

**PERSONAL GROWTH AFTER A SUICIDE LOSS:
CROSS-SECTIONAL FINDINGS SUGGEST GROWTH
AFTER LOSS MAY BE ASSOCIATED WITH BETTER
MENTAL HEALTH AMONG SURVIVORS**

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ABSTRACT

With a diverse sample of 462 parent survivors of their child's suicide we explored the association of the personal growth subscale of the Hogan Grief Reaction Checklist (HGRC) with mental health problems among longer-term survivors. In this article we offer additional validation for this scale's association with longer-term survivorship and reduced grief difficulties. We also demonstrate its negative relationship with mental health problems. In addition, we explore the demographic correlates of personal growth, which are likely to enable some survivors to experience personal growth sooner than others. Overall, the findings suggest that personal growth represents an important part in the process of healing after suicide loss.

INTRODUCTION

With little forewarning, Susan and Michael Wallach lost their 18-year-old son Jeremy to suicide about 8 years ago and have been struggling ever since

to rebuild their lives. Susan, a high school guidance counselor, found warm and supportive responses from her colleagues at the local school where she works. Her husband, Michael, an ophthalmologist, also gained much solace and support from his colleagues and their many friends in the upscale suburban community where they reside. After seeing several bereavement counselors and attending survivor support group meetings during their first 3 years after the loss, the Wallachs became interested in participating with the American Foundation for Suicide Prevention (AFSP). An idea percolated in their discussions with AFSP personnel to do a fund-raising event in their local community, raising money to making an educational film on depression and suicidality among high school students. With support from some of their close friends and family, the Wallachs staged a fund-raiser at their local temple and succeeded in collecting over \$200,000 to help finance an educational film. Now, the Wallachs still remain active in AFSP fund-raising efforts, serving on the planning committee of their local AFSP chapter's annual fund-raising memorial walks. Now, neither Michael nor Susan see counselors or attend local support group meetings. They still feel great sadness and pain over the loss of Jeremy, but feel they have turned their family's personal tragedy into "making a difference," by joining with others in combating the problem of youth suicide.

After a long and torturous course of trying to get help for their young adult son Vinny Jr., Vinny and Patti Lombardo experienced his tragic suicide by hanging 10 years ago at age 31. Afterwards, the couple never relied much on professional bereavement counseling resources but found great comfort and help in support group participation. They became part of a group of co-founding parents of a new support group with 12 other parents who lost children to suicide around the same time they lost Vinny Jr. Their support group participation extended beyond attending monthly meetings, occasionally taking vacation trips together, and marking dreaded holiday events with one another. As time passed, Patti found that continued support group participation brought her down mentally, but Vinny continued to stay active, regularly attending meetings. Recently he underwent training to become a first responder and has already made several visits to newly bereaved families under a grant that local politicians funded in his community. At support group meetings, he usually makes important contributions to help newly bereaved survivors learn that grief becomes more manageable as time after loss passes. He feels that veteran survivors like him have an obligation to "give back" to the newly bereaved. For him the support group has been the cornerstone of his recovery and well being. For the foreseeable future, he expects to remain active in helping the newly bereaved "get to a better place."

With these two illustrations we pose two important questions: Are the caring and compassionate responses of these survivors in anyway typical of longer-term survivors? And secondly, are their actions in any way linked to fewer mental health problems among longer-term survivors? These questions will be explored in the present article. In the bereavement literature, the assumption of

a caring and compassionate orientation is known as personal or post-traumatic growth (Hogan, Greenfield, & Schmidt, 2001).

In the professional bereavement literature there has been much discussion of the idea of grief to growth, and of the functional adaptations emerging among the bereaved after a tragedy. A common claim made in this literature, such as the one made by Tedeschi and Calhoun (2004), is the idea that grief and trauma present a survivor with a transformative potential, leading them to eventually take their post-traumatic stresses and change them into post-traumatic growth. A large number of articles devoted to the grief to growth theme will be found in an excellent review article by Schaefer and Moos, entitled "Bereavement Experiences and Personal Growth" (in Stroebe, Hansson, Stroebe, & Schut, 2001). Some studies have approached these subjects in more general and theoretical terms, often drawing upon illustrative case study materials (see, for example, Nadeau, 1998; Nerken, 1993; Shapiro, 2008; among others), while others have approached them from a survey research standpoint, investigating larger numbers of bereaved individuals, usually with established instruments systematically measuring personal growth. The two most widely employed instruments measuring personal growth are Tedeschi and Calhoun's Posttraumatic Growth Inventory (1996) and the Hogan Grief Reaction Checklist (Hogan et al., 2001).

As Schaefer and Moos (2001) point out, the grief to growth transition is likely to go forward differently depending upon the relationship a bereaved person had with the deceased. The loss of a child will bring a survivor along different recovery pathways, when compared to other types of losses, such as with the loss of a spouse, parent, or sibling. Our intent is to focus this article upon parents who have lost children to suicide. There is a fast-mounting research literature emerging about the adaptations of parents losing children with the two established scales of personal growth: (see, for example, Dyregrov & Dyregrov, 2008; Dyregrov, Nordanger, & Dyregrov, 2000; Polatinsky & Esprey, 2000; Riley, LaMontagne, Hepworth, & Murphy, 2007; Wagner, Knaevelsrud, & Maercker, 2007). Yet, only one study focused explicitly upon the personal growth occurring among parents following losses of children to sudden and unexpected death causes: e.g., suicide, accidents, and SIDS (Dyregrov & Dyregrov, 2008). The Dyregrovs found a majority of their Norwegian respondents experienced positive personal changes or personal growth after loss.

For the present report we sought to investigate the growth experiences of parents following the loss of a child to suicide exclusively. We also employed the less utilized scale of personal growth, the Hogan Grief Reaction Checklist. The Hogan Grief Reaction Checklist (HGRC) consists of a variety of scales measuring important elements in the grieving process. Among them is a subscale for personal growth claimed to emerge at a later point of the grieving process. The authors assert that personal growth is an integral component of bereavement. In their ground-breaking article they found longer-term survivors scored higher on

personal growth than the newly bereaved. They also noted an inverse association between personal growth scores and measures of grief difficulties, post-traumatic stress, and complicated grief. The HGRC personal growth subscale consisted of 12 questions probing whether survivors felt they had become more tolerant, compassionate, caring, and better persons following the loss of a loved one.

There has been limited work with the Hogan personal growth scale. In one study Gamino, Sewell, and Easterling (2000), with a sample of 85 mourners, found those scoring higher on the scale were more likely to experience “adaptive grieving,” which meant that they were more likely to see some good come from a death, had a chance to say goodbye to the decedent, experienced intrinsic spirituality, and had spontaneous positive memories of the decedent. Hogan and Schmidt (2002) also tested their theory of grief to personal growth with structural equation modeling, and found evidence of emergent personal growth following a loss with their cross-sectional data.

In the present work we sought to replicate the important findings of the personal growth and grief-difficulties’ associations with a sample of parent suicide survivors. We also sought to further investigate the interrelations between personal growth and survivor mental health. A recent study using the Hogan Personal Growth subscale, with a small sample of predominately newly bereaved parent survivors, found suggestive evidence of more optimism and adaptive coping among respondents scoring higher on personal growth scale (Riley et al., 2007). These findings suggested to us that those scoring higher on personal growth would show better mental health than their lower scoring counterparts. In the present work we also sought to better identify the demographic and other social correlates associated with personal growth. If personal growth represents an important part of a survivor’s mental health and healing, then a better understanding of its dynamics and social bases seems essential for clinicians’ efforts to help bereaved patients move most expeditiously toward healing after loss.

DATA SOURCE AND METHODS

Although most suicide bereavement research has been conducted among bereaved family members in clinical care settings, this study aimed to better represent suicide survivors in the community-at-large who utilize peer support groups. Thus far, only one survey research has been conducted specifically with this population (Callahan, 2000). Using the listings of support groups from the American Association of Suicidology (AAS) and the American Foundation for Suicide Prevention (AFSP) we attempted to include support group members from most regions of the country. Initially several facilitators were contacted and were asked either to furnish their membership lists or to publicize information about the study at meetings in their newsletters or on their electronic list serves. Typically, support group facilitators posted announcements in their newsletters calling for volunteers to participate in a confidential and anonymous survey of

survivors. Volunteers were directed to contact the first author who was identified as both a sociologist and a survivor of his son's suicide.

For the sake of analytic simplicity, we confined this study to parent survivors of child loss. We also made similar contacts with chapters of Compassionate Friends groups to contrast the parent suicide survivors with parents losing children from other-than-suicide-death causes. We also sought to include suicide survivors utilizing Internet based support groups. Two such groups were contacted and furnished respondents: the Parents of Suicide Support Group and the Parents Grieving Children of Suicide Group. The present survey is the first ever to investigate survivor support affiliates using the Internet.

Several newsletters and list serves played crucial roles in circulating information about our survey: the SPAN USA list serve, the Friends For Survival Inc. Newsletter, and the "Surviving Suicide" Newsletter published by AAS. These reached large audiences of survivors and clinicians. In addition, several bereavement counselors and psychologists also asked to distribute copies of the survey among their patients. Also, many survivors spontaneously offered names of additional respondents who they thought would want to complete the survey.

When the data collection concluded, 754 surveys were sent out and 540 surveys were returned, yielding a response rate of 72%. We thought this was a more than satisfactory return rate, considering the difficulty of conducting surveys on grief issues and considering the length of research instrument, a 27-page mailed survey form. Typically in mailed questionnaire surveys responses rates usually fall below the 60% mark (Hopkins & Gullickson, 1992; Kaplowitz, Hadlock, & Levine, 2004; Smith, 1995). Nonetheless, despite the high willingness of respondents to participate in this research, and their diversity of origins (support groups, clinical patient rosters, newsletter, and listserv subscribers), we cannot claim that this sample is representative of the U.S. parent survivor population. Only a sample drawn from a systematic follow-back of all suicides listed as such in official death records would be able to advance that claim. All that can be said about this sample is that it comprised a very diverse group of volunteers who were all survivors of child loss. In some instances when a support group was selected to participate in the survey, between 80 to 90% of its parent members elected to complete our surveys. In other cases, participation rates for the selected support group fell to a 50% participation rate. The same can be said about respondents that came to us from cooperating clinicians. In one case, all current patients of one therapist (that met study criteria) completed our survey. And in another case, only 40% of that particular clinician's active patients completed this survey. We had no way of knowing what the response rates could have been for those learning of our survey from newsletters, listservs, or the Internet support group. In each case we didn't know whether the people named on the lists were currently active members, whether they continued to read their mail and/or whether they met study criteria.

By drawing our sample primarily from the ranks of those with past or present affiliations to support groups, there may also have been a bias toward over

representing survivors with more mental health difficulties. Levy and Derby (1992) presented evidence suggesting that support group affiliates are likely to have more mental health problems than other survivors not using these resources. We sought to correct this possible bias in the following manner. Almost every respondent was asked, in the course of our data collection, to furnish their e-mail addresses, and approximately 400 e-mail addresses were collected from this solicitation. Toward the end of data collection all survey respondents were sent an e-mail asking if they knew of another child loss survivor who, to the best of their knowledge, had *not* used support groups or seen a professional mental health or bereavement counselor. The respondent was asked to contact this additional person, and upon obtaining that person's permission, they, in turn, were sent survey kits. Eight more respondents became survey respondents from these additional recruitment efforts. When the data collection concluded, 31 respondents in our sample reported never having participated in peer support groups or any form of professional bereavement support. Further, a total of 125 respondents, 23% of the total, reported no peer support participation or professional counseling experiences during the past 12 months.

CHARACTERISTICS OF THE SAMPLE

Our mostly support-group-based sample included 540 respondents. In the sample, females outnumbered males by a large margin of 85% to 15%, respectively. Seventy-three percent of the respondents were between the ages of 46-65; 19% were 66 or over; and 8% were of ages 45 or under. The sample also over-represented upper-status respondents: 33% had household incomes of \$90,000 or higher; 43% had incomes between \$40,000 and \$90,000; and 24% with incomes below \$40,000. Fifty-one percent of our respondents reported having managerial or professional occupations; 41% reported completing 4 or more years of college; 42% reported some college; and 17% had high school degrees or less schooling. Thirty-six percent reported having a Protestant affiliation; 26% Catholic; 10% Jewish; and 19% were affiliated with other faiths. The remaining 9% had no religious affiliation. Ninety-five percent of respondents were U.S. born, 94% were White; and 6% were from all other races. Respondents came from every state in the United States and seven others from Canada.

Of the 540 cases, survivors of suicide outnumbered all others at 86% (462 cases). Among the non-suicide loss survivors, there were 45 cases of accidental death survivors, 24 natural death survivors, 4 survivors of homicide deaths of their children, and 5 cases of survivors of deaths under ambiguous circumstances. Nine percent had sustained their loss within the last 12 months, 40% between 1 and 4 years earlier, 30% had lost a child between 4 and 10 years previously, and the balance, 21%, had lost a child more than 10 years ago. Seventeen respondents reported sustaining multiple untimely death losses in their families of either two children to suicide, the loss of a child and a partner to suicide, or some other

combination of accidental and/or natural death losses of nuclear family members. Decedents ranged in age from 8% being 15 or younger, 20% between 16 and 21, 36% between 22 and 28, 17% between 29 and 35, and 10% over 36. Clearly, adolescent and young adult deaths predominated in our sample, with over 80% of respondents reporting the loss of a son or daughter between ages 16 and 35. For this article we focused exclusively on the 462 parents that sustained the loss of a child to suicide.

MEASUREMENTS

We included items with the highest factor loadings from the 12 item array of personal growth questions on the Hogan Grief Reaction Checklist (HGRC; Hogan et al., 2001). The seven included items had factor weightings ranging from .66 to .74, while the five excluded items had weightings from .48 to .56. The included items were as follows: “I have learned to cope better with life”; “I feel as though I’m a better person”; “I have a better outlook on life”; “I have more compassion for others”; “I am stronger because of the grief I have experienced”; “I care more deeply for others”; “I am a more forgiving person.” These seven items yielded an alpha coefficient of .91 in our sample. Four hundred thirty-five respondents offered useable responses to this abbreviated personal growth scale where responses ranged from a low of 7 to a high of 35, with a mean of 24.4 ($SD = 7.07$). Response items were in a Likert-scale format with 5 points of agreement to disagreement. To enhance comprehension throughout this analysis we also refer to this scale as PG.

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 Complicated Grief Scale (Prigerson, 2002), with correlation coefficients above .70. We also administered the Complicated Grief and Impact of Events Scales to respondents. The brief GEQ scale was answered by 426 (suicide survivor) respondents, with mean score of 40.2 ($SD = 11.1$) and ranged from 16 to 80. The Complicated Grief Scale was answered by 437 respondents, yielding a mean of 28.0 ($SD = 9.0$) and ranged from 11 to 51. The Impact of Events Scale was answered by 420 (suicide survivor) respondents, with a mean of 33.5 ($SD = 8.9$) and ranged from 14 to 56. Offering our respondents a 27-page survey instrument seemed to necessitate reducing the GEQ and PG scales to their most essential elements, lest we run the risk of losing respondents’ cooperation. To enhance readability

throughout, we also refer to the grief difficulties scales as follows: abbreviated Grief Experience Questionnaire, as GEQ; Complicated Grief Scale, as CG; and Impact of Events Scale, as IES.

An index of personal psychological problems was created for this study from several questions that had been given to respondents in the Mid-Life Development Survey (MIDUS), a national survey of the middle-aged and older American population (Wethington, Kessler, & Brim, 1998). The survey asked respondents to self-rate their mental or emotional health: "How about your mental or emotional health? Is it poor, fair, good, very good, or excellent?" They were also asked a depression screener question: "During the past year was there ever a time when you felt sad, blue, or depressed for 2 weeks or more in a row? 1) yes; 2) no; 3) not depressed because of anti-depressant medication." Survey respondents were also asked to count the number of days in the past 30-day period where they were unable to go to work or carry out normal household activities (and had to cut back) because of mental health difficulties. In addition, they were also asked a life satisfaction question: "At present, how satisfied are you with your life? A lot, somewhat, a little, or not at all/none at all." We administered these same questions to our respondents and found responses associated with one another with correlation coefficients ranging from .18 to .51. Summing the responses together of

1. poor or fair mental health reports;
2. self-reported depression;
3. one or more days lost to work or housework during the past 30-day period; and
4. life satisfaction reports of little or not at all satisfied

placed respondents along a continuum from 0 to 4 along our mental health problems scale, which yielded a Cronbach's alpha of .70. Four hundred forty-seven suicide survivors offered useable responses on the mental health problems scale, with a mean of 1.67 ($SD = 1.3$) and ranged from 0 to 4. Our shorthand abbreviation for this scale was PPS.

Respondent suicidality was measured by three items:

1. Suicide thoughts: "How often during the past 12 months did you think about taking your own life?" Respondents could answer from 1 to 5 (almost never or never; rarely; occasionally; frequently; or very frequently). Respondents reported rare to occasional suicide thoughts ($M = 1.79$, $SD = 1.12$).
2. Suicide plans: Respondents were asked whether they had made any specific plan for suicide during the past 12 months. Eleven percent of respondents ($n = 56$) reported, to a "Yes"/"No" question, making a suicide plan during the year prior to the survey.
3. Suicide attempts: Similarly, nine respondents (1.7%) reported making suicide attempts during the previous 12 months.

The participant observation data presented in this article was collected over a 5-year period by the first author. It was collected from regular attendance at the meetings of a single peer support group that met on a monthly basis. These observations were verified by a second observer, in attendance at these same meetings who was a trained behavioral analyst, and a clinical social worker. All personally identifying information about respondents mentioned here has been changed to protect respondent privacy and confidentiality.

RESULTS

Table 1 presents a correlation matrix for many of the important variables explored in this investigation: personal growth (PG), brief GEQ scores of grief difficulties (GEQ), time since the loss, mental health problems scores (PPS), and reported suicide thoughts, plans, and attempts. The matrix shows all variables significantly related to each other with one exception: suicide attempts and time since the loss. Personal growth scores (PG) are positively associated with time since the loss; personal growth (PG) is inversely associated with suicidality, grief difficulties (GEQ) and mental health difficulties (PPS). As expected, our mental health problems indicator (PPS) was positively associated with grief difficulties (GEQ) and suicidality and inversely associated with time since the loss and personal growth (PG). Some of the associations were relatively strong, such as the relationship between mental health problems and grief difficulties (.61) and suicide thoughts (.54). Some of the associations with suicide plans and attempts were relatively weak. The relative weakness of associations with suicide plans and attempts probably reflects the relative rarity of these experiences among our respondents. Only 11% of suicide survivors ($n = 51$) reported suicide plans in the past year and 2% reported a suicide attempt ($n = 9$). Personal growth scores (PG) showed modest correlations with most of the mental health, suicidality, and grief difficulties variables and time since the loss (ranging at the .30 to .40 level).

We also investigated whether personal growth (PG) was simply a reflection of a lack of grief difficulties or mental health problems, or whether it stood alone and made independent contributions to explaining the variability in suicidality among parent survivors. To probe this we created a multiple regression equation with the frequency of suicide thoughts as the dependent variable and grief difficulties (GEQ), mental health problems (PPS), and personal growth (PG) as independent variables. We also included in the same equation another important confounder of grief difficulties: time since the loss. Results are displayed in Table 2. The model explained 38% of the variance in suicide thinking. All independent variables contributed additional variance to this model except time since the loss. We also re-ran the same equation omitting personal growth (PG), which resulted in a statistically significant, 4%, drop in explained variance, showing its own dynamic importance in this analysis.

Table 1. Correlation Matrix of Primary Variables in This Study (N = 462)

	Personal growth (PG)	Years since loss	Suicide thoughts	Suicide plans	Suicide attempts	GEQ scores	Mental health diffs. (PPS)
Growth (PG)	1.0000						
Years since loss	0.2979 0.0000	1.0000					
Suicide thoughts	-0.3969 0.0000	-0.2474 0.0000	1.0000				
Suicide plans	-0.1810 0.0002	-0.1561 0.0009	0.6191 0.0000	1.0000			
Suicide attempts	-0.1198 0.0133	-0.0847 0.0741	0.2983 0.0000	0.3577 0.0000	1.0000		
GEQ scores	-0.3618 0.0000	-0.2583 0.0000	0.5244 0.0000	0.3092 0.0000	0.2233 0.0000	1.0000	
Mental health diffs. (PPS)	-0.4216 0.0000	-0.3370 0.0000	0.5372 0.0000	0.3140 0.0000	0.1729 0.0003	0.6136 0.0000	1.0000
Correlation coefficient/P values							

Source: Survivors Child Loss Survey, 2006-2007.

Table 2. Multiple Regression Analysis of Suicide Thinking by Grief Difficulties (GEQ Scores), Mental Health Problems, Personal Growth Score, and Time Since the Death

Number of obs = 388		$F(4, 383) = 59.5$ $R\text{-squared} = .38$	
Independent variables	Correl Coeff.	Beta	<i>P</i>
GEQ Score	.52	.26	.0001
Personal Growth (PG)	-.40	-.18	.0001
Years Since Death	-.25	-.02	.58
Mental Health Problems (PPS)	.54	.30	.0001

Note: *P* = Level of Significance

Source: Child Loss Survey, March 2006/May 2007.

The multiple regression findings suggested that personal growth (PG) might offer independent contributions to predict differences in mental health problems over and above other established predictors, such as time since loss. We found this to be the case when we examined the means of mental health problems in our entire sample and its subsamples. We found a mean of 1.67 mental health problems for our entire parent suicide survivor sample. This mean was reduced to 1.22 for the 195 cases that had lost a child 5 or more years earlier. This mean declined still further to .94 when we counted only those 5-year post-loss survivors who had scored above the mean ($n = 139$) on the personal growth scale (PG). (This is not displayed in the tables.)

As personal growth (PG) correlated negatively with mental health problems (PPS), we plotted both of these variables separately in Figures 1 and 2 along the continuum of time since loss. The plots suggest that as the time passes after a suicide loss, personal growth (PG) scores rise and mental health problems (PPS) begin to subside. Figure 1 shows, after a slight drop in personal growth during the first year after a loss, personal growth scores rise steadily as the years after loss pass. By the fifth year, most survivors exceed the mean personal growth score. Figure 2 shows mental health problems spiking slightly in the first year after loss, and thereafter steadily declining. It should be understood that these figures are based on cross-sectional data from the 462 suicide survivors that offered ratings at different time intervals after their child's death. Only longitudinal research that follows the same sample of survivors over many years would allow us to know for certain that mental health problems decrease while personal growth increases with time since the death (see Discussion Section).

We also anticipated that those high in personal growth (PG) would be more active participants in support groups compared to those showing lower personal

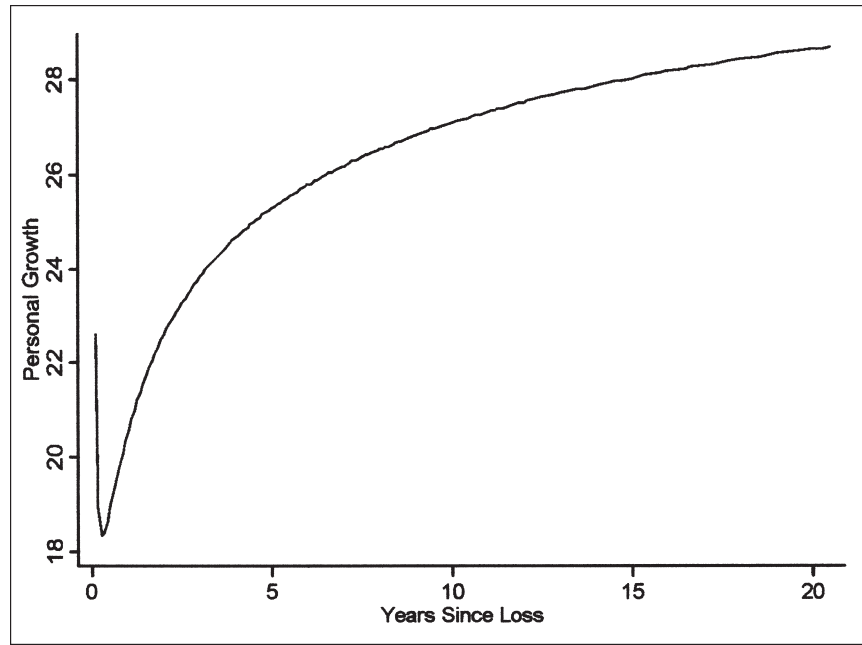


Figure 1. Lowess-smooth functions of personal growth differences by years since death.

growth scores. We expected this hypothesis to be supported only among longer-term survivors. This hypothesis was suggested by the data in Figure 1 which showed most survivors exceeding the mean scores in personal growth approximately 5 years (or later) after their losses. The hypothesis also meshed with our field observations collected at support groups, where longer-term survivors more often assumed care-giving roles at meetings. Table 3 presents the correlation coefficients for support group participation, use of professional help and personal growth. Participation was scored on a 3-point scale with the following values: (0) for no participation; (1) for attending to one to five meetings or sessions during the past year; and (2) for going to six or more meetings or sessions during the past year. If we look at support group participation among the newly bereaved (survivors that sustained a loss less than 5 years ago) we note no association between support group activism and personal growth. During this early bereavement period the only significant association noted is a negative correlation between seeing any mental health professional and experiencing personal growth. This makes sense if we re-visit Figure 2 which shows a higher number of survivors above the mean having mental health problems during the period of early bereavement. They are more inclined to seek mental health counselors and to see them more often, and

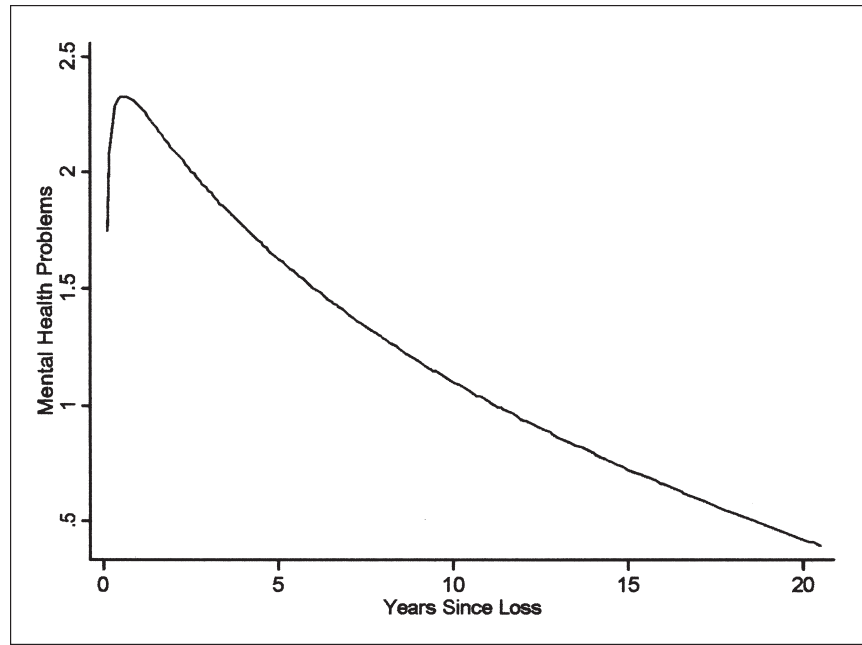


Figure 2. Lowess-smooth functions of differences in mental health problems by years since death.

are less likely to be experiencing personal growth during this period of early survivorship. Another paper, now in development, also has supported this observation that seeking professional counseling, poorer mental health, greater grief difficulties, and lower personal growth are all closely associated during the period of early bereavement (Feigelman, Gorman, & Jordan, forthcoming).

As we shift our attention to longer-term survivors, we see positive associations between support group participation and personal growth, suggesting that “giving back” has become a predominate concern among survivors who are further along in the grieving process. Interestingly, we also note no association between personal growth and seeing professional counselors during the later bereavement period. Here, again, only longitudinal data can satisfactorily demonstrate what these cross-sectional data seem to suggest: that the passage of time since a loss is associated with fewer mental health problems, greater reports of personal growth, and a diminished need for counseling among survivors.

Table 4 displays ANOVA test results comparing the means of personal growth (PG) and various demographic differences among our respondents. We collected the following demographic information: gender, age, educational attainments, socio-economic status, voting participation, political ideologies and preferences,

Table 3. Differences in Personal Growth by Participation in Survivor Support Groups and Seeking Counseling among Shorter- and Longer-Term Suicide Survivors ($N = 460$)

	Personal growth score Correlation	Sig.
Among Shorter-Term Survivors, < or = to 4.99 years ($n = 258$)		
During the past year how often did you go to a general bereavement support group meeting?	.10	.12
During the past year how often did you go to a survivor of suicide support group meeting?	.01	.81
During the past year how often did you go to a professional bereavement counselor?	.001	.99
During the past year how often did you seek help from a psychiatrist, psychologist, social worker, or psychiatric nurse?	-.20	.001
Among Longer-Term Survivors, > or = to 5.0 years ($n = 204$)		
During the past year how often did you go to a general bereavement support group meeting?	.16	.02
During the past year how often did you go to a survivor of suicide support group meeting?	.28	.001
During the past year how often did you go to a professional bereavement counselor?	-.03	.66
During the past year how often did you seek help from a psychiatrist, psychologist, social worker, or psychiatric nurse?	-.11	.10

Source: Survivors Child Loss Survey, 2006-2007

religious affiliation and frequency of participation, and urbanicity (i.e., urban vs. rural residence). Bivariate comparisons suggested the following significant differences in growth means between respondents: age, voting participation, religious affiliation, and religious participation. Scheffé post-hoc comparison tests showed middle-aged respondents (aged 35-45) had significantly lower personal growth scores than both older groups, the 56-65 year olds and those over 66. Post-hoc tests also showed that Jewish respondents were significantly lower in personal growth than Protestants and Catholics. And post-hoc testing showed that those attending religious services weekly reported significantly higher personal growth than those attending services several times yearly or less often.

Some of these factors could potentially be confounded with one another and with the time since loss variable, another established correlate of personal growth. We therefore created a multiple regression analysis of all significant bivariate correlates of personal growth. This is displayed in Table 5. In this equation all predictors, except age, explained 18% of the variance in personal growth scores. We completed an additional regression analysis (not presented in our tables) omitting all demographic correlates and simply gauged the explained variance of time since loss by itself. This equation explained 9% of the variance in personal growth. Thus, the demographic variables do indeed add predictive power to the model.

DISCUSSION

Some of our findings may evoke little surprise among suicide survivors and clinicians working closely with this population. It is a commonplace to hear longer-term survivors say they are “giving back” and trying to “make a difference” in their support group circles. But, what is more remarkable is the large number of our longer-term respondents that fell into this category. Nearly two-thirds of parents losing children to suicide 5 or more years earlier had personal growth scores above the mean for this sample. And nearly a third had scores exceeding the mean by one standard deviation unit. The considerable number of survivors who experienced high personal growth suggest a transformative potential in grief, helping people feel changed by their loss, shaping them into becoming more compassionate, caring, and help-giving persons. It will remain a task for future research to verify whether these cross-sectional findings can be confirmed in longitudinal research.

Perhaps one of our most noteworthy findings is the association between personal growth and better mental health. This extends the pioneering work of Hogan et al. (2001) who developed the personal growth subscale, suggesting its value as a clinical assessment tool for gauging survivor’s healing after loss. If survivors can be encouraged to participate in more care-giving activities with other survivors in support groups, they may facilitate their own emotional healing as well as that of others with whom they interact. Likewise, by addressing the

Table 4. Differences in Personal Growth by Various Demographic Factors among Suicide Survivors (N = 462)

	Personal Growth Means	Standard Deviation	N	df	F	Sig.
Gender						
Male	24.3	6.7	70	1,433	.03	.86
Female	24.4	7.2	365			
Age						
<45	20.8	5.7	35	3,431	5.2	<.002
46-55	23.7	7.3	165			
56-65	25.4	6.6	166			
66 or older	25.3	7.4	70			
Education						
High school or less	24.1	7.1	72	3,431	1.5	.21
Some college	25.0	6.7	188			
College graduate	23.0	7.6	83			
Postgraduate	24.6	7.2	92			
Family Income						
< 20K	21.3	8.6	27	5,423	1.3	.28
20-40K	24.1	6.0	79			
40-60K	24.4	7.4	92			
60-90K	24.9	7.1	100			
90-120K	24.4	7.3	60			
> 120K	24.9	6.9	71			
Voted in Last Presidential Election						
No	21.0	7.1	53	1,419	13.7	<.001
Yes	24.8	6.9	368			

Political Affiliation									
Very liberal	24.6	7.6	72	4,422	.16	.96			
Slightly liberal	24.6	7.1	91						
Moderate/Middle of the road	24.3	7.6	143						
Slightly conservative	23.8	6.1	72						
Very conservative	24.5	6.6	49						
Religion									
Protestant	24.9	6.3	169	4,423	2.8	.03			
Catholic	24.7	7.8	112						
Jewish	20.2	7.7	26						
Other	24.5	7.2	81						
None	23.6	6.9	40						
Frequency of Religious Participation									
Once or twice yearly	21.9	7.3	94	6,425	6.1	<.0001			
Several times yearly	23.5	7.1	106						
Monthly	24.1	6.4	53						
Two to three times monthly	25.5	6.4	14						
Every week	27.4	6.2	92						
Several times weekly	26.9	6.5	29						
Residence Type									
Urban	25.3	7.4	81	3,429	.73	.53			
Suburban	23.9	7.6	143						
Small city	24.2	6.4	112						
Farm or small town	24.6	6.8	97						

Source: Survivors Child Loss Survey, 2006-2007.

Table 5. Multiple Regression Analysis of Personal Growth by Time Since the Death and Various Demographic Attributes of Respondents ($N = 462$)

Independent variables	Correl Coeff.	Number of obs = 413	
		Beta	P
Years Since Death	.30	.25	.0001
Age	.16	.06	.23
Voted	.18	.11	.02
Religion (Jewish vs. All)	.16	.11	.02
Frequency of Religious Participation	.26	.22	.0001

Note: P = Level of Significance

Source: Child Loss Survey, March 2006/May 2007.

wider world of non-survivors, suicide survivors who help to change public perceptions of suicide, work toward raising more research funds to study suicide and mental health problems, and widen the availability of mental health services, may feel a sense of personal renewal and significant accomplishment. Working toward these goals may lead survivors along pathways that help to make their lives meaningful again, by making something “good” come from loss.

Also of interest is the relationship between levels of self-reported personal growth and the frequency of participation in bereavement support groups. Basically our data suggest that greater utilization of support groups, but not professional mental health services, is associated with greater personal growth among longer-term survivors. This may mean that for many survivors support groups may be the most helpful form of intervention, even more so than formal intervention by a mental health professional. This accords with the extremely high levels of helpfulness of support groups reported by survivors in the recent pilot study by McMenemy, Jordan, and Mitchell (2008).

Our findings also demonstrate an association between personal growth and certain demographic factors. Perhaps the most intriguing is the clear association between participation in religious activities and personal growth in our sample, suggesting the possibility that religious membership may carry salutatory effects for survivors, perhaps in terms of enhancing meaning reconstruction processes in survivors. Likewise, survivors who voted (a marker of civic involvement) also showed greater personal growth. These findings also suggest that engagement in community activity may be an important part of the healing process for some survivors and may be a valuable activity for clinicians to encourage in their

clients. Of course, the correlational and cross-sectional nature of our sample make these conclusions quite tentative, since it is equally possible that personal growth precedes and leads to greater engagement with one's community (see discussion below on limitations of this study). It was puzzling that Jewish survivors reported less personal growth than other (mostly Christian) religious affiliates. Whether Judaism presents a less receptive climate for promoting personal growth is a question that needs further investigation in future research among survivors and the general public. It should also be noted that the sample size of self-identified Jewish respondents in our study was much smaller than participants from other religions, so that generalizations from this smaller sample must be made more cautiously.

LIMITATIONS OF THE STUDY

It is important to note the limitations of this study and therefore of the confidence in and generalizability of our findings. This research has examined the relationship between personal growth and grief difficulties and mental health problems in a sample of parents who lost a child to suicide. We found an inverse correlation between growth and these other variables. Likewise, frequency of participation in survivor support groups was related to levels of personal growth in longer-term survivors, as was participation in religious activities. However, the correlational and cross-sectional nature of our data limit our ability to know the sequencing, and therefore the possible causality of these associations. For example, it is quite plausible that higher personal growth and lower levels of grief difficulties are the factors that lead to greater support group participation, rather than the opposite. Or, since personal growth and mental health problems appear to be inversely correlated, it is possible that they are simply reflections of a common underlying dimension of general grief distress (or its absence), rather than orthogonal variables. Only longitudinal studies of survivors, factor analytic work, and some form of structural equation modeling on the data from our study would allow for clearer conclusion about the causal relationship between the development of personal growth in survivors and the reduction of grief distress, as well as the utility of various coping activities such as religious or support group participation.

In addition, the Hogan personal growth scale is an attitudinal measurement. It does not include specific behavioral components of compassion, such as the number of support group meetings attended within a specified time frame; positions of leadership taken in suicide prevention advocacy work, hours spent (within a specified time frame) in fund-raising for suicide prevention causes, the number of prevention talks given to youth groups, and other manifestations of compassionate actions. Future research will be needed to better understand the relationship between attitudinal dimensions of personal growth and its behavioral manifestations than we have been able to demonstrate here.

Likewise, our sample, while showing an impressive response rate, was drawn disproportionately from the ranks of survivors who were deeply committed to support groups and more actively involved in them. The sample was also limited to parents who had lost a child to suicide. We simply do not know whether the associations that we discovered between personal growth and reduced mental and grief distress, or between higher participation in community activities and personal growth will hold true for survivors who either do not seek out support group services or who seek but are unable to locate such assistance. This broader examination of the larger community of survivors who do not become activists but who may still demonstrate considerable personal growth after a suicide will have to await the type of longitudinal research that attempts to follow all survivors of all suicides in the community, rather than just those who seek services and/ or agree to participate in survivor research (Jordan & McMenemy, 2004).

CONCLUSIONS

These tentative findings offer directions of hope and encouragement for survivors who often feel trapped in a world of enduring sadness, isolation, and meaninglessness following the suicide loss of a loved one. At healing conferences survivors often swap their stories of healing journeys, sharing accounts of new social service careers they assumed following loss, of their grant seeking efforts (whether successful or attempted) to seek funding to establish new programs helping survivors with more postvention services and to educate the public at large about suicide. Survivors carve out new identities for themselves as they assume these humanitarian enterprises.

Provisional as our present data may be, it suggests that one important way to facilitate survivor healing may be to take the loss out of the private and personal sphere and attempt to weave it into the fabric of society. As survivors do this they may find that their sadness lifts, and life again assumes new meaning with a sense of purpose. As we found elsewhere (Feigelman et al., forthcoming), following a suicide loss, survivors often encounter rejection (usually in the form of avoidance) and strain in their relations with family and friends. This isolation can magnify and exacerbate survivor grief. Joining with other survivors and working together within and beyond the boundaries of the survivor community may help suicide survivors to know they are not alone in their grief. It may also alleviate some of the hurt felt from their loss as they assume these acts of common purpose, make new friendships with other survivors, and broaden their perspectives to find new pathways of growth after the suicide of their loved one.

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