MUTUAL HELP GROUPS FOR T

by Adina Wrobleski

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The special agony of families in which a member has died by suicide is hard to imagine.* Their need for help is probably greater than that of most other bereaved families, yet they are less likely than others to receive it. Friends are embarrassed and the bereaved themselves may feel too ashamed or vulnerable to ask for help

Mutual help is given by people who are "in the same boat". If there is a stigma it is shared and because helper and helped have undergone similar experiences they can be expected to understand each other. Most organised mutual help is given in groups, and although there is no reason why mutual help cannot be given on a one-to-one basis (as in certa'n "widow-to-widow" programmes) there are many instances when group support is best. In an ideal world most bereaved would probably prefer to get individual help in the early stages of bereavement and move on to join a group later. One great advantage of the mutual help group is the opportunity which it presents for those who come for help to redress the balance by also giving it to others. Thus helped and helper are one.

Editor

* The psycho-social effects of a suicide on friends and family were reviewed by Susan Henley in **Bereavement Care**, Vol. 2, No. 2.

Individuals bereaved by the suicide of a family member or friend have been sorely neglected in empirical research. The purpose of an exploratory study carried out by the writer in 1984 was to determine the responses made by survivors following a suicide, and to either support or call into question some of the assumptions frequently made regarding suicide survivors.

Questionnaires were sent to those people who had contacted the Minneapolis Suicide Survivors' Grief Group. There were 158 responses concerning 112 deceased. (See data chart). I will use some of this data to illustrate points made on the issues in this paper, as well as drawing on my six-year experience of working in support of suicide survivors, and my own experience of suffering a bereavement by the suicide of my daughter.

EVALUATION OF GROUPS

How are groups evaluated for suicide survivors? It seems to me that this can only be done by asking the survivors themselves. This was done in the research of the Minneapolis-St. Paul groups. On a self-rating scale, the respondents were asked if they had attended a self-help group and, if so, how they rated the help they received. Of the 158 respondents, 116 had attended a group.

WHY ARE THE GROUPS HEALING?

"What makes these groups so healing in some situations and arresting in others?"

It is true that some survivors decide they do not like a group, do not feel they are helped, feel that it makes their pain worse and consequently decide not to stay with the group. I do not think this necessarily means that their grief has been "arrested".

There is anecdotal and experiential evidence that there are some individuals who work very well and easily in groups, and others who do not. The experience of the Minneapolis-St. Paul groups is that the most important benefit received is reassurance, and the breaking-down of the isolation imposed by the stigma on suicide. In all self-help groups the fundamental principle of growth is based on getting help, giving help, and ultimately getting help by giving it. The reassurance of knowing that one is not alone in one's reactions, thoughts and experiences is very consoling to suicide survivors. The experience of being able to reach out and help others, even in the midst of our own extreme pain, is very healing.

MENTAL HEALTH PROFESSIONALS AND SELF-HELP

In America there are closed groups available to those grieving a suicide. These may be led either by a mental health professional alone, or by a lay person with a co-leader who is a mental health professional. The groups are structured and usually meet for eight sessions. Historically there has been some mistrust between some mental health professionals and the self-help movement: they generally hold that suicide bereavement is so traumatising that people almost automatically need therapy to survive and, if not, at least must have a mental health professional leading the group or supervising it. Suicide survivors planning support groups have had to decide whether or not groups should have a mental health professional attached to them in some capacity. Open-ended groups such as ours do feel that survivors are able to make competent decisions about what they need, and that support groups do what people have always done for other people in grief: helping, befriending, consoling, offering advice, sharing personal experiences.

When our first self-help group was being planned in 1978 in Minneapolis, a mental health professional was consulted. He recommended that before a group was started an advisory board of 10 or 12 professionals be formed to aid and guide the survivor-leaders of the group. After consideration (and observing the efforts of a group of people who tried to do just that, with no success) it was decided that to wait for agreement and guidance from an advisory board might mean we would never get off the ground.

The fact that Minneapolis-St. Paul has five groups that have been meeting regularly, twice a month, without interruption since they started, shows the dynamism and commitment of the people making up the groups, as well as the group-leaders. These groups have shown that suicide survivors can benefit from groups that have no involvement of mental health professionals. This in no way, however, provides justification for saying that this is an anti-professional stance; it merely says that self-help and support work by themselves.

WHO BENEFITS AND WHO DOES NOT?

"Are there certain people who do not seem to benefit or who benefit particularly well from suicide survivor groups?" The only evidence we have at this point is the kind of information my research shows about the self-selecting people who come to the groups and what they report.

The group most helped are women. In my research, which covered people who did and did not attend a group, 75% of the respondents were women grieving

HOSE BEREAVED BY SUICIDE—



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the suicide deaths of men. Of people who attend groups, the ratio of women is even higher than 75%. It has been my observation that the men who come are primarily those who are grieving the death of a child. They come with their wives when they have intact and supportive marriages.

The age group that comprised the majority of survivors in my research was between 20 and 50, and income levels indicate middle and upper tax brackets. Very few people from racial minorities attend survivor groups, which may reflect the small number of suicides among those people by comparison with other Americans. Do older people feel less need for groups of this kind? Possibly. I am of the opinion that older people may tend not to attend self-help groups because (a) they feel more stigmatised than others, (b) they may not be accustomed to all the talking out that a younger generation finds so helpful, and (c) our society does not always value the old as we do the young.

ATTENDANCE AND LEADERSHIP

Strong opinions, and little hard data, exist as to how long people "should" attend groups. Some group leaders insist that the "right" way of attending is to go regularly over a number of months—some say years. I disagree with this opinion.

It is normal for the leader to feel unappreciated and insecure if there is poor attendance. Until one is used to it, it is **uncomfortable** not to know who, if anyone, will attend. Until a group leader is experienced, it can be uncomfortable beginning each group anew, with a mix of new and old survivors. It may be uncomfortable, but it does not mean that the group is going wrong or is ineffective.

It does not seem to make a difference whether groups are open-ended or closed: **most people do not stay long in support groups.** It is suggested here that it is the anxiety of the leader which leads to an emphasis on survivors attending regularly, and for a long time. One leader reported that a goal was to get people "back into the group". I feel, on the other hand, that the point of coming to a support group is to be able to leave the group. People come to receive some extra sources of reassurance and information after the suicide death. It fosters dependency to urge suicide survivors to stay with the group for months—or years; and to suggest, as some do, that suicide survivors form new social relationships based in the group is to suggest that the suicide become the focal point of the survivor's life.

It is a moot point, however, because survivors persist in voting with their feet. They decide how long they will stay in the group and whether it benefits them a lot, some, or not at all. In research in the St. Paul open-ended group, each suicide survivor attended an average of 2.5 meetings. In 1983, the Dallas group reported on the attendance at their closed, 8-session weekly groups over a period of several years: 35% had attended only 1 session, and only 24% attended all eight sessions.

HOW SOON AFTER THE DEATH?

There are also strong opinions held as to how soon after the suicide a survivor should come to a group. Some feel there should be a considerable period of time between the bereavement and attendance at the group.

The experience of the five leaders of the Minneapolis-St. Paul groups, all of whom are suicide survivors themselves, is that one should be encouraged to come to the group as soon as possible after the death—even as little as a week later.

The ignorance and bewilderment surrounding suicide is so great that the sooner a suicide survivor can be with others to gain reassurance and support, the better his or her progress will be. To suggest that it is in some way helpful for bereaved people to remain in their state of bewildered, painful helplessness ignores the pain of grief after suicide.

In conclusion, I feel that there needs to be a great deal more research, and less unsubstantiated opinions, about suicide survivors, and the survivors studied need to be drawn from support groups, not solely from clinical practice. Assumptions that many suicide survivors have pathological conditions requiring professional care are unwarranted in the majority of cases, and I feel that more respect should be given to suicide survivors' personal autonomy and their ability to make decisions in their own best interest.

RELATIONSHIPS OF RESPONDENTS TO DECEASED:

Respondents Grieving:			Deceased being Grieved:		
Relation	No.	Percent	Relation	No.	Percent
Mothers	40	25.0%	Sons	39	24.7%
Sisters	26	16.4%	Brothers	28	17.7%
Daughters	19	12.0%	Fathers	19	12.0%
Wives	17	10.8%	Husbands	17	10.8%
Fathers	12	7.6%	Daughters	13	8.2%
Brother	11	7.1%	Sisters	9	5.7%
Sons	5	3.2%	Mothers	5	3.3%
Husbands	4	2.5%	Wives	4	2.5%
Friends	4	2.5%	Fiances	4	2.5%
Others	19	11.9%	Others	17	10.7%
	158	100.0%		158	100.0%

Note: "Others" includes step and in-law relations, engaged couples, ex-spouses, grand children and other significant relationships.

COVER PICTURE

'THE DEATH OF CHATTERTON' by Henry Wallis, by courtesy of the Tate Gallery, London. Thomas Chatterton, the boy poet, was born in Bristol in 1752 and took his own life at age 18. He was 'passionate and winning in his manners, well grown and manly, having a proud air and a stately bearing.' As a child he would lock himself in a lumber room to read and write in peace. He developed a flair for spurious antique verse and family pedigrees, so skilfully done that they deceived many. At 15, apprenticed to an attorney, he became bitterly unhappy, threatening suicide. The literary 'discoveries' intrigued Horace Walpole, who exposed them as fabrications, but admitted: 'I do not believe there ever existed so masterly a genius.' Chatterton went to London to cheap lodgings, writing feverishly for 11 publications, with much work accepted but not paid for. In 1770, destitute, he died from a phial of arsenic. His tragic death has been recorded in romantic terms by several artists, this painting completed in 1856.