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AN EXPLORATORY FACTOR ANALYSIS OF THE SURVIVOR OF SUICIDE LOSS SUPPORT GROUP FACILITATOR SCALE: IDENTIFYING MEANINGFUL FACTORS FOR GROUP FACILITATION AND OUTCOMES

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DISSERTATION

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A dissertation submitted in partial fulfillment of the requirements for the degree Doctor of Philosophy in the College of Social Work at the University of Kentucky

By
Rebecca L. Sanford, MSSA, LCSW
Lexington, Kentucky

Director: Dr. Julie Cerel, Associate Professor of Social Work
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2016

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ABSTRACT OF DISSERTATION

AN EXPLORATORY FACTOR ANALYSIS OF THE SURVIVOR OF SUICIDE LOSS SUPPORT GROUP FACILITATOR SCALE: IDENTIFYING MEANINGFUL FACTORS FOR GROUP FACILITATION AND OUTCOMES

Support groups for suicide loss survivors are a relatively common resource used by those who are left to cope in the aftermath of a suicide death. Though descriptive studies have been used to provide an overview of support groups in the past, there have been no efforts to understand nuances of these groups and the impact of these groups and differing facilitation styles on the bereavement experience for attendees. This study explores primary data collected between March 2015 and December 2015 with a sample of 138 survivor of suicide loss support group facilitators in the United States and New Zealand.

Meaning making and meaning reconstruction is presented as the primary theory used to examine the attitudes of support group facilitators. Basic analytic procedures were used to explore sample descriptives, and an Exploratory Factor Analysis (EFA) with an oblique rotation was used to identify the factors within the Survivor of Suicide Loss Support Group Facilitator Scale. Three factors were revealed with a simple structure, representing the latent themes of (1) Facilitator Perspective on the Role of the Story ($\alpha = .73$), (2) Facilitator Perspective on the Role of the Facilitator ($\alpha = .63$), and (3) Facilitator Perspective on Role of the Loss Survivor ($\alpha = .59$). The final model resulted in a moderate positive correlation between factors 1 and 2 (.472), a moderate positive correlation between factors 1 and 3 (.303), and a weak positive correlation between factors 2 and 3 (.037). Bivariate analyses revealed that factors 1 and 2 both had a significant relationship with length of time the facilitator had been leading the group, facilitator’s level of compassion satisfaction, and facilitator’s level of burnout.

The findings of the EFA support the use of the scale as a tool to discern differences in facilitator attitudes about the role of meaning making and sharing of stories in the group as well as the role of the facilitator in aiding this process. The findings provide important information for understanding variation in support group facilitation.
styles and have implications for future exploration of outcomes for group attendees based on facilitator attitude and style. Implications for practice and future research are discussed.

Keywords: suicide bereavement, loss survivors, support group, facilitation, meaning making

Rebecca L. Sanford

July 28, 2016
Date
AN EXPLORATORY FACTOR ANALYSIS OF THE SURVIVOR OF SUICIDE LOSS SUPPORT GROUP FACILITATOR SCALE: IDENTIFYING MEANINGFUL FACTORS FOR GROUP FACILITATION AND OUTCOMES

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July 28, 2016
Date
DEDICATION

Dedicated to loss survivors everywhere, especially those who have graciously invited me to join them on what is perhaps the most painful and tragic journey one can endure. I am humbled by the privilege to bear witness to your story. It is a responsibility I do not take lightly. You keep me grounded and remind me why this work matters. For that, I dedicate this work to each of you.

“Grief knits two hearts in closer bonds than happiness ever can; and common sufferings are far stronger links than common joys.” ~Alphonse de Lamartine
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Chapter One

Introduction

Statement of the Problem

**Prevalence of exposure to suicide.** Over 1 million deaths by suicide occurred worldwide in 2014 (Organization, 2014). In the same year, 42,000 individuals died by suicide in the US, making suicide the 10th leading cause of death nationally and the second leading cause of death for individuals under age 24 (Drapeau & McIntosh, 2015). However, the prevalence of exposure to suicide death remains ambiguous. The original estimate of six loss survivors for every suicide death has been often cited in the literature, but was merely offered by Edwin Schneidman, renowned as the father of suicidology, as an approximation of the number of individuals intimately affected by the suicide death of a loved one (Jordan & McIntosh, 2011). This estimate is not empirically based, and it is unclear how many people are affected by each suicide death as large scale epidemiological studies to uncover a more accurate estimate have not been conducted (Berman, 2011; Cerel, McIntosh, Neimeyer, Maple, & Marshall, 2014).

Recent studies have pursued a more accurate account of the prevalence of exposure to suicide death. A random digit dial study in Kentucky found that 40% of respondents knew someone who died by suicide, and 20% considered themselves survivors having been “significantly affected by the death” (Cerel, Maple, Aldrich, & van de Venne, 2013, p. 413). More recently, a 2013 random digit dial study found that approximately 47% of those surveyed reported knowing at least one person who died by suicide (Cerel et al., in submission, 2015). Additionally, the results of this study emphasize the importance of examining psychological closeness to the decedent rather
than kinship relationship (Cerel, Maple, van de Venne, & Moore, 2014). While a preponderance of suicide bereavement literature utilizes samples of individuals with a kinship relationship to the deceased, the authors found that nearly two thirds of the respondents reported exposure to the suicide death of someone who was not a first or second degree relative (Cerel, Maple, et al., 2014).

Exposure to suicide is not a homogenous experience, and the recently proposed continuum model of suicide survivorship offers an important perspective on the impact of exposure (Cerel, McIntosh, et al., 2014). Perceived relational closeness and impact of the death are key variables in understanding the range of experiences for those who are exposed to suicide death (Cerel, McIntosh, et al., 2014). The term ‘loss survivor’ is often reserved for those most intimately affected by a suicide death, though many more people may be affected by a suicide to a lesser degree. The continuum model identifies levels of impact to suicide death, beginning with exposure to suicide, moving further along the continuum to include those who are affected by the loss, and concluding with those who identify as bereaved by suicide either in the short-term or long-term (Cerel, McIntosh, et al., 2014). Rather than merely recognizing loss survivors as those who are of immediate kin to the decedent, Cerel, McIntosh, et al. (2014) propose that emotional attachment and psychological closeness to the decedent be used as a primary factor in consideration of those considered to be suicide survivors.

Using epidemiological data coupled with the continuum model, Cerel (2015) and colleagues suggest that over 100 individuals are exposed to each suicide death, with 18 or more affected to the point that their life is disturbed temporarily or perhaps longer. At this time, it is unknown how many people are affected by suicides of people they care about,
particularly to the degree of needing or desiring outside intervention or support (Cerel, 2009).

**Impact of exposure.** Suicide loss survivors report anecdotally and through qualitative research that the suicide bereavement experience is different than other bereavement experiences (Bartik, Maple, Edwards, & Kiernan, 2013; Begley & Quayle, 2007; Jordan, 2001), though quantitative analyses have offered conflicting results (Ellenbogen & Gratton, 2001; Sveen & Walby, 2008), particularly when traditional measures of grief are used (Jordan, 2001). Qualitative research generally has been able to discern the aspects of suicide bereavement that make it a unique process (Bartik et al., 2013; Begley & Quayle, 2007), and quantitative research that measures these themes also captures the distinctiveness of the process (Bailley, Kral, & Dunham, 1999). The themes unique to suicide bereavement include guilt, anger, rejection, abandonment, and searching for an answer to why the death occurred (Jordan, 2001).

Suicide is a stigmatized cause of death which often leads to disenfranchisement of the surviving loved ones’ grief (Doka, 2002), resulting in feelings of isolation, shame, and guilt (Jordan, 2001). It is the nature of suicide as a stigmatized form of death along with the unique themes encountered in the bereavement process that makes it qualitatively different from and more challenging than other bereavement experiences (Jordan, 2001).

Suicide bereavement remains a highly understudied area of research, though some evidence suggests that loss survivors are at high-risk for negative sequelae, including depression, anxiety, trauma, and possibly even suicide (Agerbo, 2005; Brent, Melhem, Donohoe, & Walker, 2009; Brent, Moritz, Bridge, Perper, & Canobbio, 1996; Crosby,
Help for those left behind. Though the research remains inconclusive, loss survivors are believed to be a vulnerable population in need of specialized services and supports, with many survivors endorsing this perspective and the need for services (Wilson & Marshall, 2010). However, few resources exist that are specifically intended for loss survivors, and loss survivors frequently report inadequate or unhelpful responses from supports (Wilson & Marshall, 2010).

A recent systematic review of the literature on suicide bereavement indicated that of the 450 articles published on suicide postvention in the 50 years from 1965 to 2014, only 27 examined interventions for suicide bereavement (Maple et al., 2015). A significant portion of the literature on suicide-specific bereavement interventions consists of small scale studies evaluating programs, such as a residential therapeutic program (Braiden, McCann, Barry, & Lindsay, 2009), a peer support program offered as an adjunct to formal therapy (Barlow et al., 2010), and a group intervention for loss survivor widows (Constantino, Sekula, & Rubinstein, 2001a). The majority of these interventions have not been replicated or expanded further, and concern has been expressed about the methodological rigor of these studies (McDaid, Trowman, Golder, Hawton, & Sowden, 2008). Additionally, while there are agencies and organizations that host a variety of interventions and programs for loss survivors, the majority of them have not been subjected to evaluation (Sakinofsky, 2007).

Randomized controlled trials, considered the gold standard of research, are rare in suicide bereavement intervention research (McDaid et al., 2008). A systematic review
with relatively open inclusion criteria resulted in only eight controlled studies that explored the effectiveness of suicide bereavement interventions (McDaid et al., 2008). Though the review indicates promising findings from the included studies, it remains unclear whether formal interventions are actually helpful, for whom they have the greatest positive impact (such as those with complicated grief), and when interventions are likely to have the greatest impact (McDaid et al., 2008; McMenamy, Jordan, & Mitchell, 2008).

Survivor of suicide (SOS) support groups represent one common resource utilized by survivors (Feigelman & Feigelman, 2008a). SOS support groups are a relatively common resource, with over 700 groups listed on the American Foundation for Suicide Prevention (AFSP) website as of February 2015 (AFSP, 2015). Support groups have expanded greatly since they first began in the late 1970s and early 1980s (Feigelman & Feigelman, 2008a; Feigelman & Feigelman, 2008b). However, little is known about the nature of such groups and how the groups impact the bereavement experience (Cerel, Padgett, Conwell, & Reed, 2009).

**Rationale for the Study**

Despite the frequent utilization of support groups, they remain relatively unexplored in the suicide bereavement literature with no longitudinal analysis of the impact of support groups on the suicide bereavement experience (Cerel, Padgett, Conwell, et al., 2009; Cerel, Padgett, & Reed, 2009). Loss survivors commonly report subjective satisfaction with their group experience (McMenamy et al., 2008), but many loss survivors only attend a small number of groups (Cerel, Padgett, & Reed, 2009). Limited cross-sectional data on the reasons loss survivors do not return to group indicate
that the following contribute to this decision: facilitation issues, composition of the group, difficulty hearing and responding to the traumatizing stories of newly bereaved, and having adequate support outside of the group setting (Feigelman & Feigelman, 2011).

The composition, facilitation, and organization of the support groups varies widely, with each group maintaining a unique culture and style (Feigelman & Feigelman, 2008a). One particular aspect of group functioning that has not been explored in the literature is the facilitation composition and style. In other domains where support groups are used frequently, facilitation has been identified as a key variable influencing the success of the group and outcomes for group members (Beck & Keyton, 2014; Costello, 2013; Lieberman & Golant, 2002). This has not yet been explored in support groups for suicide loss.

Groups may be led by a peer who has experienced a suicide loss and may or may not have additional training in group facilitation, a professional who has advanced training but has not experienced a suicide loss, or a combination of both peer and professional facilitation with either one person who fits both descriptions or two facilitators, one who identifies as a peer and one who identifies as a professional (Sanford & Cerel, 2014). The unique nature of peer support has not been explored in the literature, though there have been preliminary analyses conducted by this author which suggest that peers and professionals differ in the theoretical and practical approaches utilized in the facilitation process (Sanford & Cerel, 2014). Thus, there is a substantial need for more research on the facilitation of SOS groups and facilitator perspectives on this process.
Theoretical Framework

Given the paucity of research on the topic and the fact that the proposed dissertation research is primarily exploratory in nature, the theoretical background of the study is somewhat limited and will focus on meaning-making. Varying perspectives on meaning making have been offered across multiple disciplines, but for the purposes of this study, the meaning-making model proposed by Park (2010) will be used as the foundation for understanding the theoretical concepts explored in the primary analysis. While some definitions take a broad focus, Park’s (2010) model offers a definition of meaning-making that explains the process often initiated by a stressful or traumatic life event. This model was selected specifically because of the emphasis on a stressful life event that triggers a unique, and often challenging, process. Park’s (2010) model incorporates tenets from several theorists who have explored the meaning making process following a stressful life event. Park describes the key tenets of her model as follows:

(a) People possess orienting systems, referred to here as global meaning, that provide them with cognitive frameworks with which to interpret their experiences and with motivation; (b) When encountering situations that have the potential to challenge or stress their global meaning, individuals appraise the situations and assign meaning to them; (c) The extent to which that appraised meaning is discrepant with their global meaning determines the extent to which they experience distress; (d) The distress caused by discrepancy initiates a process of meaning making; (e) Through meaning-making efforts, individuals attempt to reduce the discrepancy between appraised and global meaning and restore a sense
of the world as meaningful and their own lives as worthwhile; and (f) This process, when successful, leads to better adjustment to the stressful event. (p. 258)

In short, this model proposes that the meaning-making process is catalyzed by a stressful life event that leads to beliefs about the meaning of the event, attribution of responsibility, and implications of the event that are significantly discrepant from general beliefs about the world, oneself, and one’s position and purpose in the world. Meaning-making ensues in both deliberate and automatic or unconscious ways in an effort to reduce the discrepancy and the accompanying distress. Successful meaning-making efforts reduce the discrepancy and promote healthy resolution of the stress caused by the disturbing life event. Park (2010) uses the term “meanings made” to refer to the end result of the meaning-making process (p. 260). Park (2010) states that these are “end results or changes derived from attempts to reduce discrepancies or violations between appraised or global meaning” (p. 260). Healthy resolution, resulting in meanings made, may take many forms, including having made sense of the stressful life event and the significance of the event, developing a more appropriate understanding of causality of the event, and/or changed global beliefs or sense of purpose.

A suicide death can be jarring to the assumptive world of the loss survivor. For example, a father of three children may hold the global assumptions “I’m a good father” and “My identity as a father is essential to my purpose in life.” After this father’s oldest child dies by suicide, the father may experience an appraisal of the death (stressful life event) that results in discrepant beliefs, such as “I didn’t do enough to save my son, therefore I’m not a good father.” It is the discrepancy in the two sets of belief systems which prompts the meaning-making process. Successful resolution of this discrepancy
may involve significant reflection, self-assessment, and processing, with the end result of
in meaning being made through more appropriate attribution of the cause of death, such
as recognizing the son’s long battle with mental illness. Successful resolution may also
result in changed global beliefs and assumptions, such as “I do my best to support my
children and provide for their needs, but I cannot keep them safe from harm at all times.”

When examined in the context of this theoretical framework, the support group
offers an opportunity for meaning-making, specifically in the form of cognitive and
emotional processing, a meaning-making process identified by Park (2010). As Park
(2010) explains, “cognitive processing involves reappraisals and repeated comparisons
between one’s experience and one’s existing beliefs to modify one or the other, which is
achieved through thoughtful reflection, including awareness of the emotions an event
evokes and the effect it might have on one’s future” (p. 260). The group is a deliberate
strategy for engaging in processing related to the event and resulting discrepant beliefs.
The group provides an opportunity to resolve the discrepancy in a helpful and productive
way. Questions used in this study were designed to explore facilitator attitudes about the
role of the group in addressing this discrepancy to promote healthy meaning-making.

Looking to other theorists specifically in area of meaning-making in the
bereavement process, Coleman and Neimeyer (2010) suggest that sense making and
searching are the salient constructs of meaning-making. Sense making is defined as “the
reconciliation of pre-existing meanings with painfully anomalous implications of a loss”
(Coleman & Neimeyer, 2010, p. 806). Searching is defined as “the extent to which the
bereaved report actively searching to make sense of or find meaning in a loss” (Coleman
& Neimeyer, 2010, p. 808-809). Making sense of a loss does not necessarily indicate that
the bereaved finds the loss beneficial or as an opportunity for growth, but rather that the bereaved has an understanding or explanation for the event (Davis, 2001).

Though this has not been explored explicitly with suicide loss survivors, continued searching for sense in the long-term following a loss is an indication of problematic bereavement and poor grief outcomes in the general bereavement literature (Coleman & Neimeyer, 2010; Neimeyer, Baldwin, & Gillies, 2006; Winchester Nadeau, 2008). Sense-making and constructing meaning in the face of even tragic losses has been demonstrated to mediate complicated grief reactions (Coleman & Neimeyer, 2010). Loss survivors often describe the struggle that ensues to answer the question “why” and to make sense of the death (Bartik et al., 2013; Begley & Quayle, 2007; Jordan, 2001). The nature of suicide as a choice complicates the meaning-making experience as loss survivors wrestle with their loved one’s decision to leave this world (Begley & Quayle, 2007). Similar to survivors of other tragic experiences, suicide loss survivors may struggle with the question of why this particular experience happened to them. Additionally, they are left to question the intentions and motives their loved one had for choosing suicide (Begley & Quayle, 2007). Furthermore, the loss survivor may assume guilt and blame, thus attributing responsibility for the death to themselves for not having done more to prevent the death (Begley & Quayle, 2007). This may be an example of event-related beliefs that are in direct opposition to previously held global assumptions.

“Telling one’s story” and “seeking an audience for a new self-narrative” are aspects deemed important in the meaning-making process from the narrative reconstructionist perspective (Neimeyer, 2001a, p. 173). Given the stigma surrounding suicide and the disenfranchised nature of suicide grief (Doka, 2002), it is likely that many
typical avenues for engaging in the meaning-making process and finding sense in the loss are cut off from the suicide bereaved (Neimeyer, 2001a). However, the survivor of suicide support group offers an opportunity for loss survivors to explore their reactions to the loss and the discrepancies in conflicting belief systems, receiving validation, support, and a sense of togetherness from other survivors (Feigelman & Feigelman, 2008a). It is possible that the support group provides an important opportunity for the loss survivor to explore the question of ‘why’ and cognitive and emotionally process the death, all the while receiving feedback and support from other loss survivors who are also on the journey to make meaning of the loss (Supiano, 2012). This study sought to explore facilitator attitudes about meaning making and the role of the group in the meaning-making process.

Statement of Purpose and Aims of the Study

The study described herein is a follow-up to a study of facilitators of SOS groups conducted in 2012. The 2012 study of support group facilitators was intended to explore the current status of support groups throughout the United States along with consideration of the professional quality of life experienced by facilitators (Sanford & Cerel, 2014). There were considerable differences in the attitudes and opinions of group functioning and effectiveness based on the status of the facilitator as a peer, professional, or peer/professional (Sanford & Cerel, 2014). Though it is likely that the processes and functioning of each group vary widely, efforts have not been made to identify optimal group facilitation processes. It remains unclear what survivors find helpful or unhelpful in the group experience (Cerel, Padgett, Conwell, et al., 2009).
This study aims to add to the existing literature on support groups for suicide loss survivors by providing a descriptive account of SOS groups and exploring facilitator attitudes about suicide bereavement groups, particularly as it relates to meaning-making processes supported by the group. This study sought to explore: (1) descriptive information about SOS groups, (2) facilitator accounts of meaning-making processes in the group experience, (3) facilitator attitudes about the role of the group in the meaning-making process, (3) facilitator perspectives on the role the facilitator plays in catalyzing this experience, and (4) the development of a set of scales to assess facilitator attitudes and perceptions about support groups and the meaning-making process within such groups.

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Chapter Two

Review of Relevant Literature

As outlined in Chapter 1, this study aimed to explore facilitator accounts of support groups for suicide loss survivors. This study is primarily exploratory in nature though meaning making is used to contextualize the group experience and explore the facilitation process. Specifically, this study sought to quantify and measure attitudes regarding meaning making in the support group and the role of the facilitator in aiding this process.

This chapter begins with a review of the literature on suicide bereavement, with a focus on evidence that illustrates the unique and challenging nature of this process. I then discuss the needs of loss survivors as a vulnerable population, particularly emphasizing the need for formal interventions and social support. Next, I present support groups as a form of intervention used by loss survivors. I discuss the current state of knowledge on the support groups, and I explore the mode and nature of facilitation as a key element of the groups. Finally, I present theoretical and empirical support for the role that support groups play in the meaning-making process with loss survivors, accompanied by the caveat that meaning making is a process that may need to be facilitated in a skillful and active way in such groups to prevent retraumatization or rumination on the death.

**Suicide Bereavement: Emotional Reactions, Social Processes, and Negative Outcomes**

While grief is a universal experience that everyone encounters at some point, grief following suicide is not. Due to the historical perspectives associated with suicide coupled with the traumatic nature of a suicide death, suicide bereavement is often thought
to be a more difficult process than bereavement due to other types of loss (Knieper, 1999). This difference, which has been described anecdotally by survivors of suicide loss, has been subjected to limited quantitative evaluation and review (Bailley et al., 1999; de Groot et al., 2006), yet the results have not conclusively pointed towards a definite difference between suicide bereavement and other types of bereavement (Ellenbogen & Gratton, 2001; McIntosh, 1993; Ness & Pfeffer, 1990; Sveen & Walby, 2008). In this section, I explore the unique emotional reactions experienced by loss survivors, followed by a review of the social processes that can follow a suicide death, and finally conclude with a discussion of the negative health and bereavement outcomes that loss survivors may experience.

Emotional reactions. Though quantitative analysis may not detect nuances and intricacies of suicide bereavement, loss survivors and bereavement counselors are quick to identify qualitative differences in the bereavement experiences, which Jordan (2001) termed the “thematic aspects of suicide bereavement” (p. 92). There are a number of themes that arise in the wake of suicide that survivors of other types of losses typically do not experience which are likely not to be captured in traditional research methodologies and measures (Ellenbogen & Gratton, 2001; Feigelman, Jordan, & Gorman, 2009b; Jordan, 2001). Jordan (2001) identified the following themes of suicide bereavement: “meaning making around the death,” “guilt, blame, and responsibility for the death,” and sense of “rejection or abandonment by the loved one, along with anger toward the deceased” (p. 92). Qualitative studies have echoed and expanded Jordan (2001) themes of suicide bereavement (Bartik et al., 2013; Begley & Quayle, 2007; Ratnarajah & Schofield, 2008). For example, exploration of adolescent survivors of a friend’s suicide
uncovered the themes of meaning making, guilt, risky coping behavior, and relating to friends after a suicide loss (Bartik et al., 2013). Each of the themes of the suicide bereavement as originally defined by Jordan (2001) will be explored further: meaning making; guilt, blame, and responsibility; rejection, abandonment, and anger; and finally relief.

**Meaning making and the elusive question “why?”**. As suicide is typically conceptualized as a choice, survivors are left to ponder the elusive and enigmatic answer to the question “why?” (Jordan, 2001; Shields, Kavanagh, & Russo, 2015; Supiano, 2012). This is perhaps the largest unanswered question, one which many survivors search unsuccessfully to answer (Supiano, 2012), finding relief only in an answer that they deem acceptable but not necessarily confirmed. Literature on suicide bereavement suggests that loss survivors spend time ruminating on the motivation for the suicide (Bailley et al., 1999) and the meaning of the tragic death (Ness & Pfeffer, 1990). The act of suicide runs contradictory to the instinct for self-preservation, and while many people experience depression and other mental health problems that may predispose them to suicide ideation or attempts, the majority of those with mental health problems will never attempt or die by suicide. Thus, loss survivors often question why it was their loved one who died by suicide when others seemingly were able to overcome similar pressures and stressors. Questions of “why” may also involve exploration of the conversations the bereaved had with the deceased and the quality of the relationship as it may have contributed to the death (Jordan, 2001).

As previously established in the discussion of the theoretical framework for this study, the question of “why” a loved one died by suicide can give rise to the process of
meaning making for survivors (Bartik et al., 2013) by creating a discrepancy between global assumptions and causal attribution for the event. Meaning making is a consistently reported theme of suicide bereavement (Bartik et al., 2013; Hung & Rabin, 2009; Jordan, 2001; Supiano, 2012). Making sense of the suicide, a meaning-making process as identified by Park (2010), is an important part of the process for survivors (Begley & Quayle, 2007), and this theme emerges when qualitative research procedures are used (Bartik et al., 2013; Jordan, 2001). A theme clearly identified by Australian adolescents bereaved by a friend’s suicide was meaning-making, “which centered on the participant’s inability to understand the death of their friend/s” (Bartik et al., 2013 2013). However, continued searching for sense in the face of loss has been associated with negative bereavement outcomes (Coleman & Neimeyer, 2010), which gives rise to the question of the importance of meaning-making and the processes loss survivors go through to arrive at some level of sense in the loss without becoming stuck or stagnating in this position.

**Guilt, blame, and responsibility.** Loss survivors also report feelings of blame and responsibility for the death of their loved one. A sense of responsibility for the death also translates to feelings of guilt for not having done more to prevent a suicide (Cerel, Jordan, & Duberstein, 2008; Jordan, 2001). Additionally, survivors may struggle with guilt over conversations had with the deceased immediately prior to the death or for their perceived shortcomings as a friend, parent, partner, and so on (Cerel et al., 2008). From this author’s experience working with survivors directly, many reflect on the warning signs of suicide that they are able to see clearly in retrospect and the guilt they have for not recognizing the signs at the time or doing more to help their loved one. Feigelman, Jordan, and Gorman (2009a) exploration of parents bereaved by the suicide death of a
child found that those survivors whose children had attempts prior to the suicide reported increased grief difficulties, theorized by the authors to be an indication of survivor’s guilt and responsibility.

**Rejection, abandonment, and anger.** When thought of as a rational choice, suicide means that an individual has chosen to end significant relationships with loved ones. This perspective can leave loss survivors in a precarious position of feeling rejected or abandoned by their loved one (Bailley et al., 1999; Jordan, 2001; Ratnarajah & Schofield, 2008). Subsequent to the suicide, some survivors experience secondary losses, such as loss of support from friends or family (Begley & Quayle, 2007; Ratnarajah & Schofield, 2008). Additionally, children of a parent’s suicide may find that they have lost not only the parent who died by suicide but also the surviving parent who is consumed with her grief to the point that she cannot adequately provide for the emotional and psychological needs of the child, thus triggering a secondary loss or abandonment for the child (Ratnarajah & Schofield, 2008). The social processes of suicide will be discussed in more detail later, but it is important to note that survivors may experience a sense of rejection or abandonment not only from the loved one who died, but also from friends and family members who are not sure how to respond to the bereaved.

Anger towards the deceased is another common theme and one that often accompanies the feelings of rejection or abandonment. As Jordan (2001) identifies, loss survivors may question: “How could they do this to me?” (p. 92). This author has witnessed survivors’ anger towards their loved one because they did not disclose they were suicidal or ask for help. Anger may also be projected towards others who are believed to have contributed to the death. When confronted with a senseless loss,
survivors may try to make sense of the death by identifying responsibility and blame or by finding fault with someone who they believed contributed to the loved one’s decision to die. For example, one bereaved mother who lost her son to suicide blamed the drug dealer who first supplied her son with heroin, which lead to his involvement in the criminal system and eventual suicide.

**Relief.** A complicated response experienced by some bereaved individuals is that of relief (Jordan, 2001). Survivors who maintained a caregiving role for their loved one or those who were fraught with the responsibility of responding to multiple suicide attempts may have a sense of relief from no longer carrying this role and associated responsibilities (Jordan, 2001). Additionally, abusive individuals who end their lives by suicide may be survived by loved ones who feel a sense of relief that they no longer have to fear the decedent (Ellenbogen & Gratton, 2001). The relief reaction has not been explored in great detail, and it is not an identified theme of the suicide bereavement experience, but it is worthy of note given that it may create complications in the grief process (Ellenbogen & Gratton, 2001).

To be sure, not all survivors experience all of these themes, but general patterns are discernable through anecdotal reports and qualititative research with survivors. These themes are unique to suicide bereavement, and may create challenges for the survivors left behind. Loss survivors often report these themes entering into their relationships with others, creating complex social situations (Jordan, 2001).

**Social processes and discomfort in social situations.** Survivors may encounter at best unpleasant or at worst traumatizing interactions with others in their social world. “Social uneasiness” was the term identified by Begley and Quayle (2007) to describe the
discomfort experienced by survivors in social situations (p. 26). Acquaintances and even friends and family may make comments that are unhelpful to the loss survivor or may withdraw support completely (Barlow & Coleman, 2003). Additionally, the taboo nature of the topic of suicide leads to some loss survivors feeling discomforted by talking about the death with those outside the family (Begley & Quayle, 2007). Loss survivors have been reported to feel that their social networks do not adequately meet their emotional and practical needs following the suicide (Barlow & Coleman, 2003; Begley & Quayle, 2007).

Dyregrov (2003-2004) termed the lack of helpful support from social networks following a traumatic death of a child “social ineptitude” (p. 23), defined more fully as “the difficulty a social network encounters in responding to and supporting those bereaved by sudden, traumatic deaths in a manner that is appreciated by the bereaved” (p. 31). Unhelpful responses may be exhibited in the lack of anticipated support, withdrawal of support, or unhelpful advice, attributed to the lack of social norms around such losses (Dyregrov, 2003-2004). Interacting with loss survivors has been described as a stressful experience for those in the survivor’s support network (Calhoun, Selby, & Abernathy, 1984), and loss survivors are viewed more negatively by the general public than those bereaved by other types of death (Stillion, 1996). Though positive social support experiences were reported by many of the participants in Dyregrov (2003-2004) study, the negative responses from anticipated sources of support in the wake of grief ranged from unhelpful to harmful.

Both survivors and their support networks share awareness of this ineptitude following traumatic death. Close supports of a sample of loss survivors participated in a
study to contribute to a better understanding of support processes following such a death (Dyregrov, 2005-2006). An overwhelming majority (81%) of participants reported that it was “a little” or “very” difficult to support their loved one in the wake of the traumatic death of a child (Dyregrov, 2005-2006) p. 346). The difficulty was associated with “the feeling of insecurity, insufficiency, and ineptitude to cope with the situation” (Dyregrov, 2005-2006) p. 347).

Disenfranchised grief. An entailment of this social ineptitude is the phenomenon of disenfranchised grief. Disenfranchised grief is a concept that is useful in understanding the problematic and unhelpful social responses experienced by loss survivors. As a universal cultural phenomenon, death is typically met with socially acknowledged and sanctioned support for the grievers (Doka, 2002). Losses, particularly for close kin, are recognized by others in society, including friends, family, and even employers. Cultural norms guide the commonly expected reactions, the course and nature of such reactions, and the accepted time frames for bereavement reactions. However, stigmatized losses, including suicide, often are met with disenfranchisement of the grief experience, meaning that the “survivors are not accorded with the ‘right to grieve’” (Doka, 2002) p. 5). Most individuals have experienced loss at some point in life, and they can subsequently use this experience to relate to others who suffer their own loss, their own experience proving to be a guide for how to support others through the phenomenon. The relative infrequency of suicide death makes it an experience that others often find difficult to understand (Doka, 2002). The stigma surrounding the death and the lack of understanding about the act of suicide and the resulting reactions of the survivors leave support networks with no frame of reference for extending adequate and appropriate support.
(Doka, 2002). As explained previously, Dyregrov (2003-2004) exploration of social ineptitude among the support networks of tragically bereaved parents provides evidence for the lack of social norms to guide the process of extending support. The grief following suicide may be disenfranchised by support networks of the survivors or by greater society in general.

Attig (2004) further explains disenfranchised grief in this way:

The right to grieve entitles a bereaved person to grieve in a manner and when he or she needs or chooses to, free from interference from others. No one is obligated to grieve or to do so in a particular way. In response, others are obligated to honor the right and refrain from interfering in the experiences and efforts of grieving. Disenfranchisement of grief, as such interference, violates the mourner’s right to grieve. (p. 198).

He continues:

We can see that disenfranchising is not simply a matter of indifference to the experiences and efforts of the bereaved. It is more actively negative and destructive as it involves denial of entitlement, interference, and even imposition of sanction. Disenfranchising messages actively discount, dismiss, disapprove, discourage, invalidate, and delegitimate the experiences and efforts of the grieving. (p. 198).

By itself, suicide bereavement is an often disenfranchised form of grief. Additionally, close kinship relationships have received the most attention in the suicide bereavement literature, though a suicide may leave a lasting impression on friends, co-workers, teammates, and in the case of suicides that occur in public, bystanders and
witnesses (Cerel, McIntosh, et al., 2014). Grief among close family members is deemed understood and sanctioned in society, but relationships considered to be peripheral receive less attention (Lenhardt, 1997). The bereaved who fall outside of the scope of close kin are often not recognized as grievers in need of support (Lenhardt, 1997), even though the loss survivor’s perception of closeness to the decedent may be quite strong and may influence reactions in the grief process (Cerel, McIntosh, et al., 2014).

**Stigmatization.** Stigma is defined as “a mark of disgrace (either literal or figurative) attached to characteristics or behaviors that are defined as undesirable in a given society” (Robbins, Chatterjee, & Canda, 2012) p. 306). The “social ineptitude” (Dyregrov, 2003-2004) p. 23) and the lack of social norms to guide interactions with suicide bereaved individuals may have roots in the historical and contemporary stigmatization surrounding the type of death. Rather than being an indication of indifference, it is possible that social ineptitude may be a byproduct of stigma and the resulting lack of open communication and rules to guide the support giving process (Doka, 2002). Suicide is a stigmatized form of death, likely due to historical perspectives on suicide (Cvinar, 2005) and the relationship between suicide and mental illness (Arsenault-Lapierre, Kim, & Turecki, 2004), another stigmatized phenomenon. The stigma, however, does not die with the person who takes his life but rather is transferred to the loved ones left behind (Jordan, 2001; Stillion, 1996). As described by Jordan (2001): “Thus there is considerable evidence that the general stigma that continues to be associated with suicide in our society ‘spills over’ to the bereaved family members” (p. 93). Behavioral and emotional responses of the support networks of the survivor may be
influenced, at least in part, by the stigma associated with the mode of death (Cvinar, 2005).

Feigelman, Gorman, and Jordan (2009) explored the stigmatization following suicide bereavement among a large sample of parents bereaved by the suicide of their child. Traumatically bereaved parents, including those who lost a child to suicide, homicide, or accidents, reported significantly higher levels of stigmatization than parents bereaved by a child’s death from natural causes (Feigelman, Gorman, et al., 2009). Stigma was found to be a significant predictor of grief difficulties, including depression and suicidal thinking, among the sample (Feigelman, Gorman, et al., 2009).

Stigmatization was experienced by survivors in a variety of ways, most commonly reported as others avoiding the topic of suicide, lack of genuine care and concern from others, and “unhelpful advice” about the grief trajectory or how the survivor should respond or feel (Feigelman, Gorman, et al., 2009) p. 603). Stigma may result in survivors experiencing a deep feelings of shame and embarrassment (Jordan, 2001) or a sense of blame for the death, either self-imposed or communicated through the social attitudes of others (Bailley et al., 1999; Ness & Pfeffer, 1990), and it may prevent survivors from sharing their experiences with others or seeking help (Sudak, Maxim, & Carpenter, 2008).

Isolation. Stigmatized for the death and fearful of the reactions of others, survivors may retreat to a personal safe-haven, which may only be occupied by a scant number of compassionate and empathic individuals who understand the feelings of the survivor (Barlow & Coleman, 2003; Begley & Quayle, 2007; Jordan, 2001). This isolation may also occur as a result of previously established support networks.
“silencing” the bereaved by not allowing space for discussion of the loss or the decedent (Maple, Edwards, Plummer, & Minichiello, 2010). Support networks deemed to be overtly or covertly blaming towards the survivor may lead to secrecy and self-isolation from the survivor (Cerel et al., 2008). Whether self-imposed or a function of supporters withdrawing from the bereaved, isolation occurs for many survivors of suicide loss (Cerel et al., 2008). Feigelman, Jordan, et al. (2009a) found that parents who lost a child to suicide as well as other forms of traumatic deaths experienced greater levels of strained and harmful interactions and relationships with those in their support circle after the death. They suggest that “it was primarily because of these experiences, and not the type of death per say – that led to their greater grief difficulties” (Feigelman, Jordan, et al., 2009a, p. 267).

Many loss survivors, just at the time they need the most support, find that members of their support system have turned away or respond in a way that is woefully inadequate, leaving them isolated and struggling in a personal abyss (Jordan, 2001). Thus, the mode of death is significant for the loss survivors left behind and can produce a bereavement situation that is wholly unique from that which follows other types of deaths.

**Negative outcomes.** Bonanno’s (2009) research on bereavement indicates that only 10-15% of bereaved individuals develop problematic bereavement responses. However, this research has been conducted primarily with individuals bereaved by death from natural causes, not from suicide. The unique issues that suicide survivors must wrestle with coupled with the often inadequate social response leaves loss survivors at risk for negative mental health outcomes following the loss, though current evidence on
the topic offers an insufficient understanding of the specific ways in which the
differences manifest in survivors’ experiences (Ellenbogen & Gratton, 2001; Jordan,
2001; Ness & Pfeffer, 1990). This section presents a review of the current literature on
the mental health outcomes for loss survivors.

**Psychiatric functioning.** Studies of loss survivors suggest that relative to other
bereaved populations, suicide loss survivors have worse health functioning and greater
levels of depression (Brent et al., 2009; Brent et al., 1993; de Groot et al., 2006; Kessing
et al., 2003; Pfeffer, Karus, Siegel, & Jiang, 2000) and posttraumatic stress disorder
(Brent et al., 1996), particularly if the death was violent (Kaltman & Bonanno, 2003).

Additionally, while many who are bereaved experience a recovery to levels of
functioning equivalent to pre-loss levels (Bonanno, Boerner, & Wortman, 2008),
exploration and identification of maladaptive grief symptoms has led to the development
of diagnostic criteria for complicated grief (Zhang, El-Jawahri, & Prigerson, 2006).
Complicated grief has been distinguished from the typical course of bereavement and
from clinical depression (Zhang et al., 2006). Complicated grief is characterized by
intrusive memories of the loved one, strong feelings of yearning for the deceased,
avoidance of reminders related to the deceased, avoidance of interaction with others, and
withdraw from typical activities of daily life (work, social activities, etc.) (Horowitz et
al., 2003) as well as difficulty accepting the death, difficulty trusting others, a sense of
numbness, feeling that the future is meaningless and that life is empty, and anger
regarding the death (Zhang et al., 2006).

Suicide loss survivors, similar to survivors of other traumatic losses, have been
shown to have higher levels of complicated grief (de Groot et al., 2006; Melhem et al.,
2003; Mitchell, Kim, Prigerson, & Mortimer, 2005). In one particular study of loss survivors, approximately 43% of the sample met criteria for complicated grief (Mitchell, Kim, Prigerson, & Mortimer-Stephens, 2004). Complicated grief has been suggested to lead to poor long-term outcomes for the sufferer, most concerning of which is suicidality (Latham & Prigerson, 2004). In one study, bereaved adults suffering from complicated grief were found to be 6.58 times more likely to have high suicidality at baseline when compared to other bereaved groups not suffering from complicated grief (Latham & Prigerson, 2004). This higher level of risk for suicidality continued longitudinally for the bereaved with complicated grief, even when controlling for other psychiatric disorders such as depression and posttraumatic stress disorder (Latham & Prigerson, 2004).

A large-scale study of parents bereaved by the suicide of a child offered mixed results. Survivors had higher levels on the Grief Experience Questionnaire, a measure designed specifically for suicide bereavement, but not on measures of general grief or mental health (Feigelman, Jordan, et al., 2009a). Loss survivors experienced more problematic social encounters following the death, and the encounters likely account for differing grief reactions (Feigelman, Jordan, et al., 2009a).

There have been few longitudinal studies of survivors to explore the suicide bereavement process over time, which presents limitations to developing a full and complex understanding of the process. A longitudinal study of Finnish suicide survivors offered insight common grief reactions immediately following the loss and then ten years later (Saarinen, Hintikka, Vnamaki, Lehtonen, & Lonqvist, 2000). Depression, guilt, shame, somatic symptoms, and shame were commonly reported concerns among survivors (Saarinen et al., 2000). At the ten-year follow-up point, the authors found that
respondents indicated full restoration of mental well-being by three years post-loss on average (Saarinen et al., 2000). Though nearly half of the sample (45%) indicated that they had experienced deterioration in their mental health following the loss, all reported full restoration by the follow-up point. Interestingly, only 17% of the sample sought professional psychosocial assistance, though 64% of the group found the baseline interview shortly after the loss helpful in their adaptation to the loss (Saarinen et al., 2000).

**Suicidality.** At the extreme end of the spectrum of outcomes following suicide, evidence suggests that loss survivors may be at increased risk of suicide themselves (Agerbo, 2003, 2005; Agerbo, Nordentoft, & Mortensen, 2002; Cerel & Roberts, 2005; Cerel, Roberts, & Nilsen, 2005; Crosby & Sacks, 2002; de Leo & Heller, 2008; Kim et al., 2005; Pitman, Osborn, King, & Erlangsen, 2014; Qin, Agerbo, & Mortensen, 2002; Valente, Saunders, & Street, 1988) though there have been some mixed results on this (Watkins & Gutierrez, 2003) and the suggestion that there may be a number of mediating factors that influence the path to suicidality and suicide loss survivors.

While there are similarities among the reactions and feelings experienced by those bereaved by suicide, by no means is this a homogenous group. In fact, it has been suggested that parsing out subgroups of suicide survivors based on factors such as kinship, exposure to suicidal behavior before the death, and anticipation of the death may allow for more nuanced and accurate assessment of suicide bereavement and the complications associated with this process (de Groot et al., 2006; Ellenbogen & Gratton, 2001). Initial exploration of the ways in which survivors are differentially impacted by the loss indicates that those with close kinship relationship to the deceased experience
higher levels of psychiatric symptoms and greater impairment in quality of life (Mitchell et al., 2009).

**Needs of Loss Survivors**

Efforts have been made to better understand not only the bereavement process of survivors but also the needs of loss survivors, though the exploration of the needs of survivors is still very much in its infancy. In fact, McMenamy et al. (2008)’s exploration of the topic in 2008 was only the third of its type. Needs of loss survivors were captured in McMenamy’s study through the Survivor Needs Assessment Survey, developed by Jordan, which is designed to assess four primary areas: “practical, psychological, and social difficulties; formal and informal sources of support; resources utilized in healing; and barriers to finding support since the loss” (McMenamy et al., 2008) p. 375).

Survivors reported a range of moderate to high levels of difficulty with practical, psychological, and social issues experienced as a result of the death. Notably, 61% of participants reported impairment of daily activities at work or home. Most commonly cited psychological problems were intense yearning for the loved one, depression, guilt, and anxiety. Approximately a third of participants in the study reported difficulty talking about the suicide and sharing grief within the family (McMenamy et al., 2008). Discussing the death and resulting feelings within and outside the family is an oft cited challenge experienced by loss survivors (Provini, Everett, & Pfeffer, 2000). An exploration of needs and concerns among non-treatment seeking survivors of suicide loss demonstrated that approximately 18% of those contacted indicated concerns related to the loss, while another 35% indicated no concerns specific to the suicide loss, and the remaining 47% did not disclose whether or not they had concerns related to the death.
Participants reported an average of 2 concerns which included, in order of frequency reported: family relationship, stressor related, psychiatric symptomatology, and bereavement-related (Provini et al., 2000). Of the participants contacted, 26% expressed a need for assistance, including formal services, bereavement help, and coping assistance (Provini et al., 2000).

Despite the challenges faced by survivors and the needs experienced by those facing this type of loss, many survivors do not receive the professional help and support they need (Provini et al., 2000). Wilson and Marshall (2010) found that while 95% of respondents reported a need for professional help, only 44% actually received the assistance required. Lack of information particularly about where to find resources, lack of awareness of services, unavailability of resources, the thought that no one could help, depression and lack of energy to seek help, and practical barriers (distance, cost) are commonly reported barriers to seeking help (McMenamy et al., 2008; Wilson & Marshall, 2010). Though support and assistance is needed, survivors face many barriers that impede the healing process.

Though the majority of those bereaved by natural deaths will progress through their grief without the assistance of professional supporters (Stroebe, Hansson, Schut, & Stroebe, 2008), the historical and current perspectives on suicide as well as the inherent nature of the death invokes reactions that often lead survivors to formal sources of support. While survivors recognize a need for formal support and assistance (Wilson & Marshall, 2010), many find a lack of resources specific to their type of loss. Survivors may seek assistance from traditional bereavement support services only to find that their unique bereavement issues are not addressed. As previously established, a suicide death
raises many questions and discomforting feelings for the survivor, and it would stand to reason that intervention should be focused on the issues that make suicide bereavement unique. However, suicide bereavement specific interventions are not well documented in the literature. Support groups for loss survivors are one intervention commonly used by loss survivors.

**Support Groups for Loss Survivors**

Bereavement support groups are a common, and often cost effective, modality for delivering intervention (Jordan & McIntosh, 2011). Group intervention services may be therapeutic, psychoeducational, supportive, or a combination of approaches. For example, Compassionate Friends is a support group specifically for bereaved parents who have lost children. Alternatively, the Family Bereavement Program represents a therapeutic approach to group bereavement support (Jordan & McIntosh, 2011). Support groups are a commonly utilized intervention for those bereaved by losses, particularly when social support and camaraderie with others is valued, such as in the case of disenfranchised grief (Doka, 2002).

Support groups for loss survivors are one of the few resources specifically for suicide bereavement, and the groups have become a popular resource among loss survivors (Feigelman & Feigelman, 2011). As of July 2012, the listing of support groups on the publicly held listing on the website of the American Foundation for Suicide Prevention listed 670 groups throughout the United States (AFSP, 2012). This is approximately a 61% increase over the 417 identified through the AFSP website or the American Association of Suicidology website by Cerel, Padgett, and Reed in their 2007 study (Cerel, Padgett, & Reed, 2009) and a 139% increase over the 280 groups identified
by Rubey and McIntosh (1996) through the AAS directory in 1996. Further, in February 2015, the number of groups listed on the AFSP website was 772, an increase of 100 in just under three years (Prevention, 2015).

Although the number of groups in the United States has grown considerably since Rubey and McIntosh (1996) first surveyed group facilitators, the research on survivor of suicide loss support groups remains scant. SOS groups are typically categorized together, though there is considerable variation from one group to the next and little is known about the specific processes and mechanisms that function within a group.

Interestingly, although research generally indicates that loss survivors report attendance at SOS groups as at least somewhat helpful, in a study of SOS group facilitators, Cerel, Padgett, Conwell, et al. (2009) found that leaders reported that almost two-thirds (66%) of loss survivors attend 10 group sessions or less. Only 27% of survivors attend 11 to 20 sessions, and a small number of survivors (7%) attend more than 20 group sessions over time (Cerel, Padgett, Conwell, et al., 2009). It is unclear, however, if a small number of group sessions are an adequate “dose” that helps the loss survivor, or if attending a limited number of sessions is an indication that groups are not helpful for some survivors, and this is the reason they choose not to return. This signifies a need for more extensive research to understand what survivors find helpful about SOS groups, the characteristics of survivors who are likely to attend SOS groups, and the reasons why survivors return or do not return to the groups (Cerel, Padgett, Conwell, et al., 2009).

To date, no large scale studies of those who have left a survivor of suicide support group have been conducted. Feigelman and Feigelman (2011) explored the “comings and
goings” of support groups among primarily parent survivors of a child’s suicide (p. 57). This exploration was helpful in identifying the frequency of support group utilization and the reasons that bereaved parents may not return to the support groups. The most common reasons for not returning to a group in the early years of bereavement included: facilitation issues (facilitator lacked skills to control or support the group process); composition issues (size, dominating members, and cliques); the retraumatizing nature of hearing the stories of new group members; and having adequate support outside the group, including developing personal relationships with other group members that continued outside of the group (Feigelman & Feigelman, 2011). Despite the considerable contribution that this study represents to the suicide bereavement field, it is limited to understanding of the support group experience from the perspective of a bereaved parent. Additional exploration with the full scope of support group attendees is needed to better understand the attraction to and withdrawal from the support group experience.

Additionally, McMenamy et al. (2008)’s exploration of the needs of and resources utilized by a small sample (N=63) of survivors indicated that 94% of those seeking support from a suicide grief support group found the resource to be moderately to highly helpful while only 27% of those who attended a general grief support group found it to be a highly helpful resource. Further, 100% of the survivors who reached out to talk to another suicide survivor one-on-one found it to be moderately to highly helpful (McMenamy et al., 2008). Though the mechanisms functioning to make these resources helpful to survivors were not uncovered in this study, it illustrates the very pertinent point that survivors find solace and benefit from discussing the experience with others who have lost a loved one to suicide. Wilson and Marshall (2010) similarly found that an
overwhelming majority of participants who attended a grief support group received at least a small degree of benefit from participation. Feigelman and Feigelman (2011) also discovered a high level of satisfaction with the group experience: “most said their support group was their mainstay in helping them endure the sometimes treacherous course of life after loss” (p. 181). Not only did survivors find that they were accepted and understood by others who could relate to them, they also reported that survivors further along in the grief journey stood as a symbol of hope for a better future (Feigelman & Feigelman, 2011). The literature is replete with calls for further research into the support groups for loss survivors (Cerel, Padgett, Conwell, et al., 2009; Feigelman & Feigelman, 2011). This remains a highly understudied area in the suicidology field.

**Facilitation in support groups.** Although SOS groups are typically categorized as one type of support, there is considerable variety in the composition, structure, and leadership of the groups (Cerel, Padgett, Conwell, et al., 2009), and the literature is lacking information about the types of group formats and styles that are most effective for survivors. Research exploring the effectiveness of group intervention for loss survivors has primarily been conducted on groups that are facilitated by professionals and structured in the group design (Constantino et al., 2001a; Constantino, Sekula, & Rubinstein, 2001b; Mitchell, Gale, Garand, & Wesner, 2003; Mitchell et al., 2007). In few of the studies, a control group was used to further explore the effectiveness of the group intervention. Much of the literature currently available about the effectiveness of groups consists of brief evaluations that are included only as an adjunct to studies focused on survivor needs and experiences (McMenamy et al., 2008; Wilson & Marshall, 2010). Questions about the survivor’s experience in attending support groups for suicide and
general bereavement have been examined in several exploratory studies of survivor needs (Jordan & McMenamy, 2004), though the extent of the exploration is limited to a subjective assessment of the degree of perceived helpfulness of the group.

Facilitation has been identified as a key variable in understanding the objective effectiveness of support groups as well as the participant’s subjective decision of whether or not to return to the group. Though this has not been explored with SOS groups, literature from other disciplines highlights the critical role of the facilitator and specific skills and characteristics deemed to be most important for successful groups (Garcia, Lindgren, & Pintor, 2011; Lieberman & Golant, 2002). For example, in the domain of support groups for those with cancer, research suggests that leaders must demonstrate a commitment to the group (Roustan, Izquierdo Rodriguez, & Anguera Argilaga, 2013), balance the needs of individual group members and the group as a whole (Price, Butow, & Kirsten, 2006), manage dynamics to ensure everyone has an opportunity to talk, and convey empathy and understanding (Butow et al., 2007). Additional characteristics deemed important of facilitators include organization, inclusivity and compassion (Bartone, Rosenwald, & Bronstein, 2008; Butow et al., 2007), and educational qualities, such as the ability to share information (Butow et al., 2007) and necessary resources with participants (Bartone et al., 2008). Adults caring for children with special needs reported that the facilitator’s ability to manage the group was an important consideration in their decision to return to the support group (Hammarberg, Sartore, Cann, & Fisher, 2014).

Though this has not been explored in the context of large samples with quantitative data, qualitative interviews with loss survivors and other bereaved populations elucidate key facilitation issues that prevent ongoing participation in support
groups for bereavement. A qualitative study of bereaved individuals, including loss survivors, revealed that group attendees were most troubled by group facilitators who had unresolved grief issues impacting their ability to help others in the group (Dyregrov, Dyregrov, & Johnsen, 2014). Further, participants identified negative experiences in support groups related to the facilitator’s insufficient knowledge of group processes and skills in group management (Dyregrov et al., 2014). Similarly, qualitative interviews with loss survivors who attended SOS groups specifically indicated that leadership and facilitation issues were a primary reason for not returning to the support group (Feigelman & Feigelman, 2011). Specifically, participants reported concerns with the following facilitator behaviors: allowing group members to monopolize or dominate the group, not allowing group members to help one another, not engaging all members of the group, and simply lacking skills to manage the group dynamics (Feigelman & Feigelman, 2011). Another qualitative study revealed that while loss survivors who attended support groups found the fellowship and mutual understanding to be helpful, they expressed desire for professional facilitation to “help direct the group, support the recently bereaved, and keep them up-to-date with new coping strategies” (McKinnon & Chonody, 2014, p. 239).

While facilitation takes many forms, it is common in the United States for SOS groups to be led by peers who have experienced a suicide loss. It is also common that groups are created by loss survivors as a grassroots effort to help other survivors, and many groups function without support of a larger agency or organization. In a survey of suicide survivor support group leaders, Cerel, Padgett, and Reed (2009) found that close to half (45%) of the 100 group leaders who participated function without the sponsorship
of an agency or organization. This survey also found that 78% of the respondents reported a survivor as the group facilitator (Cerel, Padgett, & Reed, 2009). A majority of group leaders (67%) reported some type of formal training in suicide survivor group facilitation; close to half (42%) reported mental health or medical training and 20% reported that they did not have any additional educational experience in support group facilitation for survivors (Cerel, Padgett, & Reed, 2009). While it is possible to obtain a general picture of the facilitation of support groups for survivors of suicide loss from the information in this study, we lack knowledge about the implications of peers functioning in the role of group facilitator, particularly when there is no agency sponsorship or support. Given the importance of the facilitator and the documented concerns reported by group attendees regarding insufficient facilitation in support groups, a closer examination of facilitation is necessary, beginning with a review of peer support and group facilitation.

**Peer support and group facilitation.** Though formal definitions of peer support may vary across domains in which it is used, a constant element of peer support is that the connection with another person with whom one shares an experience “is a deep, holistic understanding based on mutual experience where people are able to ‘be’ with each other without the constraints of traditional (expert/patient) relationships” (Mead, Hilton, & Curtis, 2001) p. 135). Personal stories from survivors who have participated in support groups echo similar themes; meeting with others who have experienced a similar loss helps to assuage guilt and shame while also providing a safe place for survivors to talk about their loved one and the loss experience without fear of judgment or blame from others (Clark & Goldney, 1995).
Peer support has been established and accepted as a standard intervention in the areas of mental health, such as the Family to Family program offered by NAMI (Dixon et al., 2011), and substance abuse, such as the iconic Alcoholics Anonymous. Peer support has also been used in the health field, with support groups for men with prostate cancer and women with breast cancer (Dunn, Steginga, Occhipinti, & Wilson, 1999; Pistrang & Barker, 1998; Steginga, Pinnock, Gardner, R.A., & Dunn, 2005). Peer support and peer provided services are often used or offered in conjunction with other services, such as counseling services with a trained mental health or substance abuse professional.

Frequently, peer support services are offered under the auspices of a sponsoring agency. Alcoholics Anonymous is a notable exception to this, however, as many AA groups function independently without sponsorship or support. It is worth noting that typically there is consistency within the AA community, and regardless of location or the facilitator, AA groups function under the same general principles. The network of AA groups throughout the United States is also fairly well developed. In contrast, SOS groups do not operate under the same principles, nor is there a developed network among SOS group facilitators. The American Foundation for Suicide Prevention (AFSP) offers monthly drop-in conference calls for facilitators to have the opportunity to talk with one another and share resources and information (Prevention, 2015). Additionally, AFSP and several other organizations offer training specifically for facilitators of SOS groups. However, it remains that the underlying principles and way in which SOS groups are facilitated vary among the groups. For example, some groups have acceptance criteria that must be met before a new survivor can join the group, while other groups do not have such acceptance criteria (Cerel, Padgett, & Reed, 2009).
Because of the typically informal nature of peer support services, evaluation is often minimal or non-existent (Mead et al., 2001). Further, the culture of peer support makes research and evaluation difficult; peer support often prides itself on being different from traditional services, which are replete with evaluation efforts. Although many providers and recipients of peer support provide anecdotal evidence in support of this type of intervention, the lack of evaluation and research of the process leaves gaps in our understanding of the way in which such a service works. Not only is research and evaluation important in the process of understanding peer support, it is also vital to the intervention receiving greater attention, support, and funding (Mead et al., 2001).

The peer support movement in suicide bereavement has been pushed along by passionate survivors of suicide loss who want to support those who have experienced a similar loss. Iris Bolton, bereaved by the suicide of her son in 1977, went on to begin one of the first support groups for suicide survivors in the early 1980s, after realizing that such supports did not exist (Feigelman & Feigelman, 2008a). Since that time, SOS groups have become a relatively common resource. Many SOS groups have been started or are facilitated by survivors of suicide loss (Feigelman & Feigelman, 2008a).

Although peer support is a commonly used type of intervention for suicide loss, the research is considerably lacking on this type of support (Cerel, Padgett, Conwell, et al., 2009; Cerel, Padgett, & Reed, 2009; Feigelman & Feigelman, 2008a, 2011; McMenamy et al., 2008). There is little research exploring the effectiveness of peer support and even less that helps to further understanding of the unique characteristics and qualities that make peer support helpful to loss survivors. Additionally, the potentially problematic aspects of peer facilitation have not been explored in the literature. Given the
level of trauma reported by many loss survivors (Brent et al., 1996; Sanford, Cerel, McGann, & Maple, 2016), it is possible that some survivors presenting in group may have symptoms of posttraumatic stress disorder which could require further intervention or assistance. Peer supporters who have not received training in the symptoms of posttraumatic stress disorder may overlook such individuals who need more intensive intervention, thus providing a response inadequate for the level of symptoms and functioning of the survivor. Many groups do not use screening procedures to identify those who may need more therapeutic services (Sanford & Cerel, 2014). Consequently, bereaved individuals with complicated grief may attend support groups only to find little relief for their intense symptoms (Dyregrov, Dyregrov, & Johnsen, 2014).

Additionally, this author has received anecdotal feedback from survivors that hearing the stories of other bereaved survivors reminds them too much of their own loss. Hearing stories of others may trigger painful memories, possibly resulting in the loss survivor feeling burdened by the stress of carrying another’s pain (Dyregrov et al., 2014) or even the retraumatization of loss survivors (Feigelman & Feigelman, 2011). Loss survivors describe the unrestrained sharing of death stories as a reason why they decide not to return to the group (Feigelman & Feigelman, 2011; McKinnon & Chonody, 2014). The unhelpful experiences encountered in the group process need to be explored further to better understand how the group process works for survivors.

**Differences in peer and professional facilitation.** The findings from this author’s 2012 pilot study of support group facilitators suggests that there are a number of areas that facilitators differ in based on their status as a peer, professional, or both. On all four items querying attitudes about the effectiveness of groups, survivors, mental health
professionals, and survivor/mental health professionals expressed similar sentiments about the effectiveness of the support group in helping survivors with their grief, except on the item that asked facilitators to rate the degree of effectiveness of the group in helping survivors who are in a great deal of distress in the first few months following the loss (Sanford & Cerel, 2014). Compared to peer and peer/mental health professional facilitators, mental health professionals were less likely to agree that the group was effective in helping survivors in great distress the first few months after the death (Sanford & Cerel, 2014).

Given this, it is not surprising that professional supporters were less likely to agree that survivors should attend a support group as soon as possible following the death (Sanford & Cerel, 2014). One key difference between peers and professionals emerged from the data regarding how soon survivors are likely to be invited to attend the support group. Some facilitators establish rules for when survivors can first attend the support group, such as 3 months or 6 months post loss. The findings of this study suggest that professional facilitators are more likely to have such rules regarding when a survivor can first attend the support group (Sanford & Cerel, 2014), perhaps with the understanding that newly bereaved individuals attending too soon could recount the raw details of the story in a way that is retraumatizing to those further along in the bereavement process. The reasons for these differences need to be explored further.

Differences also emerged when examining the use and impact of storytelling in the group experience. According to facilitators completing the measures in the initial phase of the study, the majority of time in the group is spent on sharing of experiences (Sanford & Cerel, 2014). The sharing of experiences and telling of stories can be
considered an important element of meaning reconstruction following a loss (Neimeyer, 2001b), though most facilitators probably do not define the process as such. Facilitators who identify as survivors or survivor/mental health professionals were more likely than mental health professionals to agree that sharing stories is an essential element of the healing process (Sanford & Cerel, 2014). Additionally, survivor facilitators were the least likely to agree that continual sharing of stories can traumatize (Sanford & Cerel, 2014).

Although the possibility of stories serving to retraumatize group attendees was referenced immediately prior to this point, it is possible, however, that the sharing of stories allows the loss survivor an opportunity to construct the meaning of the loss while also deconstructing and reconstructing his identity following the loss. The attitudes and opinions of group facilitators are merely that – no research exists that would support these positions, and it can be assumed that personal experience provides a primary basis for the decisions that facilitators make about their respective groups.

Another interesting area of difference concerns attitudes of group facilitators and attitudes of group attendees. A 2011 study conducted by this author indicated differences in attitudes regarding group effectiveness and functioning among group facilitators and group attendees (Sanford & Cerel, 2011). Importantly, this study did not differentiate among the various types of facilitators, and all facilitators, regardless of status as a survivor, mental health professional, or both, were included in the same group. While both survivors and facilitators reported favorable opinions about the effectiveness of helping survivors cope with grief, facilitators endorsed significantly higher levels of positive responses about the effectiveness of groups (Sanford & Cerel, 2011). This study also revealed differences between group facilitators and survivor attendees in terms of the
functioning and processes of the groups. Facilitators were more likely than survivor attendees to disagree with the statement that survivors should attend group as soon as possible following the death (Sanford & Cerel, 2011), suggesting that survivors may seek out the support group sooner than recommended by the facilitators. Facilitators were more likely than survivor attendees to agree that continual sharing of stories in the group can retraumatize survivors, though both facilitators and survivor attendees agreed that sharing stories is an important aspect of the healing process (Sanford & Cerel, 2011). The varying opinions among group facilitators as well as the different opinions between group facilitators and group attendees point to the need for more detailed and nuanced exploration of the support groups.

**Meaning Making in the Group Experience**

As previously established, meaning making often occurs following a stressful life event, such as a suicide, (Park, 2010), and it is an important process in the healthy bereavement journey (Coleman & Neimeyer, 2010; Winchester Nadeau, 2008). When faced with a personally challenging or devastating loss, survivors often engage in a process of exploring and reconstructing new assumptions about the world, themselves, the death, and the decedent (Coleman & Neimeyer, 2010). As described by Coleman and Neimeyer (2010), “this process has a cyclical course in which the pain of bereavement prompts efforts to find meaning in the troubling transition, with new meanings being retained and integrated to the extent that they reduce distress; otherwise, attempts at reconstruction are likely to continue” (p. 805).

However, meaning making in suicide bereavement can be a challenge for survivors, as the survivor must reconcile the oft perceived notion that his or her loved one
chose to die and was not just a victim of happenstance. The meaning of the death becomes complicated by the fact that the true reason for the suicide died with the loved one. Attribution for the cause of the death may become a focal point in the meaning making experience for loss survivors (Supiano, 2012).

It is unclear how support groups impact the meaning making experience for survivors of suicide loss. Sharing experiences is commonly reported by facilitators as the primary activity in the group (Cerel et al., 2009), but it is not known if this is objectively helpful in the bereavement experience. It is unclear what is meant by “sharing of experiences” and how this is facilitated or managed. Telling the story and receiving validation from others who have experienced similar losses seems to be a major function of the support groups, and it may be that the nature and format of the groups allows for meaning reconstruction to occur (Supiano, 2012), regardless of whether or not it is a conscious process facilitated by the group leader. Begley and Quayle (2007)’s qualitative study of survivors offered insight, albeit limited and preliminary, into the group experience: “They also felt that the sharing of stories in the suicide bereavement group helped them make sense of their loved one’s death and they felt understood. Neimeyer (2000) has argued that meaning-making occurs in the context of ‘sense-making’ and later ‘benefit-finding.’ It would be interesting to investigate the social construction of grief and how meaning-making evolves in the context of support groups” (Begley & Quayle, 2007, p. 32).

Feigelman and Feigelman (2011) have suggested that newly bereaved survivors who join support groups are able to identify with survivors further along in their grief journey to find inspiration in these role models displaying the “new normal” and hope for
a better future (p. 182). It is in the context of such relationships that survivors are able to reconstruct meaning in their identity as a survivor of suicide loss, exploring what this new identity means for relationships with others as well as with themselves (Supiano, 2012). Additionally, loss survivors are able to construct meaning around the causal attribution for the death by exploring feelings of guilt, blame, and responsibility with others who can challenge unhelpful attributions supportively and compassionately (Supiano, 2012).

Given the fact that many survivors struggle with making sense of the loss and finding an answer to the question “why” (Jordan, 2001), it is possible that survivor of suicide support groups function to help survivors make sense of the loss and wrestle with the possible answers to the “why” question while recognizing that a final answer may never come (Supiano, 2012). The very necessary and, perhaps, integral process of reconstructing meaning may be facilitated in the support group experience. There have been recent efforts to explore meaning making processes in bereavement groups, though all research to date has been focused exclusively on professional, therapeutic groups (e.g. (MacKinnon et al., 2014; MacKinnon et al., 2015; Saindon et al., 2014). The forms and processes of meaning making in non-therapeutic support groups have yet to be explored.

**Rumination**

A common sentiment in society is that there is “no wrong way to grieve,” but excessive fixation on the death and its meaning for one’s life may be an indication of rumination, defined as “thoughts and behaviors that focus one’s attention on one’s depressive symptoms and the meanings of these symptoms” (Nolen-Hoeksema, Parker, & Larson, 1994, p. 92). Rumination has been found to be associated with negative outcomes
in the bereavement trajectory (Nolen-Hoeksema, McBride, & Larson, 1997). While the process of reconstructing meaning in the face of such a loss is an important task, repeated story telling may also be an indication of excessive rumination (Bonanno et al., 2008). Rumination may align with the process of searching unsuccessfully for meaning or sense of the loss, which also has been shown to be related to negative bereavement outcomes (Bonanno et al., 2008; Coleman & Neimeyer, 2010).

The relationship between support groups and rumination is unclear, though concern has recently been expressed about online support groups and the possibility that the immediate and constant availability and accessibility of such groups may promote rumination or make rumination more likely (Stroebe, van der Houwen, & Schut, 2008). While in-person support groups are less immediately available to loss survivors, it is unclear if sharing thoughts, feelings, and reactions in a group of others with a shared experience promotes the functional element of rumination, known as reflective pondering, or the maladaptive element of rumination, termed brooding (Joormann, Dkane, & Gotlib, 2006; Treynor, Gonzalez, & Nolen-Hoeksema, 2003). Reflective pondering is defined as a “purposeful turning inward to engage in cognitive problem solving to alleviate one’s depressive symptoms,” while brooding is defined as “a passive comparison of one’s current situation with some unachieved standard” (Treynor et al., 2003, p. 247). Story-telling in a group may be purposeful and support reflective pondering, along with growth and a change in the narrative over time. Conversely, in sharing with others who can relate, loss survivors could become fixated on the death story or a particular reaction experienced in the grief journey, such as guilt or indignation from the lack of support from loved ones, resulting in brooding. Either aspect of
rumination is possible in a support group, and the particular dominating form of
rumination in the group may be highly dependent on the facilitator and the level of active
facilitation utilized. As previously established, facilitation is a key variable in the success
of a support group, with group attendees desiring an active facilitation style capable of
managing group dynamics to ensure all attendees have their needs met. In support
groups, active facilitation may be absent, resulting in brooding rumination.

Additionally, as mentioned previously, the very telling of the story necessary in
the meaning reconstruction process may be retraumatizing for the audience (Feigelman &
Feigelman, 2011), particularly if the bereaved is focused on retelling the story of the
death and death scene. From this author’s experience facilitating groups for loss
survivors, the focus on the traumatic aspects of the death and death scene seems to be a
fixation of many loss survivors. In fact, some support group facilitators discourage telling
the stories altogether, and instead focus the group on sharing of struggle related to the
grieving process and strategies for coping (Survival, 2013, May).

Thus, therein lies the facilitator’s challenge: striking a very delicate balance
between allowing space for meaning reconstruction in the narration of stories without
further traumatizing other support group attendees or supporting brooding rumination.
Meaning making in the context of support groups has not been explored in the literature.
Given that that the retelling of the death story in support groups impacts both the
(positive) search for meaning and the possibility of engendering rumination, research is
needed to explore this complicated issue.
Summary

Given the unique nature of suicide bereavement and the risk for loss survivors to experience negative outcomes following the loss while simultaneously receiving less social support, loss survivors are a vulnerable population in need of effective services and supports. SOS groups are generally categorized as a single type of intervention, though few groups have oversight, and little is known about what actually occurs in the group meetings. Previous research has attempted to explore differences based on the status of the facilitator as a peer, professional, or peer/professional. However, this perspective may be limited and does not capture the dynamics of peer facilitation. It also does not attend to nuances that may emerge in facilitation styles relative to meaning making and the role of stories in the group experience. Thus, the present study sought to add to the existing literature by exploring facilitator attitudes about support groups through the SOS Support Group Facilitator Scale, with particular emphasis on perspectives on meaning making and the role of the facilitator.
Chapter Three
Methodology

Sampling Procedures & Characteristics

This quantitative study examined primary data collected from a sample of survivor of suicide loss support group facilitators. The survey was a one-time survey that included the Group Information Questionnaire, Group Facilitator Questionnaire, and Professional Quality of Life Scale (see Appendix B for the full survey). Respondents were asked questions regarding their perspectives on group composition and structure, facilitator experience and training, facilitator attitudes towards group functioning and effectiveness, and compassion satisfaction and compassion fatigue for facilitators.

The sample consisted of survivor of suicide loss support group facilitators in the United States and New Zealand. Facilitators in the US were identified through the publicly held listing of support groups on the American Foundation for Suicide Prevention (AFSP) website. The website was updated in October 2014, and group listing information was obtained from the website in February 2015. Although group listings change frequently, it was assumed that the listing of groups obtained in February 2015 was an extensive, though not necessarily exhaustive, list of currently active groups. This listing included 772 unique groups.

Facilitators in the US were recruited for participation in the study initially through an email sent to the address listed on the AFSP website. Some facilitators were identified as the contact person for multiple groups, and these listings were consolidated so that each facilitator only received one invitation to participate regardless of the number of groups they facilitate. An invitation to participate in the study was sent in March-April.
2015 through Qualtrics to 702 email addresses for group facilitators. Qualtrics data indicates that 369 of the 702 original emails were opened, and 150 of the 369 opened emails led to a survey being started. Of the 150 started surveys, 92 were completed. Incomplete responses were not included in the final dataset.

Several efforts were made to increase response rate for the survey. First, a $20 incentive for participating in the study was offered. Second, a reminder email was sent to all group facilitators approximately two weeks after the initial email was sent. Additionally, facilitators were informed of the option to elect a hard copy of the survey if they preferred this version or were not comfortable entering data online. Further, from June-August 2015, hard copies were mailed to facilitators who did not respond to the emailed survey invitation. In total approximately 500 hard copy surveys were mailed to facilitators, which led to 43 being returned. Approximately 45 of the surveys were returned marked “Returned to Sender”. Many of the returned surveys were initially sent to the meeting location and were likely returned as the facilitator did not have a mailbox at the meeting location (such as a library or medical facility).

Additionally, contact was made with facilitators in other countries to increase participation and to capture an international perspective on the support groups. Primary contact was made with a suicide bereavement outreach group in New Zealand, and the survey was promoted to group facilitators throughout New Zealand via their newsletter. Approximately 15 facilitators were invited to participate in the survey. Five surveys were started by facilitators in New Zealand, but only three were completed fully enough to be included in the dataset.

These sampling procedures yielded 138 participants, the majority of whom are
Caucasian (n=130; 94.2), female (n=115; 83.9%), live in the US (n=135; 97.8%) and possess a bachelor’s degree or higher (n=103; 74.6%). Complete descriptive statistics for participants are presented in Table 3.1.

**Protection of human subjects.** Participants were provided with consent information in the introductory letter and at the survey site. Participants were informed that they could terminate participation at any time in the process. Waiver of written informed consent has been approved by the University of Kentucky Institutional Review Board. Respondents indicated consent for participation in the study by electing to continue after reading the Consent Script for Web Based Survey for Group Facilitators or by returning the completed hard copy survey (see Appendix A for IRB documentation).

**Measures**

**Group characteristics.** The Group Information Questionnaire was modified from the original used by Cerel et al (2009) and more recently based on results from the pilot study of facilitators in 2012 (Sanford & Cerel, 2014). The Group Information Questionnaire was used to gather information about the group, including: meeting location, frequency, and duration; group sponsorship and agency support; group attendance; group structure and orientation for new attendees; group topics and goals; and other resources offered by the group. See Appendix B for the full Group Information Questionnaire.

**Facilitator characteristics.** The Facilitator Information Questionnaire was used to collect information about the facilitator, including: demographic characteristics such as race, sex, employment status, and education level; status as peer, professional, or peer/professional; training and experience facilitating SOS groups; and facilitator
Table 3.1
Sample Demographic Information

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<tr>
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</tr>
<tr>
<td>Female</td>
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</tr>
<tr>
<td>Hispanic</td>
<td>2.2%</td>
<td>3</td>
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</tr>
<tr>
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<td>1</td>
</tr>
<tr>
<td>Country</td>
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</tr>
<tr>
<td>New Zealand</td>
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<tr>
<td>Highest Level of Education</td>
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</tr>
<tr>
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<tr>
<td>Doctoral degree</td>
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<td>9</td>
</tr>
</tbody>
</table>
attitudes about suicide bereavement, the role of group, and the effectiveness of the group. See Appendix C for the full Facilitator Information Questionnaire.

**Compassion satisfaction and compassion fatigue of facilitators.** The Professional Quality of Life Scale was used to measure compassion satisfaction and compassion fatigue of facilitators. The ProQOL is a validated measure of compassion satisfaction and compassion fatigue (Stamm, 2010) designed with three 10-item subscales to capture unique elements of professional quality of life: compassion satisfaction, compassion fatigue, and burnout. Respondents were asked to indicate how frequently they have experienced each item in the past 30 days using 5 response options anchored by *never* (1) and *very often* (5). Examples of statements regarding compassion satisfaction include “I get satisfaction from being able to help people,” “I feel invigorated after working with those I help,” and “I like my work as a helper.” Items on the burnout subscale include “I am happy,” “I feel trapped by my job as a helper,” and “I have beliefs that sustain me.” Items on the secondary trauma subscale include “I am preoccupied with more than one person I help,” “I jump or am startled by unexpected sounds,” and “I feel depressed because of the traumatic experiences of the people I help.”

Five items on the burnout subscale were reverse scored, and items for each subscale were summed to create a total score. On the subscales, a score of 22 or less indicates a low level of the construct (burnout, compassion satisfaction, or secondary trauma), a score between 23 and 41 represents an average level, and a score of 42 or more indicates a high level of the construct (Stamm, 2010). Additionally, scoring of the subscales requires that raw scores be converted to t-scores, with an average of 50 and a standard deviation of 10 for each of the subscales (Stamm, 2010). Reliability for the
compassion satisfaction, burnout, and secondary trauma subscales are $\alpha=.88$, $\alpha=.75$, and $\alpha=.81$, respectively (Stamm, 2010). The ProQOL has been shown to have consistently good internal consistency on all three subscales. For this study, Cronbach’s alpha was conducted on the overall ProQOL scale ($\alpha=.68$) as well as the three subscales: compassion satisfaction ($\alpha=.86$), burnout ($\alpha=.75$), and secondary trauma ($\alpha=.74$). Cronbach’s alpha for the three subscales indicate good internal consistency for the measures while Cronbach’s alpha for the overall measure indicates an acceptable level of internal consistency.

**Facilitator attitudes on meaning making and facilitation.** There currently are no measures that explore facilitator attitudes and perceptions; thus, statement endorsements were developed to construct the SOS Support Group Facilitator Scale. Several items from Cerel, Padgett, and Reed (2009) study of support groups were incorporated in the final version of the scale, and additional items were included to assess the facilitator’s perspective more fully. Questions were designed to be consistent with the meaning making literature (Coleman & Neimeyer, 2010; Park, 2010). The SOS Support Group Facilitator Scale included a series of statement endorsement items that assessed facilitator perception of the role of group, the role of the facilitator, and the role of group attendees. A total of 24 items were included in the scale. Respondents were asked to indicate their agreement with each of the statements, with the following options: strongly disagree (1), mostly disagree (2), mostly agree (3), and strongly agree (4). The scale included items related to the role of group, such as: “SOS groups allow survivors to discuss the ‘whys’ and ‘what ifs’ that survivors often experience” and “SOS groups are important in helping survivors make sense of what has happened.” The scale also
included items concerning the facilitator role, such as: “SOS group facilitators should intervene to support growth and healing” and “SOS facilitators should intervene in the group process to ensure that everyone gets what they need.” Other statements pertain to the loss survivor and the general suicide bereavement experience, such as: “Being active in suicide prevention is an important part of healing” and “Survivors need to attend an SOS group forever.” The full scale is available in Appendix B. Internal reliability of this scale yielded a Cronbach’s alpha of .744. Review of the Cronbach’s alpha results suggests that there are no items that could be deleted to meaningfully improve the alpha.

**Analytic Approach**

Data were analyzed using univariate, bivariate, and multivariate procedures. Descriptive information was calculated for variables related to group structure, organization, and format as well as facilitator characteristics including education, training, experience, and compassion satisfaction and fatigue. Exploratory Factor Analysis (EFA) was used to analyze the structure of the Survivor of Suicide Loss Support Group Facilitator Scale. Factor analysis has three primary purposes: (1) to determine the structure of a set of observed variables; (2) for data reduction purposes to obtain a single measure of a latent construct; and (3) to develop parsimonious scales that measure underlying factors (Bauer & Curran, 2015). EFA is frequently used in theory development (Bauer & Curran, 2015; Osborne, 2014). Given the importance of meaning making and the role of the facilitator in supporting this process in the context of the group setting, the SOS Support Group Facilitator Scale was created to identify a set of behaviors and attitudes that could be generalized to measure these latent concepts (Bollen, 2002). To accomplish the exploration of the latent concepts, the 24 items of the
SOS Support Group Facilitator Scale were subjected to Exploratory Factor Analysis (EFA) using principal axis factoring (PAF).

Principal axis factoring (PAF) is the preferred extraction method when there are violations to the assumption of multivariate normality (Osborne, 2014). Additionally, PAF is recommended when the analysis is theoretically driven and the aim is to produce results that support interpretation of the underlying latent constructs rather than merely reducing the data empirically, as principal components analysis is designed to accomplish (Reio & Shuck, 2014). After the initial solution was obtained, rotation was utilized to achieve the simplest possible structure (Osborne, 2014). Given the nature of the analysis, it was assumed that the factors are correlated, suggesting that an oblique rotation is necessary (Osborne, 2014). Promax rotation is an oblique rotation that typically produces results that are simpler to interpret than Direct Oblimin rotation, while producing similar results (Osborne, 2014).

Finally, correlations, t-tests, and Analysis of Variances (ANOVAs) were used to explore bivariate relationships between the factors and select group and facilitator characteristics. All statistical analyses were conducted with SPSS 22.0.
Chapter Four

Results

Past efforts to understand SOS groups have focused primarily on descriptive data about groups, such as frequency, duration, and sponsorship for groups. This is the first study of SOS group facilitators that examined perspectives on group facilitation. This study also updated and expanded the current understanding of descriptive information about support groups as reported by group facilitators. Descriptive statistics are provided for the groups and facilitators. Although not all SOS groups are listed on the AFSP website, it is considered to be a relatively thorough and comprehensive list of available support groups. It is updated regularly and is commonly used by facilitators to advertise their group. Thus, for facilitator status and meeting frequency, the group information for the population obtained from the AFSP website as of February 2015 is presented as a comparison for the sample.

Descriptive Analyses

**Group characteristics.** Characteristics of the groups are presented in the following categories: group organization and sponsorship, group meeting variables, group structure, group process and activities, and group attendees and attendance.

**Group organization and sponsorship.** The majority of groups reported that they do not function independently (n=96; 70.6%). Nearly half (n=66; 47.8%) of all groups function without any sponsorship. For those groups that do have a sponsoring organization, 17.6% (n=24) are sponsored by a mental health agency, 14.7% (n=20) are sponsored by a community organization (such as a suicide prevention coalition), and 8.8% (n=12) are sponsored by hospice. Most groups do not operate with a budget
When queried about sources of funding for the group, facilitators most frequently identified sources of financial support as the sponsoring agency \((n=43)\), donations \((n=42)\), fundraising \((n=19)\), community grants \((n=10)\), facilitator’s personal funds \((n=6)\), or a fee paid by participants \((n=1)\). Descriptive information about the group organization and sponsorship is described in Table 4.1.

**Group meeting variables.** The length of time that the groups have been in operation varied considerably. Nearly a third \((n=43; 30.1\%)\) have been in operation for 1-5 years while another third \((n=44; 32.4\%)\) have been in operation for 15 or more years. Groups that have been in operation for 5-10 years were third most common \((n=25; 18.4\%)\), followed by groups in operation for 10-15 years \((n=17; 12.5\%)\), and finally groups that have been in operation for less than one year \((n=9; 6.6\%)\). The preponderance of groups that have been in existence for 1-5 years is not surprising given the rise in the number of group listings since a pilot study was conducted with group facilitators in 2012. Using information available from the AFSP website in 2012, 670 groups were identified, compared to 772 in 2015.

Open-ended groups with no fixed number of sessions that loss survivors can join at any point were the most commonly reported group format, representing 85.4\% \((n=117)\) of groups. Closed groups with a fixed number of sessions accounted for 10.2\% \((n=14)\) of groups involved in the study. Finally, 4.4\% \((n=6)\) of groups offer a combination of open and closed group formats. A group format typical of a combination style is one that begins with a closed group for new participants that allows those participants to transition to an available open group once they have completed the closed group sessions.
Table 4.1

*Group Organization and Sponsorship*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Independent Non-Profit Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>29.4%</td>
<td>40</td>
</tr>
<tr>
<td>No</td>
<td>70.6%</td>
<td>96</td>
</tr>
<tr>
<td><strong>Sponsorship</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No sponsor</td>
<td>48.5%</td>
<td>66</td>
</tr>
<tr>
<td>Mental health agency</td>
<td>17.6%</td>
<td>24</td>
</tr>
<tr>
<td>Community organization</td>
<td>14.7%</td>
<td>20</td>
</tr>
<tr>
<td>Hospice</td>
<td>8.8%</td>
<td>12</td>
</tr>
<tr>
<td>Church</td>
<td>5.9%</td>
<td>8</td>
</tr>
<tr>
<td>Social service agency</td>
<td>2.2%</td>
<td>3</td>
</tr>
<tr>
<td>Other</td>
<td>2.2%</td>
<td>3</td>
</tr>
<tr>
<td><strong>Does the group operate with a budget?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>14%</td>
<td>19</td>
</tr>
<tr>
<td>No</td>
<td>86%</td>
<td>117</td>
</tr>
<tr>
<td><strong>Sources of financial support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sponsoring agency</td>
<td>31.2%</td>
<td>43</td>
</tr>
<tr>
<td>Donations</td>
<td>30.4%</td>
<td>42</td>
</tr>
<tr>
<td>Fundraising</td>
<td>13.8%</td>
<td>19</td>
</tr>
<tr>
<td>Community grants</td>
<td>7.2%</td>
<td>10</td>
</tr>
<tr>
<td>Facilitator’s personal funds</td>
<td>4.3%</td>
<td>6</td>
</tr>
<tr>
<td>Fee paid by participants</td>
<td>0.7%</td>
<td>1</td>
</tr>
</tbody>
</table>
Monthly groups are the most common frequency reported among facilitators, with approximately 61.5% of groups \( (n=83) \) reporting a monthly meeting schedule. Groups that meet twice a month account for 24.4% of the sample \( (n=33) \), and weekly group meetings were reported by 8.9% \( (n=12) \) facilitators. Other group formats (short-term groups, less than monthly groups, and online groups) were represented in 5.1% \( (n=7) \) of the sample. Meeting frequency for the sample was proportionally similar to the meeting frequency for the known population as indicated in Table 3. According to the AFSP website, meetings are most commonly held monthly \( (n=419; 54.3\%) \), with twice monthly groups being the second most common \( (n=194; 25.1\%) \), and weekly groups reported least frequently \( (n=53; 6.9\%) \). Short term groups \( (n=28; 3.6\%) \) and unknown formats \( (n=78; 10.1\%) \) were also identified. Table 4.2 includes meeting frequency information for the sample and known population.

Group duration is most commonly 1.5 hours \( (n=86; 62.8\%) \), followed by 2 hours \( (n=41; 29.9\%) \), and finally 1 hour \( (n=10; 7.3\%) \). The most common meeting locations include a church/faith based location \( (n=54; 39.4\%) \), a hospital \( (n=16; 11.7\%) \), mental health facility \( (n=14; 10.2\%) \), and hospice \( (n=12; 8.8\%) \). On average, facilitators reported 2.12 leaders for the group, though 42.1% \( (n=53) \) respondents reported that they are the only group facilitator and 38.1% \( (n=48) \) reported that the group has two facilitators. Several groups \( (n=4) \) utilize a large number of facilitators (8 or more facilitators) who alternate facilitation duties, leading to a skewed average. Additional group meeting descriptive statistics are included in Table 4.3.
<table>
<thead>
<tr>
<th>Status</th>
<th>Sample % (n)</th>
<th>Known Population % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Monthly</td>
<td>61.5% (83)</td>
<td>54.3% (419)</td>
</tr>
<tr>
<td>Twice a month</td>
<td>24.4% (33)</td>
<td>25.1% (194)</td>
</tr>
<tr>
<td>Weekly</td>
<td>8.9% (12)</td>
<td>6.9% (53)</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>5.1% (7)</td>
<td>13.7% (106)</td>
</tr>
<tr>
<td>Characteristic</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----</td>
<td>----</td>
</tr>
<tr>
<td>Length of time in operation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than one year</td>
<td>6.6%</td>
<td>9</td>
</tr>
<tr>
<td>1-5 years</td>
<td>30.5%</td>
<td>41</td>
</tr>
<tr>
<td>5-10 years</td>
<td>18.4%</td>
<td>25</td>
</tr>
<tr>
<td>10-15 years</td>
<td>12.5%</td>
<td>17</td>
</tr>
<tr>
<td>15+ years</td>
<td>32.4%</td>
<td>44</td>
</tr>
<tr>
<td>Open/closed status</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Open (no set number of sessions)</td>
<td>85.4%</td>
<td>117</td>
</tr>
<tr>
<td>Closed (fixed number of sessions)</td>
<td>10.2%</td>
<td>14</td>
</tr>
<tr>
<td>Combination</td>
<td>4.4%</td>
<td>6</td>
</tr>
<tr>
<td>Duration of meetings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 hour</td>
<td>7.3%</td>
<td>10</td>
</tr>
<tr>
<td>1.5 hours</td>
<td>62.8%</td>
<td>86</td>
</tr>
<tr>
<td>2 hours</td>
<td>29.9%</td>
<td>41</td>
</tr>
<tr>
<td>Meeting location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Church/faith based location</td>
<td>39.4%</td>
<td>54</td>
</tr>
<tr>
<td>Hospital</td>
<td>11.7%</td>
<td>16</td>
</tr>
<tr>
<td>Mental health facility</td>
<td>10.2%</td>
<td>14</td>
</tr>
<tr>
<td>Hospice</td>
<td>8.8%</td>
<td>12</td>
</tr>
<tr>
<td>Social service/non-profit agency</td>
<td>7.3%</td>
<td>10</td>
</tr>
<tr>
<td>School/educational setting</td>
<td>5.1%</td>
<td>7</td>
</tr>
<tr>
<td>Library</td>
<td>3.6%</td>
<td>5</td>
</tr>
<tr>
<td>Crisis center</td>
<td>3.6%</td>
<td>5</td>
</tr>
<tr>
<td>Private office</td>
<td>3.6%</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>6.5%</td>
<td>9</td>
</tr>
</tbody>
</table>
Group structure descriptive statistics. The majority of groups are open and survivors can join at any time \((n=120; \text{87.6\%})\). When facilitators are contacted by a new survivor, the most common response provided is materials mailed/emailed to the loss survivor \((n=71; \text{51.4\%})\). Other common responses include an intake phone call \((n=41; \text{29.7\%})\), an intake/screening appointment \((n=19; \text{13.8\%})\), and an invitation to attend group \((n=14; \text{10.1\%})\). Most groups are open with no screening process \((n=97; \text{70.8\%})\), while 27\% \((n=37)\) interview survivors prior to their first group meeting. Two groups \((1.5\%)\) use a screening tool and only allow those who meet criteria to attend. The majority of facilitators \((n=73; \text{53.7\%})\) reported that they do not ever decide to exclude anyone from the group. Orientation to the group and group process varies for the groups represented in the study. Most groups have an informal orientation process \((n=106; \text{77.4\%})\) where the group facilitator provides information about the group and what to expect. Nearly 13.9\% \((n=19)\) of groups do not have an orientation process for new group members. Finally, 8 groups \((5.8\%)\) have a formal orientation process where the group facilitator meets with the new group attendee to provide information about the group and determine appropriateness for the group.

Level of structure in the group meetings also varies, though most groups are described as somewhat structured \((n=113; \text{82.5\%})\) with some rituals and activities consistent across group meetings but general time in the group is open discussion. Approximately 14.6\% of groups \((n=20)\) have no structure to the group meetings. And 2.9\% \((n=4)\) of groups are very structured with carefully planned rituals and topics for the group meetings. A majority of groups have ground rules or guidelines \((n=117; \text{85.4\%})\). Group rules are most commonly discussed at the beginning of each group meeting \((n=92; \text{68\%})\).
Ground rules are also reviewed in the orientation process in 35 groups (25.4%). Twelve groups (8.7%) communicate ground rules in the group brochure or on the group website. Nine facilitators (6.5%) identified that they discuss ground rules when a problem occurs or as needed. These categories are not mutually exclusive, and some facilitators communicate ground rules in multiple ways.

When asked about evaluation procedures for the group, most facilitators \( (n=71; 51.4\%) \) reported that evaluation is informal, with only 5.1\% \( (n=7) \) indicating that evaluation is formal. Additionally, 17.4\% \( (n=24) \) indicated that non-returning group members are contacted to follow-up and determine reasons for non-return. Another 41.3\% \( (n=57) \) identified that evaluation is not currently a component of the group. Variables related to group structure are in Table 4.4.

**Group process and activities.** When asked to identify the percentage of group time that is used for various meeting formats, sharing of experiences was reported as the activity that consumes the largest percentage of group time (64.7\%), followed by coping skills suggested by group members (10.6\%), coping skills suggested by group leader (8.2\%), rituals (such as opening or closing) (7.4\%), and finally lecture or educational material (4.2\%).

Most facilitators facilitate group without a theoretical framework that guides the process \( (n=99; 73.9\%) \). The most commonly reported theoretical frameworks utilized by respondents include: eclectic/multiple approaches \( (n=16) \), psychoeducation \( (n=12) \), narrative approaches \( (n=10) \), and meaning making/reconstruction \( (n=9) \). Group processes and activities are captured in Table 4.5.
Table 4.4
*Group Structure*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When survivors can join</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group is open and survivors can join at any time</td>
<td>87.6%</td>
<td>120</td>
</tr>
<tr>
<td>Survivors need to be screened or assessed prior to the group</td>
<td>5.8%</td>
<td>8</td>
</tr>
<tr>
<td>Survivors can attend only at the beginning of a group/cycle</td>
<td>1.5%</td>
<td>2</td>
</tr>
<tr>
<td>Survivors can only attend after screening/assessment and at the beginning of a group cycle</td>
<td>3.6%</td>
<td>5</td>
</tr>
<tr>
<td><strong>Follow-up provided after new contact</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Materials mailed/emailed</td>
<td>51.4%</td>
<td>71</td>
</tr>
<tr>
<td>Intake phone call</td>
<td>29.7%</td>
<td>41</td>
</tr>
<tr>
<td>Intake/screening appointment</td>
<td>13.8%</td>
<td>19</td>
</tr>
<tr>
<td>Invitation to attend group</td>
<td>10.1%</td>
<td>14</td>
</tr>
<tr>
<td><strong>Assessment/screening procedures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group is open with no screening</td>
<td>70.8%</td>
<td>97</td>
</tr>
<tr>
<td>Survivors are interviewed prior to attending group</td>
<td>27%</td>
<td>37</td>
</tr>
<tr>
<td>A screening tool is used; only those who meet criteria can attend</td>
<td>1.5%</td>
<td>2</td>
</tr>
<tr>
<td>Monthly</td>
<td>61.5%</td>
<td>83</td>
</tr>
<tr>
<td>Less than monthly</td>
<td>2.2%</td>
<td>3</td>
</tr>
<tr>
<td>Closed/short-term group</td>
<td>2.2%</td>
<td>3</td>
</tr>
<tr>
<td><strong>Ever exclude survivors from attending</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>46.3%</td>
<td>63</td>
</tr>
<tr>
<td>No</td>
<td>53.7%</td>
<td>73</td>
</tr>
<tr>
<td><strong>Orientation process</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No orientation process</td>
<td>13.9%</td>
<td>19</td>
</tr>
<tr>
<td>Informal orientation</td>
<td>77.4%</td>
<td>106</td>
</tr>
<tr>
<td>Formal orientation process</td>
<td>5.8%</td>
<td>8</td>
</tr>
<tr>
<td><strong>Level of structure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not structured at all</td>
<td>14.6%</td>
<td>20</td>
</tr>
<tr>
<td>Somewhat structured (some rituals/activities are consistent)</td>
<td>82.5%</td>
<td>113</td>
</tr>
<tr>
<td>Very structured</td>
<td>2.9%</td>
<td>4</td>
</tr>
<tr>
<td><strong>Ground rules</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>85.4%</td>
<td>117</td>
</tr>
<tr>
<td>No</td>
<td>14.6%</td>
<td>20</td>
</tr>
</tbody>
</table>
Table 4.4 (continued)

<table>
<thead>
<tr>
<th>Communication of ground rules</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussed at the beginning of each meeting</td>
<td>66.7%</td>
<td>92</td>
</tr>
<tr>
<td>Reviewed in orientation process</td>
<td>25.4%</td>
<td>35</td>
</tr>
<tr>
<td>In brochure/on website</td>
<td>8.7%</td>
<td>12</td>
</tr>
<tr>
<td>When a problem occurs</td>
<td>6.5%</td>
<td>9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Evaluation procedures</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluation is informal</td>
<td>51.4%</td>
<td>71</td>
</tr>
<tr>
<td>Evaluation is formal</td>
<td>5.1%</td>
<td>7</td>
</tr>
<tr>
<td>Evaluation is not currently a component</td>
<td>41.3%</td>
<td>57</td>
</tr>
<tr>
<td>Non-returning members are contacted to follow-up and determine reasons for non-return</td>
<td>17.4%</td>
<td>24</td>
</tr>
</tbody>
</table>
Table 4.5
*Group Process and Activities*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing of the death story</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Permitted in the intake call and meeting</td>
<td>93.3%</td>
<td>126</td>
</tr>
<tr>
<td>Permitted in the group with no details</td>
<td>3.7%</td>
<td>5</td>
</tr>
<tr>
<td>Permitted in the intake call but not the group</td>
<td>3%</td>
<td>4</td>
</tr>
<tr>
<td>Theoretical framework that guides group</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>26.1%</td>
<td>35</td>
</tr>
<tr>
<td>No</td>
<td>73.9%</td>
<td>99</td>
</tr>
<tr>
<td>Theoretical framework of facilitator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eclectic/multiple approaches</td>
<td>11.6%</td>
<td>16</td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>8.7%</td>
<td>12</td>
</tr>
<tr>
<td>Narrative approaches</td>
<td>7.2%</td>
<td>10</td>
</tr>
<tr>
<td>Meaning making/reconstruction</td>
<td>6.5%</td>
<td>9</td>
</tr>
<tr>
<td>Task model of bereavement</td>
<td>5.8%</td>
<td>8</td>
</tr>
<tr>
<td>Cognitive behavioral therapy</td>
<td>5.1%</td>
<td>7</td>
</tr>
<tr>
<td>Dual process model of bereavement</td>
<td>2.9%</td>
<td>4</td>
</tr>
</tbody>
</table>
A list of possible group goals were presented to participants to endorse as many as apply. The most commonly reported group goals include: increase emotional support \((n=134; 97.1\%)\), provide an opportunity for survivors of suicide loss to talk openly about the experience \((n=132; 95.7\%)\), reduce sense of guilt \((n=132; 95.7\%)\), increase coping skills \((n=130; 94.2\%)\), and improve emotional functioning \((n=128; 92.8\%)\). The least commonly endorsed goals include: facilitate the development of insight about the loved one’s death and why it occurred \((n=99; 71.7\%)\), provide practice assistance \((n=89; 64.5\%)\), and increase meaning making \((n=87; 63\%)\). The full list of group goals is included in Table 4.6.

When presented with a list of topics discussed in the group, the most commonly reported topics include: how to react to family and friends who expect you to move on \((n=133; 96.4\%)\), how to cope with holidays and significant dates \((n=132; 95.7\%)\), sense of guilt/responsibility about the death \((n=130; 94.2\%)\), unique nature of suicide bereavement \((n=132; 94.2\%)\), and how to respond to questions that arise and put you on the spot \((n=129; 93.5\%)\). On average, participants indicated that 62.1% of group topics are selected or determined by group attendees while 33.1% of topics are determined by the group facilitator. The complete list of group topics is included in Table 4.7.

Concerning the sharing of the death story in the group, the majority of respondents indicated that group attendees do not have any restrictions on sharing the story in the meeting \((n=126; 93.3\%)\). A small percentage of respondents indicated that group attendees are only permitted to share the death story in the intake call and not in the group \((n=4; 3\%)\) while another 3.7% \((n=5)\) indicated that group attendees can share the death story in the group but are restricted from sharing details.
<table>
<thead>
<tr>
<th>Goals</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase emotional support</td>
<td>97.1%</td>
<td>134</td>
</tr>
<tr>
<td>Provide an opportunity for survivors of suicide loss to talk openly about the experience</td>
<td>95.7%</td>
<td>132</td>
</tr>
<tr>
<td>Reduce sense of guilt</td>
<td>95.7%</td>
<td>132</td>
</tr>
<tr>
<td>Increase coping skills</td>
<td>94.2%</td>
<td>130</td>
</tr>
<tr>
<td>Improve emotional functioning</td>
<td>92.8%</td>
<td>128</td>
</tr>
<tr>
<td>Validate experiences</td>
<td>92.8%</td>
<td>128</td>
</tr>
<tr>
<td>Reduce sense of shame</td>
<td>90.6%</td>
<td>125</td>
</tr>
<tr>
<td>Reduce sense of stigma</td>
<td>90.6%</td>
<td>125</td>
</tr>
<tr>
<td>Instill hope</td>
<td>90.6%</td>
<td>125</td>
</tr>
<tr>
<td>Increase personal growth (posttraumatic growth)</td>
<td>81.9%</td>
<td>113</td>
</tr>
<tr>
<td>Increase knowledge about suicide and why people die by suicide</td>
<td>79.7%</td>
<td>110</td>
</tr>
<tr>
<td>Reduce negative emotion</td>
<td>78.3%</td>
<td>108</td>
</tr>
<tr>
<td>Facilitate development of the new identity as a survivor of suicide loss</td>
<td>77.5%</td>
<td>107</td>
</tr>
<tr>
<td>Facilitate the development of insight about the loved one’s death and why it occurred</td>
<td>71.7%</td>
<td>99</td>
</tr>
<tr>
<td>Provide practical assistance</td>
<td>64.5%</td>
<td>89</td>
</tr>
<tr>
<td>Increase meaning making</td>
<td>63.0%</td>
<td>87</td>
</tr>
<tr>
<td>Topic</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td>How to react to family and friends who expect you to move on</td>
<td>96.4%</td>
<td>133</td>
</tr>
<tr>
<td>How to cope with birthdays, anniversaries, observance of annual date</td>
<td>95.7%</td>
<td>132</td>
</tr>
<tr>
<td>Sense of guilt/responsibility about the death</td>
<td>94.2%</td>
<td>130</td>
</tr>
<tr>
<td>Unique nature of suicide bereavement</td>
<td>94.2%</td>
<td>130</td>
</tr>
<tr>
<td>How to respond to questions that arise and put you on the spot</td>
<td>93.5%</td>
<td>129</td>
</tr>
<tr>
<td>Emotions</td>
<td>92%</td>
<td>127</td>
</tr>
<tr>
<td>Stigma</td>
<td>89.9%</td>
<td>124</td>
</tr>
<tr>
<td>Personal growth since the loss</td>
<td>88.4%</td>
<td>122</td>
</tr>
<tr>
<td>Understanding of the death and the reasons why the death occurred</td>
<td>87.7%</td>
<td>121</td>
</tr>
<tr>
<td>How to handle moral attitudes about suicide</td>
<td>84.1%</td>
<td>116</td>
</tr>
<tr>
<td>Memorials/rituals</td>
<td>83.3%</td>
<td>115</td>
</tr>
<tr>
<td>Supporting other family members</td>
<td>82.6%</td>
<td>114</td>
</tr>
<tr>
<td>Continuing bonds/relationships to the deceased</td>
<td>79.7%</td>
<td>110</td>
</tr>
<tr>
<td>Attending individual or family therapy</td>
<td>78.3%</td>
<td>108</td>
</tr>
<tr>
<td>Trauma reactions</td>
<td>76.8%</td>
<td>106</td>
</tr>
<tr>
<td>How to tell children</td>
<td>76.1%</td>
<td>105</td>
</tr>
<tr>
<td>Reinvesting in relationships</td>
<td>61.6%</td>
<td>85</td>
</tr>
<tr>
<td>Spiritual/religious issues</td>
<td>61.6%</td>
<td>85</td>
</tr>
<tr>
<td>Suicide prevention</td>
<td>58.7%</td>
<td>81</td>
</tr>
<tr>
<td>When to take medication or see a physician</td>
<td>53.6%</td>
<td>74</td>
</tr>
<tr>
<td>Advocacy</td>
<td>51.4%</td>
<td>71</td>
</tr>
</tbody>
</table>
**Group attendee and attendance descriptive statistics.** Facilitators were asked to report the percentage of group attendees who identify for each race. Respondents indicated, on average, that 83.2% of group attendees are Caucasian/White, 3.1% are Black/African American, and 3.2% are Hispanic. However, the mode percentage of Caucasian/White group attendees reported by facilitators was 100%.

Approximately half of groups \( n=67; 50.4\% \) report an average attendance of 5-9 people. A quarter of groups \( n=35; 26.3\% \) reported that group attendance averages less than 5 people at each meeting. In terms of new survivors attending the group, a third of groups \( n=43; 32.3\% \) had 5-10 new survivors attend at least one session of the group in the past year. Another third \( n=39; 29.3\% \) had 11-19 new survivors attend at least one group session. Approximately 21.1% \( n=28 \) of groups had less than 5 new survivors attend at least one group meeting.

Approximately 69.9% of facilitators indicated that group members attend 10 or fewer group meetings. Additionally, on average, participants reported that 14.6% of group attendees only came to one session of the group, with 24.7% attending 1-5 sessions, 32.8% attending 6-12 sessions, and 14.6% attending more than 12 sessions.

Group attendee and attendance descriptive statistics are included in Table 4.8.

**Facilitator characteristics.** Facilitator respondents are predominately female \( n=115; 83.9\% \) and Caucasian \( n=130; 94.2\% \). Approximately 74% of participants hold a bachelor’s degree or higher. A master’s degree is the most commonly reported level of education \( n=58; 42\% \), with bachelor’s degree being the second most common \( n=36; 26.1\% \). Nearly 25% of participants report some college or less as their highest level of education. Of these, 9.4% \( n=13 \) hold a high school diploma or equivalent.
Table 4.8  
*Group Attendee and Attendance Descriptive Statistics*

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Meeting Attendance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 5 people</td>
<td>26.3%</td>
<td>35</td>
</tr>
<tr>
<td>5-9 people</td>
<td>50.4%</td>
<td>67</td>
</tr>
<tr>
<td>10-14 people</td>
<td>15%</td>
<td>20</td>
</tr>
<tr>
<td>15-19 people</td>
<td>6.8%</td>
<td>9</td>
</tr>
<tr>
<td>20-24 people</td>
<td>1.5%</td>
<td>2</td>
</tr>
<tr>
<td>Number of New Survivors Who Attended at Least One Session</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 5 people</td>
<td>21.1%</td>
<td>28</td>
</tr>
<tr>
<td>5-10 people</td>
<td>32.2%</td>
<td>43</td>
</tr>
<tr>
<td>11-19 people</td>
<td>29.3%</td>
<td>39</td>
</tr>
<tr>
<td>20-35 people</td>
<td>13.5%</td>
<td>18</td>
</tr>
<tr>
<td>More than 35 people</td>
<td>3.8%</td>
<td>5</td>
</tr>
<tr>
<td>Average Number of Sessions Each Group Member Attends</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One</td>
<td>4.5%</td>
<td>6</td>
</tr>
<tr>
<td>2-5</td>
<td>27.1%</td>
<td>36</td>
</tr>
<tr>
<td>6-10</td>
<td>38.3%</td>
<td>51</td>
</tr>
<tr>
<td>11-15</td>
<td>11.3%</td>
<td>15</td>
</tr>
<tr>
<td>16-20</td>
<td>10.5%</td>
<td>14</td>
</tr>
<tr>
<td>21-25</td>
<td>3.8%</td>
<td>5</td>
</tr>
<tr>
<td>More than 25</td>
<td>4.5%</td>
<td>6</td>
</tr>
</tbody>
</table>

What percentage of survivors who attended the group over the past year…

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Only came to one session</td>
<td>14.6%</td>
</tr>
<tr>
<td>Came to 1-5 sessions</td>
<td>24.7%</td>
</tr>
<tr>
<td>Came to 6-12 sessions</td>
<td>32.8%</td>
</tr>
<tr>
<td>Came to more than 12 sessions</td>
<td>14.6%</td>
</tr>
</tbody>
</table>

What percentage of survivors in the group are…

<table>
<thead>
<tr>
<th></th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caucasian/White</td>
<td>83.2%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>3.1%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3.2%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1.01%</td>
</tr>
<tr>
<td>Native American/Aboriginal/First Nation</td>
<td>0.7%</td>
</tr>
</tbody>
</table>
The most commonly endorsed educational background/credential was “personal experience as a survivor” with 76.8% (n=106) of the sample endorsing this option. The second most commonly endorsed credential was a social work degree (n=31; 22.5%), followed by a master’s degree in counseling or psychology (n=23; 16.7%). Approximately 10% (n=14) of respondents reported no advanced experience related to SOS group facilitation.

Facilitators were also asked the sources of training they have received related to group facilitation. The American Foundation for Suicide Prevention was the most commonly reported training source (n=90; 65.2%) with “own life experiences are the primary source of training” endorsed as the second most common option (n=56; 40.6%). A number of respondents indicating other sources of training specified that they had received suicide prevention training through programs such as QPR and ASIST. Additional sources of facilitator training are recorded in Table 4.9.

Slightly over half (n=79; 57.2%) of participants are employed full-time. However, only 25% of respondents (n=34) facilitate the support group as part of their current employment. Similarly, 23% of respondents (n=32) indicated that they are a paid staff member of the agency that sponsors the group. The length of time facilitating the group varied widely among facilitators. The average length of time facilitators had been leading the group was 8.04 years (SD=7.47), though years facilitating ranged from 1 to 30. Slightly over half (52.9%) of facilitators reported that they had been a leader of the group for five years or less. Group facilitator characteristics are listed in Table 4.10.
<table>
<thead>
<tr>
<th>Training Source</th>
<th>%</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Foundation for Suicide Prevention</td>
<td>65.2%</td>
<td>90</td>
</tr>
<tr>
<td>American Association of Suicidology</td>
<td>14.5%</td>
<td>20</td>
</tr>
<tr>
<td>The Link (Atlanta, GA)</td>
<td>10.1%</td>
<td>14</td>
</tr>
<tr>
<td>Heartbeat</td>
<td>2.9%</td>
<td>4</td>
</tr>
<tr>
<td>Barbara Rubel</td>
<td>1.4%</td>
<td>2</td>
</tr>
<tr>
<td>None</td>
<td>1.4%</td>
<td>2</td>
</tr>
<tr>
<td>Own life experiences are primary source of training</td>
<td>40.6%</td>
<td>56</td>
</tr>
<tr>
<td>Characteristic</td>
<td>%</td>
<td>n</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------</td>
<td>-------</td>
<td>------</td>
</tr>
<tr>
<td><strong>Employment Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed full-time</td>
<td>57.2%</td>
<td>79</td>
</tr>
<tr>
<td>Employed part-time</td>
<td>15.2%</td>
<td>21</td>
</tr>
<tr>
<td>Retired</td>
<td>22.5%</td>
<td>31</td>
</tr>
<tr>
<td>Not employed</td>
<td>5.1%</td>
<td>7</td>
</tr>
<tr>
<td><strong>Facilitation as Part of Current Employment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>25.2%</td>
<td>34</td>
</tr>
<tr>
<td>No</td>
<td>74.8%</td>
<td>101</td>
</tr>
<tr>
<td><strong>Paid Staff Member of Sponsoring Agency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>23.2%</td>
<td>32</td>
</tr>
<tr>
<td>No</td>
<td>76.8%</td>
<td>106</td>
</tr>
<tr>
<td><strong>Facilitator Background/Credentials</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social work degree</td>
<td>22.5%</td>
<td>31</td>
</tr>
<tr>
<td>Counseling/psychology master’s degree</td>
<td>16.7%</td>
<td>23</td>
</tr>
<tr>
<td>Doctoral degree in counseling or psychology</td>
<td>2.2%</td>
<td>3</td>
</tr>
<tr>
<td>Nursing degree/license</td>
<td>8.7%</td>
<td>12</td>
</tr>
<tr>
<td>Medical degree</td>
<td>1.4%</td>
<td>2</td>
</tr>
<tr>
<td>Chaplain</td>
<td>1.4%</td>
<td>5</td>
</tr>
<tr>
<td>Certified thanatologist</td>
<td>1.4%</td>
<td>2</td>
</tr>
<tr>
<td>Support group facilitation training</td>
<td>12.3%</td>
<td>17</td>
</tr>
<tr>
<td>Personal experience as a survivor</td>
<td>76.8%</td>
<td>106</td>
</tr>
<tr>
<td>No advanced experience related to SOS group facilitation</td>
<td>10.1%</td>
<td>14</td>
</tr>
</tbody>
</table>
Nearly half \((n=66; 47.8\%)\) of facilitators identified as peer facilitators, meaning that they have experienced the suicide death of a loved one but have no advanced training or education in a helping profession. Peer/professionals were the second most common facilitator type \((n=51; 37\%)\). Peer/professional status means that the facilitator has experienced the suicide death of a loved one or a client, and they have also received advanced training or education in a helping profession. Finally, professionals were the least common facilitator type \((n=21; 15.2\%)\). Professionals have received advanced training in a helping profession but have not experienced the suicide death of a loved one or client.

The facilitator status of the sample was proportionally similar to the facilitator status of the population available from the AFSP website as illustrated in Table 12. According to the AFSP website, SOS groups nationally are predominately facilitated by peer facilitators \((n=425; 55.1\%)\), with peer/professional facilitators identified as the second most common \((n=185; 24\%)\), and professional facilitators identified least often \((n=145; 18.8\%)\). Facilitator status could not be identified in 2.2\% \((n=17)\) of the groups listed. Though the percentages are slightly different in the sample and population, peers are the most common type of facilitators, followed by peer/professionals and then professionals. A comparison of the facilitator status for the sample and known population is included in Table 4.11.

Compassion satisfaction and compassion fatigue were measured using the Professional Quality of Life Scale. The Professional Quality of Life Scale is standardized with a mean of 50 and standard deviation of 10. For this sample, the median score for the Compassion Satisfaction, Burnout, and Secondary Traumatic Stress subscales were
50.77, 48.96, and 49.92, respectively, indicating little skew in the scores for this measure. However, 41 of the participants scored above the 75th percentile for Burnout, and 32 scored in the 75th percentile for Secondary Traumatic Stress.

**Facilitator attitudes on meaning making and facilitation.** Twenty-four items were used to measure facilitator attitudes about group facilitation. The means and standard deviations for the statement endorsement items are included in Table 4.12.
<table>
<thead>
<tr>
<th>Status</th>
<th>Sample % (n)</th>
<th>Known Population % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peer</td>
<td>47.8% (66)</td>
<td>55.1% (425)</td>
</tr>
<tr>
<td>Professional</td>
<td>15.2% (21)</td>
<td>18.8% (145)</td>
</tr>
<tr>
<td>Peer/Professional</td>
<td>37% (51)</td>
<td>24% (185)</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>0% (0)</td>
<td>2.2% (17)</td>
</tr>
<tr>
<td>Item</td>
<td>Mean (SD)</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>1. SOS groups should be run by survivors.</td>
<td>3.32 (.79)</td>
<td></td>
</tr>
<tr>
<td>2. It is better for survivors to attend group as soon as possible.</td>
<td>2.98 (.69)</td>
<td></td>
</tr>
<tr>
<td>3. Group members should attend no sooner than six months following the death.</td>
<td>1.92 (.72)</td>
<td></td>
</tr>
<tr>
<td>4. Survivors need to attend an SOS group forever.</td>
<td>1.57 (.56)</td>
<td></td>
</tr>
<tr>
<td>5. Group members are expected at some point to no longer need group services.</td>
<td>2.65 (.78)</td>
<td></td>
</tr>
<tr>
<td>6. Not everyone benefits from participation in an SOS group.</td>
<td>3.05 (.63)</td>
<td></td>
</tr>
<tr>
<td>7. Sharing stories is an essential part of healing.</td>
<td>3.67 (.56)</td>
<td></td>
</tr>
<tr>
<td>8. Continual sharing of stories can traumatize.</td>
<td>2.20 (.68)</td>
<td></td>
</tr>
<tr>
<td>9. Advocacy is an essential part of healing.</td>
<td>2.87 (.72)</td>
<td></td>
</tr>
<tr>
<td>10. Being active in suicide prevention is an important part of healing.</td>
<td>2.73 (.73)</td>
<td></td>
</tr>
<tr>
<td>11. SOS groups are important in helping survivors make sense of what has happened.</td>
<td>3.44 (.61)</td>
<td></td>
</tr>
<tr>
<td>12. SOS groups are important in helping survivors integrate the death story into their daily life.</td>
<td>3.25 (.67)</td>
<td></td>
</tr>
<tr>
<td>13. SOS groups are important in helping survivors find benefits or areas of personal growth and positive change.</td>
<td>3.42 (.54)</td>
<td></td>
</tr>
<tr>
<td>14. SOS groups allow survivors an opportunity that might not otherwise exist to tell the story of losing their loved one.</td>
<td>3.73 (.44)</td>
<td></td>
</tr>
<tr>
<td>15. SOS groups allow survivors to discuss the ‘whys’ and ‘what ifs’ that survivors often experience.</td>
<td>3.69 (.52)</td>
<td></td>
</tr>
<tr>
<td>16. It is important for survivors of suicide loss to be able to share the death story in the group.</td>
<td>3.44 (.59)</td>
<td></td>
</tr>
<tr>
<td>17. SOS group facilitators should intervene as little as possible and allow group attendees to help one another.</td>
<td>3.12 (.68)</td>
<td></td>
</tr>
<tr>
<td>18. SOS group facilitators should intervene to support growth and healing.</td>
<td>3.01 (.56)</td>
<td></td>
</tr>
<tr>
<td>19. SOS facilitators should intervene in the group process to ensure that everyone gets what they need.</td>
<td>3.14 (.54)</td>
<td></td>
</tr>
<tr>
<td>20. SOS groups must adapt to meet the needs of both the newly bereaved and those who are farther from their loss.</td>
<td>3.55 (.56)</td>
<td></td>
</tr>
<tr>
<td>21. SOS groups are more helpful for those who are more newly bereaved than those who are long-term survivors.</td>
<td>2.22 (.69)</td>
<td></td>
</tr>
<tr>
<td>22. SOS groups provide an important opportunity for survivors to practice new ideas and skills.</td>
<td>3.37 (.55)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>23. SOS groups provide an opportunity for survivors to have thoughts and beliefs challenged by others.</td>
<td>2.64 (.79)</td>
<td></td>
</tr>
<tr>
<td>24. SOS groups provide an important opportunity for survivors to gain insight and awareness into their situation.</td>
<td>3.59 (.50)</td>
<td></td>
</tr>
</tbody>
</table>

*Note.* Italicized items were not included in the final 3-factor solution.
Multivariate Analysis: Exploratory Factor Analysis

Prior to performing EFA, the suitability of data for factor analysis was assessed. First, consideration was made for the sample size and number of items included in the EFA. EFA works best with large samples, but it has also been suggested that the ratio of participants to items is of utmost concern, with 10:1 identified as the ideal and 5:1 considered acceptable (Osborne, 2014; Pallant, 2013). After excluding cases with missing data, the final number of cases retained for the EFA was 120. With 120 included participants and 24 items, the ratio for this EFA was 5:1, an acceptable ratio for exploratory factor analysis. Next, inspection of the correlation matrix revealed the presence of many coefficients of .3 and above, with 15 of the 24 items correlated above .3 with at least one other item as indicated in Table 4.13. The Kaiser-Meyer-Olkin value was .729, exceeding the recommended value of .6 (Kaiser, 1974). Additionally, Bartlett’s Test of Sphericity (Bartlett, 1954) reached statistical significance ($\chi^2(276)=816.1; p\leq.001$), supporting the factorability of the correlation matrix.
Table 4.13
Inter-item Correlations

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Initial evaluation of the EFA using Kaiser’s criterion (Pallant, 2013) revealed the presence of eight factors with eigenvalues exceeding 1, explaining 20.3%, 9.9%, 8.1%, 6.5%, 5.9%, 5.2%, 5.0%, and 4.3% of the variance respectively or 65.1% of the variance cumulatively. Three of the factors only had two items that loaded strongly on the factor, indicating the full solution is not optimal (Pallant, 2013). An inspection of the screeplot revealed a break after the fourth component, suggesting a four-factor solution. However, the results of Parallel Analysis showed only three factors with eigenvalues exceeding the corresponding criterion values for a randomly generated data matrix of the same size (24 variables and 120 respondents). Thus, the decision was made to retain a three-factor solution.

Initially, EFA with principal axis factoring and promax rotation was repeated with the original 24 items though a three-factor solution was forced. The results indicated that several items did not contribute to a simple factor structure and fit well with the forced three-factor solution, as evidenced by low communalities (under .3) and factor loadings under .3. Thus, the decision was made to remove the six items that did not load above a .3 on any of the factors (Bauer & Curran, 2015; Osborne, 2014).

This resulted in a forced three-factor solution with 18 items. Again, principal axis factoring with promax rotation was used to assist in interpretation of the factors. The three-factor solution explained a total of 47.9% of the variance, with 26.2% contributed by factor 1, 12.3% contributed by factor 2, and 9.4% contributed by factor 3. The rotated solution revealed the presence of simple structure (Thurstone, 1954), with all three factors showing a number of strong loadings and all variables loading substantially on only one factor. Interpretation of the pattern matrix and structure matrix reveal similar
structures for all three factors, though the structure matrix indicates that several items have cross-loadings on multiple factors. Composite scores were created for each of the three factors, and Cronbach’s alpha was conducted to explore the homogeneity of items on each factor. Descriptive statistics for all three factors are included in Table 4.14.

The final model resulted in a moderate positive correlation between factors 1 and 2 (.472), a moderate positive correlation between factors 1 and 3 (.303), and a weak correlation between factors 2 and 3 (.037). Exploration of the factors and item loadings suggested three factors defined as the following: (1) the facilitator’s perspective on the role of the story and meaning making; (2) the facilitator’s perspective on the role of the facilitator; and (3) the facilitator’s perspective on the role of the loss survivor. The full three-factor model and factor loadings are shown in Figure 4.1.

**Factor 1: The Facilitator’s Perspective on the Role of the Story/Meaning Making.** This factor includes nine items that concern the role of the story and meaning making in the bereavement experience. Specifically, this factor also includes items that pertain to the role of the story and meaning making in the group. Three items on the factor speak directly to the process of meaning making, whereby loss survivors seek to make sense of the death. The highest loading item on the factor is: SOS groups allow survivors to discuss the ‘whys’ and what ifs’ that survivors often experience. Two other items that loaded on this factor also directly address the process of meaning making: (1) SOS groups are important in helping survivors make sense of what has happened and (2) SOS groups are important in helping survivors integrate the death story into their daily life. The item “continual sharing of stories can traumatize” also loaded on this factor. Similar to other items, this statement concerns the role of stories in the group process, but
Table 4.14
Descriptive Statistics for the Three Factors

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<tr>
<th>Factor</th>
<th>n</th>
<th>No. of items</th>
<th>M   (SD)</th>
<th>Min.</th>
<th>Max.</th>
<th>Skewness</th>
<th>Kurtosis</th>
<th>Cronbach’s α</th>
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<tr>
<td>Making/Role of the Story</td>
<td>127</td>
<td>9</td>
<td>29.43 (2.95)</td>
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<td>-.32</td>
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<td>.73</td>
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<tr>
<td>Facilitator Role</td>
<td>128</td>
<td>5</td>
<td>16.09 (1.81)</td>
<td>11</td>
<td>20</td>
<td>-.23</td>
<td>.24</td>
<td>.63</td>
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<tr>
<td>Role of the Loss Survivor</td>
<td>130</td>
<td>4</td>
<td>9.86 (1.82)</td>
<td>5</td>
<td>15</td>
<td>-.10</td>
<td>.04</td>
<td>.59</td>
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</tbody>
</table>
Figure 4.1

Full Factor Model
its relationship to the factor and other items on the factor is quite different. First, the communality for this item is low, suggesting that it does not fit well with the factor. It also had the weakest loading (-.361) of all items in the analysis, and it loads negatively onto the factor.

The importance of story-telling and sharing the story also comes through clearly as a theme in this factor. The second and third highest-loading items concern the importance of sharing stories in the healing process and the importance of sharing the death story specifically in the group, respectively. Another item on this factor pertains to the role the group plays in offering an audience that might not otherwise exist to bear witness to the story of the loss survivor.

Two growth related items also loaded strongly on this factor: (1) SOS groups provide an important opportunity for survivors to gain insight and awareness into their situation and (2) SOS groups are important in helping survivors find benefits or areas of personal growth and positive change. Cronbach’s alpha of .734 for all 9 items suggests that an acceptable level of reliability for these items as a subscale (Tavakol & Dennick, 2011). Factor 1 and the respective factor loadings are shown in Figure 4.2.

**Factor 2: The Facilitator’s Perspective on the Role of the Facilitator.** This factor includes five items, each of which pertains to the role of the facilitator and the active nature of the group experience. The first item in this factor is “SOS groups provide an important opportunity for survivors to practice new ideas and skills.” This item pertains to the active role of group in helping group attendees move forward in their grief.

The second, third, and fourth items on this factor relate specifically to the active role of the facilitator in the group process. These items all address the active role that
Figure 4.2

Factor 1: Facilitator Perspectives on the Role of Stories/Meaning Making

- SOS groups allow survivors to discuss the ‘whys’ and ‘what ifs’ that survivors often experience.
- Sharing stories is an essential part of healing.
- It is important for survivors of suicide loss to be able to share the death story in the group.
- SOS groups allow survivors an opportunity that might not otherwise exist to tell the story of losing their loved one.
- SOS groups are important in helping survivors make sense of what has happened.
- SOS groups provide an important opportunity for survivors to gain insight and awareness into their situation.
- SOS groups are important in helping survivors find benefits or areas of personal growth and positive change.
- SOS groups are important in helping survivors integrate the death story into their daily life.
- Continual sharing of stories can traumatize.
facilitators have in the group process to promote growth and healing and ensure that all group attendees get what they need, regardless of the length of time since the loss.

The final item on this factor, “Not everyone benefits from participation in an SOS group,” speaks to the role that facilitators play in determining whether or not loss survivors should continue attending the group. Though the wording of the statement does not explicitly identify this as the facilitator’s responsibility, the fact that it loaded so strongly with this factor implies there may be an element of this decision making present in the role of an active facilitator. Cronbach’s alpha of .629 for the five items suggests low reliability, though it is possible that the low Cronbach’s alpha is due to the small number of items included in the reliability analysis (Tavakol & Dennick, 2011). Factor 2 is shown with all factor loadings in Figure 4.3.

**Factor 3: The Facilitator’s Perception of the Mode of Participation/Role for Loss Survivor.** The third factor is the weakest of the three factors, as evidenced by a Cronbach’s alpha of .589 for the four items. This factor is also the most difficult to interpret. The unifying theme among these items is that they pertain directly to the role of the loss survivor in the healing process and the perspective that the facilitator has about the tasks that the loss survivor should be completing along the journey. The first two items are “Being active in suicide prevention is an important part of healing” and “Advocacy is an essential part of healing.” These items speak to the importance of active involvement in suicide prevention efforts. The final two items are “Survivors need to attend an SOS group forever” and “It is better for survivors to attend group as soon as possible.” These items address the role of the loss survivor as an active participant in their healing journey. Factor 3 and the respective factor loadings are shown in Figure 4.4.
Figure 4.3.

Factor 2: Facilitator Perspectives on the Role of the Facilitator

- SOS groups provide an important opportunity for survivors to practice new ideas and skills.
- SOS group facilitators should intervene in the group process to ensure that everyone gets what they need.
- SOS facilitators should intervene to support growth and healing.
- SOS groups must adapt to meet the needs of both the newly bereaved and those who are farther from their loss.
- Not everyone benefits from participation in an SOS group.
Figure 4.4

Factor 3: Facilitator Perspectives on the Role of the Loss Survivor

- Being active in suicide prevention is an important part of healing.
- Advocacy is an essential part of healing.
- Survivors need to attend an SOS group forever.
- It is better for survivors to attend group as soon as possible.
**Items not included in final analysis.** There were six items that did not fit well with the forced three-factor solution, and were thus excluded from the final EFA. These items include:

1. SOS groups should be run by survivors.
2. Group members should attend no sooner than six months following the death.
3. Group members are expected at some point to no longer need group services.
4. SOS group facilitators should intervene as little as possible and allow group attendees to help one another.
5. SOS groups are more helpful for those who are more newly bereaved than those who are long-term survivors.
6. SOS groups provide an opportunity for survivors to have thoughts and beliefs challenged by others.

A review of these items elucidates the reasons they did not fit well with the three-factor solution. First, none of the items contain content pertaining to story-telling or meaning making, which explains why they did not load on the first factor. Statements 1, 3, 5, and 21 concern the structure and appropriate timing of the group service. Though these items have some similarity with the items on factor 3, they seem to be capturing different information.

Statement 17 pertains to the structure and format of group facilitation, though the phrasing of the statement may have precluded loading on factor 2 as it suggests a passive facilitation style. Conversely, items that loaded on factor 2 concern active facilitation.

While statement 23 seems like it would be a good fit for factor 2, the wording may have been problematic. Clinicians who are familiar with therapeutic modalities such
as cognitive behavioral therapy would understand the relevance of challenging thoughts and beliefs, but non-professionals may have misinterpreted the meaning of this statement. It was originally designed to assess attitudes regarding the corrective function of the group, particularly as it relates to brooding rumination (Nolen-Hoeksema et al., 1997; Treynor et al., 2003). This item may need to be revised in the future to more accurately capture this curative process.
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<th>Structure Coefficients</th>
<th>Communalities</th>
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<td>SO groups allow survivors to discuss the ‘whys’ and ‘what ifs’ that survivors often experience.</td>
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<td>0.621</td>
<td>0.425</td>
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<tr>
<td>Sharing stories is an essential part of healing.</td>
<td>0.650</td>
<td>0.605</td>
<td>0.511</td>
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<tr>
<td>It is important for survivors of suicide loss to be able to share the death story in the group.</td>
<td>0.647</td>
<td>0.583</td>
<td>0.352</td>
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<td>SOS groups allow survivors an opportunity that might not otherwise exist to tell the story of losing their loved one.</td>
<td>0.640</td>
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<tr>
<td>SOS groups are important in helping survivors make sense of what has happened.</td>
<td>0.638</td>
<td>0.721</td>
<td>0.549</td>
</tr>
<tr>
<td>SOS groups provide an important opportunity for survivors to gain insight and awareness into their situation.</td>
<td>0.508</td>
<td>0.520</td>
<td>0.309</td>
</tr>
<tr>
<td>SOS groups are important in helping survivors find benefits or areas of personal growth and positive change.</td>
<td>0.495</td>
<td>0.619</td>
<td>0.429</td>
</tr>
</tbody>
</table>
Table 4.15 (continued)

| S.O.S. Groups are important in helping survivors integrate the death story into their daily life. | 0.458 | 0.617 | 0.418 | 0.369 | 0.446 |
| Continual sharing of stories can traumatize. | 0.361 | 0.120 |
| S.O.S. groups provide an important opportunity for survivors to practice new ideas and skills. | 0.666 | 0.465 | 0.742 | 0.570 |
| S.O.S. group facilitators should intervene to support growth and healing. | 0.538 | 0.470 | 0.245 |
| S.O.S. facilitators should intervene in the group process to ensure that everyone gets what they need. | 0.525 | 0.529 | 0.292 |
| S.O.S. groups must adapt to meet the needs of both the newly bereaved and those who are farther from their loss. | 0.496 | 0.442 | 0.594 | 0.386 |
| Not everyone benefits from participation in an S.O.S. group. | 0.379 | 0.336 | 0.172 |
| Being active in suicide prevention is an important part of healing. | 0.620 | 0.603 | 0.417 |
| Advocacy is an essential part of healing. | 0.589 | 0.580 | 0.402 |
| Survivors need to attend an S.O.S. group forever. | 0.554 | 0.488 | 0.305 |
| It is better for survivors to attend group as soon as possible. | 0.440 | 0.489 | 0.302 |

*Note: Major loadings for each item are bolded.*
Bivariate Relationships with the Factors

Finally, the relationship between selected group and facilitator characteristics and the identified factors were explored.

**Group characteristics.** Sponsorship and operating with a budget did not have a significant relationship with any of the factors. In terms of group meeting variables, length of time in operation, frequency of group meetings, and group status as open or closed were not correlated with any of the factors. The presence of ground rules and the level of structure were both found to have insignificant relationships with the factors. The utilization of a theoretical framework in the group process was also not significantly related to the factors. The only significant group characteristic variable found was the item concerning the facilitator’s decision to exclude participants from the group. This variable was not related to factor 1 or 3, but it did have a significant relationship with factor 2 (t(125)=2.42; p≤.05). Facilitators who use exclusion criteria to decide who should or should not participate in the group scored higher on the Facilitator Role factor (M=16.49) than facilitators who do not use exclusion criteria (M=15.73).

**Facilitator characteristics.** No significant differences were found for male and female participants on factor 1, factor 2, or factor 3. Additionally, no significant differences were found for the three factors based on facilitator status as peer, professional, or peer/professional or the status of the facilitator as a volunteer or paid employee of a sponsoring agency. Number of years as the facilitator was significantly correlated with factor 1 (r=.277; p≤.002) and factor 2 (r=.262; p≤.003), but not factor 3 (r=.962; p=.004). Additionally, the compassion satisfaction subscale of the ProQOL was positively correlated with factor 1 (r=.375; p≤.001) and factor 2 (r=.286; p≤.002), but not
factor 3 ($r=-.089; \ p=.334$). Similarly, the ProQOL subscale of burnout was negatively correlated with factor 1 ($r=-.321; \ p\leq .001$) and factor 2 ($r=-.185; \ p\leq .05$) but not factor 3 ($r=.031; \ p=.738$). However, no significant correlation was present for the secondary traumatic stress subscale and any of the factors.
Chapter Five

Discussion and Conclusion

Study Contributions

This study contributes an updated account of the descriptive information about SOS groups from the perspective of the group leaders. The results echo earlier reviews of SOS groups (Cerel, Padgett, Conwell, et al., 2009; Cerel, Padgett, & Reed, 2009), such as that most groups do not function under the auspices of an organization or agency and are facilitated by a volunteer who has been personally impacted by a suicide death. SOS groups have continued to increased in number in the US, though research on the groups remains extremely limited, with current knowledge restricted to simple descriptions about the group organization and meeting format, as well as the subjective benefits of group attendance from the perspective of attendees. In the endeavor to better understand SOS groups beyond this basic information, this study offers a meaningful contribution towards quantifying group processes and facilitator attitudes.

As previously discussed, the extent of evaluation for SOS groups has primarily been limited to subjective perceptions of group attendees, typically through qualitative interviews or by querying loss survivors about their utilization of SOS groups among a variety of other resources. Objective measures are needed to evaluate the impact of support groups on the bereavement trajectory, and it is essential that facilitation is incorporated into evaluation procedures. This study provides important information to help quantify facilitation in ways that can contribute meaningfully to a richer understanding of the group experience. In particular, this study contributes the initial step towards development of a tool that can be used to measure facilitator attitudes and
perceptions about the support group, principally in the areas of meaning making and the role of the story, the role of the facilitator in the group process, and the roles and responsibilities of loss survivors.

**Meaning making and the role of the story.** The role of meaning making in the general bereavement experience has been thoroughly investigated (e.g. (Coleman & Neimeyer, 2010; Neimeyer, 2001a; Neimeyer, Burke, Mackay, & van Dyke Stringer, 2010), though the literature remains fairly scant on meaning making in suicide bereavement specifically (Shields et al., 2015). Further, meaning making and meaning reconstruction in the context of formal, professional interventions has also been explored, with efforts to incorporate meaning making approaches into therapeutic group interventions (MacKinnon et al., 2014; MacKinnon et al., 2015).

While these investigations have been limited to clinical or therapeutic settings, there is no reason meaning making could not also be promoted and encouraged in the support group setting. In fact, evidence suggests that meaning making occurs in an informal and implicit way in non-therapeutic support groups (Feigelman & Feigelman, 2008a; Supiano, 2012). Peers and professionals are both well positioned to assist loss survivors in the process of meaning reconstruction, though it is crucial to make explicit the meaning making process and the role of the group in this process. It is not enough to assume that this process occurs naturally or that all support groups engender meaning making. Groups differ widely, as evidenced by reported goals of the group. Though endorsed by 63% of the sample, “increase meaning making” was the least commonly endorsed group goal. It is possible that participants did not understand the language used, and a more thorough description of meaning making may have resulted in a different
perspective. Regardless, this suggests that facilitating the meaning making process is only valued as a goal in less than two-thirds of the support groups currently.

Meaning making in support groups is worthy of further review as it could prove to be a helpful framework for facilitators to utilize. In a systematic review of support groups for caregivers of patients with dementia, the use of theoretical models to guide the group was found to impact depression and well-being of the participants (Chien et al., 2011). In the current study, only 26% of facilitators reported incorporating a theoretical framework in the group process. It may be that facilitators are not working atheoretically, but rather may not be aware of the theoretical framework or name of the framework with which they facilitate the group. Meaning making is an important yet accessible theoretical framework that could be promoted among both professional and peer facilitators. The results of this study provide information about how to assess a facilitator’s perspective on meaning making and the facilitator accounts of the role that stories play in the group experience. Assessment of current perspectives can be used to enhance facilitator knowledge and skills in incorporating meaning making in the group process, particularly in the sharing of the death story.

The role of the facilitator. Suicide bereavement is a unique phenomenon, and loss survivors frequently report that it is helpful to share with others who have experienced such a loss (Feigelman & Feigelman, 2008a, 2011). Empathy for the unique reactions in the suicide bereavement trajectory is an important characteristic of the facilitator, but it is not enough. Facilitation issues are a commonly cited reason given as to why loss survivors stop attending group (Feigelman & Feigelman, 2011; McKinnon & Chonody, 2014). In both therapeutic and non-therapeutic groups, facilitation has been
established as an integral element of the group (Garcia et al., 2011; Lieberman & Golant, 2002). Efforts have been made to identify features of successful group facilitation in other domains with results providing evidence for the fact that effective group facilitation is a complex and nuanced process involving a wide variety of skills, attitudes, and characteristics (Rubel & Kline, 2008). Experiential knowledge about groups accumulates over time and serves to distinguish expert facilitators from novices (Rubel & Kline, 2008).

In SOS groups specifically, facilitators must have the skills to manage the complex group dynamics, such as containing monopolizing group members (Feigelman & Feigelman, 2011), but they must also possess the ability to recognize loss survivors who may not be appropriate for group participation due to their current levels of symptomatology. Loss survivors who have symptoms that would preclude meaningful participation in the group may experience discomfort and dissatisfaction with the group, but this could also be damaging for other group attendees, who could be burdened or retraumatized by over-sharing (Feigelman & Feigelman, 2011). Further, in the process of supporting the meaning making process, facilitators must be careful not to enable brooding rumination (Treynor et al., 2003).

The results of this study offer important information to consider in the effort to understand facilitator accounts of the facilitation process. Bivariate relationships indicate that group characteristics, such as the frequency of group meetings, agency sponsorship, or length of group operation, are not significantly correlated with the identified factors. However, significant relationships were found for several facilitator characteristics. Length of time facilitating, compassion satisfaction, and burnout were found to be
correlated with factor 1 and factor 2. Unsurprisingly, the facilitator’s use of exclusion criteria, that is using criteria to determine whether or not loss survivors should attend the group, was correlated with factor 2. This suggests that facilitator-related variables are most important in the effort to understand attitudes about meaning making or the role of the facilitator. Additionally, the scale items believed to capture attitudes about rumination did not come through strongly; thus, future revisions should include items to explore attitudes about rumination.

Interestingly, the facilitator status as peer, professional, or peer professional was not significantly related to the factors, suggesting that differences in facilitator attitudes and perceptions are more nuanced than merely their exposure to a personal suicide death or professional education and training.

The facilitator’s perspective on the roles and responsibilities of the loss survivor. As previously indicated, this was identified as a distinct factor, albeit not a very strong one. This factor identified what could be defined as expectations that facilitators have of loss survivors, including when they should attend the group and how they should engage in suicide prevention activities. This factor is tangentially related to the theoretical context for this study, though it would be interesting to explore this factor more thoroughly through a lens of the facilitator’s expectation of the general bereavement trajectory beyond the support group.

Study Limitations

The contributions of this study must be understood in the context of its limitations. Given the cross-sectional nature of the data, it is not possible to interpret causal relationships between the variables. Thus, the correlation between facilitator

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variables and the factors must be interpreted with caution. For example, it cannot be determined if facilitator attitudes about meaning making increase over time or if those facilitators who value meaning making in the group are more likely to have greater longevity in the role. The nature of these relationships over time will need to be explored to develop a more complex and complete picture.

A strength of this study was the fact that all known group facilitators in the US were invited to participate and attempts to increase the response rate were made in the form of reminder emails and hard copy mailings of the survey materials. However, the response rate was lower than typically expected for such a methodology. Despite efforts to recruit international participants, response to the survey internationally was low. Participants overall were also quite homogenous in terms of facilitator sex and level of education.

Additionally, it is important to note that the results are based solely on facilitator perceptions rather than objective data. Participants were asked to identify their agreement with various items, and it is assumed that these attitudes might translate to behaviors in the group. However, it is unclear from the current data to determine if these attitudes translate to meaningful differences in practice. Further exploration is needed to determine if the measures of meaning making and role of the facilitator are supported, particularly in an effort discern the relationship between attitudes and implementation in practice.

Finally, facilitator participants were asked whether they self-identify as a peer facilitator, meaning that they experienced the personal loss of a loved one to suicide. However, no further questions were asked about exposure to suicide, such as when the loss occurred relative to their professional training, their relationship to the person who
died, or what kind of support they received following the loss, if any. These variables are likely to be important in the facilitation experience. For example, some peer/professional participants may have experienced the loss of a loved one or even a client after their professional education training. Alternatively, peer/professional participants may have sought education in a helping profession as a result of their loss experience. It is likely that these two groups are quite different in their skill set and attitudes about the group, including the source from which such attitudes and perspectives originate. Motivation for facilitating the support group and facilitator expectations about the course of bereavement are important considerations that were not captured in this study, and further exploration is needed to better understand these issues.

**Future Directions for Social Work Research and Practice**

This study is a foundational step in the endeavor to better understand SOS groups generally and the meaning making process in support groups specifically. This study should spur additional research regarding SOS groups generally and the meaning reconstruction processes that occur in these groups. Future research should include qualitative research with facilitators to further explore the nuances of this process, the training and support necessary for productive facilitation, and the impact of SOS groups on the bereavement trajectory with a particular emphasis on illuminating effective group processes.

**Qualitative research with facilitators.** Experts in the field of suicide bereavement have identified the need for a different approach to analysis to capture important information about the bereavement and help seeking experience: “Qualitative measures of outcome that extend assessment beyond psychiatric symptoms to broader
constructs such as changes in the individual’s assumptive world, quality of life, and social adaptation might reveal a different type of intervention success” (Jordan & McMenamy, 2004, p. 346). The same can be said of the facilitator experience. Qualitative research is a much needed step to develop a more complex understanding of how meaning making is facilitated and supported in the group experience, particularly when group attendees are at various stages in the bereavement journey. Future research should include interviews with group facilitators to explore interpretation of scale items, particularly those that did not load well with the three-factor solution. Interviews may help to clarify ambiguous scale items.

**Training and support for facilitators.** Though still very much in its infancy, literature is beginning to emerge about the transition and transformation from identification as a simply a loss survivor to a helper providing peer support (Oulanova et al., 2014). Helping others who have experienced a suicide loss has been explored as a manifestation of posttraumatic growth in a small sample of peers providing support to loss survivors (Oulanova et al., 2014). Additionally, a study of online support for suicide bereavement indicated that loss survivors found that helping others helped them cope with their loss, which was explained as a reason why loss survivors maintain long-term connections to internet bereavement support (Chapple & Ziebland, 2011). Further, in the discipline of health, becoming a peer supporter has been shown to improve outcomes for the helper despite no objective changes in health functioning or status, a change attributed to a response shift process that alters the helper’s perception of themselves and their illness (Schwartz & Sendor, 1999). This is a topic worthy of exploration among loss survivors who engage in helping others as peers.
However, consideration must be made for the training and ongoing support of peer helpers. Literature in other social service domains suggests that support group facilitators, both peers and professionals, find their work meaningful and important (Butow, Beeney, Juraskova, Ussher, & Zordan, 2009), though exploration of challenges encountered by support group facilitators has uncovered common themes. These themes include: maintaining boundaries with group members and judicious use of self-disclosure (Butow et al., 2009), understanding and responding to group dynamics (Kirsten, Butow, Price, Hobbs, & Sunquist, 2006) especially with disruptive members (Galinsky & Schopler, 1994), responding to group members at varied stages in their personal process (Galinsky & Schopler, 1994), and practical issues, such as coordinating meeting space (Butow et al., 2009; Butow et al., 2005) and identifying resources for group attendees (Kirsten et al., 2006). Burnout was a common concern reported by support group leaders as well (Kirsten et al., 2006).

Interestingly, though peers and professionals report similar concerns, studies have found that peers reported more difficulties than professional facilitators, particularly around the topic of managing group dynamics (Kirsten et al., 2006; Zordan et al., 2010) and maintaining appropriate boundaries (Simpson, Quigley, Henry, & Hall, 2014), and recruiting participants (Lubas & De Leo, 2014), gesturing to the need for more adequate and effective training for support group facilitators. Evaluations of training programs for support group facilitators show promising results in the areas of cancer (Jasperse, Herst, & Kane, 2012) and mental health (Simpson et al., 2014). Additionally, among volunteer moderators in an online support group, relative to lay individuals with no training, trained
volunteers responded to suicidal messages with a more diverse range of strategies that were more therapeutic in nature (Gilat, Tobin, & Shahar, 2012).

Though training programs exist for SOS group facilitators, primarily through the American Foundation for Suicide Prevention, no systematic evaluation of the training has been conducted. Evidence informed training for support group facilitators is important to prevent “leadership inconsistencies [that] may result in inequities between support groups and access to quality support by the community” (Pomery, Schofield, Xhilaga, & Gough, 2015, p. 15). A systematic review of the skills, knowledge, and characteristics of support group leaders across a variety of settings identified the following key qualities of group leaders: “group management, group process, role modelling, awareness, willingness, agreeableness, and openness” (Pomery et al., 2015, p. 1). The exact shape and form of each of these qualities needs to be explored further in the context of SOS groups, particularly when considering the results of this study. Length of time facilitating was significantly correlated with perspectives about meaning making and the role of the facilitator, corroborating the need for facilitation training, especially for new facilitators. Further research is needed to uncover both the shared and divergent needs of peer and professional SOS group facilitators to inform training processes for both groups.

**Evaluation of the effectiveness of support groups particularly on bereavement outcomes.** Another important area of research is the usefulness and helpfulness of support groups for loss survivors more generally. Recent research suggests that grief counseling as a universal intervention for all bereaved individuals is no more effective than the passage of time (Neimeyer & Currier, 2009), and in some circumstances, it may even be detrimental (Jordan & Neimeyer, 2003). Grief counseling
is now suggested as an selective intervention, deemed most appropriate for those likely for a risky bereavement trajectory (Neimeyer & Currier, 2009). It is unclear if this also translates to support groups, which are not a therapeutic intervention but are an intervention, nonetheless. Support groups could be considered a universal intervention, targeted towards all loss survivors (Neimeyer & Currier, 2009). SOS groups are generally thought to be appropriate and helpful for all loss survivors; however, it is unclear if there are certain subsets of loss survivors for whom group is more or less beneficial.

Future research is needed on the outcomes for group attendees generally, but evaluations must not be limited to a dichotomous “group” or “no group” methodology. Research on the effectiveness of support groups must incorporate information about the unique features of the specific group, including facilitator skills, qualities, and perspectives as well as group dynamics. To more fully understand the impact of group on the bereavement trajectory, it is necessary to utilize longitudinal methodologies that evaluate the impact of group attendance, particularly the differences in group attendee outcomes based on facilitator style. Evaluation should also include measures that evaluate the subjective perception of “successful” groups based on facilitator impression/style as well as the objective outcome data. Identification of successful groups should incorporate elements of success related to aspects of group functioning (high attendance, high cohesion, etc.) as well as elements of success captured through objective measures of progress for group attendees.

Further research is needed to uncover the types of groups and the formats that are most effective, though there are barriers to accomplishing this. First, as Lieberman (1990) offered: “We have a field characterized by general knowledge about what is important,
we lack the conceptual precision to define the boundaries or limits in levels that make these characteristics central” (p. 50). This study offers a contribution towards the operationalization of key characteristics, but there is significant work ahead. Additionally, this astute quote about the lack of randomized controlled trials in the context of peer support for cancer insightfully describes the challenge of this endeavor: “The reasons may include inherent difficulties in isolating for study what is essentially a naturalistically occurring interpersonal dynamic from the complex social and community contexts from which it emanates” (Dunn, Steginga, Rosoman, & Millichap, 2003, p. 55).

Despite these challenges, intervention research in suicide bereavement is critical. The dearth of literature that can be used to inform interventions has been lamented broadly in social work (Rosen, Proctor, & Staudt, 1999). Social work research tends to be descriptive or explanatory in nature with only a minority of published research including information about interventions and the effectiveness of such interventions (Rosen et al., 1999). Although a recent review found that social work research originating from the US includes more intervention research than research originating from Europe, only 15% of research and non-research articles from the US reported on the effectiveness of interventions (Kreisberg & Marsh, 2015). Similarly, in the field of suicidology, a mere 27 of the approximately 450 articles published in the last 50 years of suicide bereavement research were focused on interventions for loss survivors (Maple et al., 2015). This means that only 6% of published literature over the past 50 years contributed to our knowledge of interventions for loss survivors. Vulnerable loss survivors deserve better—resources and interventions must be developed, evaluated, and refined to ensure effectiveness.
**Conclusion**

This study of survivor of suicide loss support group facilitators provides a more nuanced topology of the groups. The results provide support for the significance of meaning making in the group process and the role of stories in this process as well as a heuristic for assessing facilitator attitudes about these topics. The results also illuminate the role of active facilitation in SOS support groups. The study provides evidence for necessary considerations in the structuring of support groups in order to aid the search for meaning for loss survivors, as well as the need for training of facilitators engaging in more active facilitation that this structure demands.
Appendix A

Institutional Review Board Documentation

TO: Rebecca Sanford, MSSA
    Social Work
    633 POT 0027
    PI phone #: (859)323-7484

FROM: Chairperson/Vice Chairperson
      Non-medical Institutional Review Board (IRB)

SUBJECT: Approval of Protocol Number 12-0275-F4S

DATE: March 13, 2015

On March 13, 2015, the Non-medical Institutional Review Board approved your protocol entitled:

    Suicide Bereavement in Attendees of Survivor of Suicide Support Groups

Approval is effective from March 13, 2015 until March 11, 2016 and extends to any consent/assent form, cover letter, and/or phone script. If applicable, attached is the IRB approved consent/assent document(s) to be used when enrolling subjects. [Note, subjects can only be enrolled using consent/assent forms which have a valid "IRB Approval" stamp unless special waiver has been obtained from the IRB.] Prior to the end of this period, you will be sent a Continuation Review Report Form which must be completed and returned to the Office of Research Integrity so that the protocol can be reviewed and approved for the next period.

Approval is only effective for the research activities you are responsible for complying with IRB decisions, conditions and requirements. The research procedures should be implemented as approved in the IRB protocol. It is the principal investigator’s responsibility to ensure any changes planned for the research are submitted for review and approval by the IRB prior to implementation. Protocol changes made without IRB approval to eliminate apparent hazards to the subject(s) should be reported in writing immediately to the IRB. Furthermore, discontinuing a study or completion of a study is considered a change in the protocol’s status and therefore the IRB should be promptly notified in writing.

For information describing investigator responsibilities after obtaining IRB approval, download and read the document “PI Guidance to Responsibilities, Qualifications, Records and Documentation of Human Subjects Research” from the Office of Research Integrity’s IRB Survival Handbook web page [http://www.research.uky.edu/ori/IRB-Survival-Handbook.html#print responsibilities]. Additional information regarding IRB review, federal regulations, and institutional policies may be found through ORI’s web site [http://www.research.uky.edu/ori/]. If you have questions, need additional information, or would like a paper copy of the above mentioned document, contact the Office of Research Integrity at (859) 257-9428.

Chairperson/Vice Chairperson

Norman Van Tuyl, Ph.D.
Letter to Potential SOS Group Facilitator Participants

Dear Survivor of Suicide Loss Support Group Leader,

We are writing to ask for your support and assistance with a study we are conducting. I (Rebecca) am a survivor of the suicide of a dear friend and have been facilitating support groups for survivors for over seven years. I am currently a doctoral student in the College of Social Work at the University of Kentucky, pursuing a research interest in suicidology under the guidance of Dr. Julie Cerel, an expert in the field of loss survivors.

Support groups for survivors of suicide loss have become a relatively common intervention for loss survivors, and many survivors report that they find comfort in being able to identify with other people who have experienced a similar loss. However, we don’t really know who benefits from the groups, in what ways they benefit from the groups, and why some people choose to continue attending the groups while others do not.

It is our hope that this study will help shed light on these questions. We are currently recruiting groups to participate in this study. We are hoping to have participation from a wide variety of groups throughout the United States and, eventually, internationally.

There are two options for participation in the study. First, as the facilitator of the group, you will be asked to complete an online questionnaire about the group, including information about attendance, format, and content of the group as well as a questionnaire about your experience and training as a facilitator and another questionnaire about your experiences as a helper. This should take you about 40 minutes to complete and only needs to be completed once. Upon completion of this survey, you are eligible to receive $20.

Second, at the end of the survey, you will be given an option to participate in the second phase of the study. If you choose to do this, you will be asked to hand out a sealed envelope to each new group attendee for at least a year. We will send you the envelopes as soon as you tell us how many new people attend your group each month. The envelope will include a letter to introduce group attendees to the study and explain to them how to participate, if they choose.

In summary, your participation in the study would involve completing an online survey that should take approximately 40 minutes to complete in the first phase for which you would receive $20 and then distributing sealed envelopes that contain an invitation to participate in the study to first time group attendees for at least a year only if you choose to participate in the second phase.

It is our sincere hope that you will consider participating in this study to contribute to our knowledge in this area so that we can advocate for enhanced services for survivors of suicide loss. If you are interested, please click the link below to begin the process. We thank you in advance for your support of this study.

Rebecca Sanford, MSSA, LCSW
Doctoral Student/Clinical Faculty
University of Kentucky

Julie Cerel, PhD
Associate Professor, Licensed Psychologist
University of Kentucky

Web Survey Consent Script – Group Facilitators – US Participants
Hello:

You are receiving this invitation to participate in an on-line survey because of your experience facilitating a support group for those who have lost a loved one to suicide. Our research team would like to thank you for considering participating in the on-line survey. If you choose to participate, you will be one of about 200 volunteers to do so.

As explained in the introductory letter, the purpose of this study is to gather information about support groups for those bereaved by suicide and the experiences of those survivors who choose to attend support groups. You have two options for your participation level in the study. You can choose to only complete the online survey or you can participate in the full study. Your participation in the full study will include completing the online survey and then distributing introductory letters to each new participant who joins your group as well as other ongoing group members, regardless of the number of times they have attended.

This survey will ask about the group you facilitate as well as your personal training and experience in this area. You will only be asked to complete this survey once. The survey will take about 40 minutes to complete. There are no costs to participating in this study.

Participation is completely voluntary and you may skip any questions that make you feel uncomfortable. It is not anticipated that participating in the survey will place you at any risk beyond that experienced in everyday life. However, it is possible that some questions may elicit painful memories if you have also experienced a loss. Because of this, contact information for National Suicide Prevention Lifeline is provided below.

There are no costs to participating. Participants are eligible for a $20 incentive for completing the survey. This is a one-time incentive provided after completion of the online survey.

The information you provide will be kept confidential. Your information will be combined with that from other group facilitators who choose to participate. When we write about the results, we will only discuss the combined information. Your name, mailing address, phone number, and email address will be collected so that we can mail you envelopes for you to distribute to new members who attend your group. However, your contact information will only be connected to the data in a password protected document that will list your contact information and your group number. The password to this document will only be known to members of the research team.

If you choose to participate in the full study, your group will also be assigned a number, which participants from your respective group will be asked to enter when they participate in the online survey. There is a question in the survey which will ask about
whether you want to participate in the full study. At that point, you can decide whether or not you want to participate.

We will keep private all research records that identify you to the extent allowed by law. However, there are some circumstances in which we may have to show your information to other people. For example, the law may require us to tell authorities if you report information about a child being abused or if you pose a danger to yourself or someone else. Also, we may be required to show information which identifies you to people who need to be sure that we have done the research correctly; these would be people from such organizations as the University of Kentucky.

Please be aware, while we make every effort to safeguard your data once received from the online survey/data gathering company, given the nature of online surveys, as with anything involving the Internet, we can never guarantee the confidentiality of the data while still on the survey/data gathering company’s servers, or while en route to either them or us. It is also possible the raw data collected for research purposes may be used for marketing or reporting purposes by the survey/data gathering company after the research is concluded, depending on the company’s Terms of Service and Privacy policies.

Before you decide whether to accept this invitation to take part in the study, ask any questions that might come to mind now by contacting a member of the research team: investigator/doctoral student, Rebecca Sanford, MSSA at (859) 323-7484 or by email at rebecca.sanford@uky.edu or the co-investigator/advisor, Julie Cerel, PhD, at (859) 257-8602 or julie.cerel@uky.edu. Later, if you have questions, suggestions, concerns, or complaints about the study, you can also contact a member of the research team. If you have any questions about your rights as a volunteer in this research, contact the staff in the Office of Research Integrity at the University of Kentucky at 859-257-9428 or toll free at 1-866-400-9428.

Available Resources:

National Suicide Prevention Lifeline: 1-800-273-8255
http://www.suicidepreventionlifeline.org/

**click here if you agree to continue the study

**click here if you do not agree to continue the study
Appendix B

Group Information Questionnaire

This questionnaire will ask you questions about the group structure, logistical information, facilitation, and format.

Name of Survivors of Suicide Support Group ____________________________

Group Website Address _____________________________________________

Contact Person Name ______________________________________________

Contact Person E-mail _____________________________________________

Meeting Site Name ________________________________________________

Mailing Address for the Meeting Site _________________________________

City __________________________ State _______ ZIP __________

When does the group meet? _________________________________________

Country in which the group operates: _________________________________

State/Province/Area in which the group operates: _______________________

1. Is this group an independent 501(c)3 non-profit organization?
   □ Yes   □ No

2. Who sponsors the group?
   □ No sponsor
   □ Church
   □ Community organization
   □ Hospice
   □ Mental health agency
   □ Social service agency
   □ Other (please specify): _________________________________________

3. What is the name/address of the primary sponsoring organization for this group? If none, note “none” below.
   Organization’s Name _____________________________________________
   Group Street Address ____________________________________________
   City __________________________ State _______ ZIP __________

4. Approximately how long has the group been in operation?
   □ Less than 1 year
   □ 1-5 years
   □ 5-10 years
   □ 10-15 years
   □ 15+ years
5. How often does the group meet?
   □ Ongoing/on-line
   □ Weekly
   □ Twice a month
   □ Monthly
   □ Less than monthly
   □ Other (please specify): ________________

6. What is the length of each group meeting?
   □ Less than 1 hour
   □ 1 hour
   □ 1.5 hours
   □ 2 hours
   □ Other (please specify):

7. How many meetings were held in 2013? __________________________

8. How many meetings were held in 2014? __________________________

9. What is the average attendance at each meeting of the group over the last 12 months (not including facilitators)?
   □ Less than 5 people
   □ 5-9 people
   □ 10-14 people
   □ 15-19 people
   □ 20-24 people
   □ More than 25 people

10. In the last year, about how many new survivors attended at least 1 session of the group?
    □ Less than 5 people
    □ 5-10 people
    □ 11-19 people
    □ 20-35 people
    □ More than 35 people

11. Approximately how many new group members attend each session? ____________

12. Where does the group meet?
    □ Private home
    □ Mental health facility
    □ Church/faith-based location
    □ School/educational setting
    □ Crisis center
    □ Hospice
    □ Other (please specify): ________________________________
13. On average, how many group sessions does each group member attend?
☐ One
☐ 2-5
☐ 6-10
☐ 11-15
☐ 16-20
☐ 21-25
☐ More than 25

14. Does the support group operate with a budget?
☐ Yes  ☐ No

15. What are the sources of funding for your group (check all that apply)?
☐ Community grants
☐ Donations
☐ Fundraising
☐ Sponsoring agency
☐ None
☐ Other (please specify):__________________________________________

16. Does the support group sponsor any of the following (check all that apply)?
☐ Brochure/flyer about the group
☐ Newsletter
☐ Suicide awareness/prevention events
☐ Fundraising
☐ Lifekeeper Memory Quilt
☐ None
☐ Other (please specify):__________________________________________

17. Does the group offer any of the following (check all that apply)?
☐ Outreach to new survivors
☐ Speakers for community events
☐ Training
☐ Short-term financial assistance for survivors
☐ Mentoring for survivors
☐ Guest speakers
☐ Telephone support
☐ Information about resources
☐ Email support
☐ Social events
☐ LOSS team (or similar active postvention model of outreach)
☐ Survivor of suicide loss day events
☐ None
☐ Other (please specify):__________________________________________
18. Is the group:
☐ Open-ended (no fixed number of sessions)
☐ Closed (fixed number of sessions)
☐ Combination
☐ Other (please specify): ____________________________________________

19. Can survivors join the group at any time?
☐ Yes, group is open and survivors can join at any time.
☐ Yes, survivors need to be screened or assessed prior to joining the group.
☐ No, only at the beginning of a group cycle (for example, an eight session cycle).
☐ No, only after screening/assessment AND at the beginning of a group cycle.
☐ Other: ____________________________________________________________

20. How do survivors learn about the group (check all that apply)? ☐ Crisis line
☐ Coroner/medical examiner
☐ First responders (law enforcement, fire, emergency medical)
☐ Home visit/active postvention call
☐ Mental health professionals
☐ Mobile crisis team
☐ Online
☐ Other survivors
☐ Physicians or nurses
☐ 211 (information/referral)
☐ Other (please specify): ____________________________________________

21. When contacted by a new survivor, the following occurs (check all that apply):
☐ Follow-up phone call
☐ Materials mailed/e-mailed
☐ Intake phone call
☐ Intake/screening appointment
☐ Other (please specify): ____________________________________________

22. How do you assess or screen survivors prior to participation in group?
☐ Group is open with no screening process
☐ Survivors are interviewed prior to attending group
☐ A screening tool is used and only those who meet a criteria are invited to attend
☐ Other (please specify): ____________________________________________

If a screening tool is used, please describe the criteria used to evaluate whether or not survivors can participate in the group: ____________________________________________

23. As the facilitator do you ever decide to exclude anyone from the group?
☐ Yes ☐ No
If you answered yes, please describe the exclusion criteria: ____________________________
24. Which of the following best describes the process for orienting new attendees to the group?  
☐ No orientation process  
☐ Informal orientation process – group facilitator provides information about the group and what to expect  
☐ Formal orientation process – group facilitator meets with the attendee to provide information about the group and what to expect, complete forms, and determine appropriateness for the group  
☐ Other (please specify): ________________________________

25. Which of the following best describes the structure of the group?  
☐ Not at all structured (no rituals/activities or planned topics)  
☐ Somewhat structured (some rituals/activities are consistent across group meetings, such as introductions or a closing activity, but otherwise the time in group is open)  
☐ Very structured (each group meeting is carefully planned with rituals and planned topics)

26. Does the group have ground rules or guidelines?  
☐ Yes  
☐ No  
If the group operates with ground rules or guidelines, please briefly describe the ground rules/guidelines of the group: ________________________________

27. How are the ground rules/guidelines communicated to group members (select all that apply)?  
☐ Ground rules/guidelines are reviewed in the orientation process  
☐ Ground rules/guidelines are communicated in the group brochure  
☐ Ground rules/guidelines are discussed at the beginning of each group meeting  
☐ Other (please specify): ________________________________

10. What percentage of survivors who attended the group over the past year?  
  ____% only came to one session  
  ____% came to 1-5 sessions  
  ____% came to 6-12 sessions  
  ____% came to more than 12 sessions

29. What percentage of survivors in the group are (should equal 100%):  
  ____% Caucasian/white, non-Hispanic  
  ____% African-American  
  ____% Hispanic  
  ____% Native American  
  ____% Asian/Pacific Islander  
  ____% Other (please specify): ________________________________
30. How do you evaluate the effectiveness of the support group (check all that apply)
☐ Evaluation is informal
☐ Evaluation is formal
☐ Evaluation occurs annually
☐ Evaluation occurs more than once a year
☐ Evaluation is not currently a component of the group
☐ Non-returning survivors are contacted to follow-up and determine reasons for non-return
☐ Other (please specify):_____________________________________________________

If you follow-up with survivors who do not return for the group, what are the most common responses provided? ___________________________________________________________

31. What percentage of group time is used with each of the following meeting formats? (Needs to equal 100%)
   ___% Rituals (opening, closing, etc.)
   ___% Sharing of experiences
   ___% Lecture/educational content or material
   ___% Coping skills suggested by group members
   ___% Coping skills suggested by group leader
   ___% Other (please specify):_________________________________________________

32. Which of the following topics are covered in the group (check all that apply)?
☐ How to cope with holidays, anniversaries, observance of annual date of death and birthdays (or any other sensitive dates)
☐ How to react to family and friends who expect you to move on
☐ How to respond to questions that arise and put you on the spot
☐ How to handle moral attitudes about suicide
☐ How to tell children
☐ Advocacy
☐ Suicide prevention
☐ Attending individual/family therapy
☐ When to take medication or see a physician
☐ Supporting other family members
☐ Continuing bonds/relationship to the deceased
☐ Personal growth since the loss
☐ Reinvesting in relationships
☐ Spiritual/religious issues
☐ Emotions
☐ Memorials/rituals
☐ Stigma
☐ Sense of guilt/responsibility about the death
☐ Unique nature of suicide bereavement
☐ Trauma reactions
☐ Understanding of the death and reasons why the death occurred
☐ Other (please specify):____________________________________________________
33. What percentage of topics are selected by the (total should equal 100%):
   _____% Group facilitator  _____% Group attendees

34. Do survivors have an opportunity to share the death story (how their loved one died, finding their loved one, etc.)?
   □ Yes  □ No
   Please describe the reason(s) why you do or do not allow the death story to be shared in the group:
   ________________________________________________________________

35. Which of the following are goals of the group (select all that apply)?
   □ Improve emotional functioning
   □ Reduce negative emotion
   □ Reduce sense of stigma
   □ Reduce sense of shame
   □ Reduce sense of guilt
   □ Increase coping skills
   □ Increase knowledge about suicide and the reasons why people die by suicide
   □ Increase emotional support
   □ Increase meaning making
   □ Increase personal growth (sometimes called post-traumatic growth)
   □ Provide practical assistance
   □ Provide an opportunity for survivors of suicide loss to talk openly about the experience
   □ Instill hope
   □ Validate experiences
   □ Facilitate development of the new identity as a survivor of suicide loss
   □ Facilitate development of insight about the loved one’s death and why the death occurred
   □ Other (please specify): ____________________________________________

36. What do you think are the three most important things that attendees get from the group?
   a. ________________________________________________________________
   b. ________________________________________________________________
   c. ________________________________________________________________

37. Do you use a curriculum or guide for facilitating the group?
   □ Yes  □ No
   If you answered ‘yes’ above, please specify which guide you use: ________________

38. Is there a theoretical framework that guides facilitation of the group?
   □ Yes  □ No
If you answered ‘yes’ above, please specify which framework(s):

☐ Dual Process Model
☐ Meaning Making/Reconstruction
☐ Narrative Approaches
☐ Task Model of Bereavement
☐ Cognitive Behavioral Theory
☐ Psychoeducation
☐ Eclectic/multiple approaches
☐ Other (please specify):_________________________
Group Facilitator Questionnaire

This questionnaire will ask you questions about your training, experience, and general attitudes and beliefs about support groups for survivors of suicide loss.

1. The person completing this survey is:
   ☐ The only group leader
   ☐ A group leader who facilitates the group with another co-leader
   ☐ Other (please specify): ____________________________

2. Indicate the total number of group leaders (including yourself): __________

3. Are you: ☐ Male  ☐ Female  ☐ Other (specify, if desired): __________

4. Your race/ethnic group:
   ☐ White/Caucasian
   ☐ Black/African American
   ☐ Hispanic
   ☐ Asian/Pacific Islander
   ☐ Native American
   ☐ Aboriginal/First Nation
   ☐ Multiple (please specify, if desired): ____________________________
   ☐ Other (please specify, if desired): ____________________________

5. Which best describes your status as the group facilitator?
   ☐ Peer facilitator – personally experienced the loss of a loved one to suicide; no educational degree in mental health
   ☐ Mental health professional facilitator – educational degree in a helping profession; employed as a helping professional; no personal experience with a suicide loss
   ☐ Peer/mental health professional facilitator – personally experienced the loss of someone to suicide; educational degree in a helping profession
   ☐ Other (please specify): ____________________________

6. What is your current employment status?
   ☐ Employed full-time
   ☐ Employed part-time
   ☐ Retired
   ☐ Not employed

7. Is your role as the group facilitator considered part of your current employment?
   ☐ Yes  ☐ No

8. Are you a paid staff member of a sponsorship agency?
   ☐ Yes  ☐ No
9. What is your highest level of education?
- [ ] Less than high school
- [ ] High school/diploma equivalent
- [ ] Some college
- [ ] Bachelor’s degree
- [ ] Master’s degree
- [ ] Doctoral degree

10. Indicate which of the following background/credentials apply to you (select all that apply):
- [ ] No advanced experience as related to SOS group facilitation
- [ ] Personal experience as a survivor
- [ ] Chaplain
- [ ] Social work degree
- [ ] Counseling/psychology master’s degree
- [ ] Doctoral degree in psychology or counseling
- [ ] Medical degree
- [ ] Certified Thanatologist
- [ ] Nursing degree/license
- [ ] Other (please specify): ________________________________

11. How long have you been a leader or co-leader in the group? ____________ years

12. Indicate from which of the following you have received training in survivor of suicide support group facilitation skills (check all that apply):
- [ ] American Association of Suicidology
- [ ] American Foundation for Suicide Prevention (AFSP)
- [ ] The Link (Atlanta, GA)
- [ ] Barbara Rubel
- [ ] Heartbeat
- [ ] Own life experiences are the primary source of training
- [ ] Other survivor group training (please specify): ________________________________
13. Using the following scale, circle the number that best fits with your response to each question:

<table>
<thead>
<tr>
<th>1=Poor</th>
<th>2=Fair</th>
<th>3=Good</th>
<th>4=Excellent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall, how would you rate the effectiveness of support groups in helping survivors?</td>
<td>1 2 3 4</td>
<td></td>
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</tr>
<tr>
<td>How would you rate the effectiveness of the support group in helping survivors handle their grief?</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How would you rate the effectiveness of support groups in helping survivors who seem to be in a great deal of distress in the first few months after the death?</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>How would you rate the effectiveness of support groups in helping survivors who seem to be in a great deal of distress one or more years after the death?</td>
<td>1 2 3 4</td>
<td></td>
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</tr>
</tbody>
</table>

14. Using the following scale, circle the number that best indicates your agreement with each statement:

<table>
<thead>
<tr>
<th>1=Strongly Disagree</th>
<th>2=Mostly Disagree</th>
<th>3=Mostly Agree</th>
<th>4=Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survivor of suicide loss (SOS) groups should be run by survivors.</td>
<td>1 2 3 4</td>
<td></td>
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</tr>
<tr>
<td>It is better for survivors to attend group as soon as possible.</td>
<td>1 2 3 4</td>
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</tr>
<tr>
<td>Group members should attend no sooner than six months following the death.</td>
<td>1 2 3 4</td>
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</tr>
<tr>
<td>Survivors need to attend an SOS group forever.</td>
<td>1 2 3 4</td>
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<tr>
<td>Group members are expected at some point to no longer need group services.</td>
<td>1 2 3 4</td>
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<tr>
<td>Not everyone benefits from participation in an SOS group.</td>
<td>1 2 3 4</td>
<td></td>
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</tr>
<tr>
<td>Sharing stories is an essential part of healing.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>Continual sharing of stories can traumatize.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>Advocacy is an essential part of healing.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>Being active in suicide prevention is an important part of healing.</td>
<td>1 2 3 4</td>
<td></td>
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</tr>
<tr>
<td>SOS groups are important in helping survivors make sense of what happened.</td>
<td>1 2 3 4</td>
<td></td>
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<tr>
<td>SOS groups are important in helping survivors integrate the death story into their daily life.</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SOS groups are important in helping survivors find the benefits or areas of personal growth and positive change (e.g. deeper compassion for others) that they have experienced after the loss.</td>
<td>1 2 3 4</td>
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</table>
SOS groups allow survivors of suicide loss an opportunity that might not otherwise exist to tell the story of losing their loved one to suicide.

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SOS groups allow survivors to discuss the “whys” and “what ifs” that survivors of suicide loss often experience.

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It is important for survivors of suicide loss to be able to share the death story in the group.

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SOS facilitators should intervene as little as possible and allow group attendees to help one another.

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SOS facilitators should intervene to support growth and healing.

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SOS facilitators should intervene in the group process to ensure that everyone gets what they need.

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SOS groups must adapt to meet the needs of both the newly bereaved and those who are farther from their loss.

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SOS groups are more helpful for those who are more newly bereaved than those who are long-term survivors.

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SOS groups provide an important opportunity for survivors to practice new ideas and skills (such as how to deal with unsupportive loved ones).

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SOS groups provide an important opportunity for survivors to have thoughts and beliefs challenged by others.

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SOS groups provide an important opportunity for survivors to gain insight and awareness into their situation through support of others.

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15. How important do you perceive each of the following tasks to be in the overall suicide bereavement experience (both in and outside of the group)?

| 1|=Not Important at All | 3|=Somewhat Important | 5|=Extremely Important |
|---|------------------------|-----------------------|-----------------------|

Accepting the reality of the loss  | 1  | 2  | 3  | 4  | 5 |
|-----------------------------------|----|----|----|----|---|

Participating in grief education activities to learn about grief (reading, support groups, etc)  | 1  | 2  | 3  | 4  | 5 |
|------------------------------------------------------------------------------------------|----|----|----|----|---|

Learning about the unique features of suicide grief  | 1  | 2  | 3  | 4  | 5 |
|------------------------------------------------------------------------------------------------|----|----|----|----|---|

Engaging in advocacy work related to suicide prevention/awareness  | 1  | 2  | 3  | 4  | 5 |
|-------------------------------------------------------------------|----|----|----|----|---|

Emotionally processing the loss  | 1  | 2  | 3  | 4  | 5 |
|--------------------------------|----|----|----|----|---|

Adjusting to life without the presence of the deceased  | 1  | 2  | 3  | 4  | 5 |
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<tbody>
<tr>
<td>Establishing continued bonds with the deceased loved one</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Memorializing the person who died</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Acting out rituals to remember the person who died</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Receiving validation for reactions</td>
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<tr>
<td>Talking to others who have experienced a similar loss</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Engaging in individual counseling</td>
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<tr>
<td>Finding a “good enough” understanding of the explanation for the death</td>
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<tr>
<td>Remembering the life and good qualities, characteristics, and memories of the person who died and not just their death</td>
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<td></td>
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<tr>
<td>Identifying areas of growth since the loss</td>
<td>1 2 3 4 5</td>
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<tr>
<td>Developing an understanding of the role/importance of religion in the bereavement experience</td>
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<tr>
<td>Exploring challenged assumptions/identifying shifts in assumptions about the world (e.g. people are generally good; the world is safe)</td>
<td>1 2 3 4 5</td>
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16. How important **do you think the group is** in helping survivors accomplish each task?

<table>
<thead>
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<tr>
<td>Task</td>
<td>1</td>
<td>2</td>
<td>3</td>
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</table>

17. How often do you engage in these tasks related to group facilitation?

<table>
<thead>
<tr>
<th>Task</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Manage monopolizing/talkative group members</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Encourage participation among all group attendees</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Encourage connections between and sharing among group attendees</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Attend to non-verbal cues from group attendees (nervous behaviors, etc.)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Scan the room</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Guide sharing of stories and experiences</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Address potential conflicts</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Other (please specify):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Other (please specify):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Other (please specify):</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
18. Cohesiveness refers to how closely bonded members of a particular group are. How would you describe the cohesiveness of the group presently? Place an ‘X’ on the line and write in the number that best describes the current level of cohesion in the group.

10 (extremely low) Your number:_______ 100 (extremely high)

19. How do you think your group best helps attendees?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

20. What do you think is most meaningful about the group experience?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

21. As the facilitator, what do you find most challenging about the group?

_____________________________________________________________________
_____________________________________________________________________
_____________________________________________________________________

_____________________________________________________________________
Professional Quality of Life Scale

When you help people, such as facilitating a support group for people who have lost a loved one to suicide, you have direct contact with their lives. As you may have found, your compassion for those you help can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a helper. Consider each of the following questions about you and your current work or volunteer situation. Circle the number that honestly reflects how frequently you experienced these things in the last 30 days.

<p>| | | | | | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>1. I am happy.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2. I am preoccupied with more than one person I help</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3. I get satisfaction from being able to help others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4. I feel connected to others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5. I jump or am easily startled by unexpected sounds.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6. I feel invigorated after working with those I help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7. I find it difficult to separate my personal life from my life as a helper.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9. I think that I might have been affected by the traumatic stress of those I help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10. I feel trapped by my job as a helper.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>11. Because of my helping, I have felt “on edge” about various things.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12. I like my work as a helper.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13. I feel depressed because of the traumatic experiences of the people I help.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>14. I feel as though I am experiencing the trauma of someone I have helped.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15. I have beliefs that sustain me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16. I am pleased with how I am able to keep up with helping techniques and protocols.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17. I am the person I always wanted to be.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18. My work makes me feel satisfied.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>19. I feel worn out because of my work as a helper.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>20. I have happy thoughts and feelings about those I help and how I could help them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>21. I feel overwhelmed because my workload seems endless.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>
22. I believe I can make a difference through my work.  1  2  3  4  5
23. I avoid certain activities or situations because they remind me of frightening experiences of the people I help.  1  2  3  4  5
24. I am proud of what I can do to help.  1  2  3  4  5
25. As a result of my helping, I have intrusive, frightening thoughts.  1  2  3  4  5
26. I feel “bogged down” by the system.  1  2  3  4  5
27. I have thoughts that I am a “success” as a helper.  1  2  3  4  5
28. I can’t recall important parts of my work with trauma victims.  1  2  3  4  5
29. I am a very caring person.  1  2  3  4  5
30. I am happy that I chose to do this work.  1  2  3  4  5

Do you facilitate the group with a co-facilitator or multiple co-facilitators?
☐ Yes □ No

If yes, please provide the email address of the co-facilitator, if you feel comfortable doing so, so we can contact them and ask if they would also like to complete a survey about their experiences in group: ________________________________

If you are interested in your group participating in the full study, please indicate so by selecting “yes” below. As stated in the initial letter inviting you to complete this survey, your participation in the full study would require you to distribute sealed envelopes to each first time group attendee for at least a year. The envelopes will contain invitations for the group attendees to participate in a study to evaluate their grief and group attendance experiences.

☐ Yes, I am interested in participating in the second phase of the study. Please contact me at this email address: ________________________________
☐ No, I am not interested in participating in the second phase of the study.
References


Cerel, J. (2015). *We are all connected in suicidology: The continuum of "survivorship"*. Paper presented at the American Association for Suicidology Annual Conference, Atlanta, GA.


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Vita
Rebecca L. Sanford, MSSA, LCSW
Place of Birth: Sylvania, OH

EDUCATION

2005 Master of Science in Social Administration
Case Western Reserve University, Cleveland, OH
Specialization: Children, Youth, & Families

2004 Bachelor of Science
Defiance College, Defiance, OH
Majors: Social Work and Psychology

ACADEMIC POSITIONS

2011 (July)-present Clinical Faculty, University of Kentucky College of Social Work
Public Child Welfare Certification Program Site Coordinator and
Credit for Learning Instructor
Lexington, Kentucky

2011 (January-May) Instructor of Social Work, Defiance College
Defiance, Ohio

PROFESSIONAL EXPERIENCE

2009-2010 Clinical Supervisor and Therapist, Family Pride of Northeast
Ohio
Chardon, Ohio

2007-2010 Clinical Supervisor, Cleveland Catholic Charities
Cleveland, Ohio

2005-2007 Community Based Therapist, Cleveland Catholic Charities
Cleveland, Ohio

2005-2008 Community Mental Health Partner, Cuyahoga County Board of
Mental Health and Substance Abuse, Families and Schools
Together (FAST) program
Cleveland, Ohio
2004-2005  Foster Care Social Worker, Cleveland Catholic Charities
          Cleveland, Ohio

2002-2004  Supervised Visitation Monitor and Domestic Violence Shelter
          Worker, Center for Child and Family Advocacy
          Napoleon, Ohio

PROFESSIONAL PUBLICATIONS

  experiences with therapists: Implications for clinical practice. *Community Mental

  prevention and intervention? Theoretical applications for a systemic perspective.
  *Journal of Family Theory & Review*

Maple, M., Pearce, T., Sanford, R.L., & Cerel, J. (in press). The role of social work in
  suicide prevention, intervention, and postvention: A scoping review. *Australian
  Journal of Social Work*

Maple, M., Cerel, J., Sanford, R.L., Pearce, T., & Jordan, J. (in press). Is exposure to
  suicide beyond kin associated with risk for suicidal behavior? A review of the
  evidence. *Suicide and LifeThreatening Behavior*

REFERRED PRESENTATIONS

*National and International Presentations*

  Leadership: Key Considerations. Workshop Presentation at the International

Sanford, R.L., Young, L.E., & Cerel, J. (2016, April). CBT in Suicide Bereavement: A
  Survey of Survivors in Therapy. Panel presentation at the Association for Death
  Education and Counseling Annual Conference, Minneapolis, Minnesota.

  Groups: Who Attends and How They Benefit. Poster presentation at the American
  Association of Suicidology Annual Conference, Chicago, Illinois.


Cerel, J., Sanford, R.L., McGann, V., & Maple, M. (2013, April). Suicide Bereaved Survivors Experiences with Therapists: From “She Saved My Life” to “I could write a book about all of the awful things the two bad counselors did and said”. Poster presentation at the American Association of Suicidology, Austin, TX.


**Regional and Local**


**Invited Lectures and Presentations**

Presentation at the University of Kentucky Suicide Prevention Month Event.
Lexington, KY.


SCHOLASTIC AND PROFESSIONAL HONORS

2009 Heart Hands and Hope Award from Catholic Charities Services/Parmadale
2008 Young Alumni Service Award from Defiance College
2007 Spirit of Service Award from Catholic Charities Services/Parmadale
2006 St. Martin de Porres Award from Catholic Charities Services/Parmadale
2005 Heart Hands and Hope Award from Catholic Charities Services/Parmadale
2004 Outstanding Senior in Psychology Award from Defiance College
2004 Social Work Schauffler Award from Defiance College