

**INTERNET SUPPORT GROUPS FOR SUICIDE
SURVIVORS: A NEW MODE FOR GAINING
BEREAVEMENT ASSISTANCE**

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ABSTRACT

Taken among parents who sustained the loss of a child to suicide this study explores the participation of parents in Internet support groups, comparing their demographic and loss-related characteristics ($N = 104$) to other parent survivors participating in face-to-face support groups ($N = 297$). Contrary to expectations that Internet affiliates would be concentrated in under-served rural areas, we found similar levels of urban, suburban, small city and rural residents in both Internet and face-to-face subsamples. Bivariate and multivariate analyses suggested several important factors contributing to interest in Internet grief support including: 24/7 availability and opportunities to invest more time into this type of support group experience. Compared to their face-to-face group counterparts, Internet affiliates experienced greater suicide stigmatization from their families and other associates. Unable to find ready comfort and support from their personal communities, Internet users—and especially highly depressed survivors—sought and obtained valuable help from the Internet support resource.

INTRODUCTION AND OVERVIEW

Although suicide is a relatively rare event, with about 11 per 100,000 taking their lives yearly in the United States (American Association of Suicidology, 2007a), the number of suicide survivors (defined as those relatives and close friends of the suicide victim), is considerable and numbers into the millions. A recent estimate claims over 13 million persons knowing a suicide decedent from the previous year. The same study estimated that one in five of these exposed persons were family members, though the study did not differentiate between close relatives, and remote kin lost to suicide (Crosby & Sacks, 2002). Thus, the survivor toll increases rapidly, growing at a rate of at least hundreds of thousands of newcomers joining the ranks of existing suicide survivors each year.

Like others losing kin in war, natural disasters, and accidents, the psychological trauma of suicide has affective, social, behavioral and physiological consequences (Knight, 2006). Survivors are also prone to symptoms of post-traumatic stress: re-examining the event, avoiding stimuli associated with the event, numbing of general responsiveness and/or increased arousal symptoms (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004). Yet, suicide survivors also confront distinctive bereavement issues (Jordan, 2001). Jordan claims that survivors are prone to feelings of guilt and blameworthiness, feeling that they were in some way responsible for their loved one's act of self-killing. Many also experience anger and rage against loved ones for abandoning them. This, in turn, generates more feelings of guilt and blameworthiness. Another important prominent correlate of suicide, Jordan asserts, is the survivors' sense of surprise and shock that loved ones they thought they knew so well, could suddenly destroy themselves. Many survivors struggle for years trying to better understand how their lost love one succumbed to suicide.

It has also been claimed that suicide survivors are a highly stigmatized group (Cvinar, 2005). During the Middle Ages, a survivor's family was denied a church burial for their lost loved one; the kinfolk of the deceased were often forced to dispose of family property to settle church debts and were often later shunned by fellow residents (Dunne-Maxim, 2007). Presently, survivors find little institutional discrimination. However, informal social disapproval still remains. Survivors often claim that close associates avert making references to their lost loved ones, thereby invalidating their existences (Feigelman, Gorman, & Jordan, 2007).

Because of their complex grief issues and societal stigmatization, suicide survivors often experience more severe mental health problems compared to other bereaved populations. Increased suicidality, depression, PTSD, and complex grief are among some of the mental health problems commonly identified among survivors (Agerbo, 2005; Bailey, Kral, & Dunham, 1999; Calhoun & Allen, 1991; de Groot, de Keijser, & Neeleman, 2006; Farberow, 1991; Murphy, Johnson, Wu, Fan, & Lohan, 2003; Murphy, Tapper, Johnson, & Lohan, 2003).

Over the years, survivors have sought help with their multifold bereavement needs from a variety of caregivers: clergymen offering pastoral counseling, psychiatrists, psychologists, psychiatric social workers, psychiatric nurses, and other bereavement professionals. Many also have sought help by joining support groups.

Support groups vary in terms of their structures and leadership. Some are peer or professionally facilitated, some agency affiliated or free-standing community groups. Some groups operate within fixed-length terms (usually 10-12 weeks, that may then be renewed or terminated) while other groups are open-ended (where the group meets for an indefinite period) (Jordan, 2004). Survivor groups may also be further differentiated into single-loss types, such as specifically designated "survivor of suicide" groups vs. general bereavement support groups, which include survivors from a variety of different death causes, (e.g., people losing loved ones to accidents, natural causes, illnesses, suicides and /or homicides). One of the most well known (peer-based) general bereavement groups, "The Compassionate Friends," is a national organization with chapters in most major cities, available exclusively for parents sustaining the untimely loss of a child.

Peer-helping has a long established position in the U.S. Katz and Bender (1976) claim that people helping one another through the exchange of resources and caring is the backbone of American society. Dating back to the mid-1930s, with the creation of the first Alcoholics Anonymous chapter in 1935 in Akron, Ohio, by "Bill W." and "Dr. Bob" (Makela et al., 1996), support groups have steadily gained in popularity. Not only has there been a rapid expansion of groups devoted to offering peer-help for addiction-related problems (like weight control, gambling, compulsive shopping, etc.) but also for a nearly endless array of other life difficulties, developmental transitions and problems, with many related to stigmatization (e.g., surviving cancer, living with a gay, lesbian or trans-gendered identity, getting old, among others.).

Peer-helping seems to offer especially compelling appeal to suicide survivors, as compared to gaining professional assistance. Angry with practitioners for failing to successfully treat their lost loved ones, survivors are often critical and skeptical about the helping potential of mental health professionals. Many survivors begin their healing journeys putting more confidence and credence into fellow survivors, often feeling that only survivors can fully understand their particular needs and difficulties (Feigelman & Feigelman, 2006). This has also been noted in the group work literature. Garvin (1997) claims that the values of peer helping are especially important for those who have experienced rejection and/or inadequate services from mental health professionals. He goes on to claim that "there is value in non-professionally led groups because of the sense of competence they nurture" (Garvin, 1997, p. 13).

The earliest specific support groups for suicide survivors began in Atlanta Georgia in the early 1980s. Iris Bolton, a mother who lost her son to suicide in 1977, realizing there were no support groups available for suicide survivors like

herself, founded one of the first-ever in the Atlanta metropolitan area (Bolton, 2006). Later, Bolton became a leading figure in the survivor support group community with the publication of her widely read memoir, *My Son, My Son*, originally published in 1983 and the founding of The Link Counseling Center, in Atlanta, Georgia, which presently offers a wide array of counseling and bereavement support services. (Bolton, 2006). Today, an examination of the American Association of Suicidology or American Foundation of Suicide Prevention websites shows over 300 survivor of suicide support groups nationwide, most of which would be termed suicide specific, peer-led open-ended support groups (American Association of Suicidology, 2007b; American Foundation of Suicide Prevention, 2007).

In recent years another new form of peer-helping has emerged: Internet support groups. Psychcentral.com, one of the leading Internet clearinghouses for psychological information and support services, lists some 19 different national or international Web-based support groups for suicide survivors http://psychcentral.com/resources/Suicide_and_Crisis/. There are probably additional similar support groups that may not be known to this clearinghouse. Some Internet support groups have been in existence for nearly a decade or more, and others have emerged very recently. Little is known about these groups, but this knowledge gap is beginning to attract a great deal of new scholarly attention.

Behavioral scientists have begun to devote more interest to study Internet support groups and a new literature is now emerging on how people use on-line groups to get help for a range of problems, such as breast cancer (Winzelberg et al., 2003), diabetes care (Zrebiec & Jacobson., 2001), mental health problems (Schneider, Mataix-Cols, Marks, & Bachofen, 2005; Skinner & Latchford, 2006), occupational stress (Meier, 2000), children's special health care needs (Baum, 2004), traumatic brain injuries (Rotondi, Sinkule, & Spring, 2005) among other problems. Many recent studies emphasize the value of sharing medical and technical information among support group members. And several have focused on the emotional support exchanges available in support groups. Some studies have also been comparative, examining those individuals who rely upon Internet groups and comparing them to others involved in traditional face-to-face self-help groups. To date, only one qualitative study has demonstrated how survivors of suicide employ Internet and face-to-face groups to come to terms with suicide losses (Hollander, 2001). To date, no studies have investigated suicide survivors quantitatively, surveying how survivors use Internet support groups, what they value in them, whether Internet support groups appeal to distinctive subsets of survivors, and whether they offer meaningful help to suicide survivors. With survey data from Internet support group affiliates, the present study seeks to address these important informational gaps.

We also began this study specifically aiming to investigate how suicide survivors participate in Internet support groups. The sparse, but fast expanding, literature on Internet support groups suggests that Internet affiliates are likely to be

concentrated in remote rural areas where they have less access to face-to-face groups and other professional bereavement services, concentrated in the country's metropolitan places (Bacon, Condon, & Fernsler, 2000; Hill & Weinert, 2004; Lieberman et al., 2003). An unstated assumption behind this view suggests that when clients have opportunities to choose between face-to-face bereavement support and support on the Internet, they generally will select the former ahead of the latter. As we began this study we anticipated finding higher percentages of small city and rural residents in the Internet support group experience. We also expected rural residents to be spending more time participating in their Internet support groups, as they had fewer available alternatives.

METHODS

This report is based on survey data collected from one of the largest, longest-running Internet survivor of suicide support groups, the Parents of Suicide, known as the "POS" group, <http://www.parentsofsuicide.com/parents.html>. Its founder, Karyl Chastain-Beal, a survivor of her daughter's suicide, started this group in 1998. Presently, with nearly 700 people listed on its membership rolls, at least two-thirds participate with some regularity, asking questions, making comments and giving responses to each other in the support group. In order to join POS one must be a parent who has sustained the loss of a child to suicide. Step-parents, other family members and friends of the decedent are guided to join an affiliated support group, FFOS, known as the Families and Friends of Suicide.

In November, 2006 an Internet support group utilization survey was created by the first author at a secured website hosted by Nassau Community College and POS members were invited to participate in a confidential and anonymous survey of their group by visiting a designated website and registering to complete the survey installed there. Respondents could choose to complete the survey anonymously or they could provide name and address information along with their survey responses. Only six respondents chose to complete the survey without offering name and address information. Support group members were periodically reminded about the possibility of being able to complete this survey until February 2007 when 200 members had already participated.

Those furnishing name and address information were invited by mail to complete a longer bereavement survey (used in a larger ongoing study of the current authors) detailing their child loss experiences in a 27-page survey. Of 194 potential respondents, 163 requested survey forms and 116 actually completed them. This yielded a 71% response rate from those who had requested to complete the longer survey. The present analysis is based upon both the Internet-specific and the longer survey.

The sample for the larger bereavement survey was drawn from several sources: support groups listed in the American Foundation of Suicide Prevention (AFSP) listings of peer-facilitated survivor of suicide support groups, newsletters and

listserves serving the suicide survivors community from Suicide Prevention Action Network (SPAN), the American Association of Suicidology newsletter, "Surviving Suicide," and the "Comforting Friends" newsletter circulated by Friends for Survival, Inc. Additionally, several bereavement counselors and psychologists volunteered to offer the survey to some of their patients. Several Compassionate Friends chapters were also contacted and information was circulated about completing the survey among their memberships. Typically, support group facilitators placed announcements in their newsletters calling for volunteers to complete an anonymous and confidential survey. Volunteers were directed to contact the first author, who was identified as both a sociologist and a suicide survivor, to acquire surveys and return mail envelopes.

In the longer full-sample survey, 754 surveys were sent out and 540 returned, yielding a response rate of 72%. Comparisons were made between two groups of participants. The first group consisted of those in the Internet survey who completed the larger bereavement survey, and who reported spending one or more hours participating in the Internet support group during the last 12 months ($N = 104$). These Internet participants were contrasted with face-to-face support group affiliates. Face-to-face affiliates were defined as follows, survey respondents who:

1. were not already previously identified as Internet support group affiliates;
2. reported themselves as survivors of suicide; and
3. reported prior participation in a peer support group ($N = 297$).

As the findings will later show, there is much cross-over between parent survivors using different support group resources at the same and different times. For the purposes of this study what differentiates the Internet support group from face-to-face affiliates is **current active participation in the Internet group**. In contrast, in the face-to-face group, although 11 out of 297 reported some prior participation in the Internet group, none reported participation in the Internet group during the past 12 months, and all reported participation in one or another type of a face-to-face, peer-support group.

Measurements

To measure grief difficulties we used an abbreviated version of The Grief Experience Questionnaire (Barrett & Scott, 1989). The original GEQ scale consisted of 55 items. Following the lead of Bailey, Dunham, and Kral (2000) who performed a factor analysis of the scale, and identified eight distinct factors within it, we selected the two top-loaded items for each of the eight factors for our 16-item abbreviated scale. Our abbreviated scale yielded an alpha coefficient of .87. Though we had no way of verifying how closely this abbreviated scale correlated with the full 55-item scale, we did find it correlated highly with the Impact of Events Scale (Horowitz, Wilner, & Alvarez, 1979) and the Complex

Grief Scale (Prigerson, 2002), with correlation coefficients above .70 These instruments were also administered in our larger bereavement survey.

The measure of depression was the same one employed by Wethington, Kessler, & Brim in the 1998 Mid-Life Development Survey (2005): "During the past year was there ever a time when you felt sad, blue or depressed for two weeks or more in a row? 1) yes; 2) no; 3) not depressed because of anti-depressant medication." Suicidal ideation was measured by the following item: "How often during the past 12 months did you think about taking your own life? 1) Almost never or never; 2) rarely; 3) occasionally; 4) frequently; 5) very frequently."

We also constructed several measurements of societal stigmatization that were created expressly for the present investigation.

The Family/Social Strain Scale

This measure asked respondents whether, after the loss of their child, relationships with any one of 11 different groups had changed: their spouse, ex-spouse, parents, in-laws, children, siblings, other relatives, coworkers, closest friends, less close friends, and neighbors. Respondents could choose between the following answers about the group: not applicable; relationship remained the same; became closer/stronger; or became weaker/strained relations. We counted strain responses as a simple addition of the number of relationship groups that had become strained. Sixty-six percent reported experiencing strain with one or more of the relationship groups following the loss of their child and nearly half (47%) experienced strain from two or more relationship groups.

The Family Unhelpful Response Scale

In this scale we asked respondents whether any of seven different relationship groups acted helpfully or harmfully during the year after the loss of their child: their spouse, ex-spouse, parents, in-laws, children, siblings, and other relatives. Respondents were asked to rate the group's helpfulness on a 5-point scale, with very harmful at one end and very helpful at the other. We scored any 1 and 2 responses as unhelpful ones; 54% of respondents reported getting one or more harmful responses from these specified family members.

The social unhelpful response scale

In this scale we asked respondents whether any of the four different relationship groups had acted helpfully or harmfully during the year following the loss of their child: their closest friends, less close friends, coworkers, and neighbors. Respondents were asked to rate their helpfulness on a 5-point scale, with very harmful at one end and very helpful at the other. We scored 1 and 2 responses as unhelpful ones. Thirty-one percent of respondents reported getting one or more harmful responses from these non-kin groups. We anticipated all three

stigmatization measures to be intercorrelated with one another and as expected, correlation coefficients ranged from between .31 and .41.

Results

For presentational clarity we separated findings into two sections:

1. univariate findings, where a single variable or set of variables was examined; and
2. cross-tabular and multivariate findings.

UNIVARIATE FINDINGS

Use Patterns

Table 1 shows the use patterns on a weekly basis for the 200 Internet support group respondents for the month prior to taking the survey and for the previous year. If we combine the two higher frequency categories, we observe that approximately half of all respondents spent six or more hours weekly participating in the Internet support group. Once an individual joins the group they usually receive about 100 messages daily from other members. While it could take a considerable

Table 1. Frequency of Internet Group Participation

	Frequency	Percent ^a
During the last month , on an average, how many hours weekly did you spend participating?		
None	23	12
Less than 2 hours	42	21
Between 2 and 5 hours	36	18
Between 6 and 10 hours	54	27
More than 10 hours	45	23
Total	200	100
During the last year , on an average, how many hours weekly did you spend participating?		
None	20	10
Less than 2 hours	54	27
Between 2 and 5 hours	35	17
Between 6 and 10 hours	28	14
More than 10 hours	63	32
Total	200	100

^aTotals may exceed 100% due to rounding.

On-line Internet SOS Participation Survey, Nov. 2006/Feb. 2007

amount of time to digest all this material, members receive instructional materials from the facilitator helping them select items of interest and to bypass less relevant items. Members are also given guidance on how to frame their submissions to attract the widest response from other support group participants. In addition, members are also free to carry on separate dialogues between one another, which many do, as well. We did not tabulate these additional off-line interactions.

Table 2 shows that the usage time for Internet support group members still remain high even when survivors participate in face-to-face support groups or see professional counselors. Table 2 shows that 47% still spend six or more hours weekly in the Internet group, even when they reported going to meetings six or more times yearly to face-to-face groups. And 45% still spent six more hours weekly on the Internet group when they are saw counselors six or more times yearly. Even when we examined those who attended face-to-face support groups on a more frequent basis—going to 20 or more meetings within the previous year, ($N = 24$)—again, 45% still spent six hours or more weekly participating in their Internet support group. And among those going to a counselor 20 or more times

Table 2. Frequency of Internet Group Participation

	Frequency	Percent ^a
Among those attending a support group six or more times yearly, $N = 32$		
During the last year , on an average, how many hours weekly did you spend participating?		
None	2	6
Less than 2 hours	7	22
Between 2 and 5 hours	8	25
Between 6 and 10 hours	6	19
More than 10 hours	9	28
Total	32	100
Among those seeing a counselor six or more times yearly, $N = 65$		
During the last year , on an average, how many hours weekly did you spend participating?		
None	8	12
Less than 2 hours	18	28
Between 2 and 5 hours	10	15
Between 6 and 10 hours	8	12
More than 10 hours	21	32
Total	65	100

^aTotals may exceed 100% due to rounding.

On-line Internet SOS Participation Survey, Nov. 2006/Feb. 2007

during the past year ($N = 24$), 57% still spent six hours or more participating in the Internet support group. These latter data are not presented in Table 2.

Fifty-six percent of Internet support group affiliates reported some previous participation in a face-to-face peer-led support group and, of that group, 32 (or 29%) reported going to meetings six or more times during the previous year. Private bereavement counselors were reported as the dominant professional group (reported as the 3:1 favorite) seen by Internet support group affiliates as they sought additional aid in addition to their on-line support group. Of those seeking professional assistance (about half of all Internet group respondents), two-thirds saw their bereavement professional six or more times during the previous 12 months. All these data suggest that for a good portion of survivors no single caregiver source fulfills their needs for bereavement support. Many survivors seek a multiplicity of care givers—Internet support group, face-to-face group support and bereavement counselors **at the same time** to help them deal with their loss. And, it also appears that reliance on these alternative help sources does little to diminish their need for Internet support group participation.

WHAT INTERNET SUPPORT GROUP MEMBERS VALUE ABOUT ONLINE PARTICIPATION

Table 3 presents a ranked display showing what Internet support group participants value in their group. Three items stand out as especially noteworthy with more than 80% of respondents indicating these as the most important features of their support group:

1. Offering help to cope with the pain and sadness of loss, (85%);
2. Having a safe place to discuss tabooed topics, (84%);
3. Sharing information and experiences (84%). Several others were ranked at the level of intermediate importance with a range of between 60 and 70% endorsing this as a most important attribute;
4. Having the power and opportunities to discuss grief-related subjects of importance to me, (76%);
5. Having a help source available whenever survivor problems emerge (74%);
6. Memorializing one's lost loved one (73%);
7. Helping advance goals of suicide prevention and better mental health resources availability, (64%);
8. Helping to get through the holidays & other difficult times for survivors, (64%);
9. Being able to help others struggling with suicide loss issues (63%);
10. Learning how to talk about suicide openly and publicly when necessary (62%).

Table 3. Importance of Various Support Group Attributes (*N* = 200)

	Percent listing item as extremely important	Percent calling Internet group best	Percent calling F-to-F best
1. Helping me to better cope with the pain and sadness of loss	85	48	8
2. Having a safe place to discuss tabooed topics	84	57	6
3. Sharing information and experiences	84	51	7
4. Having the power and opportunities to discuss grief-related subjects of importance to me	76	58	8
5. Having a help source available whenever survivor problems emerge	74	63	8
6. Memorializing my lost loved one	73	57	9
7. Helping advance goals of suicide prevention and better mental health resources availability	64	46	7
8. Helping to get through the holidays and other difficult times for survivors	64	48	6
9. Being able to help others struggling with suicide loss issues	63	43	11
10. Learning how to talk about suicide openly and publicly when necessary	62	42	10
11. Gaining spiritual comfort and support	51	34	11
12. Helping to fix family difficulties emerging after a suicide loss	48	35	14
13. Gaining aid from effective leadership that leads discussions along helpful directions	48	40	17
14. Getting help to deal with rejection by family members, friends, co-workers, and neighbors	48	42	8
15. Deciding what to tell children about suicide	38	33	7
16. Maintaining my privacy as I reach out for help and support	37	68	5
17. Making new friendships	26	39	14

On-line Internet SOS Participation Survey, Nov. 2006/Feb. 2007

Seven other attributes were regarded as less important with about half of the sample or less deeming these as most important features of the support group:

11. Gaining spiritual comfort and support, (51%);
12. Helping to fix family difficulties emerging after a suicide loss, (48%);
13. Gaining aid from effective leadership that leads discussions along helpful directions, (48%);
14. Getting help to deal with rejection by family members, friends, co-workers and neighbors, (48%);
15. Deciding what to tell children about suicide, (37%);
16. Maintaining my privacy as I reach out for help and support, (37%);
17. Making new friendships, (26%).

Table 3 also displays the responses to rating whether these same attributes were best addressed in an Internet group, in a face-to-face group, in both equally, or in neither. We report here those who rated the Internet group as best, the face-to-face group as best, omitting the neither and both equally response categories. Results suggested that respondents were highly satisfied with their Internet support group participation. Between 33 to 68% listed the Internet group as the best place for addressing each specific need, while only 5 to 18% rated the face-to-face group as the best place for addressing that need. Even among respondents who were also active participants in face-to-face groups, only about 10% more rated the face-face context as the best choice (for each selected criteria). Among affiliates of both group types, no more than 28% deemed any one of the 17 different features as being best served in a face-to-face context. Hardly anyone, fewer than 5% of all respondents, claimed neither group addressed the 17 selected issues. This was true with three exceptions: helping to fix family difficulties, giving spiritual comfort and support, and deciding what to tell children about suicide. In each of these cases, about 25% regarded the support groups as not helpful in addressing these above issues. This suggests that respondents did not think that support groups could offer much help in these three respects.

Table 3 also shows that about two-thirds of respondents deemed Internet groups as best for: maintaining privacy as they reached out for help; and for having a help source whenever survivor problems emerged. At least for those who were active participants in them, this data generally suggests that Internet support groups were perceived as the best help-providing mechanism, even if they were also participating in face-to-face groups.

We also presented our respondents with a checklist showing their reasons for seeking an Internet group. Six different reasons were presented and respondents could endorse as many as they felt appropriate. The results are displayed in Table 4. Nearly twice as many endorsed 24/7 availability as the most important reason for their affiliation with an Internet support group when compared to the next most frequently endorsed item, the participatory style of the Internet group: (64% as compared to 38%).

Table 4. Responses to the Question:
Why did you seek your Internet support group? (N = 200)

	Percent endorsing this
1. The Internet group is consistent with my personality needs, where having 24/7 availability is needed.	64
2. I like the democratic participatory style of the Internet group.	38
3. I like the structured leadership of the Internet group.	34
4. Leadership does a good job harmonizing the diverse elements within our Internet support group.	34
5. I have no other alternative; there are no face-to-face groups within easy traveling distance.	30
6. I am "turned off" by local face-to-face groups.	25

On-line Internet SOS Participation Survey, No. 266/Feb. 2007

We also included an open-ended section in the Internet survey where respondents could offer additional comments and thoughts about the support group that helped or hindered with their healing. We grouped responses into three types: helpful, hindering and undetermined responses. Tabulations showed that helpful responses outnumbered hindering ones by a margin of at least 2 to 1. Among the more than 200 responses offered, one in particular appeared most important. Fourteen survey respondents offered statements indicating were it not for their Internet group they might have succumbed to the depression, despair and the desires to end their lives following the suicides of their children. Listed are several of the comments offered, typifying these responses:

- A) "I honestly don't know how I would have made it through the months following my son's departure if this Internet support group hadn't existed."
- B) "The Internet group has been there when no one else was or cared. POS is the main reason I am alive today."
- C) "Without the support that I received I would be dead from my own suicide, I have suffered from depression."
- D) "The group helped save my life literally as well as figuratively."
- E) "POS helped me more than mere words can say. I can't even think about how I would be today, if it wasn't for this group."

Hindering responses fell into several different (and sometimes contradictory) types: for some the group was perceived as having an overly Christian faith bias; for others it was felt to be insufficiently spiritual; some complained of too much repetition to the subjects discussed, while others felt they were

overwhelmed by the high volume of different items that were never fully processed. Another common complaint was finding it difficult to get responses to one's postings. Others complained that the support group increased their feelings of depression and sadness, as they dealt with the comments of others who appeared to be stuck in their grief or suffering from multiple suicide losses.

CROSS-TABULAR AND MULTIVARIATE FINDINGS

Table 5 contrasts the demographic characteristics of Internet support group affiliates and those associated with face-to-face self-help groups. Table 5 shows sharp contrasts between the groups. The Internet group included significantly more women, 96% as compared to 80%. Nearly 60% of Internet group members were younger than 55 years of age; this compared to 39% for face-to-face affiliates. Internet affiliates completed less formal schooling compared to face-to-face participants; in the Internet group 31% had a college degree or more professional training, which compared to 43% for face-to-face affiliates. And consistent with their educational differences, fewer Internet affiliates reported high incomes, with 21% reporting family incomes above \$90,000 yearly; this compared to 35% for face-to-face affiliates.

Twice as many Internet affiliates reported having no religious affiliation compared to face-to-face affiliates, 15% as compared to 7%. Internet affiliates were also less likely to participate in any organized religious observances. Twice as many, compared to face-to-face affiliates, reported not attending a religious service during the past 12 months, 32% as compared to 16%.

The comparison between Internet and face-to-face affiliates showed similar patterns of urbanicity for both groups. Numbers of children also showed both groups evenly matched. Yet, two other important demographic differences were noted: in the numbers of people living alone and having been divorced or separated. More Internet affiliates reported being divorced or separated, 31% as compared to 22%. And a remarkably high number, slightly more than half (52%), reported living alone; this contrasted with 19% for face-to-face affiliates. All these contrasting differences were significant at the .05 level with the Chi-square statistic.

Table 6 displays differences in grief difficulties, rates of depression, and suicidal thinking shows more elevated levels of these bereavement problems for the Internet support group members. Over 80% of Internet affiliates reported being depressed when they completed the survey, compared to about 60% of those who belonged to face-to-face groups giving similar reports. Thirty-five percent reported thinking about suicide sometimes or more often during the last year, compared to 23% offering similar reports among face-to-face members. Ten percent more Internet affiliates (17% as compared 7%) reported having a suicide plan during the past year. There were also significant differences reported between

both groups in grief difficulties as measured by our abbreviated Grief Experience Questionnaire. As a group Internet support group affiliates displayed a mean of 44 on this scale, significantly higher than the mean of 38 noted for face-to-face affiliates.

Other important grief differences were noted between these groups. Internet group affiliates consisted of more recent survivors than face-to-face group members, averaging four years since the loss of their child to suicide, compared to six years on average for face-to-face affiliates. Internet affiliates also sustained more stigmatizing responses from family, friends, neighbors and co-workers. Sixty-five percent reported experiencing unhelpful responses from family members, compared to 50% for face-to-face affiliates; 46% experienced unhelpful responses from friends, acquaintances, and coworkers compared to 26% among face-to-face group members; the mean number of post-loss strain responses shown from 11 different groups of close personal associates was 2.4 for Internet affiliates, compared to 1.7 for face-to-face affiliates. All these differences were significant either with the Chi-square probability statistic or mean difference probabilities with the oneway analysis of variance.

As a prelude to a more complex multivariate analysis of the correlates linked to grief difficulties between Internet and face-to-face support group members, we investigated GEQ differences between both groups at varying points since their time of loss. This factor, the length of time passing since a loved one has died, is acknowledged as one of the most important correlates linked to differences in grief difficulties. Table 7 displays these findings. Table 7 showed sharply contrasting patterns of grief difficulties scores for Internet and face-to-face affiliates. For the Internet group over the entire time span range the numbers show a comparatively flat response with GEQ means peaking between the second and third year after loss at 46, and thereafter receding to a low of 42. This represented a nonsignificant difference with a oneway analysis of variance test. By contrast, for face-to-face affiliates GEQ scores peaked during the first year after loss at 44 and steadily declined in subsequent years, eventually to a low of 34, a significant difference. In the last case, we included all other child loss survivors: parents losing children to suicide who did not utilize support groups, and those losing children to other-than-suicide death causes. In these 111 cases GEQ differences peaked during the second and third years and receded eventually to a low of 27, for the longest time period after child loss. These findings suggest that for Internet support group survivors grief difficulties did not show the same pattern of abatement over time that they did for the other two survivor subgroups.

Unfortunately, our foregoing analysis does not enable us to safely conclude whether the greater grief difficulties found among Internet affiliates is associated with any deficiencies from this type of support system, whether it is related to their demographic uniquenesses, the relative short-term nature of their loss experiences, the greater stigmatization from their families and other personal associates or all/or any of the above. For this multivariate regression analysis is

Table 5. Demographic Characteristics of Internet and Face-to-Face Support Group Affiliates ($N = 401$) Percent/ N

	Internet	Face-to-face	χ^2/df	p Value
Gender				
Male	4/4	20/58		
Female	96/100	80/239		
Total	100/104	100/297	14.5/(1)	.0001
Age				
35 or younger	1/1	0/0		
36-45	9/9	5/16		
46-55	49/51	34/101		
56-65	35/36	42/125		
66 or older	7/7	19/55		
Total	100/104	100/297	16.8/(4)	.002
Education				
High school graduate or <	10/10	13/38		
Some college, technical education	44/46	44/132		
College graduate	13/13	20/60		
Postgraduate	18/19	23/67		
Total	100/104	100/297	10.4/(3)	.02
Family income				
20K or less	10/10	5/15		
Over 20K & < 40K	16/16	18/53		
Over 40K and < 60K	21/22	22/64		
Over 60K and < 90K	33/34	20/58		
Over 90K and < 120K	11/11	16/46		
Over 120K	10/10	19/54		
Total	100/103	100/290	13.4/(5)	.02
Religion				
Protestant	31/32	40/118		
Catholic	25/26	27/80		
Jewish	4/4	8/23		
Other	25/25	18/52		
None	15/15	7/20		
Total	100/102	100/293	10.5/(4)	.03

Table 5. (Cont'd.)

	Internet	Face-to-face	χ^2/df	p Value
Frequency of religious attendance				
Never	31.7/32	15.5/46		
Yearly	28.7/29	23.0/68		
Several times yearly	7.9/8	14.2/42		
Monthly	5.0/5	3.4/10		
Several times monthly	6.9/7	11.5/34		
Weekly or >	19.8/20	32.4/96		
Total	100/103	100/296	19.5/(5)	.002
Residence				
Urban	20/21	19/55		
Suburban	36/37	34/100		
Small city	21/22	28/83		
Small town or farm	22/23	19/57		
Total	100/103	100/294	1.9/(3)	.597
Current marital status				
Married	66/67	69/205		
Divorced	25/26	20/59		
Separated	6/6	2/5		
Never married	0/0	1/3		
Widowed	3/3	8/25		
Total	100/102	100/297	10.4/(4)	.034
Total number of children ever had (adopted, biological, steps)				
One	8/8	7/20		
Two	29/30	36/107		
Three	26/27	30/89		
Four or more	37/38	27/78		
Total	100/103	100/294	4.5/(3)	.212
Present living arrangements				
Lives with others	48/87	81/242		
Lives alone	52/93	19/55		
Total	100/180	100/297	57.5/(1)	.0001

Table 6. Time Since Loss, Stigmatization, Adaptations, and Grief Difficulties among Internet and Face-to-Face Support Group Affiliates ($N = 401$)
Percent or Mean/ N

	Internet	Face-to-face	χ^2/df	p Value
Mean years since loss ^a	4.1/104	6.1/292		
Depression				
No	17/18	38/114		
Yes	75/78	54/161		
No because of antidepress. meds.	8/8	7/22		
Total	100/104	100/297	16.0/(2)	.0001
Frequency thought about taking your life during past 12 months				
Never	49/50	65/189		
Rarely	17/17	12/36		
Sometimes	19/20	17/49		
Frequently	11/11	4/13		
Very frequently	5/5	2/5		
Total	100/103	100/292	12.4/(4)	.015
Had plan for suicide in past 12 months				
No	83/85	93/271		
Yes	17/17	7/21		
Total	100/102	100/292	7.8/(1)	.005
Attempted suicide in past 12 months				
No	97/100	99/285		
Yes	3/3	1/4		
Total	100/103	100/289	1.0/(1)	.315
Mean Grief Experience Questionnaire score (GEQ) ^a	43.9/98	38.4/272		
Experienced unhelpful responses from any family members				
No	35/36	50/149		
Yes	65/68	50/148		
Total	100/104	100/297	7.5/(1)	.006
Experienced unhelpful responses from any coworkers, friends, or acquaintances				
No	54/56	74/220		
Yes	46/48	26/77		
Total	100/104	100/297	14.7/(1)	.0001
Mean total of stigmatizing responses from all personal associates ^a	2.4/104	1.7/297		

^aOne way mean analysis yielded F probability of $< .001$.
Child Loss Survey, March 2006/May 2007

Table 7. Oneway Analysis of Variance of Grief Difficulties (GEQ Scores) by Time Since Loss among Internet, Face-to-Face Support Group Affiliates and All Others ($N = 478$)

Time since loss	Mean	Std. Dev.	Freq.	F Signif. Probability
Among Internet Affiliates ($N = 98$)				
Less than 1 year	43.3	12.1	7	.64
1.01–3 years	46.0	9.4	39	
3.01–5 years	42.4	10.5	22	
5.01–9.9 years	42.8	11.6	24	
10 or more years	41.5	11.4	6	
Among face-to-face affiliates ($N = 269$)				
Less than 1 year	43.8	9.5	22	.001
1.01–3 years	43.0	9.4	78	
3.01–5 years	37.2	10.2	46	
5.01–9.9 years	35.7	10.6	72	
10 or more years	34.1	11.0	51	
Among all other child loss survivors ($N = 111$)				
Less than 1 year	41.8	12.1	19	.001
1.01–3 years	44.6	12.4	29	
3.01–5 years	33.4	10.9	15	
5.01–9.9 years	37.7	10.7	25	
10 or more years	27.0	9.9	23	

Child Loss Survey, March 2006/May 2007

needed to begin to disentangle the pattern of associations between all potential predictor variables and to discern their associations with differences in grief difficulties.

Table 8 begins this task of disentanglement as we examine the interplay between all significant bivariate demographic correlates of grief difficulties and Internet vs. face-to-face affiliation in the same model. In this analysis Internet/face-to-face membership still remains a significant predictor of GEQ differences when demographic variables were included. In this multivariate model three other demographic factors remained significant: gender, age, and the frequency of religious participation. Religious affiliation, educational differences, marital status differences, income differences and living alone were found to be redundant to this model and were dropped in the more complete multivariate model that appears next.

Table 8. Multiple Regression Analysis of Grief Difficulties (GEQ Scores) by Support Group Type and Various Demographic Attributes

Independent variables	Beta	<i>p</i>	Number of obs = 358		
			<i>F</i> (9, 348) = 10.22		
			<i>R</i> -squared = .21		
Internet/face-to-face	-.112	.028			
Gender	.146	.005			
Age	-.254	.001			
Education	-.063	.230			
Religion	.067	.181			
Frequency of religious attendance	-.140	.006			
Marital status	.060	.317			
Family income	-.024	.681			
Live alone	-.024	.679			

p = Level of significance
Child Loss Survey, March 2006/May 2007

In Table 9 we introduce two new important and potentially confounding variables into the multivariate analysis: the time since loss, and the stigmatization/strain variables. In this new equation we also include the carryover significant demographic predictors from Table 8, and the type of support group experience, and combine these in a new multiple regression analysis. The new equation has a modest predictive power, accounting for 31% of the fluctuations of grief difficulties. In this equation six variables were significantly associated with the dependent variable: the total strain/stigmatization score, the unhelpfulness of friends, the time since loss, gender, age, and religious attendance. In this equation certain groups showed higher grief difficulties than others: men over women, younger people over older people, the religiously inactive over the religiously active, and shorter term bereaved over longer-term bereaved. In this equation the type of support group experience—whether Internet or face-to-face—became redundant in the presence of these other more powerful predictors. In this equation the stigmatization/strain variables alone accounted for the largest portion of explained variance, 10%.

The last table we present, Table 10, addresses the differences in Internet support group participation. We have taken all significant correlates of current Internet support group membership from Tables 6 and 7 and correlated them with amounts of Internet participation during the past 12 months. Consistent with the hypothesis

Table 9. Multiple Regression Analysis of Grief Difficulties (GEQ Scores) by Support Group Type and Various Demographic Attributes, Time Since Loss and Stigmatization Experiences

Independent variables	Beta	<i>p</i>	Number of obs = 364		
			<i>F</i> (9, 348) = 19.67		
			<i>R</i> -squared = .31		
Internet/face-to-face	-.041	.389			
Gender	.125	.007			
Age	-.190	.001			
Frequency of religious attendance	-.155	.001			
Time since loss	-.151	.002			
Family unhelpful	.092	.066			
Friends/acquaintances unhelpful	.110	.022			
Total stigmatization score	.210	.001			

p = Level of significance
Child Loss Survey, March 2006/May 2007

expressed in the introduction, we expected rural and small city residents to be more actively involved in the Internet support group than big city or suburban residents. No significant association was obtained demonstrating such a pattern with the correlation analysis nor with a Chi-square significance test (that is not displayed here). In fact, there seemed to be a nonsignificant trend with both of these tests in the opposite direction of our hypothesis showing urban residents to be more actively involved in the Internet support group, as compared to those from all other residence categories.

Otherwise, Table 10 shows the following groups more actively involved in Internet support group participation: people with less formal education, those whose friends and acquaintances responded unhelpfully to their loss and those whose family and friends displayed more overall strain/ stigmatization to their loss event. Thus, it appears that the Internet support group is a refuge for these types of people in particular. It is interesting to note that neither the time since loss nor grief difficulties per se showed any apparent association with Internet group involvement.

DISCUSSION

This exploratory study of Internet support group affiliates of parents who sustained the loss of a child to suicide has yielded some unexpected findings.

Table 10. Bivariate Correlations of Time Spent Participating in Internet Support Group by Various Demographic Attributes, Time Since Loss, and Stigmatization Experiences

Independent variables	Correlation Coeff.	<i>p</i>
Residence: Urban/rural	-.158	.09
Gender	.100	.29
Age	-.01	.91
Education	-.198	.03
Religion	-.02	.83
Frequency of religious attendance	.04	.65
Living alone	.04	.54
Marital status	.07	.46
Time since loss	-.149	.13
GEQ score	.07	.46
Family unhelpful	.15	.10
Friends/acquaintances unhelpful	.18	.05
Total stigmatization score	.20	.035

p = Level of significance
Child Loss Survey, March 2006/May 2007

Previous discussions of Internet support groups suggest that these groups have particular appeal to clients living in remote rural locations, who may be beyond the reach of face-to-face support group alternatives and professional support services. This research has failed to confirm this supposition. The present findings showed similar percentages of rural, small city, and larger metropolitan residents affiliated with Internet and face-to-face alternatives. We found as many Internet group members from big city locations like New York, Baltimore, Philadelphia, or Denver, and their surrounding suburbs as we did for face-to-face support group affiliates. It is also interesting to note that many Internet group members participate in face-to-face groups, as well.

In addition, there was little variability in the rates of support group participation across differences in places of residence. Instead, what appeared to be associated with higher Internet participation was being unable to gain support and comfort from family and friends. Those who joined an Internet support group, and who spent more time on-line participating in it, were more likely to have encountered unhelpful responses from family and friends and greater stigmatizing/strained

responses from their entire social circles. It seems plausible that as a barricade of disinterest and rejection was established within survivors' personal communities, they felt impelled to seek comfort, validation and support within the Internet group.

Another noteworthy finding from this investigation was the revelation of support group member benefits. Although a minority of affiliates, 30%, saw their Internet group as the only viable alternative because of lack of access to any support services, about two-thirds of all respondents perceived the most important benefit of the group to be its 24/7 availability. This factor led all others by a large margin in creating the preference for this type of support system. Another less clearly articulated benefit experienced by Internet support affiliates was the opportunities it presented for more extensive support group involvement. Approximately half of all Internet respondents spent six or more hours **weekly** in support group participation. If survivors had seen a bereavement counselor on a weekly basis and attended two different monthly face-to-face support group meetings, they still would have found it difficult to rival this high level of support group participation. Internet support groups offers members nearly limitless availability for participation. This also appeared to contribute to its distinctive appeal.

Bivariate and multivariate analyses also suggested that survivors with distinctive demographic characteristics were over-represented in this group. When multivariate controls were applied, more women, younger survivors, and those less connected to conventional religious observances were over-represented, compared to their face-to-face counterparts. Survivors who lived alone, who were divorced or separated, with lower incomes and with less formal schooling were also more likely to be among the Internet affiliates. We must keep in mind this exploratory research is based on the affiliates of a single Internet survivor support group, the Parents of Suicide. Whether these patterns will hold among samples of non-parent suicide survivors and among parent survivors of different Internet support groups will remain a task for future research.

Our data also bear on the question of the helpfulness of Internet support groups in enhancing the adaptations of survivors of child suicide loss. From several angles, the evidence was unmistakably clear that respondents perceived considerable benefits from their Internet support group experience. Even though more than half of all respondents had exposure to face-to-face support groups, fewer than 18% of all respondents rated them best on the 17 different criteria of potential support group benefits, while anywhere from 33 to 68% rated the Internet group as best on these same criteria. As respondents expressed it in their evaluations of different support group benefits, two different advantages stood out: being able to maintain one's privacy while reaching out for help and having a help source available whenever survivor problems emerged. Approximately two-thirds appreciated these particular features of their Internet experience.

From the open-ended part of our survey respondents reported more helping responses from the support group versus hindering ones in a ratio of 2 to 1. Only six respondents remarked that the Internet support group participation contributed to worsening their feelings of depression, while 14 others commented that they perceived this group as their lifesaver, helping them to stay alive after having come to their lowest point of depression and despair. With 80% of support group members describing themselves as presently depressed, and 35% harboring suicide thoughts sometimes or more often during the past year, the significance of these lifesaving remarks takes on additional meaning. At least in this sample, the Internet group participants appear to be more depressed, socially isolated, and a more suicidal group of survivors, for whom a traditional “twice a month” support group format is likely to be insufficient. The participants also reported that, contrary to concerns that are sometimes raised about the safety of anonymous social contact through the Internet, these survivors overwhelmingly found the Internet group to be of great benefit. Again, as more research is completed among more representative samples of suicide survivors, we will be better able to judge whether the evaluations given by these groups members are typical for Internet affiliates generally.

Our cross-sectional survey data does not enable us identify the chain of causal forces affecting the differences in grief difficulties. This remains a task for future longitudinal study. Yet, for now, we see a possible association between the intensification of grief difficulties survivors encountered as they have difficulty gaining acceptance and bereavement support from families and other personal acquaintances and their affiliation with an Internet support group. The greater failure of their personal communities to provide emotional comfort and support, at their most vulnerable time after loss, may have helped to engender the need for greater support group participation. What distinguished Internet affiliates from their face-to-face counterparts in bivariate analysis—higher grief difficulties—did not yield additional information when stigmatization differences were included in the same multivariate model, suggesting that greater stigmatization—and not Internet membership per se—accounted for these differences. Of course, since our data is only correlational in nature, it is also possible that the directionality of the causation may be reversed. That is, rather than being “rejected” by their social networks, people who have more difficulty in relationships in general, or in seeking social support from family and friends after the suicide, may then seek out a more anonymous arena for social interaction where they are more able to elicit the support that they need in a way that is better suited to their personality and coping style. Again, future studies will need to clarify this issue, one that likely involves a complex and interactive process that leads to a failure of face-to-face bereavement support.

It should also be noted that the unhelpful and unsupportive responses from family and friends, following a suicide loss, appears to be associated not only with heightened grief difficulties but also with more depression and suicidality

among survivors. For example, those respondents who experienced strain from two or more relationship groups showed 50% higher levels of depression, compared to those experiencing no negative responses in their personal relationships. Thus, stigmatization and strain may put the suicide survivor at a higher risk for mental health problems including their own suicidality. It will be a task for future research to verify whether the patterns demonstrated here, from data collected on this single case of parent survivors relying upon a particular Internet support group also apply more broadly to different loss relationship situations and to other parents sustaining the untimely losses of children.

Another worthwhile finding produced by this research can be found in the ratings of perceived support group benefits shown in Table 3. At the highest level of importance there appeared to be themes of personal help and coping assistance, offering an open and safe place and sharing information among survivors as the quintessentially important elements of support group membership. At the second level, gaining intermediate levels of endorsement, additional themes of helping others emerge, helping to prevent suicide in the larger society and becoming more skillful advocates. We suspect as survivors endure the early acute difficulties of survivorship, greater concern for promoting the secondary set of goals increases, while the first set remains paramount for the newly bereaved. These ideas are often shared in the survivor community as suicide prevention change agents reflect upon how, where and when they may gain additional adherents from the larger survivor community. We see investigating these values and their adherents among different subsets within the survivor community as another especially worthy task for future research.

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