way.

Yet, on the other hand, we have also seen members leave groups for the obverse of this reason, when the group did not actively encourage much, if any, informal or formal social relations between members.

Alice Higgins (pseudonym) started attending one support group facilitated by a parent who had lost a child and eventually dropped out after discovering little socialization between members after meetings. She was hoping to connect with others and bond together, but in this group, after meetings most everyone shook hands, gave each other hugs and took off on their separate ways. Several months later she tried attending a different group, further from where she lived, in the hopes of finding what she was seeking. The new group was run by a single woman, much like herself, who had survived the loss of a partner and included several other single women who had experienced partner losses. The women in Alice’s new group befriended her and as time passed she became closely attached to some. Alice felt very happy in her new group; it offered her grief assistance, more helpful support for coping with partner loss, and new friendships. Her attraction to the second group was an especially powerful one.
Group facilitators remain in an ambiguous situation in encouraging informal social relations among their members. A strictly task-oriented approach, discouraging member interaction beyond grief issues, can inhibit the development of member rapport, essential for facilitating a survivor’s healing over the longer course. But, a clique-riddled group is likely to discourage many newly bereaved from being attracted to the group. Facilitators tread a fine line in encouraging socializing among their membership. The power of within-group-friendships helps promote common goals among survivors, helps them work through their grief problems over time, but informal social relations can occasionally create conflicted intergroup relations and can impose barriers for the rapid inclusion of the newly bereaved.

In another case, Eileen Brody (a pseudonym) reported having no interest in socializing with the other members of her group after meetings.

I declined invitations to attend social events that the facilitator or others organized, like summer picnics and occasional dinner parties. However, when I saw the people again at later meetings I had the feeling that some of them thought I was stuck up and unfriendly. I resented all these additional social obligations beyond the meetings. I preferred spending most of my free time with my family and friends.

Facilitators need to offer group members a comfortable place to express their grief issues, the primary purpose of an SOS group and group goals should be clearly identified. If a group has an additional social agenda, beyond its grief-related mission, this should also be clearly articulated. With this clarity, stated at the onset, new members will be able to make more informed decisions about participation. Emotional connectedness among support group members is vital to achieve support group goals. Facilitators will need to promote this, without socialization expectations, especially in the groups where grief work is the group’s singular focus.

Our follow-up interviews suggested many different reasons leading survivors to depart from support groups, beyond the ones we have already mentioned. Below we list several additional profiles of departures by newly bereaved survivors.

Gale Frost (a pseudonym) lost her 38-year-old son to suicide 2 months before she started coming to group. She came to three consecutive meetings and felt the meetings greatly helpful to her. Much as she wished to continue participating, she said she would have to take a short break until she completed her cataract surgery. As a widow, whose night-driving abilities were limited, she had previously been escorted to meetings by her daughter or son-in-law. She said her son-in-law was very busy and she couldn’t repeatedly impose on him. And as for her daughter, she couldn’t come again as she became too depressed after listening to survivors’ loss stories. Gale reported being stuck, unable to return to group until she completed her eye surgery.
Regina Goldsmith and her husband Robert (pseudonyms) started attending group almost immediately after their 17-year-old son killed himself. After being humiliated by some of his school peers in a practical joke, their son drove the family car into a utility pole. Both attended group for four or five meetings and then Robert stopped coming because his work schedule had changed. Regina continued attending for the next three meetings, but, then she too withdrew. In a followup interview Regina voiced her gratitude for the group but said that unless both she and her husband were able to come to the meetings together, the group had little value. She and her husband had always done things jointly and without his involvement, it seemed pointless to continue.

Maureen Shaughnessy (pseudonym) lost her 36-year-old son to a self-inflicted gun-shot wound and started attending a support group about 6 weeks after his death. She came regularly to meetings for about 6 months, was a frequent vocal contributor, then abruptly stopped participating. At follow-up, she remarked she was beginning to get to a better place with her grief and a lot of good things were now going on in her life. She joined a gym and was getting regular exercise. She was active in her church and had met a number of new friends there; she participated in an outreach program visiting homebound sick and infirm parishioners. And most important of all, from a bereavement standpoint, through her new church associations, she had connected with four other widows, two of whom had also lost a child. One of these women was even a suicide survivor. The women met monthly, either going to one or another’s homes for dinner or out to a restaurant, where they spent an entire evening together socializing. She said she now feels very comfortable talking about her grief issues with these other women. In addition, she had reached a new level of rapprochement with her daughter-in-law, with regular communication and access to her young grandson. This latter benefit had previously been denied to her immediately after her son’s death.

As we sum up these last three cases, we note that a support group must fit into the framework of a survivor’s life. Sometimes it must also mesh with other family members’ needs. Family members may be needed to facilitate a survivor’s access to attend group meetings. In some cases, a survivor may be unwilling to pursue a support group if it places added burdens on their family relations or marital stability. And a survivor who already has a core of available supportive significant others may feel continued support group participation to be unnecessary.

Departures among Survivors with Longer Associations in Support Groups

Our follow-up interviews suggested two contrasting departure patterns. Among the newly bereaved, grieving needs were often mentioned in the decisions to withdraw from groups. For longer-term survivors, by contrast, these concerns were seldom expressed. Many longer-term survivors we interviewed expressed the belief that they had minimal needs for current grief support.
Pam Bacon (pseudonym) shared such a view as she reflected on her 6-year absence from support groups. She said:

I was a “regular” in two groups for many years. My older son was 14 years old when he died, and it has been 14 years since his death. This is putting me into a strange new place. Now I’ve lived more years with the memory of Jackie, than I’ve had of living with him. I still think of him everyday and I’m sure I will for the rest of my life. But I don’t need the groups any more. I guess you could say I outgrew them. Mind you, at the beginning, I needed to relive my loss. Hearing other survivors’ loss stories helped me to relive mine. I had to come to terms with my loss and the support group helped me do that. I learned a great deal from it. Part of my problem after my son died was not having much confidence in myself. I was shattered after Jackie died. I kept blaming myself; he was so young. Working through the grief helped me to rebuild my self-confidence. Eventually I got back enough nerve to return to high school science teaching. It took me about 5 years to do that and I think I owe it to the groups to helping me. I never relied on therapists... Eventually I stopped going [to group] I guess because I didn’t need to do it for myself any more. The only reason to stay in group after that would have been to make grief work a central thing in my life. And I didn’t want to do that, so I ended it. Actually, my husband, younger son and I are pretty busy nowadays; we lead pretty full lives.

Another survivor expressed her departure from support group in a different way. Lillian Gage (pseudonym) whose 38-year-old son died by hanging 4 years ago, was a regularly attending support group member until about 7 months ago. She said: “the support group was a Godsend; it had made me at home with my grief.” At first she was totally distraught, full of questioning, blaming herself and not knowing what to do to calm her troubled soul. But the support group was:

wonderful medicine; I was free to speak my mind and I knew I would be understood. I felt safe there. There wasn’t anything I couldn’t talk about in the group. We’re all in that same place together.

After a while Lillian felt more at home with her grief and didn’t need the group as much as she did immediately after her son’s death. She stopped going for other reasons: fatigue: she had a physically demanding job cleaning homes and looking after several frail elderly people and didn’t have much energy left to go out at night to meetings. In addition, the glare from night driving was another problem. Lillian said that hearing the loss stories of the newly bereaved survivors didn’t bother her much. She said,

If I could say calming things to them I was glad to do that, but there were other people in the group, who did a better job of it than me. So I was OK with giving it up.

For many longer-term survivors, the experience of staying in the group after having worked through their immediate grief problems, weighed heavily on them.
Loretta MacIntosh (pseudonym), an 11-year survivor of her 22-year-old son’s suicide, remarked:

I was in the group for 7 years; it was enough already. Hearing the new people come in and tell their loss stories—seeing their tears, seeing them all welled up with so much emotion, guilt, and shock—it all brought me down and back to the place I started from. I didn’t need this anymore. The support group had been my salvation. I belonged to two of them. I made a half dozen very close friends in the groups over the years. I still see these friends; we all lost children to suicide around the same time; and we comfort each other. This perhaps is the best help for me now: being with my friends. Now, there are a few rare occasions when I do get sad again, (like when we are invited to a wedding and it reminds me of my son not being alive), being with my friends comforts me. My husband and I go out to dinner with some of them, sometimes. We’ve even taken vacation trips together. We also celebrate difficult days together like Mother’s Day. I thank God for their support.

When asked if Loretta was involved in any suicide prevention activities, she said she helped at an annual local community walk fund-raiser; she solicited donations and volunteered at the registration desk. She said,

I enjoy doing these things; it helps the cause and I do it with some of my good friends, who I’m always glad to see again. We pitch in and try to do what we can to change things.

Erica Kaufman (pseudonym), another long-term survivor, whose 20-year-old daughter took her life 10 years ago, reported making the rounds with her husband in trying almost every conceivable therapeutic resource to deal with their loss.

I think I was lucky to have my husband willing to try all the different therapies with me together. I’ve seen other families where the wife does all the grief work and the husband stays home watching football games or something. I don’t think that’s such a good plan. First, my husband and I tried a grief counselor who was a social worker and that was very helpful. After that, we tried Compassionate Friends. The CF people were nice; no one ever said a negative word to us but we never felt completely comfortable there. I don’t think any of those people knew what we were going through with a suicide. You have to be with suicide survivors to get the feeling of true compassion and support. Later on, we went to an SOS group for over 3 years and that was much better than the general bereavement group, but the best group of all was an 8-week treatment group we completed at a family mental health clinic. They put eight of us suicide survivors together into a single group and we bonded. After the 8-week session, we decided to meet at one of our homes, and have monthly meetings. We even considered hiring a grief counselor to lead our meetings but one of us was an experienced social worker, so we didn’t need to hire anyone. We did that for about 3 years and it worked fine. Eventually we stopped our monthly meetings and just got together with each other informally, which some of us still do now.
My husband took training as a first responder and every now and then he is called out to counsel a newly bereaved suicide survivor. I can’t do that. Once I go back to all those early grief things—blame, shock, confusion, etc.—it pulls me down. I can’t go back there. My husband and I do what we can with suicide prevention. We do fund-raising, help organize an annual local community walk; we’re on a local chapter board for a mental health service organization; I used to go into the high schools with a group of other survivors, giving suicide prevention talks to students, but I don’t have the time to do that anymore.

Sally Forbes (pseudonym) lost her son 13 years ago when he took his life at age 16. She and her husband Hank belonged to an SOS and a general bereavement group and faithfully went to both group’s meetings for about 7 or 8 years. They made several close friendships with other survivors in these groups who they still see from time to time. Sally felt that it was the grief support they received from their survivor friends that helped them the most to ultimately accept their loss.

They [her support group friends] have been like a family to me when my own family failed and didn’t know what to do or say to us; they still avoid mentioning our deceased son and act as if he had been consumed by the plague or something. Eventually we didn’t need to continue going to the meetings any more, so we stopped. Later on, in my church I was approached to co-lead a bereavement group with another woman who lost her son. We co-facilitated a group for about three years. At its peak, we had 14 people in our group. It seemed like a good thing to do, but eventually it pattered out, at least for me it did, when I got a new job. At that point, I had to give my part over to my co-facilitator. I still help out at an annual bereavement conference in our community. It’s a big conference and I usually help out with the registration and I sit at the conference resources table helping newly bereaved attendees make the most of the conference. At the conference I also give away copies of my book about my son’s life and death.

Post-Traumatic Growth

Follow-up interviews suggested far more evidence of post-traumatic growth among longer-term survivors than among the newly bereaved. Post-traumatic growth is reflected in social change actions, when survivors act collectively to alter the fabric of society, to prevent suicide, and to diminish the stigma that now surrounds it and other mental health problems. As survivors support organizations committed to suicide prevention and take part in many actions at the local and/or national level addressing the problems of suicide and mental health treatment availability, these acts reflect post-traumatic growth. Survivors do many of these things: they lead or co-lead survivor support groups; they work with others to organize bereavement conferences; they engage in fund-raising efforts to provide more support for research on mental health problems; they
participate in political action aimed at providing more and better mental health and bereavement services in their communities; a few act as educators, writing books or articles on suicide or mental health issues, also giving talks to community groups about suicide and helping to change the stereotypical thinking about mental health problems and suicide. Many post-traumatic growth efforts are aimed at fund-raising for some of the many organizations supporting mental health and suicide research: NARSAD (The Brain and Behavior Research Fund), NAMI (The National Alliance on Mental Illness), AFSP (American Foundation of Suicide Prevention), SPANUSA (Suicide Prevention Action Network), SPIORG (Suicide Prevention International), among others.

Even newly bereaved survivors may be involved in acts reflecting post-traumatic growth. For example, one newly bereaved survivor successfully advocated in her community to establish a first-responder’s program, to have teams of trained survivors visit the newly bereaved to help them deal with the unbearable shock of suicide loss. Other newly bereaved survivors have initiated memorial walks, golf outings and similar fund-raising events honoring their lost loved ones, and have raised monies for mental health research. For most, these empowering acts have helped channel survivors’ grief into socially purposeful enterprises.

Facilitators must be cautious about incorporating fund raising and suicide prevention goals into their discussion time at meetings lest they offend those members who want and need grief work to be their group’s exclusive focus. There also may be potential conflicts with members advocating for different service organizations. Suggesting that members discuss advocacy matters among themselves after meetings is an effective way to reduce such conflicts. Here again, the facilitator sometimes treads a fine line in possibly offending different factions within their memberships as they allot (or fail to allot) sufficient discussion time to interested advocacy parties. Facilitators need to strike the right balance between emphasizing the personal dimensions of doing grief work and at the same time providing survivors with opportunities to connect to the larger society. For most of the newly bereaved, there is little energy and interest available to pursue collective goals, but brief discussions of other survivors’ activities, after the initial pain of loss, can be important to instill hope.

**SUMMARY AND CONCLUSIONS**

We asked the longer-term survivors in our follow-up sample, who comprised the majority, to evaluate what had given them their most important help for coping with and transcending the despair of their suicide losses. A few indicated that a very good counselor had given them great help, especially during their first early months after loss. Yet, as most took stock of their primary help-rendering agents, most said their support group was their mainstay in helping them endure the sometimes treacherous course of life after loss. As Lillian Gage said, support group was her “Godsend,” “wonderful medicine” for helping her to accept the loss.
of her son and still move forward with her life. Others said they don’t know how they would have made it to the present without the help of their group and the other survivors who they had met along the way, since they began their healing journeys.

Generally, survivors felt that in the support group they were “understood” in their new and difficult roles as suicide survivors. Some reported greatly looking up to longer-standing survivors as role models who demonstrated visions of a new normal to them. Some felt greatly inspired by these other survivors, especially those who appeared to demonstrate profound resilience (such as the mother who lost two teenage children in a single automobile accident, or the father who sustained two suicide deaths of children in his family, or another wife whose husband had shot himself in her presence). The survivors who expressed profound admiration for these loss victims felt that if these individuals could rebound after such extremely tragic loss circumstances, there must be hope for them, and there must be something they can learn from joining their support groups.

In the groups, survivors use one another as reference points for gauging their own healing progress. We repeatedly heard comments suggesting this in our participant observations among those who felt group was an important helping force. As one survivor remarked:

> When I heard Ellen (pseudonym for a newly bereaved member) talk about her issues—trying to get her other family members to come to meetings, sharing her feelings of immense guilt and anger, etc.—I could see how far I’ve come since I joined the group.

For some, these actions of sharing loss stories help them recognize that it may be time for them to move on from group. As Pam Bacon expressed it, “I don’t need to re-live others’ loss stories any more to help me come to terms with my own loss.”

Again and again we heard that new friendships with other survivors were extremely important for these survivors in helping them to feel better. Many survivors found their social networks shrinking after their suicide losses, as some close family members and friends said hurtful things about their lost loved one or suggested accusative roles for their parts in the demises of their loved ones. In other cases, significant others’ failures to acknowledge the loss and avoidance actions left survivors with hurt feelings. Others bereaved by suicide or other sudden death losses almost always knew what to say to show compassion and to act supportively to a survivor; they remembered each others’ important death anniversary dates and for all these and other reasons, provided great comfort.

As survivors meet one another in their support groups, at healing conferences, or in online chat groups, they now find they have many new friends with whom they can go out dining, spend a social evening together, or even plan vacation trips, as a few reported doing. As many survivors remain active in bereavement
or suicide prevention advocacy work, they now have the comfort and pleasure of working together with former support group members, re-connecting with one another at these events. Thus, support groups help strengthen the bonds of friendship and community between survivors.

As we assess the support group over time, we recognize that the structure of the open-ended group may become a zone for potential conflicts as the forum offered to the newly bereaved may clash with the expectations and needs of many longer term survivors, who feel they have largely accomplished what they sought out to do in accepting their losses. While longer-term survivors show support for the newly bereaved and help them openly express their sorrow, anguish, and confusion, some longer-term survivors ultimately realize they need to withdraw from the support group to avoid reliving their own painful feelings of suicide grief. Some of these longer-term survivors may even be brought to a sad realization that their own healings may never progress to the level of their expectations, as evidenced by their strong aversions to the deep sorrow and tears of the newly bereaved. As they understand that grief has many diverging forms, and that there is no one single model of “good grief,” each survivor seeks to find his own personal level of grieving comfort and the things he must do to achieve and preserve his well being. Yet, after any overall assessment, most would agree that open-ended support groups are nurturing environments that successfully address the healing needs of the newly bereaved and also serve to generate a cadre of potential peer leaders among longer-term survivors.

This analysis suggests numerous other dividing points within an open-ended SOS group. Survivors come to the meetings bearing a diversity of losses: of children, partners, parents, siblings, and friends. At meetings they expect to find sufficient discussion time allotted to their particular bereavement circumstances so that they may feel supported and understood. Yet, if we look at the comings and goings of members over our 7½-year history of participating in and running a support group, we note attachments of far shorter durations to support groups exhibited by those losing siblings and parents, than among child loss and partner loss survivors. Many of the latter two populations remain affiliated in groups for 3 years or more, while the former two populations rarely remain affiliated beyond a year. Whether these differences reflect different magnitudes of grieving difficulties experienced by each of the respective populations, or whether the partner and child loss constituencies exert dominating influences, thereby marginalizing sibling loss and parent loss survivor constituencies, we are unable to say. Future research should further investigate whether there is a perceived shortage of available forums for those sustaining losses of parents and siblings in survivor of suicide support groups.

Potential division points within support groups extend beyond the already mentioned ones to include the delicate balance of encouragement of informal social relations among members and supporting advocacy interests among members. Both of these areas present worrisome issues for facilitators to strike
the right balance lest they offend significant segments of their memberships. Our follow-up interviews gave abundant evidence for the importance of the friendship ties that survivors make with one another along their healing journeys. These ties, and the goals that these survivors now share, are especially important in connecting survivors in society in new and personally meaningful ways. Many survivors regard these attachments, some made in professionally-led therapy groups or others nurtured in open-ended SOS groups, as tremendously important in their post-loss lives. Such ties help to legitimate their new survivor identities and lead them to accept their losses with greater equanimity.

We see clinicians as having a key role to helping their survivor patients coordinate their care seeking efforts in meaningful and constructive ways. This is especially true during the early post-lost years when a survivor is likely to rely upon clinicians to the greatest degree. This inquiry has shown how focusing upon support groups can better illuminate the process by which survivors heal after suicide losses. Hopefully, more future research will draw upon this most fertile resource.

**AUTHORS’ BIOGRAPHIES**

Beverly Feigelman, LCSW is currently an Adjunct Professor of Social Work at Adelphi University in Garden City, New York and also maintains a private psychotherapy practice. She is an educational consultant for the Bellmore-Merrick (Long Island, New York) School District training graduate social work students for practice in secondary-school settings. Ms. Feigelman is a member of various suicide prevention organizations including the American Foundation of Suicide Prevention, SPAN-USA, and the American Association of Suicidology and is a survivor of her son’s suicide. She is also author of several articles on addiction treatment and social work education. She currently serves as Chair of the Long Island Chapter of the Association for the Advancement of Social Work With Groups.

William Feigelman, PhD is currently Professor Emeritus and Adjunct Professor of Sociology at Nassau Community College in Garden City, New York where he has taught for more than 42 years and still teaches part-time. Author or coauthor of six books and more than 40 journal articles, he has written on a wide variety of social science subjects: child adoptions, youth alcohol and drug abuse, problem gambling, tobacco use, and cessation and intergroup relations. Most recently, since his son Jesse’s suicide in 2002, he has focused his professional writings on youth suicide and suicide bereavement. A member of the American Association of Suicidology and the Association for Death Educators and Counselors, he is presently completing a large scale survey of parents who lost children to suicide and other untimely death causes.
REFERENCES


Direct reprint requests to:

William Feigelman
181-34 Aberdeen Road
Jamaica, NY 11432
e-mail: feigelw@ncc.edu