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# SURVIVING AFTER SUICIDE LOSS: THE HEALING POTENTIAL OF SUICIDE SURVIVOR SUPPORT GROUPS

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**ABSTRACT**

With participant observations from peer-facilitated suicide survivor support group meetings, collected over a four-year period, this article applies Shulman's dynamics of mutual aid theory to explain how survivors' healing is facilitated by support group participation. Shulman's principles provide guidance on how survivors help and empower each other to deal with their grief in survivor support groups. Group facilitators can provide more clarity and direction to survivors with Shulman's principles, better helping survivors to navigate the bewildering course of healing after suicide loss. We also suggest ways group facilitation knowledge—an essential resource for enhancing healing— can be more widely distributed.

**Key Words**: suicide bereavement, suicide survivors, support group, healing, mutual aid group

This analysis explores the neglected and dimly understood population of suicide survivors. Either because of stigma, fear, or a combination of these and other emotions, both the public-at-large and behavioral science researchers have paid scant attention to this population and to how survivors repair their lives after




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experiencing the devastating loss of a loved one to suicide. In this article we probe this question, focusing on a commonly used survivor resource: peer support groups. Survivors often join these groups in their efforts to seek comfort and support after a loss and to counteract the personally depreciating aspects of suicide stigmatization. In this project we collected participant observation data from the members of a single survivor support group that we observed over a four-year period.

In our analysis, we apply Shulman's dynamics of mutual aid theory (Shulman, 2006) which we see as very helpful for elucidating some of the most important mental health challenges that survivors face in attempting to cope with loss and to advance their own (and each others') healing. We also see Shulman's dynamic principles serving as an important blueprint for group facilitators to follow as they seek to promote survivor healing in the most expeditious manner. In our view, when conducted with intelligence and compassion, survivor support groups represent a valuable tool for advancing survivor mental health and healing, which hopefully, will be demonstrated in the course of this exposition.

## SUICIDE SURVIVORS

Although suicide is a relatively rare event, with approximately 30,000 people taking their lives in the United States each year (American Association of Suicidology, 2007), 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, close friends, and mere acquaintances 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 prone to post-traumatic stress symptoms: reexamining the event, avoiding stimuli associated with the event, numbing of general responsiveness, and/or increased arousal symptoms (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004).

Suicide has been described as a "death like no other" (Redfield-Jamison, 2006) and suicide survivors 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 their loved one for abandoning them. This, in turn, generates more feelings of guilt and blameworthiness. Another important prominent correlate of suicide, Jordan

asserts, is 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 loved one succumbed to the tragedy of suicide.

It has also been claimed that suicide survivors are a highly stigmatized group (Cvinar, 2005). The shunning against survivors manifests itself in different ways. One survivor reported her experience of being rejected in a newly formed therapy group for recently bereaved mothers suffering child loss. At the initial meeting of this group, one of the members remarked to the therapist and to the others:

> I can't be in this group with her [the parent sustaining the suicide loss]; this is not possible. My five-year-old died of a brain tumor; he wanted to live. What good can I ever get from being in the same group with someone whose child died by his own hand?

Another suicide survivor, in response to a discussion about stigmatization, said:

> People never said anything really bad to me. It was not what they said; it was what they didn't say. Some people who I thought would offer solace remained quiet. And most people just said nothing [after my son's death] and seemed to try to avoid any discussion. It was as if my son never existed.

Because of their complex grief issues and societal stigmatization, suicide survivors often experience 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; Bailley, 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 while others are agency affiliated or freestanding community groups. Some groups operate within fixed-length terms (usually 10-12 weeks, which may then be renewed or terminated), while other groups are open-ended and meet for an indefinite time period. In open-ended groups, new members can join at any time (Jordan, 2004). Survivor groups may also be further differentiated into general bereavement support groups, which include survivors from a variety of different death causes (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. Alternatively, other bereavement support groups only accept members from a single type of loss or group of survivors, such as survivors of suicide groups, where all members share a similar loss: the loss of a loved one from suicide.

Some suicide survivors attending generalized bereavement groups have reported feeling different from other grievers and tend to drop out of these groups (Dunne, McIntosh, & Dunne-Maxim, 1987). Many suicide survivors also shy away from professionally-led bereavement groups, preferring to seek help exclusively in survivor-led groups. Criticism against the medical-psychiatric profession is often a dominant theme expressed in peer-led survivor support groups, especially among the newly bereaved. Some frequently expressed criticisms include disappointment with mental health professionals who seemed overly preoccupied with collecting fees, appeared insensitive to the side-effects of prescribed medications, and neglected to communicate serious suicide risk concerns with family members. Some survivors even express the belief that had their lost loved one received better care, this person would be alive today. Participants in peer-led survivor groups often claim that only other suicide survivors can offer meaningful understanding and help to those suicide bereaved.

Among professionals, criticism and skepticism is often expressed about peer-facilitated support groups. At a recent group work conference, one professional conferee voiced her concerns:

> I'm worried about nonprofessionals running support groups on their own for survivors. I question whether someone without professional training can provide help to such fragile and vulnerable people. I think there is a real danger that an improperly facilitated group may leave a survivor deeply frightened, exposed and more at risk. You need professionally trained leadership for these groups.

Obviously, the dialogue between peer- vs. professional-led bereavement groups eventually leads to a level of complexity beyond the scope of this analysis. For the present, we are simply interested in exploring how peer-led bereavement support groups offer participants meaningful help with their grief and loss experiences. If evidence from generations of Alcoholics Anonymous members offers any guidance, it would seem that self-help bereavement support groups present promising therapeutic possibilities.

As stated earlier, for many survivors today, peer-facilitated groups are the preferred model of help. Garvin (1997) believes 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 nonprofessionally-led groups because of the sense of competence they

nurture" (p. 13). Garvin also recommends that professionals include greater cultivation of peer support even in professionally-led support groups.

In this report, our focus will be upon open-ended, peer-led support groups for survivors of suicide. These groups are probably the largest single locus today where survivors find immediate solace and support following the suicide loss of a loved one. Yet, little has been written about these groups.

The reliance upon peer-led support groups for helping with different personal problems has a long history in the United States, dating back to the mid-1930s, with the creation of the first Alcoholics Anonymous chapters in 1935 in Akron, Ohio, by "Bill W." and "Dr. Bob" (Makela et al., 1996). However, 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 survivors of suicide support groups nationwide, most of which could be identified as for suicide survivors exclusively, peer-led, and open-ended support groups (American Association of Suicidology, 2007; American Foundation of Suicide Prevention, 2007).

Among helping professionals, there is much interest in understanding how group participation promotes individual psychic well-being. Katz and Bender (1976) state that people helping one another through the exchange of resources and caring is the backbone of our society. Gitterman and Shulman (2005) advance that a powerful healing force is released as people discover they are not alone in their feelings. Groups provide opportunities for multiple interactions and relationships which expand opportunities for problem solving and vicarious learning (Finch & Feigelman, 2002; Reid, 1997).

In groups, there are opportunities to tell one's full-story in an accepting atmosphere; the group affords its members an ability to help each other and enhance their own self-esteem in the process. Groups also present the availability of successful role models (Garvin, 1997). In this report we will apply Shulman's dynamics of mutual aid theory to explain how survivors' healing is facilitated in support groups (Shulman, 2006). Shulman's principles provide guidance on how survivors are helped with their grief and loss experiences in survivor support groups. As peer and professional facilitators better understand and appreciate the utility of Shulman's theory, they can more readily advance goal attainment in survivor support groups.

## METHOD

This research draws on participant observations collected over a four-year period while both authors regularly attended monthly meetings of one survivor of suicide (peer-led) support group. Both authors experienced the suicide loss of their son, enabling them to become regular group members, which members euphemistically refer to as "the club none of us ever wanted to join." The group studied was located in a suburban community in one of the country's largest cities. For this report, all names and personally identifying information about respondents were changed to protect respondent confidentiality. Both investigators provided a cross-check on one to another, making sure observations were accurately recorded. Yet, throughout this presentation, wherever necessary, nonessential details of observations and persons have been changed to safeguard each participant's privacy and confidentiality.

The group studied held monthly two-hour meetings which began with a brief informal socialization period. Following this, in the formal part of the meeting, the facilitator provided an introduction to the 15 to 35 people seated in a circle together. Next, the facilitator encouraged group members to participate in an initial "go-around," briefly introducing themselves, stating their full or first name, their relationship to the decedent (attendees held a variety of relationships to decedents: parents, children, partners, spouses, siblings, other relatives, and friends), the self-killing method employed, and the significant survivors of the decedent. New members were offered the option of passing over their turn if they felt unable to share this information at this time. After the initial go-around, the facilitator opened the meeting to those wishing to make general remarks and to respond, non-judgmentally, to each other. Periodically the facilitator redirected the flow of communication and assured new members opportunities to speak if they wished to do so. At the close of the meetings, the facilitator led the group in a ritualized reading of the serenity prayer, which was then followed by another informal socializing period where members shared coffee and cake together.

Support group members were never explicitly asked for their consent to collect data on their group interactions. That consent appeared implicit in the cooperation offered to this report's second author, who asked members to participate in a survey of this survivor support group. With the endorsement and cooperation of the group's facilitator, members were asked to complete a lengthy survey of their bereavement experiences. More than two-thirds of the regularly attending membership completed this survey. Most survey nonparticipants offered apologies to the second author when they found they could not complete the survey. In most of these cases, members expressed appreciation to the second author for doing this study of survivors, but regretted that the painful memories evoked by answering some of the questions prevented them from participating.

It was also known among group members that the first author was employed as a clinical social worker with a psychotherapy practice. In view of what has

already been said about survivor skepticism toward mental health professionals, it might seem that the first author's role in this capacity would impose a barrier to her acceptance within this group, and would even lead to her being cast as a potential group enemy. Yet, this never occurred during the course of our data collection. At all times, the first author was recognized as a suicide survivor primarily and often became a valued resource to the group, sometimes supplying insights into mental health problems, professional terms, and technical information about hospitalization and medical insurance questions. Interestingly, her dual status as both a survivor and a professionally trained clinician actually helped some members to feel less guilty about their own losses. As one participant described it at a meeting:

> I have been very hard on myself since Dotty's death, beating myself up for missing important clues that might have prevented her from taking her life, but with you in the same situation as me, and having lost your own child—in spite of all your knowledge and years of professional experience—I've come to realize how mystifying these mental health problems really are. Even mental health experts can be taken by surprise by a suicide in their family. It may not be nice for me to say this, but meeting you and hearing about your experience has made me feel more forgiving of myself.

## ANALYSIS

In this report we apply Shulman's 10 important dynamic principles of mutual aid to show how healing is advanced in survivor of suicide support groups (Shulman, 2006). Shulman offers the following 10 principles to show how people use groups to address their psychosocial needs:

1. The "All-in-the Same Boat" Phenomenon
2. Discussing a Taboo Area
3. Mutual Support
4. Individual Problem Solving
5. Sharing Data
6. The Dialectical Process
7. Mutual Demand
8. Rehearsal
9. Universal Perspective
10. The "Strength-in-Numbers" Phenomenon

Below we briefly discuss each of Shulman's principles and how they are operationalized in support groups to advance the recovery of survivors. We present relevant anecdotal observations and excerpts demonstrating how these principles emerge in the course of the suicide survivor support group experience.

## The "All-in-the-Same Boat" Phenomenon

Group members gain support by discovering that other group members have similar problems, concerns, feelings, and experiences. They learn they are not alone (Shulman, 2006). In the initial go-around, as members introduce themselves, they share a very important part about their survivor experience: how their lost loved one died. This information bonds them together. From the very beginning of the meeting a clear linkage of common experience is established. Thus, in the suicide survivor support group, people find they are not alone. The shock, isolation, stigma, and confusion impacting on every part of one's life—from the inability to perform simple daily routines to the loss of one's total belief system—all this is shared. Members also begin sharing personal loss stories. Irv, a middle-aged investment banker, recounted his experience of losing his 22-year-old daughter Betsy:

> When Betsy died, for the first three months following her suicide, I didn't want to get up in the morning. I felt my life was over. I would wake up and for a split-second I was ok, everything was normal in my life, but then, I would remember, Betsy was dead. It felt like a knife thrust into my stomach. I've never felt such pain before. I kept hoping I would really wake up and find that this was only a horrible nightmare. I couldn't believe that I would never see her again. During those first months I felt like I must have been in some kind of trance. I don't know how I got to the office and did my work during that period, I was such a mess.

Others in the group nodded as they too remembered their early reactions to the suicides of their loved ones; this included the visceral pain, the shifts between denial and reality, and the trance-like functioning in one's daily life.

After suicide, the original fabric of the family is destroyed and the entire family is forced to reintegrate (Dunne, McIntosh, & Dunne-Maxim, 1987). Frequently, family members react differently to the suicide and are unable to support each other. Some family members come to the group alone, without their partners. For one survivor, Maria, the group is her only place to be heard.

> I have been coming to the group alone, without my husband Tony, for three years now, since right after Pat, our 22-year-old son, took his life. I tried to get Tony to come here with me but he refuses. Tony never was much of a talker about feelings and now, he doesn't want to talk about Pat, period. I think he feels guilty and I know he also blames me—I was the one who insisted that we stop rescuing Pat all the time and hold him accountable for the messes he kept getting into. I don't feel guilty about Pat's death now and coming to group has been a huge help for me. In the beginning it was the only safe place to speak about my son. Maybe if Tony came to group, he would feel better too.

Whether survivors come to meetings with one or more of their significant others (such as attending meetings with a spouse, child, or sibling as is often done) the

most important thing is that survivors bond with one another at meetings, sharing a common consciousness-in-kind.

### Discussing a Taboo Area

One member enters a taboo area of discussion, thereby freeing other members to enter as well (Shulman, 2006). The safe culture of the support group allows survivors to challenge the stigma and shame associated with suicide. One openly shares feelings and is not rejected or abandoned; one is allowed to express grief and anger, suicidal thoughts, disappointments with others, and even, for some, the feeling of relief that after years of living with a chronically depressed, suicidal person, the suffering, for everyone, is finally over. The freedom to say these things diminishes the sense of isolation and feelings of guilt.

Sometimes, one member, taking the first risk, leads the group to a different place. Mary, after several months in group, talking about her son Jeff's impulsivity, depression, and an earlier traumatic experience in college, finally takes a risk and shares more of her story.

> The night my son hanged himself, Jeff had been coming down from a cocaine binge. I was ashamed to talk about this here before because I wanted to protect him and me. I was afraid that you would think less of him—his life, his death, and my loss because of his cocaine use. I know how society looks at people who use drugs. Jeff was very talented and loving and he deserves more than that.

After Mary's disclosure, there is silence as she waits to see how others respond. After a brief pause, others in the group begin sharing their own previously withheld stories of loved ones' abuses of alcohol and other substances. Their spirited exchange suggests that members are relieved; their losses are validated and they have one less secret to hide.

## MUTUAL SUPPORT

Group members provide emotional support to one another (Shulman, 2006). In the survivors' group, members demonstrate acceptance, offer hope that the pain will lessen with time, and suggest concrete ways to cope with problems. Ken and his wife Robin acknowledge this mutual support phenomenon:

> When we first started coming here eleven months ago, we felt hopeless and even though we have lots of friends and family, this place felt different—a room full of strangers and yet we felt comfortable. People really understood us. In the beginning, I was amazed to see how some people, here longer than us, were functioning so well, even laughing a little. Now, I meet new people coming here for the first time and I can see that Robin and I are not in the same place. Our pain feels different. Time does that. Someone once said these meetings work because of talk, tears, and time. I think that's true.

Yalom and Leszcez (2005) talk about the power of expectation, the installation and maintenance of hope, the benefits of the group experience with individuals at different points along a coping-collapse continuum, and the importance of observing the improvement of others. Another aspect of mutual support, which is crucial for survivor healing, is the ability to forgive others for whatever self-blame and guilt they suffer. A survivor, Betty, describes how by supporting others she was able to eventually let go of her own guilt.

> After my son's death I felt guilty and ashamed. After all, there had been warning signs and I was a trained mental health professional. Years ago I had even driven one of my patients who had taken an overdose of aspirin to the hospital emergency room and saved her life. How had I failed my own son? In the group I listened to others tell their stories, many also feeling guilty that they had not prevented the death of a loved one—a husband, a father . . . it went on and on. At first, I distanced myself, believing my guilt was worse. My crime was more severe. Most of these people did not have my skills and expertise. I was more guilty: a horrible mother and an incompetent clinician. Over time, while helping others (including other mental health professionals who were also survivors) to feel less responsible for a death they could not have prevented, I began to be less hard on myself. My son had made the decision to end his life in spite of everything I had done or could have done.

A very important part of the process of gaining mutual support is putting aside the sense of blameworthiness. As survivors begin their healing they begin to realize that the cause of their loved one's death was never within their power.

### Individual Problem Solving

The group members help one member to solve a problem, receiving help themselves while offering it to another (Shulman, 2006). In the survivor group, a member has the opportunity to hear from not one but many others, with diverse backgrounds and experiences in dealing with certain similar situations. It is very supportive to have this orchestra of responses available, and in addition, it is also empowering. "It is this very process of picking and choosing which serves to help us feel progressively more in control of our own lives and which makes it possible for us to resume fully our adult lives in the face of this tragedy" (Dunne, 1992, p. 9). A member, Paula, asks for help with conflict with her in-laws.

> I have a problem with my in-laws. My husband Chris was cremated one year ago and now his family is pressuring me to spread his ashes. I just can't do this.

The group is first supportive, "How can they do this to you!," several members remark at the same time. Next, Paula remarks, "I want to hold onto him, and I can't let go." One member supports Paula's right to determine the time for this ritual to occur, saying "each person grieves differently and you were his wife." Finally, another member, a parent who lost her son, who apparently

identified with Chris' parents, asks Paula: "What about them? Maybe they need some closure as part of their own healing. Didn't they lose their son?" Paula tearfully listens. Finally, another member shares her own solution to this dilemma; she displays a small gold locket containing some ashes of her loved one. She wears this locket close to her heart and says this has allowed her to part with the rest of his remains. Paula listens, appears less disturbed and nods gently.

## Sharing Data

Members of the group have had different life experiences, through which they have accumulated knowledge, views, and values that can help others in the group (Shulman, 2006). In the survivors' group, members share specific information about the healing process—where they are now, how they were then. Sometimes this information is volunteered and other times it is shared in request to someone asking for help. One member, Lois, almost two years since the death of her son John, is feeling pressured to "speed up" the mourning process by seemingly well-meaning friends and family.

> This second year without my son John feels even harder. People expect me to "move on" and to get rid of John's clothing and possessions, but I can't. Is this normal? Will I ever be able to clean out the closet? Do I have to?

Others in the group provide support by saying "take the time you need, only you can make these decisions; it does get easier, with time to go through possessions." Then another member, Anne, shares how she handled this kind of challenge:

> I couldn't stand to change anything in my son Brian's room for a long time. It was like a "shrine" and I would go in there and cry. But then, my daughter had a baby and I decided to convert the room into a play room for my new grandchild's visits. I changed the wallpaper, the carpeting, and put in some baby things. Now, when I go into the room, of course I still think of Brian and sometimes I still cry a bit but I also enjoy the new light in my life—my granddaughter. When she visits, we play games, read books, and laugh and I point to his photos on the wall and tell her stories about her Uncle Brian.

Sometimes group members talk about how they deal with "toxic" people or give themselves permission to avoid certain painful situations. Other times, they speak about the benefits they derive from supportive therapists or psycho-tropic medications. For some, visits to psychics or enhanced religious activity or spirituality provide comfort and they talk about this too. Members share traditional as well as more unusual ways they use to cope with their losses. One member, Terry, a survivor who lost her 18-year-old daughter four years ago, speaks about her communal visits to grave sites with her "Mothers' Cemetery Club," a small subgroup of women from the survivor group.

> We bring flowers but we also bring miniature toys, Halloween candies, holiday decorations, whatever. One New Year's Day we even brought a bottle of champagne and drank a toast to them and us.

This interchange provided an opportunity for the group to laugh and to experience relief as they talked about this taboo topic so openly.

## The Dialectical Process

Group members confront each other's ideas. The group is a sounding board and a place for one's views to be challenged and possibly changed (Shulman, 2006). As in other mutual aid groups, the exchange of differing views in the survivors' group allows members to examine their personal beliefs and the beliefs of others. This leads to an expansion of thought and facilitates change (Finch & Feigelman, 2002). One member, Fiona, speaking of her brother's suicide, voices her criticism of her brother's fiancee. She says:

> I can't help but blame my brother's fiancee for his death. She pressured him and he had no where to turn.

The group supports Fiona but then someone adds:

> How easy it is for all of us to look for someone to blame: ourselves, the psychiatrist, and others, rather than to accept the fact that someone chose to end their life.

With this last remark, Beth, who lost her fiancee Steven, challenges Fiona:

> I am still blamed for Steven's death by his family and I have to tell you how much it hurts. Steven and I lived together for three years, we loved each other, were engaged to be married, and I thought his family accepted me and our relationship. His family knew a little but not the full story of his depression; the different medications he took, the course of his therapy. He wanted to keep it a secret, but in the end I lost him. How can they not know that I lost my whole life with his death?

Beth begins to cry. Fiona listens; she too begins to cry.

In another support group session, Joan, a divorced woman who lost her adult daughter Barbara three months ago, is accompanied to the meeting by her surviving son Matthew, himself a divorced parent with a young son. Matthew is here today, eager to talk about his mother and how her crying and expressions of guilt seem excessive and are upsetting to him. "I don't know why she blames herself. I try to bring over my son, he's a great kid, for frequent visits to cheer her up but she is often unable to get up from the sofa." A group member asks him to be more compassionate to his mother, saying: "you lost your brother but your mother lost her child. It's not the same." Matthew responds: "I can't imagine losing my son. I'd probably flip out." The possibility of such a loss emotionally overwhelms him and he reaches for his mother's hand to comfort her.

## Mutual Demand

Group members offer each other help by making demands and setting expectations on personal behavior (Shulman, 2006). The survivors' group encourages members to move from being victims to becoming survivors by making demands for growth and change. These changes may be small, may be behavioral or attitudinal but, with each change, survivors become more empowered. It is important for survivors to measure their healing progress according to their own yardsticks, as there is definitely no "one size or one method fits all." While the group makes demands for growth, it also acknowledges change in others, no matter how small (Dunne, 1992). Sometimes the discomfort of facing one's peers without having acted upon some helpful suggestions motivates members to change and take risks.

Many struggles are universal in the survivor group, such as the conflict between going on with one's life and feeling guilty. One member, Antoinette, a widow, speaks about her difficulty in celebrating the holidays with her children; other members who have already experienced this try to help her.

> I feel guilty because since my husband shot himself on Christmas day, two years ago, I have been unable to continue with the family tradition of selecting and decorating a large holiday tree. I feel terrible because my kids, ages 10 and 12, are missing out but I don't have the energy.

Members speak of their own experiences and how they push themselves to function, even when it is hard, so that their children don't have to worry about them. "They already lost their father, they don't need to worry that they are going to lose their mother, too."

Fred, who lost a son, Peter, shares his struggle:

> I was very close to Peter and for a long time couldn't think about doing anything fun with my surviving son Rick (or my wife for that matter, either). My wife and I were close to separation over this. Luckily, I realized that this was not fair to my family. Nothing can be done to bring Peter back, and I just had to push myself.

At a subsequent meeting, Antoinette shares her decision to purchase a smaller Christmas tree this year, one with roots, that she and the children will decorate and then plant outside, after the holiday. Antoinette has responded to the group's mutual demand. She is being a good mother and is also honoring the valued tradition established early on in her marriage.

## Rehearsal

The group becomes a forum to try out new ideas and skills (Shulman, 2006). In the survivors' group there is always discussion of how to deal with difficult people and situations, including holidays, birthdays, death anniversaries, and so forth.

These are difficult events for families that have lost loved ones and members share their struggles and methods of coping. The rehearsal in group, with the support and feedback from one's peers, greatly reduces anticipatory anxiety and promotes self-esteem. One member, Lisa, speaks of her anxiety about her dead brother's approaching birthday and wonders how she and her family will get through this day.

> Next week will be my brother's birthday. He would have been 36 and my family seems to be avoiding the topic. I don't want to upset my mother but I think we should talk and plan something.

Members of the group encourage her to talk about the day, how she would like to spend it and with whom. They also share memorial actions that worked for them: going to a loved one's favorite restaurant, ordering their preferred foods, renting and watching one of their favorite movies, writing birthday messages in a journal, or making memorial donations in their name.

## Universal Perspective

The group members begin to view their personal situations in terms of universal issues within a social context (Shulman, 2006). In the survivors' group, suicide is viewed not only as something that happened in your life, but something connected also to a larger picture of institutional shortcomings such as inadequate mental health resources, limited funding for suicide prevention and research, or societal stigma regarding depression, substance abuse, and suicide.

For many survivors, this wider perspective allows them to move away from personal blame and begin to turn their grief into social action. For some survivors, grief becomes a transformative experience (Fielden, 2003) and posttraumatic stress disorder evolves into posttraumatic growth (Tedeschi & Calhoun, 2004). People talk about beginning volunteer work for the first time in their lives, establishing memorial foundations, or writing and publishing memoirs that help others. While not all survivors move onto social action, with time and exposure to the healing support of others in their support group, many achieve greater understanding of suicide as a social problem, its risk factors, preventive interventions, and the need for more research and knowledge. One member, Bud, speaks in group about legislation he is supporting:

> I want to tell you about Timothy's Law because it is important for us to get behind this much needed legislation to get mental health parity. I'd like to pass around a petition for signatures after the group.

Some members, especially those in the early months of bereavement, seem too numb to be interested in doing more than their day-to-day survival routines of getting up and to going to work, but for others, Bud is presenting an opportunity to take action.

### The "Strength-in-Numbers" Phenomenon

Group members are strengthened to take on difficult tasks through the support of other group members (Shulman, 2006). Members of suicide support groups are strengthened as they unite with other survivors. They become advocates for suicide education, prevention, and legislative social action and engage in fund raising for improved research. They join other organizations to participate in community events such as AFSP Annual Out of the Darkness Suicide Walks or they collaborate with others to lobby in Washington, D.C. with SPAN-USA. They begin on-line support groups, create memorial Websites, publish support newsletters, participate in research studies to "tell their stories." They decrease their feelings of shame and isolation and they become empowered. Jerry Reed, executive director of the Suicide Prevention Action Network USA talks about the power of survivors to make a change:

> Survivors are changing the landscape of suicide awareness. By sharing their personal stories, they are able to turn grief into action and communicate the urgent need to take concrete steps to prevent more deaths by suicide (Myers & Fine, 2006, p. 262).

This last step brings survivors into new roles as change agents, helping to educate to de-stigmatize suicide and mental illness, fund-raising, and politicizing, essentially turning their grief into meaningful social action.

## CONCLUSION

With Shulman's dynamic principles we have demonstrated how survivor support groups help survivors advance with their healing after a suicide loss. No longer marginalized, survivors are able to offer each other important mutual aid, helping each other deal with the necessary life adjustments following a suicide loss. As survivors discover their similarities, they are drawn together to form a natural therapeutic environment. Between the successful models of coping behavior that survivors offer to each other, their mutually reassuring and supportive responses, survivors are able to move beyond the isolating sadness of loss and once again envision possibilities for hopeful and meaningful future actions.

There is no more convincing proof of the value of support groups for survivors than the testimonies they themselves offer at group meetings. As Jane stated at a recent meeting:

> All my life I have been shy about speaking up about myself. When I first started coming here, I sat like a clam; I was afraid to open my mouth. But now, I'm in a much better place. I'm stronger and I can talk in this group to tell my story and help others. I can even advocate for myself now when I have to. In my early grieving days I was full of self-doubt and I couldn't think about disagreeing with anyone in my family who said anything about how I was

> supposed to grieve. Now, if anyone puts something out there that seems unhelpful to me I'll tell them, loud and clear.

Mike framed it differently.

> You remember how I was a year ago, when I first came to meetings all I talked about was how I failed Mike Junior. All I thought about was how my life was over. After work, I just wanted to go home, watch some dopey tv shows and call it a day. When my wife suggested we take the family vacation to Disneyland we had planned before Mike Junior's death, I snapped at her. I said, "What are you crazy? How are we going to enjoy an amusement park? There's no fun in life any more." But after coming here and talking it out, I've come to understand the selfish stupidity of that idea. I can't bail out on my wife and surviving son. We all have to make the best of it. Well, you know we went to Disneyland, and we had a good time down there. We even talked about Junior there—he loved that place. And we cried and missed him together. We've got to move on. Junior would not have wanted us to mope about, and in his loving memory, we won't. I've come a long way with this group.

Yet, natural healing is by no means assured within this context. Although we have not dwelt on support group deficiencies, we did observe occasional instances when people expressed dissatisfaction with the support group and withdrew. Members who withdrew cited a variety of reasons: displeasure with the facilitator and other group members for monopolizing the group's meeting time; feeling that the group was overly preoccupied with issues peripheral to recovery after suicide; sharing the belief that continued involvement with the group "brought them down."

No leadership will successfully address all the many and potentially conflicting interests and needs of members. There are also important developmental processes going on within survivor support groups. Newly bereaved survivors enter groups primarily seeking emotional support for the profound "psychache" they are experiencing (psychache is defined as a general psychological pain that reaches intolerable intensity; Shneidman, 1998). Longer-term survivors will more often approach support group meetings from the vantage point of what they can give back to the newly bereaved. There are likely to be others who feel they have moved on with their grief, and no longer benefit from support group participation. These differences in group member motivations may offer useful leads for future research on how bereavement support groups are sustained, prosper, and/or break down.

Survivor support group members come from a wide range of social class memberships. Some bring with them extensive experience from Alcoholics Anonymous, Weight-Watchers, and similar groups following the self-help peer support model. Others enter survivor support groups as relative newcomers to self-help. Some enter groups with a vast reservoir of participation experiences

from religious, civic, occupational, and other voluntary associations, while others begin support group participation for the very first time.

All survivors share a common need for informational materials on the dynamics of suicide and the social and psychological aspects of grief and bereavement after suicide death. As support group members, they also need specific information on ways to make their group known to newly bereaved suicide survivors in the community, guidance on how to act non-judgmentally at meetings, how to ease newer members into their groups, techniques for engaging less vocal participants, and related matters.

After sustaining a suicide loss, many survivors initially go on the Internet in their eager and sometimes desperate searches for help. Many survivors presently find considerable help at four important clearinghouses for suicide information: The Suicide Prevention Resource Center (www.sprc.org); the American Association of Suicidology (www.suicidology.org); The Suicide Prevention Action Network (www.spanusa.org); and The American Foundation of Suicide Prevention (www.afsp.org). Many find their local support groups through the listings posted at the AAS and AFSP Websites.

Yet, at the time of this writing there is limited informational assistance available to help survivors better manage their support groups. Presently, the only places where group facilitation materials and training are available are through AFSP and SPAN-USA. SPAN now offers a valuable 95-page support group facilitator's guide at their Website. AFSP offers a comprehensive facilitator training program in three or four different cities yearly, but at the participant's own expense. AFSP also currently offers monthly telephone conference call-in opportunities for new and /or experienced support group facilitators. While important, these opportunities are simply insufficient for addressing the thousands of support group affiliates throughout the country who need information to better manage their groups and meet members' needs. We should also not lose sight of the fact that the suicide survivor population is growing at a rate of at least hundreds of thousands yearly, though only a portion of this number will seek help in survivor support groups.

Our recommendation, accordingly, would be to post more support group facilitation training materials on Websites which can be easily downloaded by interested parties. We would also suggest the creation of an ongoing information exchange or Internet chat group that would offer professional expertise to survivor group facilitators at least biweekly. In addition, we recommend subsidized mentorships and training workshops for survivor facilitators to acquire and refine their group facilitation skills as other worthy projects for the suicide information clearinghouses to pursue.

The present research has demonstrated the value of peer support groups to suicide survivors. Peer support is an especially low-cost alternative for helping people deal with the crisis of suicide loss. Much more research is needed to better understand how survivor peer support groups work, to better identify which

survivors are best helped by them, and to identify those survivor characteristics best matched with alternative treatment approaches. These important questions about these groups remain for future research and exploration.

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

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