UDST #687898, VOL 37, ISS 1

POSITIVE EXPERIENCES FOR PARTICIPANTS IN SUICIDE BEREAVEMENT GROUPS: A GROUNDED THEORY MODEL

ANITA D. GROOS and JANE SHAKESPEARE-FINCH

QUERY SHEET

This page lists questions we have about your paper. The numbers displayed at left can be found in the text of the paper for reference. In addition, please review your paper as a whole for correctness.

Q1: Au: Please provide received and accepted dates.
Q2: Au: Note: British spellings have been changed to American spellings throughout per journal style. Please check and confirm edits.
Q3: Au: Please add publisher location for Lifeline Australia 2009a reference.
Q4: Au: Please add publisher location for Lifeline Australia 2009b reference.
Q5: Au: Please add page range for Neimeyer & Sands reference.
Q6: Au: In Robinson et al. 2008 reference, APA style is to list 6 authors, followed by ellipses, and final author.

TABLE OF CONTENTS LISTING

The table of contents for the journal will list your paper exactly as it appears below:

Positive Experiences for Participants in Suicide Bereavement Groups: A Grounded Theory Model
Anita D. Groos and Jane Shakespeare-Finch

3b2 Version Number : 7.51c/W (Jun 11 2001)
File path : P:/Santype/Journals/TandF_Production/UDST/v37n1/UDST687898/UDST687898.3d
Date and Time : 30/10/12 and 14:27

Death Studies, 37: 1–24, 2013

ISSN: 0748-1187 print/1091-7683 online
DOI: 10.1080/07481187.2012.687898

Routledge
Taylor & Francis Group

POSITIVE EXPERIENCES FOR PARTICIPANTS IN SUICIDE BEREAVEMENT GROUPS: A GROUNDED THEORY MODEL

ANITA D. GROOS

School of Psychology & Counselling, Queensland University of Technology, Brisbane, Australia and Lifeline Community Care Brisbane, Brisbane, Australia

JANE SHAKESPEARE-FINCH

School of Psychology & Counselling, Queensland University of Technology, Brisbane, Australia

Grounded Theory was used to examine the experiences of 13 participants who had attended psycho-educational support groups for those bereaved by suicide. Results demonstrated core and central categories that fit well with group therapeutic factors developed by I. D. Yalom (1995) and emphasized the importance of universality, imparting information and instilling hope, catharsis and self-disclosure, and broader meaning-making processes surrounding acceptance or adjustment. Participants were commonly engaged in a lengthy process of oscillating between loss-oriented and restoration-focused reappraisals. The functional experience of the group comprised feeling normal within the group, providing a sense of permission to feel and to express emotions and thoughts and to bestow meaning. Structural variables of information and guidance and different perspectives on the suicide and bereavement were gained from other participants, the facilitators, group content, and process. Personal changes, including in

Q1 Received ■; accepted ■.

We are extremely grateful to the suicide bereavement group participants who took part in these interviews. Their generosity in giving additional time and sharing their experiences has helped give some insights into this very complex and painful area. We hope this study will be able to assist others bereaved by suicide through enhancing future groups. Thanks also to the group facilitators who assisted with the research process and Julie Aganoff (General Manager Programs, Lifeline Community Care Brisbane) who made this collaboration possible.

The suicide bereavement groups run by Lifeline Community Care Brisbane in 2007 and 2008 were funded by the Commonwealth Department of Health and Ageing as an adjunct to the StandBy Response Service.

Address correspondence to Jane Shakespeare-Finch, School of Psychology and Counselling, Queensland University of Technology, GPO Box 2434, Brisbane Qld 4001, Australia. E-mail: j.shakespeare-finch@qut.edu.au

relationships and in their sense of self, assisted participants to develop an altered and more positive personal narrative.

Suicide is devastating for those affected by it and a range of coordinated population and community-based suicide prevention strategies have been introduced in Australia, including the Living is for Everyone Framework (Department of Health and Ageing, 2008). These prevention strategies seek to foster collaboration across multiple sectors and have focused on normalizing help-seeking behavior and reducing social stigma surrounding mental illness. Australian figures indicate that suicide deaths exceed deaths by motor vehicle accidents (Department of Health and Ageing, 2008) and it is acknowledged that statistics tend to underrepresent the extent of suicide (Australian Bureau of Statistics, 2007; DeLeo, 2007). Regardless of the actual figure, it is clear that many people are impacted by suicide. The provision of support and services for family members and others affected by a suicide death is long recognized as a need and the concept of postvention as prevention is receiving increasing support (e.g., Andriessen, 2009; Cerel, Jordan, & Duberstein, 2008).

Suicidal death has been described as usually sudden, unanticipated, untimely, often violent, and subject to stigmatization by the community (Moore & Freeman, 1995). Others have suggested that although such a death is sudden, it is not necessarily always unanticipated (Australian Psychological Society, 1999). Few studies have evaluated suicide specific interventions (Jordan & McMenamy, 2004), and a recent needs assessment noted that there is little research on the natural coping efforts used by people bereaved by suicide (McMenamy, Jordan, & Mitchell, 2008). Several recent articles also highlighted the gaps in effectiveness research and understanding of the needs of people bereaved by suicide in a support group context (Cerel, Padgett, Conwell, & Reed, 2009), common definition and nomenclature problems (Andriessen, 2009), and they emphasized the need for more intervention studies (Robinson et al., 2008). Cerel et al. (2009) identified that it is important to evaluate support groups to determine the most helpful approaches and benefits gained from participating in such groups. This study addresses this call for further research by examining the experience of people attending suicide bereavement groups offered by Lifeline Community Care Brisbane, Australia.

Lifeline was founded in 1963 by the late Reverend Dr. Sir Alan Walker after he received a call by a distressed man, who 3 days later took his own life. Sir Alan launched a crisis line and the 24-hr telephone service remains a major commitment to suicide prevention. Lifeline's services have also been expanded to include a number of programs that promote mental health, well-being, and help-seeking behaviors including key service streams such as a 24-hr crisis counseling line; face-to-face counseling for individuals, couples, and families; school-based counseling; financial counseling; and community recovery. The StandBy Response Service (LIFE Communications, 2010) provides crisis intervention, support and referral specifically for people bereaved by suicide. These referrals have included three group processes: the structured suicide bereavement and subsequent pain management groups, plus monthly suicide bereavement peer support groups. Lifeline Australia has also recently coordinated a collaborative project on best practice standards for suicide bereavement support groups (Lifeline, 2009a, 2009b).

Suicide Bereavement and Social or Professional Support

Suicide bereavement is distinct from mourning other types of death in the thematic content of the grief, social processes surrounding the bereaved, and impact on family systems (Jordan, 2001). People bereaved by suicide often show higher levels of feelings of guilt, blame, rejection, or abandonment by the loved one, which can also manifest as a sense of responsibility or anger (Bailley, Kral, & Dunham, 1999), or shame, stigma and the need for concealing the cause of death (Sveen & Walby, 2007). Callahan (2000) suggested a model combining posttraumatic reaction and grief as most appropriate in the suicide context. Complicated grief, which shares many features with depression and posttraumatic stress disorder, has also been found in relation to suicide bereavement, carries risks of suicidal ideation (Cerel et al., 2009), and may be more common for people in a close relationship to the deceased (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004).

Several small studies have explored social support after suicide and highlight the element of self-stigmatization, with those bereaved often feeling more pressure to explain the cause of death

and reporting that others treated them differently after the suicide (Dunn & Morrish-Vidners, 1987–1988; Farberow, Gallagher-Thompson, Gilewski, & Thompson, 1992; Moore & Freeman, 1995). Research on the impact of adolescent suicide on peers, siblings, and parents has documented high rates of depression in surviving siblings and mothers (Brent, Moritz, Bridge, Perper, & Canobbio, 1996). Barlow and Coleman (2003) explored some of the important issues in forming healing alliances within and outside the family following a suicide death, and Cerel et al. (2008) noted that "suicide is a confusing death" and such "ambiguity seems to increase the need within a social network to affix blame" (p. 39).

A recent comprehensive quantitative review of psychotherapeutic interventions for the bereaved indicated a small but significant effect that is in contrast to general psychotherapy treatment reviews demonstrating substantially improved symptoms and function (Currier, Neimeyer, & Berman, 2008). The authors concluded that there is a need for a greater focus on who is likely to benefit from grief interventions with an apparent relationship between the level of bereavement related distress and the likelihood of successful therapeutic outcomes. Although indicated interventions showed the most encouraging results post-treatment and at follow up, the majority of studies fell into the selective intervention category (e.g., for people with heightened risk of distress symptoms following a violent death) and showed a small effect size post-treatment but none at follow up. Interventions targeting universal populations again included only a small number of studies and failed to produce better outcomes than would be expected by the passage of time (Currier et al., 2008).

The benefits of a constructivist-narrative approach in relation to integrating the violent death of a loved one (by accident, homicide, or suicide) has been extensively discussed by Currier, Neimeyer, and others (see, e.g., Currier, Holland, & Neimeyer, 2006; Currier & Neimeyer, 2007; Neimeyer & Currier, 2009). Enhanced sense making following such losses is associated with a more favorable bereavement outcome, whereas a failure to find meaning is conceptualized as a critical pathway to complicated grief symptoms (Currier et al., 2006; Neimeyer & Currier, 2009). Sands (2009; Neimeyer & Sands, 2011) has recently focused on the issues of meaning making, relationships with the deceased,

and the self in her tripartite model of suicide grief that identifies the themes of "trying on the shoes," "walking in the shoes," and "taking off the shoes." She described the challenges of coming to terms with the intentionality of the suicide, emphasized that self-narrative plays a central role in the process of making sense of the death and that understanding, reconstructing, and repositioning relationships are central tasks for the bereaved (Sands, 2009).

Stroebe and Schut (2001) similarly suggested that grieving is an ongoing and fluctuating process that incorporates avoidance and confrontation. In their dual process model of coping with bereavement, oscillation between loss and restoration orientation can be a dynamic and important part of the coping process. In this context, restoration incorporates issues that need to be dealt with or the struggle to shape a new identity and relationships. Although the dual process model (Stroebe & Schut, 2001) does not incorporate many of the traumatic and guilt-related elements that appear to dominate the suicide bereavement experience, it is highly relevant in the context of Jordan's (2009) suggested recovery task of learning to dose exposure of the loss and trauma. As discussed by Neimeyer and Sands (2011), suicide represents a particularly challenging and acute crisis of meaning both in terms of the "event story" of the death and the "back story" of the relationship with the deceased.

As noted by Cerel et al. (2009) there is no research or consensus about the optimal time to join a support group after a suicide bereavement. Janoff-Bulman (2006) also noted that time is a crucial but understudied variable in trauma research. However, the recent review of interventions for the bereaved failed to show any evidence for the importance of timing as a crucial moderator of intervention outcome (Currier et al., 2008). In the context of their research on stress, care giving, and bereavement in a chronic illness situation, Folkman and Moskowitz (2000) argued that coping processes that can generate and sustain positive emotions in the face of chronic stress involve meaning. Calhoun and Tedeschi (2006) have developed a framework where posttraumatic growth, or positive post-trauma change in psychological functioning, is multidimensional. The posttraumatic growth model depicts personal growth as an outcome following a major life event and meaning or sense making of the experience is both a coping strategy and precursor to the gaining of wisdom.

Earlier and specific suicide bereavement support group programs (Farberow, 1992) suggested reductions in feelings of grief, shame, and guilt from pre- and post-intervention assessments; and participants reported high levels of satisfaction with the program. Another study found decline on all symptom categories and participant responses indicated that the program goals were helping them to put the suicide into perspective and to express feelings without being judged (Rogers, Sheldon, Barwick, Letofsky, & Lancee, 1982). A narrative analysis of another suicide bereavement group reported that participants articulated heightened wellbeing and a personal sense of community through sharing the narratives of loss with each other in that setting (Mitchell, Dysart Gale, Garant, & Wesner, 2003). More recently, Feigelman and Feigelman (2008) confirmed these findings of the positive effects of support groups for those bereaved by suicide and particularly point to facilitators providing guidance and clarity that assisted in group participant's healing journey. Further, Feigelman, Gorman, Beal, and Jordan (2008) demonstrated that participation in such support groups could be beneficial regardless of the mode of intervention, whether it be face-to-face or through the internet.

Typically, bereavement support group programs have involved four, eight, or 10 sessions (Jordan & McMenamy, 2004; Murphy, 2000; Murphy et al., 1998), or open-ended formats with participants attending groups whenever they wished (Cerel et al., 2009; Rubey & McIntosh, 1996). In common with many other group processes in the health and psychology field, there is very little information available about the people who choose not to participate or who drop out of groups (Butow et al., 2007). Cerel et al. (2009) suggested that most people bereaved by suicide do not seek formal support or mental health treatment in the United States. Other estimates are that approximately 25% access support groups or therapy in countries where this is available (Andriessen, 2009). The present study sought feedback from past participants of three Australian suicide bereavement groups in the service enhancement context. This study was based on an interpretive and constructivist paradigm and used Grounded Theory, an inductive or abductive strategy of inquiry that allows for the use of multiple sources of information (Glaser & Strauss, 1967).

Method

Suicide Bereavement Group Participants

Three suicide bereavement groups were run by Lifeline Community Care Brisbane in 2007–2008 with 17 participants being eligible for recruitment to this study. At the initial contact with the service, participants were made aware of the evaluation component of the groups and consent forms were distributed at the first group session, which included permission for follow up. Thirteen people responded to the invitation to be involved in the further research process and participated in interviews, giving a response rate of 76%. Group participants were predominantly self-referred resulting from wide community advertising via print media and radio and became aware of the groups through other contact with Lifeline or from information provided by their doctor or counselor.

Suicide bereavement group participants had the option of attending all of the weekly sessions (120 min each including a break) for the 6- or 8-week program offered in each instance. Sessions were offered at two Lifeline offices in metropolitan Brisbane, either during the day (around lunchtime) or after business hours. Group sessions covered the following issues: the grieving process and traumatic loss, physical and emotional feelings, coping strategies, honoring a life, and looking toward the future. These foci align well with the recovery tasks for people bereaved by suicide outlined by Jordan (2009). Each group was led by two facilitators, which included a psychologist and either another psychologist, social worker, or counselor. Group participants were also offered the opportunity for individual interactions or counseling sessions with the group facilitators. The groups were closed to new members after the second session.

To date, all but one suicide bereavement group participant have been female. The majority of people who had died by suicide were male (76.9%), and most were a son (30.8%), daughter (15.4%), brother (15.4%), and partner or spouse (15.4%) of the support group participant. Other relationships (23.1%) included sister, nephew, and son of a friend. The most frequent age group of participants was 51–60 years (61.5%), followed by 41–50 years (23.1%), and 21–40 years (15.4%). The average age of the person at the time

of their death was 31.23 years ($SD = 10.43$, range 20–58, $n = 13$). The average number of suicide bereavement group sessions attended was 4 ($SD = .82$, range 3–5, $n = 4$) for the first group, which offered six sessions, and 7.4 ($SD = 1.01$, range 5–8, $n = 9$) for the two subsequent groups, which offered eight sessions. The time since the suicide bereavement ranged from less than one to seven years with an average of 1.77 years ($SD = 2.09$, $n = 13$).

Procedure

Face-to-face interviews were conducted by the principal researcher in the participant's home or at a Lifeline Community Care Brisbane office. A semi-structured format sought to elicit stories and group experience-based narratives. However, it became apparent that individual concerns often steered the direction of the interviews. This gave an opportunity to gain insight into the complexity of the suicide bereavement experience and generated data surrounding a large number of concepts and categories. The introductions and interviews took up to one hour ($M = 35.5$ min $SD = 10.6$, $n = 13$), were audiotaped and transcribed verbatim within 48 hr.

Approach to the Data

Interviews were analyzed using a Grounded Theory process of inquiry (Glaser & Strauss, 1967). The intention of this method is to generate a theoretical framework by constant comparison of data (Glaser & Strauss, 1967). Theoretical sampling and a variety of data sources can aid with achieving saturation of categories and the theoretical model. Glaser (1998) suggested that it is important to identify a core category during the initial selective coding process and that this can become a guide to further data collection. Although statistical analysis and counting is not recommended within the method (Christiansen, 2007), Rennie (2006) suggested that the frequency of assignment of units of analysis can be an indicator of the generality of a concept among the participants. This frequency information was used during the sorting process to develop and refine the emerging theory. To provide a guide to prominence, the following distinctions are used throughout reporting: a few (1–3), some (4–6), most (7–9), or nearly all participants (10–13) mentioned a particular issue. To recognize the validity of

participant's experience and perceptions, their own narrative and quotes are emphasized throughout the results.

Results

Core Category: Feeling Normal in the Group

The initial core category of normalizing and gaining perspective by being with diverse others also bereaved by suicide was explored in further interviews and redefined as feeling normal in the group. A sense of normality and different perspectives on the suicide and bereavement is a fundamental part of the group experience, which is gained from other participants as well as the information and guidance provided by the facilitators. Numbers in the brackets represent participant identification. Representative statements by participants included "overall, the biggest positive was a sense of normality in the group; that this actually happens to others . . . You You can survive this" [4]; "the thing I found most helpful was for the first time in two and a half years, I sat there and everyone knew what I was going through . . . it's not the actual personal story, you know, it's the people left behind and we are all in the same boat - . . . that's where it's just much easier because you know, there is no explaining that has to be done" [5]; "you don't have to be long winded and explain why. You don't have to be defensive. It just is and they get it . . . and . . . you don't really get this unless you've been through it" [6]; and "you forget in all of your own self absorption, that there are other people who have gone through something so close, it's quite scary . . . But it was reassuring . . . to know that somebody else had died in such similar circumstances" [9].

The fact that a suicide death was different from other bereavements featured in many of the stories and meaning-making processes. By providing the sense that a suicide bereavement can happen to anyone, the group experience enabled participants to hear stories from others and gain the insight that no matter how hard they may have tried to prevent it, it is not possible to keep a loved one safe at all times (this was particularly the case for parents). Nearly all of the participants interviewed included a focus on the normalizing aspect of the group experience, supporting the conclusion that this was appropriately identified as the core category.

Structural Group Components and Information and Guidance

Because this research was conducted in the service evaluation and enhancement context, a significant part of the interviews considered participant's experiences of positive and negative aspects of the groups and sought feedback that could inform future group practices. The central category of information and guidance was identified as contributing to the experience of feeling normal in the group.

There were many positive comments about the group experience and interaction with others bereaved by suicide. However, people often found it difficult to articulate what group content had contributed to this helpfulness or change in how participants dealt with their loss. For example, "it's really hard, I felt that it [the group] was such a positive thing, but it's very hard to explain why . . . It just was good and I guess it fulfilled a need that hadn't been fulfilled" [6].

All participants talked about the benefits of a good group structure, content, and process, and this formed the basis of the category of information and guidance provided by the group experience. A few participants also mentioned trauma as a helpful concept. As one participant put it, "that was one of the things that was particularly well done. That you have two problems, you've gone through a trauma and you are going through grief" [5].

Although some participants mentioned challenges in group facilitation or interpersonal dynamics (e.g., ensuring that all participants have input), all had positive things to say about the group leadership. The involvement of other family members was another slightly contentious issue. This was deliberately avoided for the first group while subsequent groups did allow family members on a case by case basis. Some participants expressed they were glad their family member had not been part of the group. The reasons given were a need to go on the journey by themselves or that they would not have felt open to share in such detail because the other family member was also present.

The benefits of participant diversity were highlighted in relation to good group composition and in relation to when would be good timing for such a group. Diversity was particularly mentioned as a positive component by members of the first and largest group. A few subsequent members also mentioned a sense of being

in the wrong group, or that another participant presented some challenges; suggesting that some participants sought greater similarity in bereavement experience, relationship, or grieving stage within the group. All those interviewed acknowledged that there were constraints on group composition based on who chooses to participate. Participants suggested that there was no prescription about when a group process would be most helpful but rather that this is determined by the individual, whenever people are ready or looking for such support.

The length of time since the suicide was also perceived as an important characteristic of participants as it could provide useful insights to what others could work towards or expect in relation to managing their pain and grief. As described by one participant, "Because it seems to me that timing, of how long it's been is sort of so important. Everyone judges one another or rates one another on the length of time . . . And you have certain expectations of behaviour on how long it's been" [2]. While seeing the progress made by others was able to instill hope and provide support to some participants, a lack of adjustment to the loss also provided a point of comparison and motivation to try to resolve current issues. As described by one participant, "I could relate to everything she was saying, in terms of the actual death. But . . . the fact that she was still stuck in that spot a good few years later . . . frightened me . . . because I thought, oh heck, I don't want to be in a place like that in a few years time" [9].

Functional Group Experiences and Personal Change

Aside from the core category of feeling normal in the group, the domain of functional group experiences included the central categories of permission and making meaning. Properties or concepts contributed or were linked to each of these categories in several ways and created a flow of theoretical relationships toward the making meaning category and into the personal change domain. Permission to grieve, express emotions, talk about the loss, and disclose fears and guilt were topics frequently mentioned by nearly all participants. These aspects, and feeling normal in the group, were also verified as important experiences through the secondary data from the end of group evaluation questionnaire.

Representative statements included "the permission to be hurting. The permission to be in pain, the permission to [say] . . . ok, this is where you are at the moment, and it's bloody horrible, and you are allowed to be there, but things will get better, you know. And they did not say, "time helps", or anything like that" [7]; "it was good to actually make me explore my emotions . . . I think it did help to actually say things aloud" [8]; and "suddenly I was able to let go of that façade, and just, you know, let the emotions run" [10]. "I just think in particular in the first two years, you are just looking for every opportunity to talk about what's happened. And there aren't enough opportunities. And so . . . a) to be able to talk about it to someone, and b) as vividly as you are able to do in that forum, was a great relief" [4]; "Because that far down the track . . . people stop asking about your loss. And that was just nice that I could talk about him and feel safe. You know, feel like I was in a comfort zone with other people that understood. So that was really important to me" [6]; "It was really just a chance to perhaps be in a safe environment, talk about things that you don't normally bring up in a normal conversation. Ah . . . Well you shouldn't anyhow (laughs)" [9]; and "there was less pressure on me because a lot of the issues that other people had, I shared. And so it was really kind of almost relaxing because they could talk about things which were of interest to me and I didn't actually have to do much, and could just sit there and listen" [13].

In relation to searching for answers and disclosing their fear and guilt, participants said "you've got to deal with that, the unknown, the guilt that everybody, everybody carries . . . around "why" did this person die. What didn't I do, how come . . . you know, you try to love them and then they . . . especially as a mum, you know, feeling like somewhere you've failed or whatever" [3]; "Because I was still actually trying to fix the problem, you know . . . by trying to find the answers as to why this has happened and why I hadn't managed to stop it" [4]; "I now live with a level of melancholy . . . and sadness, and a level of fear. Because I've got two other sons . . . So I am terrified of that" [5]; "Because I had terrible guilt that my brother died . . . So I felt that somehow I could have prevented it. But I realised when they said to us that, you know, there is not one thing that usually makes them commit suicide, it's usually a lot of things. I was able to release that guilt" [10]; and "Because suicide as they explained, tends to be different to sudden death or murder even, because it leaves the question

mark . . . and it leaves the people behind wondering if there is anything they could have done at any time to help. And they feel often, very guilty, very fragile because they think that they somehow were responsible or didn't act correctly" [12].

Effortful reappraisal of cognitions and changes in group participants' way of thinking formed a large component of the group and ongoing experience of the bereaved whose fundamental assumptions, schemas, or understanding about their world had been shattered by the death. People often articulated an early period of seeking answers or trying to fix the past, "trying to blame someone" [1], dealing with self-blame, and a gradual move toward greater manageability of remembering and a return to self-care. For many participants, there appears to be a considerable struggle in the work of acceptance. Acceptance and compassion for the self and others was mentioned by nearly all participants. The group helped participants to gain a sense that they could survive this experience and helped to reinforce approach coping strategies rather than avoiding thoughts of the deceased or their suicide. Representative statements included "maybe just that, realising, face the facts, that is what's happened" [1]; "recognising the fact that . . . the pain will never go away . . . but you do learn to adjust more to it" [4]; "But, somehow you get there; no, or you don't get there, you just keep going don't you. That's what it's about" [5]; "I'm resigned to it all, but accept, to me says that's ok. And this will never be ok" [6]; "what I sort of realised was that, it doesn't matter how much you love someone . . . it doesn't protect them from suicide" [10]; and "I say I've accepted it but I don't know if I have or not" [11].

In relation to compassion for the self and others, "I think I helped quite a few people there. Because I was further down the track. And I knew where they were and, we don't have to say much to one another" [2]; "having the compassion of really understanding that pain. Truly understanding that pain" [3]; "I've got to, sort of, take a step forward and reach out, and just shut up and listen to somebody else for a change" [9]; and "I think a lot of us ruminated afterwards, and some women found it really difficult to go home after those sessions" [12].

The challenges of managing emotional distress and traumatic elements of dealing with suicide bereavement were acknowledged by nearly all participants through the concept of avoidance versus

forcing themselves to talk about it through the group process. Enduring distress and intrusive thoughts were challenges that were also experienced by many participants. Thus, a combined property of forced engagement and enduring distress is considered within the overall model of the group experience and has been located within the personal change domain. Participants said, "it made me realise there is no point in going along with a bloody messed up head. Yeah, I've got to go talk about it and all this kind of stuff even if I may not want to. I've just got to go force myself and realise certain things" [1]; "it was just this thing that talking about it actually made them [other group members] acknowledge that the person was gone" [12]; and "after I reached a point, several months I think it was, that I felt that I was kind of coping and was ok. I think what I did, unconsciously or subconsciously was to just shut it all away and move on as best I could. But I didn't manage to shut the things away in a very orderly fashion. And I've learnt over the years to kind of keep a lid on it. And I was very fearful of opening that lid [by going to the group]" [13].

Categories or concepts mentioned by fewer participants, but also linked to the suicide bereavement experience of meaning making and personal change, were a return to self-care and engaging in activities to connect with the deceased, their interests, and, more generally, remembering them. Only one participant mentioned spirituality as an important element of the process of remembering and making meaning, while another talked about her personal belief system she did not do so with a particular reference to the suicide death.

Changes in perception of the deceased, self, and others are also important elements of a broader change in life perspective or priorities, and the transformation of one's relation to others and the world. For one participant a new relationship formed soon after the death was significant as it gave a different perspective on another's hard life and promoted appreciating the day-to-day little things. The experience of being bereaved by suicide clearly made people value and take greater care of those close to them, which is a facet of the central category of relationships. Others chose to continue to invest in important intimate relationships, and thinking through prior family issues was an important component of dealing with the loss. One participant was about to commence a new job in the welfare sector at the time of the interviews that represented a

shift in values and goals. Another person clearly articulated a need to use the loss for greater good. This concept was also linked to a sense of frustration with existing resources.

Embracing a change in thinking, effortful reappraisals, and perspectives on significant others are in stark contrast to the perceived pressure to change or move on that was articulated by some participants in relation to other external processes. According to the participants, many people just do not know how to approach the issue of suicide, the emotional pain experienced by those bereaved by suicide, or the enduring distress and grief. The following quotes illustrate this: "And the psychologist, mine at least was good, but she was all about moving on . . . And you'd almost feel guilty if you dragged it back to the bereavement . . . So, then you're stuck. You think . . . the bereavement and the loss is there every second of every day . . . But everyone is expecting you to, to move on . . . And you can't" [2]. "And he [husband] just [said], you're not allowed to talk about [person who died by suicide], you're not allowed to cry, you just have to put it in a box, put it in the corner, it's over and done with, get on with life" [7].

Relationships were mentioned by nearly all participants and related to functional group experiences through new friends and compassion for self and others, as well as the personal change and meaning-making processes. The group also helped to address particularly the concerns of parents in terms of gaining a perspective on the loss from the view of a sibling and the commonly felt experience of hypervigilant parenting expressed by several mothers in the group. For example, "Every day, checking that the girls are ok, if anything would start going wrong . . . you know, you're super vigilant of your other children" [2]; "I had other dramas . . . It was in my face, that, am I going to lose another child?" [3]; and "The word 'no' does not come into my vocabulary very much anymore . . . I've decided that there is nothing more important than them [other children] being alive" [5].

Model of the Group Experience and Grounded Theoretical Framework

As described above, the core experience of being in the group is gaining a sense of normality (extending to acceptance and compassion for self and others). The central categories of information and guidance provided by the structural group components, and

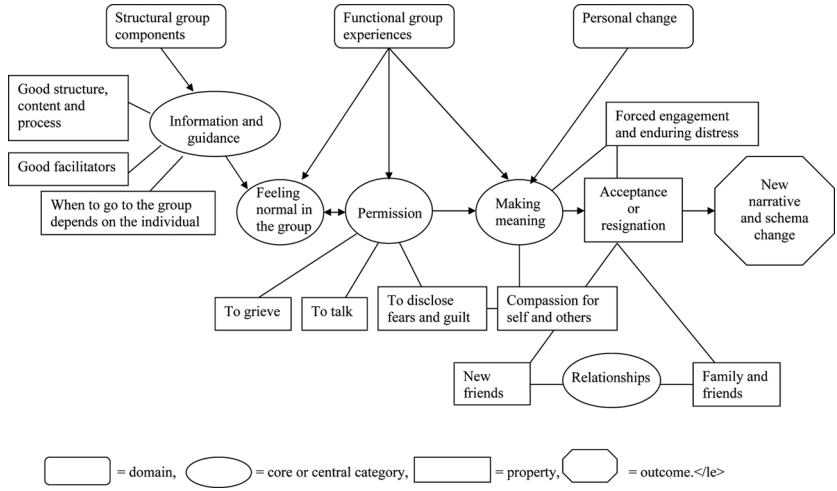

FIGURE 1 Model of the group experience and grounded theoretical framework.

permission to grieve, talk, and disclose fears and guilt in that setting, enhanced this sense of feeling normal in the group. Relationships and new friends within the suicide bereavement group also contributed to this positive experience (see Figure 1).

Discussion

There was strong positive feedback from nearly all participants about the groups existence (and further promotion), process, and facilitation. This was captured by the structural group components and category of information and guidance in the model and is consistent with Feigelman and Feigelman's (2008) findings. The categories relating to functional group experiences, personal change, and the overall model sought to explore the issues of whether group participation is beneficial for adjustment, personal growth, and perceived positive outcome, or in making meaning from the loss. The group experience, talking extensively about the loss, and sharing with others who have suffered a similar bereavement, held strong positives for the interviewees. This was achieved particularly through normalizing the suicide bereavement experience and is consistent with earlier findings (e.g., Farberow, 1992;

Rogers et al., 1982; Wagner & Calhoun, 1991–1992). Being involved in the group process also generated hope for participants by observing and learning from others with different suicide experiences. In particular, it was important to gain a sense that the pain will ease and adjustment or coping with the loss will improve. Most of these elements align well with important group therapeutic factors identified by Yalom (1995) and are captured within the model under the categories of feeling normal in the group, permission, and making meaning.

Universality, catharsis and self-disclosure, instillation of hope, learning from others, and altruism are common elements of group processes (Yalom, 1995). Janoff-Bulman (2006) suggested that the content of one of the assumptions or schemas of our cognitive-emotional systems that is shattered by a tragic and traumatic loss is the phrase, "I never thought it could happen to me" (p. 84). The group experience and re-appraisal of such cognitions exemplifies the realization that suicide bereavement actually does happen to others and in a wide range of circumstances.

The group experience provided an opportunity for participants to work on meaning-based coping processes. For many participants, this effortful thought process and the level of pain experienced were, at different stages, due to the time elapsed since the bereavement and the individual's own post-trauma trajectory or meaning-making process. Consistently, gaining a perspective on such a journey was an important and useful element of the group process and diversity of participants. Meaning making may have occurred through forced engagement with the group process, group and private rumination, or developing greater compassion for the self and others (including the deceased, family and friends). It seems that repeatedly talking about the circumstances prior to and after the suicide in a supportive atmosphere is helpful. Although all participants talked in some form about the concept of acceptance, many in this study were ambivalent about what this meant for them. This concept links to the elements of enduring distress and from the posttraumatic growth and coping literature, the recognition that both adjustment and continuing distress can be present at the same time.

In line with a posttraumatic growth framework (Calhoun & Tedeschi, 2006), the model developed in this study proposes that the gaining of insight, development of new narratives surrounding

the suicide, and schema change are the desirable outcomes from involvement with the suicide bereavement group. Both this study and earlier research indicate that adjustment and recovery are ongoing processes rather than a time-limited task or milestone to be reached (e.g., Farberow, 1992; Wagner & Calhoun, 1991–92).

Acceptance of the loss and manageability of remembering some of the circumstances of the death were particularly difficult for some group participants. The group experience of permission to talk about the death, grieve openly, and to disclose fears and guilt, seems to have assisted participants in reflective, shared, and more deliberate rumination (Calhoun & Tedeschi, 2006), which appears to help facilitate the process of acceptance, making meaning, sense of ability to survive the experience, and growth. Consistent with previous qualitative research (e.g., Dunn & Morrish-Vidners, 1987–1988; Wagner & Calhoun, 1991–1992), much of the meaning- and sense-making process for participants in this study included the need to explore some of the reasons why the suicide had occurred and address distressing emotions of guilt, blame, hurt, and anger. Consistent with other models, acceptance or resignation thus occurs alongside elements of enduring distress (Calhoun & Tedeschi, 2006; Folkman & Moskowitz, 2000; Jordan, 2009; Sands, 2009; Stroebe & Schut, 2001).

Although emotions were intense for all those involved in the Lifeline suicide bereavement groups, this was particularly true for parents who had lost a child through suicide. They expressed their emotions of guilt, blame, and fear, and this extended to being hypervigilant for other children, which is consistent with past research findings that complex family dynamics often accompany a suicide death (Australian Psychological Society, 1999; Jordan, 2001). Aside from gaining perspective on the loss and past or ongoing family dynamics, for many, the elements of sharing, and a high level of disclosure in the group, led to important new relationships and support structures able to address gaps or challenging interactions that often occurred outside of the group. Murphy, Johnson, and Lohan (2003) similarly reported that parents attending a bereavement support group were four times more likely to find meaning in the violent death of a child than parents who did not attend.

There is no consensus about the optimal time to join a support group after suicide bereavement (Cerel et al., 2009). Good timing for the suicide bereavement groups was specifically explored in this study and the majority of interviewees suggested that this was an individual choice based on when people felt ready for such an experience. There were a few suggestions that soon after the bereavement (3–6 months) would be advisable. Other participants in this study suggested around 2 years after the suicide as people would have had the opportunity to deal with some of the intense grief and be ready to engage in a process that would assist further with their adjustment.

Lack of support and understanding within existing social spheres, or a heightened need for emotional support, was evident in earlier studies (Dunn & Morrish-Vidners, 1987–1988; Farberow et al., 1992; Moore & Freeman, 1995) and the suicide bereavement groups seem able to address this issue well. From the perspective of the bereaved, family and friends offered the best support they could, but it was the support from others bereaved by suicide who they met through these groups that provided what they wanted most and did not include implicit pressure to move on and complete the bereavement process.

Limitations

In common with previous research, we know nothing about people who chose not to be involved in this group process. These individuals may seek assistance through other professional support, existing peer or community groups, or rely on their own resources and support networks. The response rate for interview follow-up was good at 76% and those who declined to be interviewed gave reasons that were not related to the group process itself, which suggests that there was no systematic bias in the subset that were interviewed. The model and categories identified also mirrored closely those provided by all but one of the potential participant pool in a brief evaluation questionnaire completed at the end of the group process. The results presented here have therefore been able to capture the experience of people attending the Lifeline suicide bereavement groups well, and the findings have relevance to future practice. However, it is important to note that group and interview participants were almost exclusively female.

Conclusion

This study explored how participants viewed events that were part of their suicide bereavement group experience and how these influenced more personal processes to adapt to the loss. The results suggested a model for understanding the key elements of the group and personal processes, how they assisted participants in making meaning or sense of the loss, and how this may have contributed to greater accommodation, acceptance, or adjustment. In this context the desirable outcome was defined as new narratives and schema change, and the group experience assisted participants with new interpretations, coping strategies, and supportive social and family relationships. The model included the identification of core and central categories important for future suicide bereavement group processes and where individual counseling efforts may also impact (e.g., permission vs. move on concepts).

Future work to extend this model could consider the clinical or counseling sphere as a source of important data. This study deliberately separated the research and service delivery components to enable free exploration of any potentially problematic elements within the group process and to minimize distress for participants. More detailed discussion about the traumatic elements surrounding the suicide death (e.g., seeing the body at the time) would enhance the theoretical understanding of the enduring distress category.

This study confirmed that trauma and posttraumatic growth processes are valid areas to explore in this population, as are meaning-based coping strategies, the relationship focus of the tripartite model of suicide grief, and the dual process bereavement model including loss orientation, restoration orientation, and oscillation. All these concepts or models incorporate the recognition that distress and positive affect or growth can co-occur in challenging and stressful situations. The issue of acceptance of, or resignation to the loss, needs further discussion in this context. The experience of being bereaved by suicide is complex and confusing; hence coping efforts and adjustment to the loss will often be particularly difficult and lengthy. Sands (2009) similarly stressed the non-linear nature of the suicide related grief experience and the need to deal with intentionality, reconstructing and understanding the death story, and repositioning the pain of the deceased and

bereaved as important elements of the adaptation process. A group experience and engaging in some of this narrative and meaning re-construction with others bereaved by suicide can be helpful.

References

Andriessen, K. (2009). Can postvention be prevention? *Crisis*, *30*, 43–47.

Australian Bureau of Statistics. (2007). *3303.0—Causes of death, Australia, 2007*. Retrieved from www.ausstats.abs.gov.au/ausstats/subscriber.nsf/0/0704E1206AE55EB5CA25757C00137C46/$File/33030_2007.pdf

Australian Psychological Society. (1999). *Suicide: An Australian Psychological Society discussion paper*. Melbourne, Australia: Author.

Bailley, S. E., Kral, M. J., & Dunham, K. (1999). Survivors of suicide do grieve differently: Empirical support for a common sense proposition. *Suicide and Life-Threatening Behavior*, *29*, 256–271.

Barlow, C. A., & Coleman, H. (2003). The healing alliance: How families use social support after suicide. *Omega*, *47*, 187–201.

Brent, D. A., Moritz, G., Bridge, J., Perper, J., & Canobbio, R. (1996). The impact of adolescent suicide on siblings and parents: A longitudinal follow-up. *Suicide and Life-Threatening Behavior*, *26*, 253–259.

Butow, P. N., Kirsten, L. T., Ussher, J. M., Wain, G. V., Sandovar, M., Hobbs, K. M., Hodgkinson, K., & Stenlake, A. (2007). What is the ideal support group? Views of Australian people with cancer and their carers. *Psycho-Oncology*, *16*, 1039–1045.

Calhoun, L. G., & Tedeschi, R. G. (2006). The foundations of posttraumatic growth: An expanded framework. In L. G. Calhoun & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: research and practice* (pp. 3–23). Mahwah, NJ: Lawrence Erlbaum Associates.

Callahan, J. (2000). Predictors and Correlates of Bereavement in Suicide Support Group Participants. *Suicide and Life-Threatening Behavior*, *30*, 104–124.

Cerel, J., Jordan, J. R., & Duberstein, P. R. (2008). The impact of suicide on the family. *Crisis*, *29*, 38–44.

Cerel, J., Padgett, J. H., Conwell, Y., & Reed, G. A. (2009). A call for research: The need to better understand the impact of support groups for suicide survivors. *Suicide and Life-Threatening Behavior*, *39*, 269–281.

Christiansen, O. (2007). A simpler understanding of classic Grounded Theory: How it is a fundamentally different methodology. In B. G. Glaser & J. A. Holton (Eds.), *Grounded Theory seminar reader* (pp. 401–418). Mill Valley, CA: Sociology Press.

Currier, J. M., Holland, J. M., & Neimeyer, R. A. (2006). Sense-making, grief, and the experience of violent loss: Toward a meditational model. *Death Studies*, *30*, 403–428.

Currier, J., & Neimeyer, R. A. (2007). Fragmented stories: The narrative integration of violent loss. In E. K. Rynearson (Ed.), *Violent death: Resilience and intervention beyond the crisis* (pp. 85–100). New York, NY: Routledge.

Currier, J. M., Neimeyer, R. A., & Berman, J. S. (2008). The effectiveness of psychotherapeutic interventions for bereaved persons: A comprehensive quantitative review. *Psychological Bulletin, 134*, 648–661.

DeLeo, D. (2007). Suicide mortality data needs revision. *Medical Journal of Australia, 186*, 157–158.

Department of Health, & Ageing. (2008). *LIFE livingisforeveryone.com.au: A Framework for Prevention of Suicide in Australia.* Retrieved from www.livingisforeveryone.com.au/LIFE-Framework.html

Dunn, R. G., & Morrish-Vidners, D. (1987–1988). The psychological and social experience of suicide survivors. *Omega, 18*, 175–215.

Farberow, N. L. (1992). The Los Angeles survivors-after suicide program: An evaluation. *Crisis, 13*, 23–34.

Farberow, N. L., Gallagher-Thompson, D., Gilewski, M., & Thompson, L. (1992). The role of social supports in the bereavement process of surviving spouses of suicide and natural deaths. *Suicide and Life-Threatening Behavior, 22*(1), 107–124.

Feigelman, B., & Feigelman, W. (2008). Surviving after suicide loss: The healing potential of suicide survivor support groups. *Illness, Crisis and Loss, 16*, 285–304.

Feigelman, W., Gorman, B., Beal, K. C., & Jordan, J. (2008). Internet support groups for suicide survivors: A new mode for gaining bereavement assistance. *Omega-Journal of Death and Dying, 57*, 217–243.

Folkman, S., & Moskowitz, J. T. (2000). Positive affect and the other side of coping. *American Psychologist, 55*, 647–654.

Glaser, B. G. (1998). *Doing Grounded Theory: Issues and discussions.* Mill Valley, CA: Sociology Press.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of Grounded Theory: Strategies for qualitative research.* New York, NY: Aldine De Gruyter.

Janoff-Bulman, R. (2006). Schema-change perspectives on posttraumatic growth. In L. G. Calhoun & R. G. Tedeschi (Eds.), *Handbook of posttraumatic growth: Research and practice* (pp. 81–99). Mahwah, NJ: Lawrence Erlbaum Associates.

Jordan, J. R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior, 31*, 91–102.

Jordan, J. R. (2009). After suicide: Clinical work with survivors. *Grief Matters, 12*(1), 4–9.

Jordan, J. R., & McMenamy, J. (2004). Interventions for suicide survivors: A review of the literature. *Suicide and Life-Threatening Behavior, 34*, 337–349.

LIFE Communications. (2010, January 27). Bereavement. *LIFE News, 8.* Retrieved from http://www.livingisforeveryone.com.au/LIFE-News-issue-8.html

Lifeline Australia. (2009a). *Practice handbook: Suicide bereavement support group facilitation.* Lifeline Australia and Commonwealth Department of Health and Ageing.

Lifeline Australia. (2009b). *Towards good practice: Standards and guidelines for suicide bereavement support groups.* Lifeline Australia and Commonwealth Department of Health and Ageing.

McMenamy, J. M., Jordan, J. R., & Mitchell, A. M. (2008). What do Suicide survivors tell us they need? Results of a pilot study. *Suicide and Life-Threatening Behavior*, *38*, 375–389.

Mitchell, A. M., Dysart Gale, D., Garand, L., & Wesner, S. (2003). The use of narrative data to inform the psychotherapeutic group process with suicide survivors. *Issues in Mental Health Nursing*, *24*, 91–106.

Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer-Stephens, M. K. (2004). Complicated grief in survivors of suicide. *Crisis*, *25*, 12–18.

Moore, M. M., & Freeman, S. J. (1995). Counseling survivors of suicide: Implications for group postvention. *The Journal for Specialists in Group Work*, *20*, 40–47.

Murphy, S. A. (2000). The use of research findings in bereavement programs: A case study. *Death Studies*, *24*, 585–602.

Murphy, S. A., Johnson, C., Cain, K. C., Gupta, A. D., Dimond, M., Lohan, J., & Baugher, R. (1998). Broad-spectrum group treatment for parents bereaved by the violent deaths of their 12- to 28-year-old children: A randomized controlled trial. *Death Studies*, *22*, 209–235.

Murphy, S. A., Johnson, C., & Lohan, J. (2003). Finding meaning in a child's violent death: A five-year prospective analysis of parents' personal narratives and empirical data. *Death Studies*, *27*, 381–404.

Neimeyer, R. A., & Currier, J. M. (2009). Grief therapy: Evidence of efficacy and emerging directions. *Current Directions in Psychological Science*, *18*, 352–356.

Neimeyer, R. A., & Sands, D. C. (2011). Meaning reconstruction in bereavement: From principles to practice. In R. A. Neimeyer, H. Winokuer, D. Harris, & G. Thornton (Eds), *Grief and bereavement in contemporary society: Bridging research and practice*. New York, NY: Routledge.

Rennie, D. L. (2006). The grounded theory method: Application of a variation of its procedure of constant comparative analysis to psychotherapy research. In C. T. Fischer (Ed.), *Qualitative research methods for psychologists: Introduction through empirical studies* (pp. 59–78). Burlington, MA: Academic Press, Elsevier.

Robinson, J., Pirkis, J., Krysinska, K., Niner, S., Jorm, A. F., Dudley, M., et al. (2008). Research Priorities in Suicide Prevention in Australia. *Crisis*, *29*, 180–190.

Rogers, J., Sheldon, A., Barwick, C., Letofsky, K., & Lancee, W. (1982). Help for families of suicide: Survivors support program. *Canadian Journal of Psychiatry*, *27*, 444–449.

Rubey, C. T., & McIntosh, J. L. (1996). Suicide survivors groups: Results of a survey. *Suicide and Life-Threatening Behavior*, *26*, 351–358.

Sands, D. (2009). The tripartite model of suicide grief: Meaning-making and the relationship with the deceased. *Grief Matters*, *12*, 10–17.

Stroebe, M. S., & Schut, H. (2001). Meaning making in the dual process model of coping with bereavement. In R. A. Neimeyer (Ed), *Meaning reconstruction and the experience of loss* (pp. 55–73). Washington, DC: American Psychological Association.

Sveen, C. A., & Walby, F. A. (2007). Suicide survivors' mental health and grief reactions: A systematic review of controlled studies. *Suicide and Life-Threatening Behavior*, *38*, 13–29.

Wagner, K. G., & Calhoun, L. G. (1991–1992). Perceptions of social support by suicide survivors and their support network. *Omega*, *24*, 61–73. 880

Yalom, I. D. (1995). *The theory and practice of group psychotherapy* (4th ed.). New York, NY: Basic Books.