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A Support Group Intervention for Children Bereaved by Parental Suicide

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Abstract

TOPIC—Bereavement is considered by many to be among the most stressful of life events, and it becomes particularly distressing when it concerns the suicide death of a parent. Such an event is especially traumatic for children.

PURPOSE AND SOURCES—The purpose of this paper is to present a case for support group interventions designed specifically for child survivors of parental suicide. The authors provide a theoretical framework for supportive group interventions with these children and describe the structure of an 8-week bereavement support group for this special population of suicide survivors.

CONCLUSIONS—A case is made for designing and implementing group interventions to meet the mental health needs of this important group of individuals.

Search terms

Bereavement; support group; child; survivors of suicide

Background

While the death of a parent is a traumatic event for anyone, it may be especially intensified for young children. Children who experience the death of a parent may experience anxiety and/or depressive symptoms, fears, angry outbursts, and regression in developmental milestones (Dowdney et al., 1999). Studies suggest that when the parental death is due to suicide, the impact can be associated with more severe and long-lasting problems in comparison to nonsuicidal deaths (Cerel, Fristad, Weller, & Weller, 1999). This assertion is supported by studies demonstrating higher rates of anxiety, depression, poor school performance, and decreased social adjustment among children who are survivors of parental suicide than among those whose parents died by natural causes (Cerel et al.; Pfeffer et al., 1997; Sethi & Bhargava, 2003).

Child survivors of parental suicide are left with the challenge not only of trying to understand why their parents died by suicide, but also of coping with the social stigma of a

suicidal death (Cerel et al., 1999). Yet, clinicians find little information concerning appropriate and effective psychotherapeutic techniques to guide their attempts to help these children adjust to the death of their parents. In a paper entitled "Effective Communication with Bereaved Child Survivors of Suicide" (Mitchell et al., 2006), the authors review psychosocial outcomes and communication issues associated with bereaved children of parental suicide. In the present paper, the authors outline the theoretical underpinnings and the practical design of a survivors suicide support group for bereaved children (of parental suicide).

Support Group Interventions for Childhood Survivors of Suicide

Despite the results of studies suggesting an increased risk for psychiatric disorders and social maladjustment in children grieving the loss of a parent due to suicide (Pfeffer et al., 1997; Cerel et al., 1999; Sethi & Bhargava, 2003), there is a dearth of studies that assess the use of support group interventions to address the special needs of this population. This may be due to the relative lack of mental health services specifically designed to assist children bereaved by suicide. In the United States and Canada, most psychotherapeutic group interventions are designed for adults, thereby serving very few children (Ruby & McIntosh, 1996).

Nevertheless, research suggests that support groups benefit children by allowing them the opportunity to talk with others who share the unusual and disruptive experience of parental suicide. Pfeffer and colleagues examined 39 suicide-bereaved children who received 10 psychotherapeutic group sessions aimed at helping them to cope with the death and compared results to another 36 suicide-bereaved children who received no intervention. The results demonstrated fewer reports of anxiety and depressive symptoms in the psychotherapeutic intervention group than the control group (Pfeffer, Jiang, Kakuma, Hwang, & Metsch, 2002).

Such empirical studies outline the risks of increased psychiatric disorders and social problems following parental suicide. The consequences of these struggles are often seen years later by clinicians who work with adult childhood survivors of suicide. Campbell notes that adult childhood survivors of suicide are "forever changed by this indescribable and complicated bereavement" (Campbell, 1997, p. 330). The subjects in his sample reported problems with social relationships, occupational functioning, and frequent problems with drug and alcohol use. When asked, they unanimously agreed that they would have benefited from the chance to talk about the suicide that they experienced as children while still in childhood (Campbell, 1977). Interventions in the form of therapeutic support groups are one way to address this need.

A Framework for Children's Support Group Interventions

Lego (1984) defines the support group as an intervention which uses the client's present ego strength, and through the use of support and encouragement further strengthens it. Webb (1993) points out that the group serves an important purpose; that is, to help the child cope with bereavement in the company of other children who are similarly bereaved. The common ground of group support helps to decrease feelings of embarrassment or being different that might otherwise lead the child to withdraw while grieving (Lego).

Evidence suggests that support groups especially designed for children may prove useful for children in the aftermath of parental suicide. This idea is consistent with the work of Yalom (1985). Although he does not explicitly address the application of his theoretical group model to work with children, Yalom does identify a number of curative factors that may be

hypothetically extended to children, provided that attention is paid to the unique cognitive, emotional, and social developmental needs of children.

When planning interventions with this population in the form of a support group, it is important to consider the question of a child's readiness to respond to the traumatic loss of a parent by suicide. Webb (1993) suggests that many children may want to avoid dealing with issues that cause them to experience upsetting feelings, and so it is reasonable to expect that they may require time before they are ready to express their grief. Because grief takes place over time, the primary concern for clinicians are those symptoms that interfere with the child's social, emotional, or physical development (Webb), such as when the child's ability to carry out his or her usual activities or when progress made towards achieving developmental tasks is impaired.

Signs of depression such as feelings of sadness, difficulties with sleep, and loss of appetite may be consistent with those associated with a major depressive episode, and may be significant enough to meet the criteria set forth in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 1994). However, a diagnosis of major depression is not usually given unless the symptoms are still present after 2 months following the death or include significant impairment in functioning, severe preoccupation with worthlessness, psychomotor retardation, suicidal ideation, or psychotic symptoms (American Psychiatric Association).

Therapeutic factors that may be especially useful when working with child survivors of suicide include the instillation of hope, emphasizing universality and interpersonal learning, facilitating group cohesion and catharsis, as well as imparting information. Yalom (1985) underscores the importance of instilling and maintaining hope as a foundation necessary for the implementation of all other therapeutic aspects of group therapy. Because members of support groups, including child survivors of suicide, may be at various points on their adjustment to loss and have different abilities to cope with their new circumstance, group members identify contact with others who have learned to cope effectively with situations similar to their own as particularly important (Yalom). Group members often express the belief that they are best understood by those who have coped with similar circumstances and have survived.

Yalom's theories support the position that children who have experienced the suicide of a parent may benefit from a group environment that fosters a sense of hope by creating possibilities for them to interact with one another around the issue of suicide. Specifically, child survivors of suicide, in the midst of such life-altering trauma, need a safe place where they can begin to explore and try out newly acquired beliefs about themselves and the world around them. The alleviation of physical and psychological symptoms such as difficulty sleeping, nightmares, and anxious or depressed moods may contribute to a renewed sense of pleasure in daily activities and the ability to enjoy life once again. Therapeutic goals for child suicide survivors include not only instilling hope for the future, but also enhancing skills necessary to cope with such difficult circumstances. Such goals may contribute to a decreased incidence of complicated grief, suicidal ideation and attempts, or completed suicides in child survivors of suicide. The presence of hope fosters the continuation of normal childhood development as well as the possibility of greater resilience among survivors.

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Proceeding from the belief that all human beings have strong social needs for acceptance and interaction with others, the group offers possibilities for therapeutic learning. More

specifically, members are presented with emotions that may have been difficult for them to deal with in the past (Yalom, 1985). The support group allows the child survivors of suicide to interact in a safe, nonjudgmental venue not otherwise available to them, due to the inability of the nonbereaved to effectively empathize. Wagner and Calhoun (1991–92) note the difficulty experienced by those outside the circle of grief in communicating with the bereaved. Those outside are often worried about social perceptions and floundering due to the lack of social rules to help guide the behavior of potential comforters. They state, it is often easier to avoid the bereaved than to make a mistake (Wagner & Calhoun). Among bereaved peers, however, the child develops satisfying relationships and gains potential benefits such as lessened social anxiety, increased self-esteem, and a decreased need for self-concealment through realization that disclosure does not result in abandonment or ridicule. As these changes occur, a positive feedback loop is established through which a growing sense of approval and acceptance improves self-esteem, encouraging improved communication with parents, siblings, and peers and discouraging problematic behaviors that are age-inappropriate, impulsive, or aggressive. With the development of interpersonal successes within the safety of the group, there may be a renewed tolerance for social risk-taking and a willingness to become more emotionally involved in the world (Yalom).

Role of Support Group Facilitators

The roles of clinicians when facilitating child survivor of suicide groups are numerous. One important role is that of sharing information. Providing explanations and clarifying information is therapeutic in that it replaces uncertainty with credible explanations that can be woven into cohesive narratives, helping to restore participant's sense of control over their lives (Dysart-Gale, Mitchell, & Wesner, 2003). Group facilitators thus address participants' fundamental needs for access to open, honest explanations regarding the nature of suicide, death and dying, and an understanding of the grief process.

Another essential role of the facilitator is to establish participants' expectations that the group will be not only a safe place to explore painful emotions, but is also designed to help members cope with their loss. To this end, the facilitator must convey a caring, respectful presence by empathic, active listening. This characterizes the authentic therapeutic encounter and promotes group cohesiveness through the establishment of safe and respectful boundaries. The facilitator maintains this environment of safety while conducting a variety of therapeutic activities of a verbal, written, artistic, and/or interactive nature. It cannot be emphasized strongly enough that the facilitator must have a firm faith in the group process, and in the potential of the group as a means of healing and improving quality of life (Yalom, 1985).

A Bereavement Support Group for Child Survivors of Parental Suicide

Future research is needed to determine if support group interventions help child survivors cope with the loss of a parent by suicide. This paper contributes to this effort by describing one such support group conducted at an outpatient psychiatric clinic in a large eastern U.S. city, the Children's SOS (Survivors of Suicide) Bereavement Support Group. The SOS group utilizes both psychotherapeutic and psychoeducational interventions to provide support, information, and to begin to alter children's thoughts, feelings, and behaviors. Specific interventions involve the use of activities that encourage the use of the children's cognitive, verbal, written, and drawing skills.

A key element of the SOS group is the creation of a supportive atmosphere. Throughout the 8 weeks of the support group intervention, the children begin to view other members of the SOS group as friends with whom they share common everyday likes and dislikes, not just the experience of parental suicide. The group provides a comfortable environment in which

to share their experiences of their parents' deaths, their thoughts and feelings about the suicide, and to learn new ways of coping with the death of their parents.

In the SOS group, special care is taken to accommodate the level of cognitive development of the children in the group. Age-appropriate information helps these children develop an understanding of suicide in general and of their own parent's death in particular. Consideration of the child's cognitive development is essential in order to explain the concept of death and to clarify potential misconceptions they may have regarding the nature of death. For instance, awareness that death is an irreversible and universal phenomenon allows for a more realistic understanding of the event of suicide.

Children in the SOS group are also provided with supportive education about the grief process and what they can expect as their grief work progresses. This includes discussing the concept of grief and the common thoughts, feelings, and behaviors associated with it. Participants often express appreciation for the realization that they are not alone and that other children experience similar thoughts and feelings.

Support group facilitators need to be committed to the belief that the group atmosphere provides a safe place for the exploration of troubling cognitive beliefs and angry or ambivalent feelings.

Support group facilitators need to be committed to the belief that the group atmosphere provides a safe place for the exploration of troubling cognitive beliefs and angry or ambivalent feelings. Support group interventions include group activities that encourage children to incorporate a positive, enduring sense of the deceased parent into their present reality. Interventions such as teaching problem-solving skills and methods to obtain help when needed are included in the hopes of reducing the vulnerability of the participants. The structure of the SOS support group intervention is outlined below. Examples are provided to illustrate the therapeutic value of various components of the intervention.

The 8-Week Sessions of the Children's SOS Bereavement Support Group

The SOS Bereavement Support Group is designed for children who have lost a parent or other family member through suicide. It is facilitated by an advanced practice registered nurse. The group typically consists of children ranging in age from 7 to 13 years. From six to eight children attend the group each week and their gender distribution is typically equal. For the majority of the children, their parent has died by suicide within 2 to 6 months before involvement in the SOS bereavement group. The SOS group meets every other week for 1.5 hr over an 8-week period.

The Children's SOS Bereavement Support Group is progressive in design. This method reinforces the previous material discussed while introducing new information in each subsequent session. Various activities are used to enhance the children's interactions and involvement in the group meetings. The facilitator uses activities such as drawing pictures and playing games to encourage the children to talk about their feelings. Each group session ends with 15 min of activities such as guessing games or snack time. This not only allows each session to end on a positive note, but also allows the children to become better acquainted as the group progresses. As the children become more comfortable expressing their feelings, the group discussions become more detailed to better help the children deal with specific concrete issues concerning the loss of their parent. The following section provides an overview of each group session activity.

Session 1

Goals for the first session include orientating the children to the purpose of the group, as well as providing an overview of the methods that will be used to achieve the identified therapeutic goals (i.e., use of group discussion, teaching, art activities, etc.). This, along with establishing and reviewing ground rules such as confidentiality, help to create an environment that feels safe for the children, and promotes the development of trust within the group. An important activity in the first group meeting focuses on introducing the children. Every child states his or her name, age, grade in school, and favorite activities/hobbies.

Furthermore, following Yalom's curative factors (1985), this initial session begins the process of imparting information, allowing group members to come to a common understanding of the nature of suicide. This basic understanding is necessary to help the children comprehend what has happened to their parents. To this end, the facilitator elicits the children's perceptions of suicide and death and uses these descriptions as the point of departure for a simple discussion about the nature of suicide.

It is important for bereaved children to understand the causes of suicide in order to begin accepting and coping with the loss. Thus, in the first session, children are presented with an age-appropriate discussion of suicide as a function of an underlying medical condition. This discussion is based on the commonly accepted characterization of suicide not as a personality defect or volitional act, but as a biological imbalance caused by a lack of serotonin. It is explained that an imbalance in serotonin is connected to aggressive, violent, and impulsive behaviors (Jiwanlal & Weitzel, 2001), possibly setting the stage for individuals to follow through with the act of suicide. To present this complicated material, the facilitator makes use of the children's ability to understand through the analogy of suicide as an illness.

The group facilitator begins by discussing a heart attack and what happens to the body when a person suffers a heart attack. Then, the children compile a list of possible causes such as shock, stress, injury, sudden events, and "if your heart stops working." Next, the facilitator discusses how the same causes for a heart attack could be responsible for a person's brain functioning improperly. This enables the children to make the connection that such a "brain attack," like a heart attack, is beyond an individual's control. The group facilitator explains that such a "brain malfunction" is not something an individual is completely aware of because it is an illness. Children seem to readily understand through analogy that their parents' suicide was caused by his or her "brain being sick" and not working as it should have. One little boy was able to then make his own analogy that when the brain stops working correctly, such as when someone commits suicide, it is like a computer in sleep mode. "It is still on but you cannot do anything with it." This example demonstrates how children are able to translate new concepts into their own words, better relating them to their own lived experiences.

Session 2

The goal of the second session is to allow each participant to express his or her feelings associated with the parent's suicide in greater detail. As the children begin to feel more comfortable interacting with one another in the group, the facilitators' primary therapeutic goals for the participants are to develop a sense of hope, and an appreciation that others share their experience (universality). These goals are accomplished through discussion, allowing participants to begin the process of self-disclosure as they feel comfortable. Additionally, drawing and writing activities allow for the identification and expression of feelings that they might otherwise be unable to articulate.

One representative activity, originally adapted from the book *A Bunch of Balloons: A Story-Workbook for Young Children* (Ferguson, 1992) focuses the children's awareness on both the losses they have sustained through their parents' deaths, and what still remains. Each child is given two pieces of paper. On one piece of paper, they are asked to draw five balloons floating away and write their parents' name on the bottom of the page. Inside each of the five balloons, the children write the name of one thing they lost when their parent died. Examples of what children write include memories, the house, happiness, and a friend. One 7-year-old girl wrote "her mind" and another, "her sports" and "Dad's belongings." Almost always, one child identifies "the future" with their deceased parent as something they have lost.

On the second piece of paper, the children again draw five balloons, but this time, the balloons are attached to something (e.g., a string). Inside these balloons, the children are asked to write five things they still have, even though their parent is dead. In these balloons, the children identify such things as their mom (if a father has died), friends, other family members, pets, memories, and pictures. This activity addresses the children's desire to know that their needs will continue to be met (Rando, 1988). By articulating what they still have, the children are reminded that they still have other people who care about them and will support them. It also gives them the opportunity to remember activities that they used to do with their deceased parent. Even though he or she is no longer living, the child will inevitably note memories of the good times shared with the deceased parent.

Session 3

In this session, therapeutic goals continue to focus around instilling hope and making explicit the universal nature of the children's experience. This is accomplished through use of activities that increase opportunities to interact and share with each other around the issue of parental suicide. In this session, there is the possibility for a sense of catharsis as the children begin to express feelings towards their deceased parent, the event of parental suicide, and its effect on their lives in its aftermath.

In the third group meeting, when the children are better acquainted with one another, they share pictures of the deceased parent and memories of activities they did together. To help the children express their feelings, they engage in activities that allow them to describe their emotions surrounding the death of their parent. One activity used in this session includes having the children write a letter to their deceased parents. The goal of this activity is to provide the children with an opportunity to symbolically express their feelings about the suicide, as well as to describe events in their lives since the death.

By articulating what they still have, the children are reminded that they still have other people who care about them and will support them.

Some children express anger toward their deceased parent in these letters and tell them they were "selfish." One boy stated he had learned from the support group that his father suffered from an illness, and that his suicide was not an act of abandonment. Nevertheless, the child was still not ready to accept his death and is still hurt his father is no longer with him. Many of the children write about specific things they miss doing with the deceased parent, such as "wrestling on the couch" or "reading books." They also discuss good things that have happened to them since the death, such as getting good grades, winning an award, or making new friends. This exercise appears to be especially beneficial to those children who are not able to share their feelings verbally in earlier groups. These children are glad to be able to write down their emotions and thoughts, and are subsequently able to share more verbally within the group.

Session 4

In the fourth session there is a shift from centering around the act of parental suicide towards the effect it has had on the child. Therapeutic goals, in terms of Yalom's (1985) curative factors, emphasize in this session imparting information, specifically in relation to the phenomenon of grief, further illumination of members' universal and common experiences, and an increasing sense of group cohesion as the children are able to rely upon each other for acceptance and support as they share their feelings.

The fourth session focuses more on the children's personal grief and less on the deceased parent. The group leader explains what grief is and then facilitates a discussion about learning to cope with the death of a parent. As the group session progresses, the topics advance from learning about suicide to coping and moving on with their lives.

Around this time, the children are asked to draw a picture of grief and discuss the meaning of their picture. To provide an example, one group member, a 10-year-old boy, drew a picture of a television with a grey picture. When describing his picture, he said it was like "waiting and waiting for something to happen that takes a long time." Another child drew a black cloud, and reported an inability to feel happiness any-more. A 6-year-old girl once drew a picture of herself crying and also one laughing, stating she does not feel sad *all* the time.

Session 5

In the fifth session, ongoing therapeutic goals include continued emphasis upon instilling hope, universality, group cohesion, and, in particular, interpersonal learning. As they are engaged in activities that facilitate the expression of feelings that may have been difficult for them to deal with in the past, their responses are allowed to unfold in an atmosphere of safety and acceptance. As participants experience an increasing sense of validation, self-esteem, and approval within the group, they increase their willingness to disclose and explore. This, in turn, permits them to develop and practice interpersonal communication skills, setting the stage for improved relationships both inside and outside of the group.

By the fifth session of the SOS group, the children are encouraged to talk about grief and ways of dealing with it. To help the children comprehend the concept of grief, the leader asks the children to define the word *grief*. The most common response is "grief is what someone feels or how someone expresses her or his emotions when a person dies." The group members list on a board the emotions they have experienced since the death of their parent (e.g., words such as anger, hate, frustration, sadness, confusion, bad dreams, and worries). Although the words often express negative emotions, one 15-year-old shared her sense of "relief," that she no longer had to worry about her father.

During this session, children will also talk about other people's reactions to them, and express feeling as if they are "under a microscope" with "everyone watching them." These children also express a fear of being judged by others because their parent died by suicide. They often express fear and the preference for making up stories such as "it was an accident," "a heart attack," or that the parent "moved to Paris." The discussion then focuses on the issue of disclosure: what needs to be told to others and what does not. They also discuss what may happen if they tell a friend a lie about their parents' death when they know the truth surrounding the death. Children in the group typically reach consensus that they can control the amount and nature of information they disclose to others. Ultimately, children are encouraged to develop their own story concerning the facts around their parents' death. After this session, one 11-year-old asked his aunt to explain what specifically had happened to his father and she was able to honestly answer his questions. Up until this point he had not been active or involved in the group, but once he had the necessary

information to form his story, he was able to become involved and productive within the group setting.

One 10-year-old girl appeared particularly engaged with this material. After some discussion, she asked if the fact that she had not cried at her father's funeral meant that she had had a bad relationship with him. The facilitator of the group explained that children of different ages express their grief differently. The girl was relieved to learn that the way one expressed oneself does not necessarily indicate what that person was feeling, and that indeed people do grieve differently.

Because dealing with the loss of a loved one may be more difficult during the holidays, the facilitator helps the children explore ways in which they can remember the deceased parent and make him or her part of the holidays even though the parent is no longer living.

Session 6

This session allows for the possibility of catharsis as the children become engaged in a discussion designed to integrate conflicting feelings toward the parent who has died. Session 6 focuses on an important aspect of grieving, identifying positive ways to remember the individual who has died. Children's age-related cognitive development may require clinicians to provide supportive assistance as children come to terms with the task of determining how to remember their loved one (Rando, 1984). In this session, the group members are asked to describe their deceased parent, their jobs, their hobbies, and how the two of them spent free time together.

Because dealing with the loss of a loved one may be more difficult during the holidays, the facilitator helps the children explore ways in which they can remember the deceased parent and make him or her part of the holidays even though the parent is no longer living. Some suggestions from the children were to "buy an ornament for the Christmas tree each year" for their parent, "visit the cemetery," or "look through old pictures" to reminisce. Similarly, the facilitator discusses other anniversaries (such as birthdays) to show that although holidays and special events may be difficult times, remembering past years with his or her deceased parent and the good times they shared, the child can keep alive a loving memory (Rando, 1984).

Session 7

The integration of opposing and conflicting emotions is further explored in session 7, with the goal of continued therapeutic, curative catharsis (Yalom, 1985). It is also important, as the group approaches the final session, to discuss the impending termination of the group in concrete and explicit terms. For children who have experienced such a sudden and traumatic loss as that of a parent by suicide, the ending of the group must be clearly defined and discussed throughout the course of the support group so it is not experienced as unexpected or disruptive.

In week 7, the children are asked to draw an animal that reminds them of happiness, and another picture that reminds them of sadness. Children will describe their animals differently depending on the nature of the relationship with their deceased parent. One 7-year-old drew a picture of a giraffe as sadness, because it was vulnerable and easily killed, and a snake as happiness because "it could go undetected by predators." In the same group, a 15-year-old girl drew the same animals but in reverse. The snake was described as "sneaky" and "could hurt if it bit you" and her giraffe was described as "peaceful and graceful."

Drawing in all stages of the therapeutic process may be extremely useful. Drawing allows children to give expression to things they might otherwise be unable or unwilling to verbalize (Malchiodi, 1998). The SOS group facilitator encountered a striking example of this from a child whose father had completed suicide by asphyxiation. In their account of the events, adult family members consistently asserted that the child was outside the home when his father died, and further, that the child remained completely unaware of his father's death until he was told by his mother after his father's body had been removed from the family home. The adult family members expressed comfort and relief that they had been able to protect the child from the unnecessary trauma of viewing his father's body. The child verbally confirmed this account, but his drawing revealed that he had colored his father's face a grotesque blue. The drawing provided the facilitator with new information, which was discretely incorporated into the plan of care without causing additional trauma to the child or family.

The use of drawings with children is also useful for documenting the progression of their grieving process. Mitchell, Dysart-Gale, and Wesner (2003) found that over the course of therapeutic support group sessions, adults are able to progressively recast their narratives of loss from ones of hopelessness and helplessness to ones of agency and hope. Children, with their under-developed verbal and cognitive abilities, pursue this process through drawing. Drawing both happy and sad pictures focuses the children's attention on the twofold nature of their grief work: to acknowledge sadness, and to move toward restoring happiness. Sharing these drawings over the course of several sessions not only reinforces the participants' awareness that others have suffered losses similar to their own, they also present examples of how other childhood survivors of parental suicide developed coping strategies to come to terms with their loss.

Session 8

In this final session, as Yalom states, "termination is more than the end of therapy; it is an integral part of the process of therapy" (Yalom, 1985, p. 368). The leader must encourage the group members to share their feelings about the ending of the group, acknowledge the relationships that they have developed with one another, and identify the loss of the group and their relationships with each other. Allowing and encouraging the children to say goodbye to each other highlights the importance of acknowledging endings and can provide a model for dealing with future losses. The potential therapeutic value of this experience cannot be overstated with this particular group of children.

Week 8 focuses on concluding the SOS bereavement group with a pizza party. This permits the children to relate to each other as friends in a relaxed atmosphere. During this session the children play a guessing game that reinforces words featured in the group discussions over the previous seven sessions. Not only do words like "suicide" come up, but more often than not, so do positive words that express a sense of accomplishment and hope.

Conclusions

The death of a parent, particularly by suicide, can be devastating for children. Therefore, it is not surprising that studies show that suicide-bereaved children may face long-term problems both emotionally and socially. These children are at risk to experience anxiety, depression, and social problems. Warning signs that a child may need further referral and treatment would be any major deviation from their baseline level of functioning and usual behaviors. Often children regress behaviorally for a period of time, so it is important to monitor the duration and severity of such changes. This becomes important because suicide bereavement may be more difficult by the often present social stigma and lack of social support. Not only is there the challenge of coping with the loss of a loved one, but also in developing an

understanding of why individuals die by suicide, a challenge to children lacking intellectual maturity, as well as to the surviving parent.

Support groups such as the one just described can be designed to help children comprehend what suicide is and why it can happen. They can be helpful because people will compare themselves to others that they view as similar to themselves, especially when they lack other methods of evaluating their beliefs and opinions (Van Dongen, 1993). Such support groups provide activities that enable children to express their feelings while developing skills to cope with the death, as well as to learn ways of remembering the deceased. Through effective communication and support after a parental suicide, children may come to understand death and suicide.

Increased efforts to help children cope with the suicide of a parent or other family member are needed. Although we did not formally evaluate mental health outcomes in these children, future research designed to evaluate the effectiveness of survivors of suicide support groups with children are desperately needed. It is then that we may be in position to evaluate what is needed, what works and what does not, and what effects various treatments have on children's psychosocial functioning.

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