1991

Therapeutic group approaches for issues related to suicide

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<https://doi.org/10.15760/etd.6150>

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AN ABSTRACT OF THE THESIS OF Ardis Sherwood for the Master of Science in Education: Counseling presented July 1, 1991.

Title: Therapeutic Group Approaches for Issues Related to Suicide.

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The purpose of this thesis is to (a) summarize a sample of the literature that pertains to suicidal behavior; (b) explore the benefits of the group approach for people who experience suicide-related issues; (c) provide information and models for special suicide-related groups; and (d) discuss age-variations of suicidal behavior.

Suicide is the ninth leading cause of death in the United States and children, adolescents, and adults, age 65 and older are the populations at highest risk for suicide. The act of suicide is the culmination of the interaction among various psychological, environmental, social and situational factors. Suicide is rarely precipitated by a single factor and depression is identified as the major predictor of suicidal behavior. The symptoms of depression (e.g., anhedonia, low self-esteem, withdrawal, feelings of helplessness and hopelessness) reduce the ability to generate workable solutions to problems and adopt effective ways to cope with life events.

Group therapy is recommended as a treatment modality for people with suicide-related issues. This method of treatment addresses many of the special needs of this population (e.g., psychological pain, inability to adjust and cope, cognitive constriction, social isolation, hostility and rage). People who are at risk for suicide need the opportunity to satisfy their needs in a supportive environment that promotes communication, acceptance, and appropriate and constructive methods of coping with stressful events. Groups provide unifying and connecting relationships, decrease feelings of loneliness and isolation, and promote conditions that facilitate the adaptation of effective strategies for coping with life situations.

The steady increase in suicide rates and the fact that

people who have attempted suicide have a higher rate of suicidal behavior indicates that the traditional methods of intervention and prevention for people who have suicide related issues are inefficient. There is a need for the reassessment of current perspectives on suicide prevention, and the development of more effective and practical methods of responding to people with suicide-related issues.

**THERAPEUTIC GROUP APPROACHES
FOR ISSUES RELATED TO SUICIDE**

**By
ARDIS SHERWOOD**

**A thesis submitted in partial fulfillment
of the requirements for the degree of**

**MASTER OF SCIENCE
in
EDUCATION:COUNSELING**

**Portland State University
1991**

TO THE OFFICE OF GRADUATE STUDIES:

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ACKNOWLEDGEMENTS

I have many people to thank for their unselfish and unrestricted contributions toward the completion of this thesis. I have been blessed with a dedicated faculty who create an atmosphere that cultivates eminence in education, and the extensive support of family and friends.

My academic advisor and the chairperson of my thesis committee, Dave Capuzzi, prodigiously influenced my decision to commence the thesis project. Dave, not only encouraged, inspired and stimulated my desire to write, he offered me the invaluable opportunity to contribute chapters in several of his publications. His faith in my writing capabilities empowered me to gain the courage, confidence and determination to undertake these projects. He has been my consistent advocate, and throughout the writing of the thesis, he has provided excellent guidance, support, and calm reassurance. I thank you, Dave.

I am especially grateful to Hanoch Livneh, my graduate assistant supervisor, thesis committee member, mentor and friend, for his humor, his understanding, his generosity, and his dedication to excellence in education. Hanoch's influence is reflected in all my work, and his meticulous editorial

talents significantly contributed to the quality of this thesis.

I was also fortunate to have Art Terry and Gerald Guthrie on my thesis committee. Art is my encourager and motivator, and promoted my personal growth throughout my graduate experience. I thank him for his trust, enthusiasm, and positive influence on my life, and for his quiet provision of hope and courage that enabled me to accomplish my goals. I am indebted to Jerry Guthrie for his commitment to quality education, his humanitarianism, his generosity, his flexibility, and his imperturbable approach to the completion of this thesis.

I owe a special note of appreciation to Carol Burden, faculty member of the Department of Counseling and Special Education, who altruistically gave me vital emotional support and encouragement. Most important, she made me laugh, and repeatedly facilitated my reacquiring a positive perspective toward life. She provided the motto of my thesis, a quote that helped me smile, kept me going, and enabled me to realize that "brain deadness" is usually a transient condition:

Writing is very easy. You just sit
there until the drops of blood form
on your forehead. Author unknown.

In many ways, my education has been a family project. They have made many sacrifices so I could complete my education, and I cannot express the gratitude I feel toward

them. To my friend and cherished husband, Robert Hawes, and my sources of joy, sons, Brad and Brian Myers, and daughter, Amy Hawes: Thank you for your support and understanding. I love you very much.

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CHAPTER I

INTRODUCTION

If only my body would die as the rest of me has. (Cavan, 1964, p. 305).

SCOPE OF THE PROBLEM

Suicide is a universal phenomenon. It is the ninth leading cause of death in the United States (Beck, Brown, Berchick, Stewart & Steer, 1990). The act of killing oneself transcends differences in race, gender, age, economic status, and ethnic background, and the devastating consequences of suicide can ubiquitously impact any family, any community, and any society.

Research studies indicate that adolescents and older adults represent the populations most at risk for suicidal behavior. The suicide rate among adolescents and children has increased by 300% over the last 30 years (Gilliland & James, 1988), and suicide is now the second leading cause of death in the United States for adolescents between the ages of 11 and 24 (Capuzzi & Gross, 1988). These data do not include children who attempt suicide or who manifest self-destructive ideation. Over 25,000 children under 12 are hospitalized annually because they are at risk for suicide (Stiles &

Kottman, 1990). Statistics indicate that the rate of suicide is even higher among people, ages 65 and older (Osgood & Brant, 1990; Saul & Saul, 1988). In 1988, the rate for suicide among older adults in the United States was 21.5 per 100,000, and the rate for adolescents was 13.1 per 100,000 (Osgood & Brant, 1990).

The ratio of completed suicides for women over 65 is double the rate for the United States population, and for men over 65, the ratio is four times the national average (Gilliland & James, 1988). Data reveal that more attempts at suicide are made by adolescents (ages 15-24) and women (ages 25-64), but older adults and men (ages 25-64) have more successful completions of suicide and choose more lethal ways to die (Henry, 1987; Saul & Saul, 1988; Vidal, 1989). Research also shows that people who attempt suicide are at greatest risk for a repeat attempt during the first two year period following the original attempt, and adolescent attempters have a high rate of repeating the attempt during the first few post-suicide-attempt months. Despite this dire prognosis, suicide attempters are seldom referred for further psychological services (Curran, 1987).

It is estimated that 75 to 85% of all persons who commit suicide were suffering from an unrecognized and/or misdiagnosed state of depression at the time of their death (Bogdaniak & Coronado, 1987). Unfortunately, depressive conditions may be overlooked and untreated in the populations

who are at highest risk for suicide. Physicians and clinical practitioners are prone to dismiss or misdiagnose symptoms of depression in adults who are older (Kermis, 1986), and children and adolescents have a diminished opportunity for assessment and treatment of depression because they are not likely to be under the consistent care of a physician (Morphey, 1988).

The national statistics become even more alarming when the warnings that both suicide attempts and suicide completions are significantly underreported are considered (Allberg & Chu, 1990; Gutstein & Rudd, 1988; Saul & Saul, 1988; Stefanowski & Harding, 1990).

A number of researchers note that mortality data contain intentional cover-ups by physicians or family members or misclassification as accidental death when evidence of suicide is insufficient. It has been suggested that a more accurate picture might be revealed by multiplying given statistics two-maybe threefold (Gutstein & Rudd, 1988, p. 5).

The escalating incidence of suicidal behavior in the United States may indicate the need for the reassessment of current perspectives toward suicide prevention, intervention and postvention treatment programs, and the development of more effective and practical methods of responding to people who are distressed by issues related to suicide. The purpose of this thesis is (a) to review and amalgamate a representation of the existing literature that pertains to suicidal behavior; (b) to examine the reparative factors of

the therapeutic group¹ approach to treatment; (c) to proffer criteria and models for special suicide-related groups; and (d) to explore age-specific variations in suicidal behavior and the corresponding therapeutic strategies for these populations.

DYNAMICS OF SUICIDE

Society and Suicide

In Western cultures, a high rate of suicide has historically been viewed as being detrimental to the interests of a society, and cultures have staunchly sought to prevent suicidal behavior through the initiation of negative social sanctions. Deterrents to suicide have included mutilation of the body, confiscation of the estate of the deceased, public disgrace, denial of a Christian burial, and excommunication or imprisonment for those who survived the suicide attempt. Societies have justified their efforts to discourage suicide through many mechanisms. Historically, suicide has been sanctioned on religious (killing oneself is a sin) or civil (defaulting on one's obligation to the state) grounds. In more recent times, medical grounds are used to justify suicide interventions. People who are suicidal may be judged to be

¹The term "therapeutic group" will be used to denote any group approach (e.g., group therapy, group counseling) that incorporates "therapeutic factors" in the treatment process.

temporarily insane, and because they are a danger to themselves, society has a moral obligation to interfere with their decision to die (Siegal, 1988).

Suicide mortality statistics can be used as a way to assess the propitiousness and quality of a culture. Durkheim (1951) proposed that societal pressures and influences are the major determinants of suicidal behavior among its people, and suicide rates are related to the extent of social integration and to the degree of regulation within the social system of the culture. Suicidal behavior can arise from (a) social alienation or lack of identification with a group that promotes common values and traditions; (b) intense social integration and extreme identification with social institutions of the society; (c) a perceived or real collapse in the norms and moral rules of the society; and (d) inflexible social constraints which can thwart the development of individual goals.

Many studies indicate that the psychosocial factors of the society and the family constellation greatly contribute to the risk of suicidal behavior (Capuzzi & Gross, 1988). Hendin (1988) asserts that children learn characteristics of a culture that predispose them to adopt certain modes of coping with distressing situations. His research revealed that the lives of young people who had attempted suicide had been permeated with abandonment, annihilation, depression and distress, and these motivating forces of death were

intrinsically intertwined in their relationships with their parents. For example, when a nation becomes preoccupied with destructive behaviors or conditions for living that are designed to kill life, not sustain it (e.g., tension, rage, emotional alienation, blocked communication, rejection, devaluation of children and the family), the children of that society strive to escape from the internal and external anger, and avoid the pain and turmoil by further numbing and isolating themselves. In a society that foments the emotional death of its individual members, the act of suicide and suicide ideation can become a viable way of coping with life situations.

Gernbacher (1985) maintains that certain types of societies (organized structures consisting of three or more interacting individuals) can propagate suicidal tendencies among their constituents. These "suicide societies" focus on the attainment of perfectionistic, inexplicable and unachievable idealistic goals. The unconscious or covert aim of these societies is the termination of their own existence. These egocentric, narcissistic societies demand that their members (a) unconditionally embrace the system and its dogma; (b) compulsively seek to consummate the irrational objectives of the society; and (c) refute and revile all other societies. The perpetual and futile struggle to fulfill unattainable ideals creates an aura of shame, humiliation, and despair in the populace, and these reactions generalize into attitudes

of self-hatred, vindictiveness, and hopelessness. The probability of suicide increases as the "suicide society" becomes more cohesive and comprehensive in its lethal mission.

According to Gernbacher (1985), there are three distinct types of "suicide societies": Antipathic, Synpathic and Apathic. These societies doggedly pursue dissimilar aspirations, but use fairly uniform methods of oppressing their population into obedience and compliance. "Suicidal societies" strive to obtain unequivocal dominance over their populations through (a) the indoctrination and education of youth; (b) a system that rewards conformity and punishes uniqueness; (c) the assignment of rigid social roles; (d) the development of folklore that promotes the tenets of the society; (e) the formation of subgroups that reflect determined doctrines; and (f) the maintenance of leaders who project the image advocated by the society.

1. Antipathic society. The Antipathic society tenaciously glorifies absolute power. The energy and resources of this society are directed toward economic, political and military control, and these competitive aims are achieved through exploitation, intimidation and conflict.

2. Synpathic society. The synpathic society is obsessed with innocence. This society seeks to gain immortality through infinite love, altruism, and benignity. Since the achievement of these lofty, unrealistic ideals always loom somewhere in the distant future, the goals are never really

actualized, nor are they put into everyday practice. Blind faith of the possibility of their occurrence maintains the irrational mission of this culture. Ironically, to survive, the Synpathic society often forms a hypocritical symbiotic alliance with a Antipathic society.

3. Apathic society. The Apathic society deifies absolute transcendence and the acquisition of abstract intellectual, aesthetic, scientific, philosophic, and esoteric goals. This society scorns mundane pursuits, yet usually exploits the more worldly social systems to survive. This high premium on detachment eventually leads to depersonalization of societal members, the denial of self, and the obliteration of the individual.

Theories that focus on societal determinants of suicidal behavior often fail to account for individual circumstances, personal motivations, and possible explanations as to why some members of a society attempt and/or commit suicide, and some do not. Gernbacher (1985) states that ultimately, it is the person's own unconscious beliefs that evoke the susceptibility toward social suicidogenic factors, and it is his or her own personal suicidal motivations which actuate suicidal impulses.

Individual Factors Related to Suicidal Behavior

The identification of a propensity toward suicidal behaviors is a complex and difficult task. There has been a vast amount of research directed toward the substantiation of common denominators that cause suicidal behavior, but these

investigations have failed to establish any outstanding characteristics manifested by all people who attempt or complete suicide. Depression is the most prevalent commonality among people who attempt suicide (Mintz, 1988), yet the relationship between depression and suicide is a complex one. A multitude of studies have concluded that there is a genetic component in depressive disorders, but studies which have attempted to link suicide attempts and completions with genetic factors have been inconclusive, and have not successfully separated suicide risk from risk for depression (Rainer, 1988). Frederick and Resnik (1988) state

There is no evidence that such complex behavior as one's own self-destruction resides in the genes. Behavior is motivated and it is learned, although structure, unconscious conflicts, and neurobiochemistry do affect the way in which it is learned, felt, and expressed (p. 21).

The attempt to link suicide and depression is further complicated by the fact that numerous people attempt and commit suicide without manifesting any symptom of depression.

Researchers have agreed on a number of interactional factors that are correlated with suicidality (Capuzzi & Gross, 1989; Gilliland & James, 1988). Suicide is considered to be a process, and suicide attempts and completions are the climax of this process (Bogdaniak & Coronado, 1987). A comprehensive approach that incorporates psychological, behavioral, social and situational factors, and examines the interaction among these factors, enables professionals to comprehend the common

clues and patterns associated with suicidality, and facilitates the estimation of the risk for suicide.

Suicide is rarely precipitated by a single factor. (Please refer to TABLE I, page 11.) Depression is the major warning signal of suicidal behavior, and vulnerability increases when both depression and impulsiveness are present (Capuzzi & Gross, 1989; Garfinkel, et al., 1988). There are also significant correlations between feelings of hopelessness, depression and suicidal behavior (Asarnow, Carlson & Guthrie, 1987; Beck, et al., 1990). The emotional and behavioral features of depression (e.g., sadness, low self-esteem, feelings of helplessness, lack of control over situations and self, despair, self-degradation) can affect the way depressed people view the world. These feelings and beliefs can produce a frame of reference that can generate certain dysfunctional and debilitating coping mechanisms (e.g., withdrawal and isolation, anhedonia, low tolerance for frustration, dependent behaviors, inept problem solving and communication skills, cognitive rigidity, anxiety). Depressive behaviors can (a) reduce the ability to develop solutions to troublesome situations, and amplify feelings of hopelessness; and (b) elicit negative reactions and rejection from other people, and further diminish weakened emotional bonds.

Inadequate coping skills decrease the chance that people,

TABLE I
ASSESSMENT OF SUICIDAL RISK

Research (Capuzzi & Gross, 1989; Garfinkel et al., 1988; Gutstein & Rudd, 1988; Henry, 1989; Morgan, 1981) identifies the following crucial variables that can denote potential suicidal behavior:

- . Depression
- . Psychological Pain
- . Difficulty with interpersonal relationships
- . Inability to adjust and cope
- . Cognitive constriction (rigidity in thinking)
- . Low self-esteem
- . Social isolation
- . Anxiety and distress
- . Hostility and rage
- . Poor communication skills.

Certain precipitating behaviors, events and life circumstances, increase the probability that suicide-prone individuals will actively initiate the climax of the suicide process. Previous attempts at suicide are one of the best predictors for determining suicidal risk (Garfinkel, et al., 1988). Another major clue to the probability of overt suicidal behavior is the severity of depression manifested by the client (Hatton, Valente & Rink, 1977b). Counselors, who are assessing the possibility of suicidal risk in a client should investigate the following conditions:

- . The seriousness of the crisis
- . The client's coping strategies and current ability to problem solve
- . Any prior history of suicide ideation
- . The client's direct statements or indirect hints of intent to die
- . The client's present affective or mental status
- . The client's social resources
- . The client's personal resources
- . The specificity of suicide plan

In addition, studies (Bogdaniak & Coronado, 1987; Capuzzi & Gross, 1989; Garfinkel, et al., 1988; Gutstein & Rudd, 1988; Hatton, Valente & Rink, 1977b) reveal that the following factors are indicative of the future dangerousness of suicidal risk in clients:

- . Excessive use of alcohol and/or drug dependency
- . Poor impulse control
- . History of acting out behaviors
- . Prolonged depression
- . Dramatic personality changes
- . Acts of making final arrangements
- . Family conflicts and stressors
- . Sudden mood reversal
- . Intense desire to die
- . Tendency for suicide attempts to increase on days significant to client
- . Family history of suicide

who are depressed, will experience positive events and receive environmental reinforcers, and increase the probability of aversive reinforcement. Alienation and negative experiences help to maintain the nullifying emotions and concepts. The devastating effects that episodes of depression have on the life circumstances of people who are depressed can lead to lasting maladaptive compromises in personal adjustment, and these perverse accommodations, which increase with successive episodes, intensify the risk of suicide. Losses (e.g., divorce, familiar roles, death, emotional ties) compound this risk (Garfinkel, et al., 1988). The incessant accumulation of debilitating life experiences and the individual perceptions of these experiences are critical factors leading to the possibility of suicidal behavior. Moreover, persons who are prone to suicide frequently have difficulty expressing their thoughts, feelings and needs, and are consequently, unable to discuss and resolve issues that surround disappointments and losses (Capuzzi & Gross, 1989).

This inability to assertively and effectively communicate with others can lead to feelings of internalized anger and resentment, and individuals may seek to alleviate this inwardly directed rage through self-destructive behaviors. People who are at risk for suicide need the opportunity to express their internalized rage in a supportive environment that promotes communication, acceptance, and appropriate and constructive methods of coping with persistent noxious events.

Group therapy is recommended as a logical treatment modality for persons who are depressed and/or suicidal. This method of intervention addresses the human need to be part of a unifying and connecting relationship, decreases feelings of loneliness and isolation, and provides a powerful catalyst that facilitates the courage and motivation necessary for adopting and practicing more effective strategies for coping with life situations.

BENEFITS OF THERAPEUTIC GROUPS

The goal of belonging is fundamental to human nature, and other people or society constitute the prime focus of the individual. People define themselves by their perception of how significant others respond to their behavior and through comparisons of how their performance compares with the accomplishments of other people (Adler, 1954). The need for interpersonal communion is so strong that most people will shape their behavior so they can attain the necessary acknowledgement, nurturance and approval of significant others. As children, they tend to stress the parts of themselves that are accepted by their external environment, and negate personality components that are ignored or castigated by other people. Eventually, they form a self-concept that is based on the perceived appraisals of significant others, and develop mannerisms and behaviors that reflect this cognitive organization of how they understand the

world and their relationship to it (Mullahy, 1980). Thus, through human interactions, people establish their own unique conception of the nature and the meaning of living, the possibilities and dangers of their existence, an assessment of their own assets and liabilities, and determinations about their future prospects in life. Throughout their existence, unless powerful interventions cause their convictions to change, they will consistently seek to maintain behaviors that will validate this pseudo self-image (Adler, 1954).

According to Yalom (1985), these interpersonal distortions are reconstructed primarily through the processes of consensual validation² (comparing interpersonal evaluations with the reactions of others) and the corrective emotional experience³ (a critical point in therapy or counseling during which there is an emotional response to an event, a testing of reality, and a subsequent reflection and understanding of the implications of the experience). Yalom (1985) defines the therapeutic process as "an adaptive modification of interpersonal relationships" (p. 25), and maintains that the group experience provides the most powerful medium for the

²The term, consensual validation, was introduced by Harry Stack Sullivan and refers to the continuous comparison of thoughts and feelings among groups members that facilitate modification and correction of interpersonal distortions.

³The phrase, corrective emotional experience, originated with Franz Alexander, denotes the resurrection of a previously repressed or denied traumatic emotional situation.

achievement of self-understanding and positive personal growth.

...the group setting offers far more opportunities for the generation of correctional emotional experiences; in the individual setting, the corrective emotional experience, valuable as it is, may be hard to come by because of the insularity and unreality of the patient-therapist relationship (Yalom, 1985, p. 26).

The therapeutic group provides a social microcosm that presents a vast assortment of real life situations which can inspire change-oriented tension in group members. For example, participants can experience feelings of rivalry and competition, disagree over beliefs, and struggle for dominance and control of group interactions. These tensions are precursors to change, but first must be transformed into a corrective emotional experience. Two conditions are necessary for this conversion: (a) members must perceive the group as a safe and supportive environment so "differences can emerge"; and (b) there must be a flow of honest feedback that "permits effective reality testing" (Yalom, 1985, p. 26)

Yalom (1985) proposes that therapeutic change in individuals is an extensive and complex process, and transpires through a complicated network of interrelated variables that he calls "therapeutic factors". The group process inspires, generates, motivates and actuates these "therapeutic factors" or human experiences; thus, the group members are the agent of change. Conversely, in individual therapy, the agent of change is the relationship between the

therapist and the client, and the success of therapy is dependent on this more limited interaction. The following are some of the "therapeutic factors" that Yalom (1985) offers to describe the benefits of group therapy:

1. Instillation of hope. The introduction and maintenance of hope is a necessary condition for successful therapy. Group therapy members are continuously exposed to other members who (a) have similar problems, (b) have improved during group, (c) have learned to effectively cope with their problems, and (d) have experienced a positive outcome from the group encounter.

2. Universality. Many people who are in distress believe that they are unique in their pain, and fear their problems, impulses, and fantasies will be abhorrent and unacceptable to others. This sense of uniqueness promotes social isolation, and feelings of alienation. Members of a therapeutic group experience a powerful sense of relief when they come to understand that others have similar problems, urges, feelings and concerns. Group members report that the disclosure process of the counseling group enables them to feel more in touch with their environment, and re-establishes a sense of connectedness with other human beings.

3. Imparting information. Although, at the conclusion of a gainful group involvement, participants will have amassed a wealth of information about cognitive, emotional and behavioral functioning, implications of symptoms,

interpersonal and group dynamics, and the process of therapy, generally, group leaders do not use a didactic approach to impart information, and new knowledge is absorbed implicitly through the group interaction.

4. Altruism. Group members benefit from the group process of receiving and intrinsically giving love, support, reassurance, insight and feedback to each other. People who are distressed are often self-absorbed, demoralized, and believe that their contributions are valueless to others. The realization that they can be important to other people enhances their self-esteem, and they discover that, as they attempt to heal others, they also become healed. An additional advantage of this reciprocal sharing process of groups is that members are exposed to a variety of sources for feedback and support. Furthermore, people in therapeutic situations may distrust the observations of a paid professional, and group members are often more inclined to regard the feedback from other participants as spontaneous and truthful. Thus, acceptance and understanding from other group members may have greater influence toward positive change than does empathy from the group leader.

5. The corrective recapitulation of the primary family group. Group counseling members share a common history of dissatisfactory experiences in their primary group, the family of origin. The group format resembles a family in many ways, and offers the opportunity for early familial growth-

inhibiting conflicts to be relived and resolved. Through the group process, old roles can be explored and challenged, and members can be encouraged to test, adopt, and generalize new and effective ways of behaving.

6. Development of socializing techniques. Social learning or the development of basic social skills is a fundamental feature of therapeutic groups. When group leaders encourage honest disclosure and candid reactions among group members, participants may be presented with their first opportunity to receive accurate interpersonal feedback about aspects of their social behaviors. The group process facilitates the acquisition of more effective social skills, and group members learn constructive ways of responding to others, become less judgmental, learn appropriate methods of conflict resolution, and become more capable of expressing and receiving empathy.

7. Imitative behavior. Imitation or modeling is a strong therapeutic force, and groups furnish a diverse arrangement of modeling sources. Members may use the group leader as a prototype, choose a group member, or combine certain attributes of several people to formulate a desired way to behave. Group members can also profit from observing the therapy of another client who has a similar problem, and vicariously gain insight from this interaction.

8. Interpersonal learning. A spontaneous, interacting group will eventually evolve into a dynamic social microcosm

where individual group members will reveal their maladaptive patterns of behavior, and other participants will collectively evaluate and react to those behaviors. Each member simultaneously creates and responds to this social interaction. Interpersonal learning occurs when group members (a) receive accurate feedback; (b) gain insight into how their behavior impacts themselves and others; (c) accept personal responsibility for their behavior; (d) become motivated toward change; (e) risk new ways of behaving; (f) experience success in new behaviors (new accepting responses from group members and good feelings about self); and (g) generalize new behaviors to situations outside the group.

9. Group cohesiveness. Cohesiveness is the sense of identification and attractiveness people feel toward the group and the leader and its members. The extent of affinity among participants can fluctuate overtime, and is considered to be a necessary condition for therapy. The intensity of cohesiveness experienced by group members contributes to their degree of acceptance of group values, and this level of acquiescence is positively correlated with the extent of respect members attribute to the consensual evaluation of the group. Highly cohesive groups generate mutually satisfying relationships among members, and create favorable conditions for positive change. In addition, these groups are able to work through conflict, and achieve a constructive benefit from uncomfortable interpersonal learning experiences. Cohesive

groups promote self-disclosure, better group attendance, intermember trust, appropriate risk taking behaviors, and intimate interpersonal exchanges.

RATIONALE FOR THESIS

Although the group method has been extensively used to treat a wide variety of mental health concerns, the traditional treatment for suicidal clients has been the individual therapy model (Hipple, 1982). Despite the numerous indications of the positive benefits of the group therapy approach for support and treatment of suicidal populations (Motto, 1979), counselors and therapists have been advised not to select clients who are severely depressed or suicidal for group therapy (Frey, Motto & Ritholz, 1983). Almost twenty years ago, Billings, et al., (1974) speculated that the scarcity of group therapy programs for individuals at risk for suicide might reflect on both the recency of the suicide prevention movement and ignorance about the procedure and process of establishing suicide-related treatment groups. Yet, in 1991, there seems to be a persistent resistance toward using this mode of treatment for issues related to suicide. Stefanowski-Harding (1990) limits her discussion on therapeutic treatment modalities with children who are suicidal to (a) family therapy, which addresses the dynamics and interactions within the family; (b) individual therapy, which focuses on the child's "unique psychopathology", the

child's understanding of family dynamics, and learning to determine and accept what he or she can or cannot change; and (c) some combination of both types of therapy. Henry (1987), in a paper written to provide mental health professionals with assistance in assessment and interventions for adolescents who are at high risk for suicide, recommends individual counseling for interpersonal deficiencies and family therapy for family deficiencies. Vidal (1989) cautions that counselors should avoid forming "suicide groups".

The obvious connotation of such groups is that its members constantly discuss suicide. The counseling approach may fuel the feeling that suicide is an acceptable alternative to solving problems (Vidal, 1989, p. 29).⁴

This reluctance to use the group model for suicidal clients has been attributed to (a) administrative resistance (Frey, et al, 1983; Robertson & Mathews, 1989); (b) concerns about professional competency when working with suicidal clients; and (c) fear of legal liability in case of a suicide (Hackel & Asimos, 1981; Motto, 1979; Robertson & Mathews, 1989). In addition, Kaplan and Sadock (1972) suggest that therapists may have a tendency to avoid working with certain types of groups because some of the themes typically dealt

⁴Billings, et al. (1974) state that, with few exceptions, the issue of suicide is inconsequential to the suicide-related group therapy process. "In this setting, there is nothing remarkable or unique about a suicide attempt except as an area of common experience" (p. 167). The concerns discussed in suicide-related groups are similar to those introduced in other types of groups, and members generally focus on loneliness, interpersonal relationship difficulties, fear of rejection, and other problem that are common to all people.

with in the group, such as death and dying, can evoke anxiety reactions in the therapist, and Sudak, Ford, and Rushforth (1988) further assert that the anxieties experienced by therapists who lead groups for suicidal individuals preclude the usefulness of this approach as an exclusive method of treating this population.

During the 1970s, a movement began toward using the group therapy approach as a remedial intervention for persons who were depressed and at high risk for suicide (Asimos, 1979). The need for efficacious programs for these populations had become increasingly urgent since the passage of the Community Mental Health Act of 1963 which (a) severely limited their access to specialized hospital care; and (b) mandated the initiation of community treatment approaches. The group method was advocated for several reasons. First, people who are suicidal often have an compelling need to be a part of a amalgamated, accepting social support system, and groups provide a sense of connectedness which can reduce the feelings of loneliness and alienation that are commonly manifested by people who are depressed and/or suicidal. Second, some people who are suicidal resist treatment because they fear society will stigmatize them (e.g., label crazy, insane) when they seek therapy. The group approach can minimize their apprehensions and maximize their proclivity toward treatment. Third, the group setting promotes corrective change through powerful forces, such as disclosure, feedback and modeling.

Fourth, the group interaction promotes the perception of the therapist as more human and accessible, and facilitates the processes of identification and transference. And finally, the group method is efficient and can treat greater numbers of persons who are at risk for suicide (Hackel & Asimos, 1981).

Although the effectiveness of the group treatment modality has been widely documented (Hipple, 1982; Robertson & Mathews, 1989), most of the papers written have been descriptive, impressionistic reports and lack the controlled clinical trials necessary to impartially assess the therapeutic effect of group work with suicidal clients (Frey, et al., 1983). The literature has also seriously neglected research reports that describe how to use the group treatment format as a primary intervention method for suicide (Hipple, 1982). The infrequent reports of controlled studies that have investigated the effectiveness of group work for suicidal clients indicate that this treatment modality is a potent intervention for persons at risk for suicide.

An epidemiologic study by Billings, et al. (1974) compared various treatment modalities (individual therapy, traditional group therapy, day treatment centers, inpatient therapy, no treatment), and found that the special suicide group was the most effective intervention for the reduction of mortality rates in suicidal persons. Frey, et al. (1983) in a study designed to further clarify the causal relationship

between treatment and outcome, researched the influence of a special group therapy program for persons at high risk for suicide, and also reported a significant reduction in rates of mortality among therapy group members when compared to outpatient services or no treatment at all. Patsiokas and Clum (1985) measured the effectiveness of three modes of intervention for suicidal persons: (a) a problem-solving focused group, (b) a cognitive-restructuring focused group, and (c) a nondirective control group that consisted of ten individual unstructured therapeutic sessions. Their research revealed that, from pre-to-post-treatment, suicide ideation scores were not lowered in the control group, dropped 43% in the cognitive-restructuring group, and were reduced by 60% in the problem-solving group. Suicide intent was reduced in all three treatment plans, and the study indicated that the problem-solving therapy had "a powerful effect on hopelessness" (p. 289). The authors speculated that as individuals learn and adopt effective problem-solving skills, they become more optimistic about the prospect of the future.

Therapists, who use the group therapy model as their primary treatment program for suicidal clients, are positive in their assessment of the efficacy of this approach (Asimos, 1979; Comstock & McDermott, 1975; Frey, et al., 1983; Hipple, 1982; Motto, 1979; Robertson & Mathews, 1989). Reports repeatedly mention the special therapeutic factors of suicide groups, such as the social support network of the group

treatment and its reparative impact for persons who are experiencing feelings of hopelessness, helplessness and isolation (Asimos, 1979). Comstock and McDermott (1975) further state that

Group therapy offers appropriate means for dealing with many problems commonly found among suicidal patients, including poor impulse control, lack of future orientation, feelings of sadness and low self-esteem, inability to recognize areas of competence, and failure to accept personal responsibility (p. 44).

The protective atmosphere of the group provides a unique environment where members can (a) satisfy their need to belong, to be accepted and to give and receive love; (b) become more socially integrated as offers of support, understanding and hope are exchanged among group members; (c) disclose information about themselves and receive feedback from other group members; (d) improve communication and coping skills; (e) learn problem-solving techniques; (f) recognize and practice positive thought patterns; and (g) come to understand that their concerns are not unique, and they are not alone (Hipple, 1982; Robertson & Mathews, 1989). In addition, the group experience offers an unparalleled social resource for corrective influence (Dinkmeyer, 1975). Suicide intervention groups can (a) promote a focus on practical issues of the problems of daily living; (b) eliminate the customary resistance to treatment programs (Robertson & Mathews, 1989); (c) give group members an opportunity to express emotions and to vicariously experience the feelings

of other group members (Goldman, 1986); (d) provide a here and now experience that allows group members to observe each others' attitudes and behaviors (Dinkmeyer, 1975); and (e) be informational, educational, and motivate members to attempt new, action-oriented coping strategies (Poey, 1985).

The literature demonstrates that, when people who are at risk for suicide, are given the opportunity to openly discuss and explore the possibility of suicide, they experience feelings of relief and reduction in suicide ideation (Capuzzi & Gross, 1989). Because the group experience provides many positive experiences to the suicidal client, Hipple (1983) suggests that therapists for suicidal clients seriously consider this modality as an option for treatment.

CHAPTER II

SUICIDE INTERVENTION GROUPS

The primary concern of any therapeutic venture with suicidal and depressed persons is the preservation of life (Billings, et al., 1974, p. 161).

GUIDELINES FOR GROUP LEADERS

Counselor Characteristics

Potential counselors, for groups that focus on issues related to suicide, should be grounded in the basic theories of group counseling, be thoroughly trained in the fundamental principles of group dynamics, and be knowledgeable about group processes and procedures. It is also essential that prospective counselors have received extensive training in the fundamentals of working with persons who are suicidal and/or depressed, and can recognize the signs and symptoms of the pre-suicidal syndrome (Hipple, 1982; Robertson & Mathews, 1989). Basic therapist qualities should include: (a) emotional maturity; (b) an high level of self-awareness; (c) accurate listening and responding skills; (d) poise; (e) nonjudgemental demeanor; (f) a stable self-concept; and (g) the ability to analyze and accurately diagnose potential problems. In addition, the following recommendations are provided for group leaders of suicide intervention groups:

1. Counselors are knowledgeable about the ethical and professional issues specific to working with suicide-related groups, recognize their own individual moral beliefs, and comprehend how these values can relate to the issues of autonomy and responsibility (Clements, Sider & Perlmutter, 1983).

2. Counselors have experienced personal therapy, and have explored and appreciate any personal issues, biases or unfinished business that might limit their ability to optimally function as a group leader (e.g., the belief that persons who are depressed are immature and demanding will likely preclude the development of a therapeutical relationship, and will probably obstruct the psychological growth of the group members).

3. Counselors maintain a current knowledge of recent research in the disciplines of group work and suicidality.

4. Counselors are licensed and covered by professional liability insurance.

5. Counselors obtain personal group experience by participating, as a group member, in a self-exploration or therapeutic group.

6. Counselors possess the ability to effectively co-facilitate a group. Working with suicidal clients can be emotionally and physically exhausting, and professionals who lead special suicide groups suggest that the group should be led by two professional counselors (Billings, et al., 1974;

Hipple, 1982). Ideally, three therapists should be assigned to the group to ensure that at least two co-facilitators are present at each group session. The use of multiple therapists can provide a reciprocal support system for group leaders and an opportunity to debrief and receive feedback from other professionals. In addition, the use of co-therapists can (a) promote a greater potential for group continuity, (b) provide additional feedback perspectives, (c) maximize the benefits of emotional support and insight, and (d) allow members to emulate the behaviors of more than one role model.

7. Counselors should be confident in their ability to correctly diagnose an individual's degree of lethality, and must be willing to make an instantaneous, decisive intervention (e.g., involuntary hospitalization).

8. During emotional crises, suicidal clients can become extremely needy and demanding, and counselors should have a high tolerance for dependent behavior. If therapists experience increased anxiety when clients exhibit dependency needs, they may have a tendency to withdraw, and individuals who are suicidal may perceive this maneuver as another form of rejection and abandonment. In addition, because a suicide crisis can occur at anytime, it is advantageous if counselors can be prepared to maintain flexible schedules so they can be present in times of crisis (Gilliland & James, 1988; Hipple, 1982; Klein, 1985; Motto, 1979; Robertson & Mathews, 1989).

Role and Function of the Counselor

Suicide intervention group members need a particularly safe milieu to talk about their feelings, concerns, thoughts and behaviors, and suicide-related groups must provide participants with an environment of unconditional acceptance and complete support. Hipple (1982) and Billings, et al. (1974) suggest that, in order to create a non-threatening atmosphere for the group, facilitators should introduce as few formal expectations to the group as possible, and avoid making premature demands and setting unrealistic goals. These actions will significantly increase the possibility of failure in group members, and reinforce their feelings of inadequacy and low self-esteem. Clients may also encounter feelings of guilt if they sense that they are not recovering fast enough, and may develop more intense feelings of hopelessness, helplessness and futility. These groups primarily deal with issues of life and death, and it is recommended that group leaders sensitively facilitate the group in an active, directive, and gentle confrontive style. Therefore, it is important that therapists are comfortable in energetically managing the process of the group. In addition, when a client experiences a crisis, it is imperative that (a) the condition is immediately discussed, (b) problem-solving techniques are quickly implemented, and (c) alternate behaviors are promptly rehearsed and adopted (Hipple, 1982).

SHORT-TERM GROUP THERAPY MODEL

The group therapy approach, as an intervention for suicidal clients, is generally initiated as a short-term method of treatment (Hipple, 1982). This model of group therapy typically ranges from 6 to 60 sessions, rarely uses psychodynamic exploration, and customarily focuses on a specific theme or treatment modality (Poey, 1985). Short-term therapy is considered to be an effective intervention during and after the crisis phase of suicidal behavior. Frey, et al. (1983) found that the strongest beneficial changes occur within the first five group sessions, and suggest that the early treatment programs are crucial in the prevention of additional suicidal behaviors. They further propose that "...the special suicide group appears to support the natural and oftentimes slow healing that occurs after a suicide crisis" (p. 291).

Throughout this acute crisis period, people may be out of control, disoriented, and unable to make appropriate choices. They may experience frequent suicidal thoughts and manifest overt suicidal behaviors. These clients may have a limited capacity to tolerate anxiety and may not have the resources that are necessary for doing psychological group work. The support-oriented short-term group that focuses predominately on symptomatic relief, social interaction (e.g., support, imparting information, interpersonal learning), the understanding of precipitating events, and the development and

implementation of adaptive coping strategies, more effectively meets the needs of clients experiencing suicidal impulses (Hipple, 1982).

Short-Term vs Long-Term Therapy

The purpose of short-term group therapy is to meaningfully identify core conflicts and begin the process of examining personal implications of those issues. It is not designed to extensively explore deep-seated emotional conflicts, or to achieve a lasting structural change in personality (Klein, 1985). Comstock and McDermott (1975) advocate a two-step approach for group intervention with suicidal clients. First, the short-term therapy crisis intervention is needed to confront the suicidal behaviors, and to facilitate exploration of dysfunctional emotions and actions. Second, since the crisis interventions of short-term therapy may have a limited effect on people who are prone to suicide, the additional strategies of long-term psychotherapy are necessary to alter the self-destructive tendencies that are the result of ongoing, submerged psychological problems. Conversely, Billings, et al. (1974) found it unnecessary to separate the group process into stages of long-term and short-term approaches to therapy. In their experience, members of long-term groups (6 to 30 months) tend to become active participants in working with newer members, and a complimentary therapeutic system transpires from this experience. As members become committed to the group, they

assume more self-responsibility and begin to be energetically involved in their own therapy and in the recovery process of other members. The new group members begin to perceive the veteran members as effective role models, respect the feedback which is offered by seasoned group participants, and become more hopeful about their capability to change and grow. During this reciprocal exchange, the experienced members become less self-centered, more constructively involved with others, and thus, increase their feelings of self-identity and self-worth.

Suicide as a crisis. Suicide can be defined as a crisis situation, and suicidal behaviors are then considered to be manifestations of that crisis (Hatton, Valente & Rink, 1977a). Crisis is a state in which intolerable barriers obstruct life goals, and aspirations are perceived as no longer attainable. These obstacles, which exceed the resources and coping mechanisms of the person, can arise from both developmental and situational events, and unresolved crises can result in chronic and long-term dysfunctional modes of behavior. Often the original crisis and its accompanying discomfort will disappear, and the person may feel the crisis has been resolved. In some cases, memory of the crisis may be repressed from awareness, and during times of stress, may resurface in self-destructive behaviors, such as attempts at suicide. Clients may seek help during a suicidal crisis, and seem to achieve a sense of equilibrium during the counseling

sessions, but unless the original crisis is resolved, the primordial trauma will often emerge the moment new stressors are presented, and the client will again manifest extreme anxiety, agitation and/or pathology (Gilliland & James, 1988).

As clients move out of the crisis period, their issues will change, and they will need to explore deeper levels of emotions and underlying personality disturbances. Group leaders can either gradually make the transition toward the processes of long-term therapy (e.g., examination of unconscious material, incorporation of anxiety-provoking interactions, exploration of negative effect, nondirectional leadership), or they can refer clients to appropriate treatment programs (Hipple, 1982). The methods and practices of long-term therapy are beyond the scope of this thesis, and the focus will be on the procedures and processes of short-term therapy.

Structure of Short-Term Therapy

Treatment groups use both the traditional group format of a closed group and the nontraditional format of an "open-ended" or "drop-in" group (Motto, 1979). The closed group model does not allow new members to join the group after the formation of the original group. Closed groups are considered to be preferable for the use of insight-oriented therapy groups because they promote a stable and consistent environment that encourages the disclosure process and feelings of solidarity among group members. The open group

format allows new members to join the group at anytime, and often gives participants the option of choosing when and how often they will attend group sessions (Motto, 1979).

The open group format is preferred by many professionals for the crisis-oriented short-term therapy process (Asimos, 1979; Billings, et al., 1974; Comstock & McDermott, 1975; Hipple, 1982; Motto, 1979; Robertson & Mathews, 1989). The acute phase of suicidal behavior is generally short in duration, and during this interval, the more intense therapeutic processes of exploration that are indicative of the closed group process may increase the clients' feelings of anxiety and depression (Asimos, 1979; Hipple, 1982). The open model also ensures that any person who is experiencing suicidal impulses will have the opportunity to immediately join a group and benefit from the processes of group therapy. Asimos (1979) declares that clients will feel less threatened if there is a

...de-emphasis on contractual agreements and imposed expectations regarding attendance and participation in suicide intervention groups. Rather, group members are told to come when they want to, and need to, and there are no guilt feelings if they miss a meeting because they have broken no contract (p. 110).

She further asserts that the open group format offers a benign environment of unconditional acceptance in which members learn they are worthy of love, and thus, gradually come to understand that they can safely share their negative thoughts and emotions without loss of self-esteem or fear of rejection.

Selection of Group Members

The recruitment and selection of members for a suicide intervention group can be a formidable and complicated process. Hipple (1982) advises that

A common myth about starting such a group is that not enough appropriate clients are available at any given time to warrant the beginning a such a special group. It is my contention that many agencies are not aware of how many clients who might profit from such a group experience are on the case role at any given time (p. 247).

He suggests that if the group has an open, continuous format, the group can be initiated with as few as two or three members. Clients can then be progressively enrolled and terminated throughout the existence of the group.

One of the first issues that counselors face when forming a group is the selection of a heterogeneous or homogeneous group composition. The heterogeneous group is composed of people who do not share a specific symptom or circumstance. Group members are dissimilar in their problems, ages, gender, personality traits, strengths, limitations, and/or socioeconomic backgrounds. The literature suggests that the heterogeneous group promotes self-disclosure and has a greater potential to influence personality change and behavior modification (Klein, 1985). Conversely, the homogeneous group has a membership that shares a common condition, and the focus of the group is directed toward the alleviation of that condition. Homogeneous groups tend to be more didactic, and members are prone to superficially interact and self-disclose.

However, in groups with a common focus, the members are more apt to (a) identify with each other, (b) quickly unite and bond to other group members, (c) attend more meetings, and (d) offer more support to other members of the group (Klein, 1985; Yalom, 1985). The rapid development of cohesion among group members enables the group to work efficiently and effectively, and facilitates a prompt reduction of debilitating symptoms common to members of suicide prevention groups.

It is extremely difficult to establish a true homogeneous group composition, and it is recommended that leaders of suicide-related groups remain flexible in their approach toward group composition. Group members will have different histories, unique personalities, special environmental situations, and will demonstrate individual responses to treatment (Frey, et al., 1983; Robertson & Mathews, 1989). Robertson and Mathews (1989) suggest that it is desirable to select members according to gender in adolescent groups because the same-gender group composition accentuates the members' commonality of problems, and facilitates disclosure within the group. Hipple (1982) maintains that, in adult groups, a mixture of genders is ideal, although groups may be composed of more women than men because of the higher incidence of suicide attempts in women.

Other guidelines for group leaders to consider during the screening process (Frey, et al., 1983; Hipple, 1982; Robertson

& Mathews, 1989) include:

1. Potential group members should have a moderate to high rating of lethality. Clients with a low risk for suicidal behavior may be adversely affected by the intense emotions and acting out behaviors of more lethal group members.

2. People who are psychotic or individuals who are prone to violence are generally disruptive to the group process, and are considered to be inappropriate for a suicide intervention group.

3. Persons who are actively involved with alcohol or drugs should be excluded from the group. Suicidal ideation and suicidal behaviors need to be the primary psychological issues for group members.

Group Limitations

During the initial session of the group, the co-leaders discuss the goals and objectives of the group, define the rules of confidentiality, survey the members' expectations toward the group experience, and take care of other "housekeeping" tasks (e.g., meeting time, place, attendance guidelines). In addition, Hipple (1982) describes certain ground rules that are specific to suicide intervention groups. These include:

1. Rule of no secrets. Group members are encouraged to obtain assistance from people outside the group, and all interactions of external support must be shared within the

group.

2. Physical safety rule. Leaders advocate the release of emotions and communication about pernicious behaviors, but prohibit acting those behaviors out in the group. Clients are allowed to be angry during group sessions, but are not authorized to hurt themselves, threaten other group members, or destroy property. As clients learn that they can vent intense emotions without indulging in physical demonstrations, they become more self-confident in their ability to be self-controlled, and will generalize this more appropriate response to external environments.

3. Confidentiality rule. Therapists must inform group members that, when they believe there is a high probability of suicidality in a client, it is their ethical and legal responsibility to ensure the safety of the client through immediate intervention, and to report the possibility of the suicidal behavior to authorities and family members.

4. Record keeping issues. Hipple (1982) recommends that leaders of suicide-related groups keep accurate and complete records because of the legal risk involved in facilitating this type of group. Clients should be informed of any record keeping procedures.

5. Contract. Many therapists of special suicide groups stipulate that a signed formal contract, in which clients agree not to harm themselves, is a precondition for entry into the group. This contract also serves as a powerful

intervention for the reduction of suicidal behaviors.

Goals and Functions of Short-Term Therapy

The primary goal of short-term therapy is the confrontation and prevention of suicidal ideation and destructive behaviors in group members. Leaders (and members) should be actively responsive to the immediate needs and crises of group members, and should encourage the expression of feelings, and the acquisition of different, more functional behaviors (Comstock & McDermott, 1975; Hipple, 1982; Robertson & Mathews, 1989). Subsequent group goals may be:

1. **Reduction of distress.** Clients with a potential for suicidal behavior are often depressed and angry. Didactic techniques can be helpful in initiating the process of insight into the etiology of suicidal and depressive states (Billings, et al., 1974). During the group process, members can be assisted in understanding (a) how rage contributes to depression and suicidal impulses; (b) how painful and debilitating behaviors and emotions, such as depression, withdrawal, self-inflicted punishment, repressed rage, anxiety and feelings of guilt are developed and incorporated into the individual's behavioral repertoire; and (c) the long range effects of these maladaptive ways of coping on the individual's quality of life. The conscious awareness of these growth-nullifying behaviors and their pernicious consequences can be an important movement toward the reduction of symptoms, and the ensuring corrective management of these

negative ways of responding to environmental stressors. The alleviation of rage can also be a step toward the remission of self-defeating symptoms and group leaders should support and assist clients in therapeutic catharsis (i.e., the expression of their intense emotions and feelings of rage). Furthermore, counselors should encourage clients to realistically identify the source of their anger. This insight can help thwart the internalization of the rage process which often precipitates suicidal behaviors (Comstock & McDermott, 1975; Klein, 1985). However, Billings, et al. (1974) offer some cautions regarding the usage of therapeutic catharsis. Unless certain necessary and ideal conditions are present in the group, the ventilation of passionate feelings may inefficaciously result in spurious improvement or may produce enduring and injurious repercussions in group members. Thus, a premature release of threatening material may merely enable the client to achieve a transient relief, or more importantly, the ineffectual use of catharsis can be detrimental to the client's sense of self, and consequently, he or she may become too emotionally distraught to assimilate the acceptance, encouragement and reassurance of the group. Internal tension is relieved by the expression of emotional feelings when the group member (a) has a conscious awareness of the angry feelings (group members may deny feelings); (b) is aware of the defense mechanisms that contribute to the suppression of the feelings of rage (group members may fear

rejection, loss of love or self-esteem, and deny self freedom to express emotions); and (c) feels assured that the group provides an honest, caring and supporting environment in which his or her feelings will be respected and accepted, and understands that, while others may object to certain behaviors, they still retain an overall liking for him or her as a person.

2. Encouragement of self-disclosure. Group leaders seek to promote a non-threatening, supportive group environment that enables members to share personal information about themselves. The counselors model appropriate interpersonal communication skills, and guide the group members to reveal experiences and concerns that are occurring in the here-and-now. Personal disclosure facilitates (a) a sense of group cohesion (members feel less isolated and lonely); (b) a milieu of belongingness (members can perceive a commonality in problems and difficulties); (c) feelings of acceptance and empathy toward other group members; (d) social interest and involvement with other individuals (Dinkmeyer, 1975); (e) self-awareness; and (f) feelings of support. Self-disclosure also allows members to absorb, practice and adopt competent interpersonal communication skills (Hipple, 1982).

3. Encouragement of self-responsibility and self-management. Group members are encouraged to become aware of, focus on, and monitor their thoughts and emotions, and then connect these internal processes to their external behaviors.

Insight into the relationship between thoughts, feelings and actions can influence tendencies toward impulsive movement, and can enable clients to control dysfunctional behaviors. New coping methods (e.g., via relaxation training, assertiveness training) can be practiced in the group, and generalized into clients' everyday living situations through the use of homework assignments (Comstock & McDermott, 1975; Hipple, 1982).

4. Enhancement of self-concept. People who are in a suicidal crisis have a tendency to focus on their negative attributes, and fail to realize the positive qualities they possess. During group interactions, these preoccupations with the negative aspects of life are challenged, and emphasis is placed on the positive aspects of group participants. Members are exhorted to discuss their strengths and favorable attributes within the group, and are given homework assignments that emphasize propitious characteristics (Hipple, 1982).

5. Consideration of future goals. People who are at risk for suicide often have a negative expectation about future events, and this pessimistic outlook reduces their ability to visualize alternative ways to cope with painful situations. People who are suicidal need to acquire hope that eventually their problems will be resolved, and realize that relief from distress is a possibility. The act of suicide becomes more appealing when there is no perceived hope for

positive future occurrences, and the resolution to kill oneself is diminished as hope for the future is re-established. Group members are encouraged to acknowledge daily gains (e.g., completion of small, obtainable subgoals, movement toward positive cognitions and emotions), set realistic goals, and develop life-sustaining action plans that have a positive and optimistic orientation toward the future (Hipple & Cimboric, 1979).

6. Development of external support systems. Initially, the group leaders and other members may be the primary sources of support for clients. The group leaders can immediately begin to orient clients toward reaching out, and seeking support from significant others, and thus, reduce members' dependency on the group. Group members are taught how to identify personal needs, and communicate these requirements to significant others. If significant others are not responsive to the needs of the clients, clients are encouraged to learn ways of enlisting the assistance of alternate support systems. Clients can learn by observation and practice to directly communicate their need for assistance, and homework assignments can help clients realize this external support system (Hipple, 1982).

7. Motivation of clients in the pursuit of extended therapy. Suicidal clients often manifest the dysfunctional symptoms of ongoing personality disturbances, and long-term therapeutic interventions are necessary to alter self-

destructive tendencies. As clients become capable and willing to tolerate the heightened anxieties of a more intense therapeutic process, group leaders encourage them to seek and commit to an appropriate extended treatment program (Comstock & McDermott, 1975).

Interventions for Suicide Prevention Groups

Problem-solving techniques. Feelings of hopelessness, helplessness, and deficiencies in interpersonal problem solving skills are highly correlated with suicidal behaviors (Asarnow, et al., 1987; Beck, et al., 1990, Patsiokas & Clum, 1985). People who attempt suicide may perceive their problems as insurmountable and may regard the act of suicide as the only solution to their predicament. This inflexible thinking process is often manifested by suicide-prone individuals, and can negate the ability to recognize the existence of alternate possibilities.

Depression rigidifies their thinking and hinders their ability to envision alternatives or make judgements concerning probable outcomes of different available options. It constricts and narrows their view concerning future possibilities (Siegel, 1988, p. 92).

Through a process of education and practice, group members learn problem solving skills, such as (a) identifying the problem, (b) investigating the facts related to the problem, (c) concentrating on the important aspects of the situation, (d) exploring possible solutions to the problem, and (e) testing these solutions for effectiveness. The study

by Patsiokas and Clum (1985) indicates that when clients, who are prone to suicide, understand and practice appropriate methods of problem-solving, their sense of hopelessness is reduced, and they have a more optimistic visualization of the future. In addition, research has shown that, as people acquire effective behavioral skills, their sense of self-efficacy increases, and their tendency to experience extreme, dysfunctional emotional arousal during periods of distress is diminished (Lawrence & Ureda, 1990).

Cognitive restructuring. Since depression is highly correlated with suicidal impulses (Asarnow, et al., 1987; Garfinkel, et al., 1988), many therapists use cognitive restructuring approaches which are designed to reduce depressed states in suicide-prone clients. These interventions are based on the premise that self-defeating thinking processes are determinants in the manifestation of depression. For example, themes of suicide ideation often involve negative expectancies and attitudes of hopelessness about the future (e.g., internalized belief that there is something intrinsically wrong with self, that one has to have permission to live, that one deserves negative outcomes, that change is impossible) or irrational beliefs about the self, life events, and how the suicide attempt will evoke favorable life changes (e.g., significant others will alter unwanted perceptions or feelings about the client) (Patsiokas & Clum, 1985).

The goal of therapy is a cognitive restructuring of erroneous, invalidating and self-defeating perceptions, and the counselor will provocatively question, gently confront, and challenge the client to relinquish and change the dysfunctional beliefs that underlie these faulty cognitions. During the entire procedure, the leaders make a conscious effort to teach and encourage the client to develop self-generated rational thinking processes (Grieger & Boyd, 1980).

Self-observation. Group members are encouraged to monitor and record overt and covert behaviors, and to reflect on the recorded behaviors (e.g., question motives, accurately identify emotions). Self-observation interventions are effective for two reasons. First, they increase the client's ability to understand and control behaviors, and encourage self-responsible actions. And second, the act of monitoring brings these behaviors into conscious awareness, and thus, can decrease the frequency of the behavior.

Action plans. Suicidal people are often consumed with negative expectations about the future, and commonly focus their thoughts on problems that have occurred in the past. This orientation toward hopelessness makes it difficult for suicidal clients to have positive expectations about their existence in the future. Group members are encouraged to identify and generate solutions to problems and develop action plans that focus on future events. During periods of crisis, these agendas may need to identify day to day activities, and

as the client reestablishes emotional equilibrium, the plan of action can be extended into weeks and then, months (Hipple, 1982).

CONSIDERATION FOR COUNSELORS

There are several areas of potential difficulty that seem to be common to group work with suicidal and depressed populations. These can include (a) counselor anxiety, (b) shared depressed affect in the group setting; and (c) the attempted or completed suicide of a group member.

1. Counselor Anxiety. The role of group therapists for suicide intervention groups demands a more active and directive approach to counseling, and consequently, group leaders become more responsible for the direction of the group process. Hipple and Cimboric (1979) caution that leaders may inadvertently make the subtle transition from being responsible for the treatment of persons who are at risk for suicide to being responsible for the lives of persons who are suicidal. Group leaders must be aware of and actively guard against the possibility of this transformation of personal goals because the feelings of being accountable for the survival of others can generate reactions of extreme anxiety in counselors and damage the therapeutic process. It is recommended that counselors for suicide intervention groups develop resources for formal and informal peer consultation, and use these professional relationships to honestly and

openly address their feelings and emotions, and to discuss treatment objectives and strategies. This approach not only reduces reactions of anxiety before they evolve into feelings of anger, resentment, impotence and inadequacy, it also provides an established professional source of support if a client does commit suicide.

2. Depressed atmosphere. Many people who are suicidal experience feelings of depression. The communication of depressive symptoms (e.g., helplessness, hopelessness, apathy, despair) can be contagious, and the group members may come to project a shared sense of futility that is damaging to the therapeutic process of the group. Leaders must be able to effectively intervene, and interrupt the propensity for negativism in the group (Comstock & McDermott, 1975).

3. Attempted suicide. When group leaders assess that a group member has a high risk for suicide, they must be prepared to make a swift intervention and ensure the safety of the client. Therapists should establish a network of reliable emergency resources that are available during a suicide crisis (e.g., medical, family support system), and research and thoroughly familiarize themselves with the local requirements for involuntary hospitalization (Hipple, 1982).

4. Suicide of a group member. If a member of the group commits suicide, the surviving group members may experience feelings of denial, guilt, anger, grief, hopelessness, and fear. Members frequently review past group interactions, and

ask "what if" questions. Honest disclosure of personal reactions and emotions about the suicide by group leaders can encourage members to experience and express their own feelings and apprehensions. Counselors may have to work on the grieving process for several weeks, while gradually guiding the group back to the here-and-now processes of constructive therapy. The focus on the present will allow members to become aware of how survivors are victims of suicide, and how they can avoid similar self-destructive behaviors (Comstock & McDermott, 1975; Motto, 1979).

CHAPTER III

SUICIDE POSTVENTION GROUPS

No one will talk to me. They act as if it never happened (Wroblewski, 1984, p. 177).

Public and professional education about issues and facts related to suicide is a fairly recent phenomenon. It has only been during the last few decades that research has been directed toward establishing commonalities in suicidal behavior and empirically evaluating the effectiveness of treatment programs. The steady and dramatic increase in the rates of suicide in certain populations has demonstrated the intense need for suicide-related literature that explicitly describes programs that can prevent suicide, intervene with persons who are suicidal, and provide assistance for survivors of suicide (persons who have experienced the suicidal death of a friend or loved one) (Wroblewski, 1984). In the last few years, many books and articles have been written about prevention and intervention, but little attention has been focused on the aftermath effects of a suicide. It is estimated that, each year, almost 300,000 people may be intimately impacted by a suicide completion, and an additional twelve million individuals may be traumatized by a loved one's

attempt at suicide⁵ (Hiegel & Hipple, 1990). Despite a critical need for assistance programs for survivors of suicide, postvention⁶ is a seriously neglected component in the study of suicidality (Constantino, 1989; Valente, Saunders & Street, 1988).

The knowledge about postvention is further hampered by inadequate research practices and sampling biases (Valente, et al., 1988). According to McNiel, Hatcher and Reubin (1988), there are several serious methodological problems in the existing postvention literature that limit the potential for generalization to other suicide-survivor populations. First, the majority of studies reported in the literature are based on clinical cases and limited to clients who are in treatment. This results in an overestimation of bereavement reactions in this population. People who have responded to a death by suicide with adaptive coping mechanisms are less likely to seek treatment and probably will not be included in the research data. Second, the preponderance of these studies have not included appropriate control groups and do not rule out the possibility that other forms of death may elicit similar survivor responses. Third, the existing studies have predominately relied on interview data, and have failed to use

⁵These estimates may be lower than actual figures because of under reporting practices.

⁶Postvention is a term coined by E. Schneidman (1981) and refers to helpful and appropriate actions rendered to survivors of suicide attempts and completions.

standardized assessment instruments. And fourth, the literature on reactions to a death by suicide has not adequately addressed the occurrence of other factors (e.g., family systems variables) that might influence bereavement response strategies.

Families who encounter a suicide frequently have a history of dysfunctional relationships, impaired communication systems, emotional or psychological disturbances, experiences of separation and loss, and other family stressors (Capuzzi & Golden, 1988). The past experiences of individuals and the coping mechanisms developed as a result of that experience can shape their strategy of response to a traumatic event, such as a death by suicide. Thus, the pattern of emotional reaction to the suicide, the resolution of grief, and the adjustment to the death are unique to each person, and can vary according to the interaction of numerous individual factors. These mediating components can include (a) the quality and type of relationship between the survivor and the deceased; (b) the reserve of coping strengths available to bereaved individuals; (c) the circumstances surrounding the death; (d) the social support system available to and used by the survivor; (e) the age and gender of both the survivor and the person who committed suicide; and (f) the cumulative losses and stressors experienced during the adjustment period (Foglia, 1977; McNiel, et al., 1988).

BEREAVEMENT RESPONSES TO SUICIDE

Bereavement is the slow process through which survivors acknowledge a death, and strive to create some meaning out of the death. Most mental health professionals generally agree that the most difficult type of bereavement is mourning a death by suicide because the loss is premature and unexpected (Valente, et al., 1988). Immediately after a suicide, survivors can be obsessed with a multitude of noxious emotions. Feelings of grief, horror, shock, shame, guilt, and bewilderment are thrust upon them as they simultaneously attempt to deal with the suicidal death (Shelaman, 1981). This unhealthy complex of disturbing and intrusive emotions can result in depression, psychological distress, social isolation and suicide ideation.

The majority of studies indicate that, in comparison to survivors of other types of death, suicide survivors experience (a) a more encompassing distress reaction, (b) a greater number of clinical symptoms, and (c) a higher intensity level in these symptoms (Constantino, 1989). Symptoms manifested by survivors of suicide include (a) deeper resentment and anger; (b) phobias; (c) debilitating fears (about death, possible harm befalling other family members); (d) nightmares and dreams about the suicide; (e) self-recriminations; (f) excessive guilt; (g) apathy; (h) feelings of loneliness; (i) greater risk of physical illness; (j) difficulty in concentration; and (k) acute shame (from social

stigma) (Constantino, 1989; Wroblewski, 1984).⁷

Survivors can come to believe that if they had been more understanding, more attentive, and more loving, the suicide could have been averted. If the person who commits suicide has manifested a history of emotional distress and attempts at suicide, survivors may initially react with a sense of relief that the ordeal is finally over, and their loved one is no longer in agony. This assuagement can quickly revert to intense feelings of excessive guilt for having such "unacceptable" and "self-serving" feelings. Some survivors feel guilty for being the one who lived, or for not being able to predict the possible occurrence of suicide (Hiegel & Hipple, 1990). Social attitudes, stigmas and taboos exacerbate this sense of guilt.

Most survivors feel anger toward their loved one, but society frowns on the expression of anger, so the survivor feels guilty instead. Guilt can be called society's automatic response to a suicide (Hiegel & Hipple, 1990, p. 57).

This repressed anger is often turned inward and can lead to a chronic and debilitating depression.

⁷It is possible that these unrelenting and caustic reactions to the suicide provoke a tendency in physicians to prescribe tranquilizing drugs to suicide survivors. Data reveal that people who are grieving the death of a loved one by suicide use more mood altering and sleep inducing medications than other groups experiencing bereavement (Hiegel & Hipple, 1990). This practice may furnish temporary relief from the debilitating symptoms, but overall, it is a detriment to the amelioration of the distress. Antipsychotic medications inhibit the grieving process because they thwart the ability to acknowledge and work through the stages of grief (e.g., denial, anger, internalized rage, depression).

Those who have sustained the loss of a loved one by suicide may learn to protect themselves from intrusive emotions through the development of various dysfunctional coping mechanisms. Survivors of suicide may perceive the suicidal death as a personal and ultimate rejection (Hiegel & Hipple, 1990), and may become emotionally shut-down to block the painful repercussions of the suicide, thus denying themselves the opportunity of developing future nurturing and life-giving relationships. Generally, survivors of suicide do not have an opportunity to say good-bye to their loved one, and they may avoid letting go, and become symbiotically and emotionally tied to the deceased. By refusing to say good-bye, they can cultivate an aura of psychic numbness and circumvent the dolorous emotions that are associated with the death. Survivors may attempt to blame the suicide on external forces (e.g., another person, oneself, society, mental health agency), and thus prevent the acknowledgement of their own anger and rage toward the person who killed himself or herself. The consequences of blaming can include the inability to work through the process of grieving, and the perpetuation of chronic, deleterious emotions that preclude the capability of re-embracing life.

Suicide survivors who demonstrate adaptive coping mechanisms are likely to have experienced a positive relationship with the deceased, and can realistically attribute the cause of death to circumstances that were beyond

their control. Those who felt they caused or could have prevented the death in some way typically encounter difficulties in adjusting to the suicide (Foglia, 1977). The potential for a successful grieving experience is also affected by the relationship to the deceased. The bereavement response to suicidal death can be experienced quite differently among parents, children, siblings and spouses, however, the intensity of the sorrow and grief is a consistent connection shared by all these relationships.

There have been some people who sentimentally assume that the suicide death of a child must be "the worst". This is true for parent survivors, but not for the widow left alone after her husband's suicide. It is not true for the child whose parent committed suicide, or the person whose sibling killed themselves. The fact is that every suicide death is the "worst" for the specific survivors (Wroblewski, 1984, p. 178).

The following section discusses some of the reactions that are common to survivors who experience the suicidal death of a parent, a child, a spouse or a significant other.

Suicidal Death of a Parent

Children. Children survivors of a parental suicide often perceive themselves as completely helpless and totally unprotected from future traumatic events (Hiegel & Hipple, 1990). Younger children have not yet developed an autonomous sense of self, and although their cognitive development is not advanced enough for them to effectively cope with the complex and baffling behavior of suicide, they will still attempt to

make sense of their parent's death. Young children often use an egocentric approach to understand life events. They have a tendency to believe that the external environment is organized, created and centered around them. They may have difficulty understanding the suicide from a broader perspective, and may relate the death to something about themselves. Thus, they may blame themselves for the death, and come to believe that if they had changed a behavior (e.g., went to bed on time, argued less, stayed at home), the parent would still be alive. They may conclude that they were abandoned because they are unworthy, not loveable or "bad".

The child's attempt to comprehend and process the suicide may be blocked by behaviors of the surviving parent. The surviving parent may prohibit discussion about the suicide or may deny it was a suicide and lie about the circumstances surrounding the death. Even when the child has witnessed the death or discovered the body, the surviving parent may discredit the child's description of the death by attributing the child's reality to imagination, a bad dream, or childhood confusion. These distortions in communication deny the child the reality of his or her own experience, and negate the child's opportunity to talk about the suicide and release the feelings of fear, hostility, shame, self-blame, guilt and/or anger. As a result, the child may respond to the overwhelming trauma of parental suicide by developing rigid defense mechanisms (e.g., denial, repression, introjection) (Foglia,

1977).

Young children may protect themselves from further rejection by refraining to regain trust in others and abstaining from relationships of close personal involvement. Children survivors may also over-identify with the dead parent. They may assume mannerisms, attitudes, values and goals of the deceased parent, and may decide that they also will have to commit suicide. Children's suicidal behavior, following the death of a parent, may be precipitated by depression and loss, or may be the overt expression of the desire to be reunited with the dead parent (Hiegel & Hipple, 1990).

Adolescents. Research has seriously neglected investigating the adolescent grieving experience, the impact of bereavement on this population, and the variables that influence the course of adolescent bereavement (Valente, et al., 1988). Adolescents may process the experience of suicide differently than younger children because of the myriad of changes that are involved in the physical, emotional, cognitive, and social developmental processes of normal development. During this time of transition from childhood to adulthood, adolescents experience profound physical changes, a tremendous hunger for peer approval, rapid growth in cognitive abilities, an intense need for autonomy and independence, and a multitude of psychosocial stressors. In addition, adolescents are attempting to formulate intimate

sexual and social relationships, develop a mature value system that will guide them through adulthood, and establish their own unique sense of identity.

The normal course of adolescent development can create sources of unmanageable distress for adolescents, and the complicated bereavement of a death by suicide may increase the distress to limits that are beyond the capabilities of most teenagers. Thus, adolescents, who encounter the death of a loved one by suicide, may not be able to master the developmental tasks that are necessary for positive growth. For example, adolescents naturally experience a primary loss when they attempt to gain individuation and separation from their parents, and the death of a parent or significant other can intensify this loss, obstruct the process mastery of independence, and increase the probability of problematic bereavement. Suicide, during the development of cognitive skills and self-esteem, may have a deleterious impact on the formation of a self-identity and may promote a pessimistic belief system. Moreover, the bereavement process may complicate or impair the generation of a mature value system, and some adolescent survivors may come to value suicide as an acceptable way to solve problems (Valente, et al., 1988).

The development of flexible and abstract thinking processes enables most adolescents to logically consider the possibilities and solutions to problems. However, because of the heightened egocentrism and narcissism of adolescence, this

exploration has a tendency to be self-directed. Adolescents may look for ways to blame themselves for the death, and extensively examine past interactions and conversations to find circumstances that can substantiate their feelings of guilt.

Despite their advanced cognitive processes, adolescents may romanticize the death of a person by suicide (e.g., classmate) and perceive this event as a dramatic escape from the everyday difficulties of life. The need for peer identification and the propensity for instant gratification can aggrandize the risk of adolescent suicide, and suicide impulses are further increased when adolescents identify with, idealize or fantasize about a reunion with the person who committed suicide (Valente, et al., 1988).

Studies indicate that adolescents manage grief better when they are able to talk openly about the suicide with supportive persons. Conversely, when adolescents avoid discussing the suicide of a significant other, they are prone to develop maladaptive reactions to the death, such as suicide ideation, preoccupation with being reunited with the deceased, and avoidance of intimate relationships. Unresolved bereavement and the inability to mourn may lead to future pathology and increase the potential for adolescent suicide (Valente, et al., 1988).

Empirical evidence indicates that adolescents who have survived the suicide of a loved one are at greatest risk for suicide; the failure to grieve seems to further increase that risk

(Valente, et al., 1988, p. 176).

Suicidal Death of a Child

Any death of a child is a harsh, agonizing and inconsolable experience. Parents often suffer from the effects of anguish and distress from this significant loss for years after the child has died, and although the feelings of despair may abate overtime, the hazy ambiance of sorrow is constantly with them. A child is irreplaceable, and parents do not expect to outlive their children. Parents describe this gut wrenching experience as an incomprehensible occurrence, a loss of continuity, and express a sense of being cut off from the future.

To lose a parent or a lifelong friend is often to lose the past: the person who died may be the only other living witness to golden events of long ago. But to lose a child is to lose the future: what is lost is no less than one's life project--what one lives for, how one projects oneself into the future, how one may hope to transcend death (Yalom, 1989, p. 123).

When parents lose a child through a death by suicide, the bitter ramifications from this loss are even more intense and acutely longer lasting, and many parents report that the relentless torment is not attenuated overtime. Parents of children who die by suicide often endure consuming and aggravating reactions of guilt and depression. They may believe that they failed to protect and care for the deceased child, and undergo exposed feelings of shame because their love was not enough to keep the child alive. They may blame

one another, fail to understand and support one another in the grieving process, and may eventually separate or divorce (Hiegel & Hipple, 1990; Yalom, 1989). As a defense against these onerous feelings of guilt, parent survivors often refuse to accept suicide as the cause of death, and feel hostile toward persons who attribute the child's death to suicide (Foglia, 1977).

Parental responses to a child's suicide can have a powerful influence on other children in the family. Parents who are depressed often are physically and emotionally withdrawn, and are unable to attend to the needs of their children. As a consequence, surviving children may feel angry, resentful, and abandoned. If the parents are obsessed with the memory of the dead child, the surviving children may feel jealous of the sibling who committed suicide, and these feelings can result in surviving children experiencing additional pernicious reactions of intense guilt and shame (Yalom, 1989). Eventually, children may come to believe that their parents will love them again if they too were dead.

The family may also suffer from a loss of community support. Blaming mechanisms (e.g., parental neglect must have caused suicide of child) or refusal to acknowledge the suicide because this recognition elicits the realization that their own children might be vulnerable to suicide, may precipitate community abandonment of the surviving members of the family. This vicious cycle of avoidance often drives community members

to encourage the family to move away (Hiegel & Hipple, 1990).

Suicidal Death of a Spouse or Significant Other

The ability to anticipate and prepare for a death significantly contributes to the survivor's ability to accept the death. An accidental death or an unexpected suicide of a spouse or significant other usually results in more severe reactions to grief and difficulty in adjustment to necessary role changes (Hiegel & Hipple, 1990). Survivors of spousal suicide experience feelings of shock, sorrow, rejection, guilt, loneliness, anger, self-blame and hostility. Overriding these conflicting emotions is the shame which is derived from the social dishonor of losing a spouse through suicide.

Research suggests that younger spousal survivors of suicide encounter severe obstacles to an adaptive resolution of bereavement (Hiegel & Hipple, 1990). Young survivors with children may be forced to simultaneously (a) attempt to resolve their own issues of grief; (b) adjust to being a single parent; (c) fulfill the role responsibilities of the deceased parent; (d) financially support their family despite a reduction in available sources of income; (e) assist the children in their grieving process; and (f) cope with the reactions of society. As a group, young spousal survivors occasionally demonstrate reactions to the suicide that are different from other populations of spousal survivors. They may seek to rectify the unhappiness caused by the suicidal

death by sacrificing their own happiness, and marry someone who is chronically ill or disabled, or they may devote their life-energy to altruistic, grandiose and unrealistic "save the world" goals. These patterns of behavior may be reactions to suicide-related feelings of rejection, abandonment, and irrational guilt, and to the emotional barricade that protects society from acknowledging a death by suicide (Hiegel & Hipple, 1990).

Older survivors of spousal suicide often feel intense anger at having to spend their remaining years alone. Their natural sources of support may have dwindled throughout the years (e.g., death of peers, siblings, parents), and reduction in income, transportation barriers and physical deterioration due to the aging process may limit their ability to develop alternate sources of support (Hiegel & Hipple, 1990). Widow survivors of suicide typically express feelings of isolation. In some cases, this reclusion is self-imposed (e.g., fear of further rejection, feelings of shame), but these women generally find that there is a resistance to involvement when they attempt to secure emotional support from friends and relatives. Consequently, they feel hurt and repudiated, withdraw, and become isolated (Foglia, 1977). Husbands who have lost their wives through suicide are especially prone to experience low morale, helplessness and negative expectations about the future, and commonly do not attempt to discuss their feelings about the suicide (Hiegel & Hipple, 1990).

The furtive silence that shrouds the death by suicide decreases the possibility for an constructive resolution of the grief process, and increases the risk for survivor suicide. Wrobleski (1984) maintains that as long as society views suicide as a disgrace and enforces communication bans and other proscriptions on this type of death, there will be a need for separate bereavement groups for suicide survivors.

SOCIAL STIGMA

Wrobleski (1984) asserts that social stigma is the legacy the lack of education has given suicide survivors. Suicide may be viewed as a cowardly behavior, a mortal sin, a revengeful act, or a desperate attempt of a victim who has been wronged by significant others. Many people consider suicide to be a moral rather than a mental issue, and insurance companies have policy limitations that allow them to deny benefits to survivors of a death by suicide (Constantino, 1989). Issues of social stigma aggravate the problems of suicide survivors. Although survivors have a tremendous need to communicate their feelings, they may avoid discussing the suicide with natural sources of support because they feel shame or anticipate societal blame. Family and friends may feel threatened by the suicide and may be unable to reach out and comfort the survivor. They may experience feelings of powerlessness and attempt to ascertain the cause of death by subjecting survivors to a battery of alienating

and rejecting "why" questions (Hiegel & Hipple, 1990). These self-protecting interrogations may serve as a shield and as a reassurance to others that the same tragedy of suicide cannot happen to them.

The subject of suicide is often avoided and the death by suicide may be treated as a non-event. Consequently, suicide survivors may become socially isolated, and their chances of effectively coping with the crisis are diminished (Constantino, 1989; Wrobleski, 1984).

The availability of external support systems is one of the most critical factors differentiating individual vulnerability from invulnerability; that is, separating individuals who survive a crisis with no harm from those who experience lasting damage (Carter & Brooks, 1990, p. 379).

Proficient programs of postvention can provide the necessary support for survivors of suicide, and can strengthen previously existing sources of support (Carter & Brooks, 1990).

APPROACHES TO POSTVENTION

Schneidman (1981) parallels the human response to a death by suicide to the "disaster syndrome", in which survivors of a disaster (e.g., sudden, unexpected event such as an earthquake or plane crash) become emotionally stunned, lethargic, unresponsive to external stimuli, dependent, and sustain a loss of self-identity and self-esteem. Suicide survivors typically experience shock and denial, and can be

unaware of their need for assistance. The social-emotional alienation phenomenon reduces their ability to mourn and develop coping mechanisms, and they frequently need the structure of professional therapy to ventilate their feelings. However, they may not seek counseling because they may be distrustful of postvention (Constantino, 1989). Carter and Brooks (1990) suggest that crisis counselors initiate postvention by actively pursuing survivors and Junghardt (1977) recommends that the intervention be initiated with 24 to 48 hours after the suicide.

Postvention is a therapeutic intervention that allows the grieving survivors to discuss and ventilate the unrelenting, detrimental emotions (e.g., anger, shame, guilt) that often accompany a death by suicide. There are several approaches to postvention, and intervention can be initiated through individual or group counseling using the following formats: (a) short-term consultation (1 to 3 sessions of emergency support); (b) intermediate-convergent (10 to 12 sessions focused on crisis resolution and restoration of pre-crisis functioning); (c) long-term therapy (intensive therapy centered on insight, adaptation, fundamental personality change and increased level of psychological health) (Carter & Brooks, 1990); and (d) grief support groups (focus on common problems of suicidal death, alleviation of emotional distress, acceptance and adaptation) (Wroblewski, 1984). Whichever format is chosen, the group approach is the preferred method

of postvention in helping survivors of suicide cope with psychological distress (Carter & Brooks, 1990; Constantino, 1989; Wroblewski, 1984). Groups facilitate the reintroduction of stability into the lives of the bereaved, and re-establish the opportunity to benefit from interpersonal relationships.

The final portion of this chapter will be used to explore two approaches to the intermediate-convergent group format, and to provide an example of a grief support group.

SUICIDE SURVIVOR BEREAVEMENT GROUP

Freeman (1991) presents a structured group model for survivors of suicide that is predicated on the combination of Yalom's (1985) therapeutic factors, Parkes' stages of grief, and Worden's tasks of grief (in Freeman, 1991). The group strategy, which facilitates movement through the stages of the grief process, was developed for use in a community suicide and crisis center. However, it can be productively applied to other mental health settings. This close-ended group is limited to eight to ten participants who have experienced the death of a significant other by suicide. Prior to group involvement, potential members are screened to determine if this type of group is an appropriate intervention for their needs, and if the prospective members' behavior is suitable for group inclusion. Possible members are excluded from the group and referred to other modes of therapy if (a) they are manifesting pathological reactions to grief; (b) they are in

an immediate crisis situation (e.g., the energy of the group may be mobilized toward solving the crisis, and as the group energy is depleted, it tends to neglect the issue of bereavement); and (c) they do not possess the basic social skills that are necessary to profit from the group experience (e.g., social avoidance, impulsivity, rigid thought patterns, antisocial behaviors). The established group meets for two hours each week for eight weeks.

The following is a brief overview of the goals and procedures of each session (Freeman, 1991):

■ First session. Yalom's (1985) therapeutic factors of installation of hope and universality are the primary goals of the first group meeting. Group members share their perceptions of the suicidal death and their emotional reactions to this experience, and group leaders focus on support, the normalization of feelings and the commonality of these disclosures. As group members realize that they are among people who have encountered similar ordeals and face comparable emotions, they experience relief and acceptance, begin to identify with and commit to the group, and develop hope that a mitigation of their pain and suffering is possible. Group leaders close the session by warning participants that their sadness will probably increase during the next few weeks. This intervention gives survivors permission to grieve and frustrates the manifestation of the disappointment and discouragement that can arise when members

perceive they are regressing rather than progressing through the grief process.

■ Second session. Group members are invited to reconnect with each other by disclosing their experiences of the past week. The goals of this session are the comprehension and normalization of the grief experience, and the facilitation of movement through the grief process. Group leaders use a didactic approach to implement the therapeutic factor, imparting information. Parkes' (in Freeman, 1991) stages of grief: (a) numbness; (b) yearning; (c) disorganization and despair; and (d) reorganization of behavior, and Worden's (in Freeman (1991) tasks of grief: (a) accepting the reality of the loss; (b) experiencing the pain of grief; (c) adjusting to the physical absence of the deceased; and (d) diverting emotional energy to other relationships, are presented and discussed with group participants. By addressing the intellectual aspects of the stages of grief, and outlining the concrete steps that promote the mitigation of grief, leaders empower survivors to actively work toward the resolution of their bereavement process. During the final portion of the session, participants identify their goals, and disclose their group expectations and special needs. Group rosters are distributed, and members are given the optional opportunity to develop connections (outside group experience) with other survivors.

■ Third session. Each survivor relates the events of the previous week, and after a brief review of the tasks of grief, members are prompted to share (a) their immediate stage of grief, (b) their present coping mechanisms, and (c) personal experiences of suicide-related social stigmatization. This reciprocal sharing process promotes the therapeutic factor of altruism. As members experience empathy for other participants, they become less self-absorbed, and more interested in the well-being of other survivors. This communal feeling facilitates a capacity for the courage that is needed to face the problems of grief.

■ Fourth session. Again, participants check in with each other with a brief review of past week's activities, and are then invited to talk about their perceptions of the funeral and how, if possible, they would have changed this experience. This intervention acuminates awareness that the death is real and permanent, and facilitates the expression of undisclosed painful emotions. Group empathy and support intensify during this grief work, and this interaction promotes the therapeutic factor of group cohesiveness. Group leaders close the session by asking participants to bring photographs of the deceased to the next session.

■ Fifth session. This session continues to incorporate the previous therapeutic factors and integrates the additional therapeutic factors of the development of socialization techniques, imitative behavior and catharsis. Group

participants are encouraged to share photographs of their loved ones, and discuss the memories that are associated with these pictures. Leaders invite members to examine their regrets and losses (e.g., role of deceased in their lives, what they miss most, what they have lost, what they miss least). Through the guidance of the leaders, the processes of consensual validation, correctional emotional experiences, and imitative behavior, survivors learn how to (a) talk to others about their suicide-triggered losses; (b) release emotions that may be hidden or repressed; and (c) replace "unacceptable" grieving patterns with more appropriate behaviors.

■ Sixth session. The prior activities, which emphasized the expression of feelings and the identification of that which cannot be restored, facilitate the grieving processes of accommodation, adaptation and acceptance. Participants are now encouraged to initiate the process of saying goodbye to the deceased by an emotional withdrawal from the person who committed suicide and an inauguration of the task of living without their loved one. This session stresses the therapeutic factor of interpersonal learning, and enables survivors to gain insight into their behavior, accept responsibility for their actions, and become motivated toward change.

■ Seventh session. The therapeutic factor of interpersonal learning continues as group members are invited

to share specific examples of how they are presently coping with the death of their loved one by suicide. These coping mechanisms are evaluated and examined for effectiveness, and goals that were established in the second week are reviewed. Survivors are encouraged to face the reality that life will continue without the deceased, and to make preparations toward the diversion and reinvestment of emotional energies into alternate relationships. Group leaders facilitate the discussion and recognition of the five elements of the existential factors as introduced by Yalom (1985):

1. Life is sometimes unfair and unjust.
2. Ultimately, there is no escape from the experience of pain or from death.
3. Regardless of close interpersonal relationships, an individual must face life alone.
4. When the basic issues of life and death are faced, individuals live life more honestly, and focus less energy on the trivialities of life.
5. Regardless of the amount of support and guidance received, the ultimate responsibility for one's life experiences resides within the individual.

■ **Eighth Session.** The final session focuses on the re-evaluation of where members are in the tasks of grieving, and the tasks they need to accomplish in their journey toward bereavement resolution. Group leaders encourage comments and feedback from participants, and terminate the group with the

provision of community resource referral information.

ADOLESCENT POSTVENTION GROUP

Carter and Brooks (1990) perceive postvention as an opportunity for change toward positive developmental growth. They use an intermediate-convergent structure with a group therapy format for their school-based postvention program. They advocate this approach because it (a) yields short-term psychological adjustments; (b) reaches multiple survivors; and (c) provides ample time to assess risk and to strengthen and expand external and internal support systems. They also recommend that potential group leaders are trained in issues related to suicide and are qualified to work with postvention groups. Their procedure is to immediately offer postvention services to school administrators and faculty members in the event of a student suicide. After the initial staff meetings, they conduct a rapid assessment of school resources, suicide survivor risk, and need for further interventions.

The first intervention that Carter and Brooks (1990) recommend includes students who have been identified by school staff as close friends of the deceased student and other students who are highly distressed by the suicide. The primary purpose of this first intervention is to prevent additional deaths among the student survivors by (a) assessing the emotional needs of the survivors, (b) providing immediate emergency support, and (c) establishing options for further

therapeutic support. In addition, the goals of the first session are (a) creation of a safe, accepting environment in which students can openly express feelings of anger and sadness; (b) unconditional acceptance and validation of these intense emotions; (c) assessment of students' support systems; (d) evaluation of students' plans for obtaining support; and (e) scheduling of additional postvention sessions.

Students, who are at risk, are proactively encouraged to attend the second session. If necessary, a formal postvention group is formed during this meeting. This group can be composed of students who are survivor-victims, or can be a multifamily group, and include students, parents, and other family members. Generally, the authors have found that the predominate theme of the group is remaining psychologically sound while coping with uncontrollable losses. The group process centers around disclosure of intimate feelings, and topics can include (a) the fears surrounding the conflict between self-protection and commitment to an interpersonal relationship; (b) past and future losses (e.g., divorce, death, relocation, developmental milestones); (c) communication difficulties in interpersonal relationships; (d) holidays and special anniversaries; and (e) problem solving tactics. The authors caution that auxiliary support is crucial for therapists of postvention groups. There is a tremendous amount of responsibility in working with a group of adolescent suicide survivors, and the consultant, who is

not emotionally involved with the group, can objectively evaluate the proceedings of the group, and increase the effectiveness of the group process.

THE SUICIDE SURVIVORS GRIEF GROUP

Wrobleski (1984) states that suicide survivors have an inordinate need to verbalize their feelings, and this need to talk about the suicide lasts longer than family and friends are willing to listen. The wall of silence that surrounds the death by suicide inhibits the necessary ventilation of emotions. Suicide survivors are not encouraged to discuss the events surrounding the death, and this enforced silence compounds the relentless impact of suicide. The Suicide Survivors Grief Group (SSGG) gives people the opportunity to receive important emotional support from others who share a similar experience, and thus, begin the process of acceptance and recovery.

The SSGG (Wrobleski (1984) is an open, ongoing postvention group that meets twice a month for two hours. People can choose their own attendance schedules, and the average number of meetings attended is six meetings over a period of three to six months. The group welcomes all persons who were affected by the suicidal death (e.g., spouses, parents, siblings, children, friends) and often operates as a surrogate family for these survivors. The open group format is advantageous because new survivors can benefit from

experiences of veteran survivors. As newcomers to the group are exposed to the experiences of people who are further along in the grief process, they are forewarned about the possibility of future, unexpected grief responses, and this awareness can diminish some of the apprehension that emerges when they anticipate the unknown aspects of bereavement. Furthermore, people, who are recovering from grief, model behaviors that reassure new members that there is hope for overcoming their intense distress reactions to the suicide.

The group leader commences each session by requesting that all members introduce themselves, and state who died, and how and when the death occurred. This is an important function of the group and it serves two purposes: (a) shared experiences promote group bonding and feelings of empathy; and (b) as members repeatedly reproduce this narration, they gradually become desensitized to stigmatized words that surround death by suicide. The cause of death may be too overwhelming for new members to accept, and desensitization enables them to talk more freely about the suicide, teaches them to use literal terms when they speak of suicide (e.g., killed themselves, bled to death), and promotes acceptance of the death. The leaders of SSG groups are empathetic (yet emotionally uninvolved to avoid burnout), nondirective, and participate minimally in the group interaction.

The focus of the group is on the common problems of suicide, and there is no agenda or predetermined topics at

meetings. In an accepting and nonjudgemental milieu, people discuss the needs and problems they are dealing with that day. "The greatest need of suicide survivors is reassurance that what they are going through is "normal"" (Wrobleski, 1984, p. 175). Disclosure and the sharing of similar experiences, feelings and ideas encourage people and enable them to learn effectual ways of coping with suicide.

CHAPTER IV

AGE-SPECIFIC VARIATIONS FOR SUICIDE-RELATED GROUPS

ADULTS WHO ARE OLDER

As previously discussed, Americans, ages 65 and older, comprise the population group that has the greatest risk for suicide completion (Osgood & Brant, 1990; Saul & Saul, 1988). Research indicates that adults over age 65 initiate fewer attempts at suicide, but the percentage of successful suicide completions increases significantly as people become older (Achte', 1988; Gilliland & James, 1988; Saul & Saul, 1988). This disproportionate vulnerability toward suicide escalates even further among people 75 years and older. Men and women over age 75 commit suicide three to four times more often than younger adults (Saul & Saul, 1988).

Researchers have uncovered several factors that may possibly explain why a person who is older is more likely to succeed in the attempt to take his or her own life. A study by Achte' (1988) revealed that only 34% of unsuccessful suicide attempters under age 25 really wished to die, while 76% of adults over 65 expressed genuine regret that the attempt had not been successful. This earnest desire to die is reflected by the fact that, in comparison with younger adults who attempt suicide, adults who are older use more

violent and lethal methods to attempt suicide. The selection of a means that is more certain to elicit death suggests that older suicide attempters have given the matter of suicide long and careful consideration, and have an earnest desire to commit suicide (Achte', 1988). In addition, older suicide attempters are more secretive about their intention to end their lives, and are less apt to use a suicide attempt as a way to gain attention or as a disguised cry for help. Consequently, when older adults attempt suicide, they are usually successful (Saul & Saul, 1988).

Many professionals are concerned that the seriousness of the risk of suicide for adults who are older is vastly underestimated. Research data do not include the numbers of suicides from indirect life-threatening behaviors (Saul & Saul, 1988) and the possibility strongly exists that the rate of suicide among people, 75 and older, may be underreported and some suicidal behavior may go undetected. Osgood and Brant (1990) define life-threatening behavior as

...repetitive acts by individuals directed toward themselves, which results in physical harm or tissue damage and which could bring about a premature end of life (p. 115).

This covert form of suicide can include refusal to eat or drink, rejection of medications, propensity toward serious accidents, self-mutilation, and swallowing foreign substances or objects. Their study of suicidal behavior in long-term

care facilities indicates that (a) there is a fairly high incidence of suicidal behavior among adults who are institutionalized; (b) suicide from life-threatening behavior occurred with some frequency; and (c) overt and covert suicides are often unreported.

Saul and Saul (1988) studied the incidence of suicide rate in long-term care facilities. Their research revealed "a striking lack of information" (p. 239). Furthermore, their study indicated that long-term care facilities are often reluctant to report possible suicides or attempts at suicide. The authors proposed the following explanations for this phenomenon. The facility may feel vulnerable to punitive repercussions when a suicide is reported because:

1. Family members often feel guilty when placing a relative in an institution, and may blame the institution for inadequately caring for the loved one.

2. Due to lack of public funding, long-term care systems may be underfinanced, and budget restrictions may reduce their ability to properly care for residents. Social guilt about inadequate public assistance may be targeted toward the institution.

3. The institution may be actually responsible for the death because the staff emotionally and/or physically neglected the resident.

The disturbing reports on the susceptibility of suicide among people who are older have initiated research on the

factors related to suicidal behavior in this population, and the development of prevention and intervention programs that successfully meet the needs of older adults.

Issues Related to Suicidal Behavior in Adults who are Older

Having a sense of responsibility for one's own life and the freedom to make personal choices are highly desirable attributes in our society, and are sought after by most people, regardless of their age. Yet, sometimes, as people grow older, they experience situations where they have diminished capacities for control and freedom of choice.

In studies with varied populations (e.g., older adults) and age groups, a perception of control over one's life circumstances has been shown to be associated with a positive mood, satisfaction with daily experiences, and a deeper, more meaningful participation in the journey through life (Langer & Rodin, 1976). There is believed to be a reciprocal relationship between feelings of control and affective consequences (Holahan & Holahan, 1987). People experience a general sense of well being when they have a perception of control over situations, and when people feel competent and positive about life events, they tend to discern that they have causal control over life events. Conversely, when people encounter many aversive circumstances, they tend to sense a lack of personal control, and develop negative attitudes that can lead to distress and maladaptive behaviors (e.g., depression, suicide) (Holahan & Holahan, 1987; Reich, Zandra

& Hill, 1987)). The belief in a lack of control over circumstances is reinforced by these self-defeating attitudes, and a vicious cycles of depression can develop.

Reich, et al., (1987) suggest that the aging process itself could fundamentally transform peoples' comprehensions about the causation of events, or it may modify the effect of those experiences on the well-being of people who are older. Perhaps it is not the aging process per se that changes peoples' views on their ability to achieve internal mastery over life circumstances. Possibly these negative metamorphoses are strongly influenced by our society's pessimistic and mythological perceptions about the "unpleasant" decline that accompanies the aging process.

Rotter (1975) theorized that peoples' subjective expectations regarding the reinforcement value of a situation have a strong effect in determining their behavior. He also noted that increases and decreases in expectancy tended to vary depending on the nature of the situation and on consistent differences among people. Some individuals tend to believe that their own actions determine the outcome of most environmental and internal events. Others seem to attribute most of their life situations to chance, luck, fate, other people's actions, and external influences. These internal and external locus of control orientations are generalized views of personal control, and are contingent on other factors, such as peoples' beliefs about the outcome of

an event, their value system, their age and their gender. People with a high expectation for internal control of reinforcement are more likely to be motivated towards goal achievement and successful coping strategies.

Experiences that reduce peoples' opportunities in life are likely to make them more external. If poverty, social prejudice, adverse environmental conditions, and the self-internalization of restricting connotations act as controls or form insurmountable barriers for certain populations, it is reasonable to expect that these experiences will create a sense of helplessness and alienation in those people. In reality, there are many people who experience situations in which they literally have little or no personal control (e.g., institutionalization for older individuals), and both the prevention and treatment of learned helplessness require that (a) they have an awareness that they can escape, and (b) escape is possible.

The role losses associated with normal aging (e.g., retirement, loss of friends and loved ones), negative stereotypes about the aging process, and the fact that one out of four elderly people can expect to live in poverty by the time they reach their 65th birthday (Moss & Halamandaris, 1977), may alter older peoples' perception of self-efficacy. Also, the extent to which people believe that they can produce effects can determine

...whether coping behavior will be initiated,

how long it will be sustained in the face of obstacles and how much coping effort will be expended (Holahan & Holahan, 1987, p. 65).

Separation and loss. As people grow older, they are often faced with an incessant series of significant losses (Leszcz, 1990). These major privations can include (a) mandatory retirement and loss of professional and social status; (b) reduced sources of income; (c) diminished influence among friends, and within the community; (d) impaired physical and mental capabilities (particularly loss of hearing or vision; loss of speech; loss of ambulation/mobility) (Osgood & Brant, 1990); (e) loss of home; (f) separation from family, friends, and other sources of emotional and social support; (g) gradual deterioration of the body and subsequent changes in physical appearance; and (h) loss of personal freedom and the opportunity to control one's life (Achte', 1988; Saul & Saul, 1988). As each loss occurs, the older individual must strive to regroup and attempt to adapt to these changes in order to achieve psychological equilibrium (Achte', 1988; Leszcz, 1990). The pervasive series of deprivations, especially restrictions on freedom and sense of control, can lead to a severely damaged or altered sense of identity, to a drastic loss of self-esteem and to feelings of emptiness, worthlessness and depression (Achte', 1988; Leszcz, 1990).

Depression. Epidemiological evidence indicates that the incidence of depression does not increase with age, however, depression is common among people who are older because of the major life changes this population experiences (Achte', 1988; Leszcz, 1990). It is projected between 12% to 18% of older people have a clinically significant depression, and furthermore, many professionals believe the incidence of major depression is underestimated and misdiagnosed in the elderly. Older adults who are depressed are seriously at risk for suicidal behaviors. A correct diagnosis of depression and referral to treatment is extremely important because even minor depressive episodes and periods of bereavement, can be life-threatening to older people (Achte', 1988; Kermis, 1986).

Groups for Adults who are Older

The literature⁸ indicates that older adults benefit greatly from peer experiences. Consequently, despite the fact that reports on the positive effects of group work with this population are neglected by professional research for counselors (Goldfarb, 1972; Zimpfer, 1987), the homogeneous group format has evolved as the principal model for counseling older adults (Kaplan & Sadock, 1972; Zimpfer, 1987).

Groups are an excellent way to provide services for older clients. Group counseling is, of course, more economic, but

⁸Most of the literature on older adults has been written by professionals in the fields of nursing, gerontology, and social work, and is anecdotal and descriptive in nature (Zimpfer, 1987).

more importantly, the special qualities of group work seem to suit the requirements of older adults. People who are older often suffer from loneliness, and have diminished opportunities for social interactions. Groups can furnish that social contact and offer the friendships that can thwart loneliness and rejection, and thus, help repair injuries to self-esteem. Groups for older adults can circumvent isolation by presenting the opportunity for participants to share beliefs, information and feelings, and to receive feedback from others who are experiencing similar circumstances. Groups can decrease depression in older populations by promoting mental and physical activity. Moreover, groups allow the grieving process to occur in a supportive environment, and facilitate a structured atmosphere in which problem-solving and coping skills can be learned and adaptation to life's changes can be modeled and practiced (Leszcz, 1990; Saul & Saul, 1990; Zimpfer, 1987).

Groups for depression. Leszcz (1990) advocates an eclectic approach, that incorporates psychodynamic, developmental and cognitive-behavioral models of group therapy, for the treatment of depression in older populations. The main goal of this integrated model of group psychotherapy is to restore a sense of mastery, competence and purposefulness in each group member, and ultimately repair the damaged sense of self. Leszcz (1990) asserts that the simultaneous homogenization of these strategies generates a

more powerful approach to therapy. He maintains that certain behavioral modification techniques are necessary for optimal treatment of older persons who are depressed. When these models are synthesized, the cognitive-behavioral interventions, which promote the acquisition of specific skills, advance the desired goal of psychological mastery, strengthen the psychodynamic and developmental approaches, and facilitate the regeneration of the injured sense of self. In a synchronous process, as the elements of self-destruction (e.g., self-hate, despair) are explored and discussed, the insight gained by the client facilitates the introduction, acquisition, and reinforcement of new and appropriate responses to social interaction, communication, and self-perception, and the development of adaptive problem-solving and coping skills (Frederick & Resnik, 1988)

1. Psychodynamic concerns. Proponents of the psychodynamic approach postulate that the sense of self is strongly influenced by each individual's unique abilities, achievements, interpersonal relationships, and resources. Losses that can be associated with the aging process (e.g., loss of personal capability, relationships, functions and roles) "...may result in an impoverished sense of self with feelings of depletion, worthlessness, depression and helplessness" (Leszcz, 1990, p. 381). A group atmosphere that promotes belonging, cohesion, disclosure, support and grieving can facilitate the restoration of a diminished self-esteem.

2. Developmental concerns. Robert Butler (Lewis & Butler, 1974) maintains that people who are older undergo a natural "life review" process, during which they explore, organize and evaluate life events, and reach a personal resolution regarding the positive and negative aspects of their past behaviors. Structured group therapy that focuses on this reminiscient process (a) promotes a co-hort effect among participants; (b) allows them to share significant events, (c) facilitates the resolution of interpersonal conflicts; and (d) renews feelings of self-worth through the verbalization of past achievements and personal successes (Bledsoe & Lutz-Ponder, 1986). Furthermore, the act of reminiscing about former accomplishments can reduce apprehension and insecurities about hermetic future occurrences (Leszcz, 1990).

Getzel (1983) proposes that a poetry-focused group approach can assist people who are older to encounter and work through the pervasive and painful losses that can be associated with growing older. The combination of group therapy and the creative expression of poetry is a powerful mechanism that can promote the effective resolution of older age developmental processes, leading to acceptance and adaptation to life changes. Poetry encourages the reminiscient process, the expression of intense and debilitating emotions, and insight into past events and future possibilities.

Reminiscient therapy groups that are facilitated by a

nondirectional leader have a tendency to evolve into an arena in which participants become fixated on the past, and group members may generate and reinforce feelings of guilt over irreversible transgressions. Leaders can prevent this harmful occurrence by consistently guiding the reminiscence process back to the here-and-now experience of the group (Leszcz, 1990).

3. Cognitive-behavioral concerns. Cognitive-behavioral group therapy incorporates behavioral and cognitive strategies to the group setting. The major goal of this approach is to identify, challenge and change dysfunctional attitudes and irrational beliefs that promote feelings of depression. Insight is considered to be a preliminary contingency for the working-through process, but it is not a sufficient condition for constructive change. The maladaptive cognitions that constitute the core of an individual's disturbance are usually so well practiced, reinforced and deeply ingrained into the behavioral system that a simple awareness of the situation will rarely be enough to elicit a significant modification of behavior (Leszcz, 1990). As group members gain insight into their feelings and behaviors, a transformation of their irrational beliefs can be obtained when they engage in repeated, energetic and multimodal efforts to refute those beliefs. The group leader (a) provocatively questions and challenges the validity of the participants' depressogenic behaviors and cognitions; (b) assists members in formulating

more adaptive beliefs; and (c) encourages participants to develop self-generated rational thinking processes (Grieger & Boyd, 1980).

According to Saul and Saul (1990), one of the significant goals of group therapy is the facilitation of the ability to experience feelings of joy. Their group psychotherapy model for people who are older is based on the incorporation of Yalom's (1985) group therapeutic factors with structured joyful experiences, and focuses on (a) assisting group members in learning and adopting effective strategies for coping with the stresses of the aging process; and (b) embracing a healthier, more self-satisfying and self-fulfilling approach to the experience of living.

The authors suggest that "unrecognized and undiagnosed" (Saul & Saul, 1990, p. 354) depression from the stress of change, role losses, loneliness, isolation, anxiety, anger, and feelings of loss of control over one's life may obstruct the ability to enjoy the daily activities of living. Depression and joy are viewed as antagonistic emotions, and this group approach (a) promotes joyful experiences through the group therapeutic factors of interaction, experience, insight, and conceptualization; (b) encourages the realization of a complete human emotional experience (sorrow through elation); and (c) facilitates the understanding of the impact these emotions can have on psychosocial functioning.

Saul and Saul (1990) present the following categories

which (a) systematically apply joyful experiences to the group process; and (b) complement and strengthen Yalom's (1985) group therapeutic factors (Saul & Saul, 1990, pp. 355-363).

- The joy of finding oneself.
- The joys of relationship.
- The joys of loving and being loved.
- The joys of self-actualization.
- The joys of helping and being helped.
- The joys of touching--physical, spiritual, symbolic.
- The joys of discovery, rediscovery, and insight.
- The joy of creativity.
- The joys of laughter and sharing laughter.
- The joy of living, of feeling alive.

CHILDREN AND ADOLESCENTS

During the past ten years, the suicide rates for adolescents and children have significantly increased (Kalafat, 1990; Vidal, 1988). Accidents are typically listed as the primary reason for adolescent and childhood death, but many professionals believe that suicide is now the leading cause of death in younger populations (Allberg & Chu, 1990). It is estimated that, in the United States, a child attempts suicide every 90 seconds, and an adolescent dies from the act of suicide every 90 minutes (Capuzzi & Gross, 1989). Data imply that adolescent attempts at suicide are increasing, and the age of childhood attempters grows progressively younger

each year. National surveys of schools reveal that 10% to 15% of student populations have attempted suicide. This is an extremely disturbing figure because the probability of a completed suicide is profoundly magnified among adolescents who have attempted suicide (Kalafat, 1990). The puzzling and frightening phenomenon of cluster suicide, in which the suicide of one teenager triggers "copy-cat" behaviors in other teenagers, further jeopardizes the adolescent population (Garfinkel, et al., 1988).

The reports on childhood and adolescent suicide behavior have shocked and disheartened the American public.

No matter how often the topic is reported or discussed, it always arouses dismay, disbelief and confusion, because it defies comprehension why some adolescents choose to end their lives, and when it happens, why it creates such a ripple effect on other teenagers (Allberg & Chu, 1990, p. 342).

Public concern has stimulated extensive research to investigate the occurrence of suicide in children and adolescents. This research has produced various possible explanations that relate to the increases of adolescent suicide, but has not identified specific conditions, situations or stressors that cause suicidality in younger populations (Kalafat, 1990). However, research has established that certain variables (e.g., depression, dysfunctional family environment, issues of separation and loss, environmental pressures, peer problems, low self-esteem, family history of suicide), when presented in a cluster of

symptoms, are significantly correlated with adolescent suicide. It is anticipated that an examination of the relationship among these factors will augment the understanding of adolescent suicide, and facilitate the development of effective prevention and intervention programs.

Issues Related to Suicidal Behavior in Children and Adolescents

Childhood suicidal behavior usually evolves through a three phase process. In the first stage, the child encounters a stressful situation (e.g., marital conflict, illness or death in family, feelings of abandonment or rejection). During the second stage, the sensations of distress are intensified, and the child develops feelings of helplessness and hopelessness. The final phase of the suicidal process is the crisis stage, in which the child experiences an profound threat to his or her well-being, and becomes highly vulnerable to self-destructive behavior (Stiles & Kottman, 1990).

Separation and loss. The majority of children and adolescents who manifest suicidal tendencies are reacting to some type of loss (Henry, 1987; Stiles & Kottman, 1990). One of the most common precipitating events for childhood suicidal behavior is the loss of a significant other through divorce, death or chronic illness. In a vulnerable child or adolescent, even the loss of a pet can become a precursor to suicidal behavior (Capuzzi & Golden, 1988; Henry, 1987). These losses can lead to a diminished self-esteem, feelings

of hopelessness and helplessness, and depression (Stiles & Kottman, 1990).

Depression. Children and adolescents, who have demonstrated suicidal behavior, typically share the symptom of depression (Allberg & Chu, 1990). Recent studies have revealed that very young children experience depression, and children, as young as age five, have been diagnosed as having an affective disorder (Stefanowski-Harding, 1990). Diagnosis of childhood and adolescent depression is extremely important because younger people who are depressed, make more frequent and lethal attempts at suicide (McWhirter & Kigin, 1988). However, complications in assessment can arise because depression is often expressed differently in young people (Alexander, 1988; Allberg & Chu, 1990; Stefanowski-Harding, 1990). Depressed children and adolescents often do not exhibit the obvious symptoms of depression (e.g., sadness, apathy, withdrawal), and may manifest this disorder through destructive or unrealistic play and/or attention-getting or acting out behaviors. Other behavioral disturbances that can mask childhood depression include: (a) anorexia nervosa; (b) learning disabilities; (c) psychosomatic illnesses; (d) antisocial behavior; (e) school failure; and (f) alcohol and drug abuse (Allberg & Chu, 1990; Capuzzi & Gross, 1989; McWhirter & Kigin, 1988; Stefanowski-Harding, 1990; Stiles & Kottman, 1990). Studies indicate that the majority of teenage suicide attempters habitually use chemical substances, and

many professionals believe this destructive behavior is an attempt to self-medicate themselves against the debilitating effects of severe depression (Allberg & Chu, 1990).

Family history. Depression is directly correlated with deficiencies in strategies for coping with life situations. Many children are not nourished by a stable and functional family atmosphere that provides support and encouragement, and in which significant others model positive communication and effective coping and problem-solving skills. When parents of dysfunctional families do not demonstrate adequate or successful ways to deal with distressing events, their children may perceive their own situation as hopeless, and fail to develop the necessary skills of survival (Allberg & Chu, 1990). In addition, adolescents and children who have not been exposed to self-sustaining skills, may become overwhelmed by the natural, yet stressful circumstances of maturation and development (e.g., academic achievement, formation and maintenance of relationships, peer pressure, sexual behavior, issues of separation and identity), and may perceive suicide as a way to escape distress (Capuzzi & Gross, 1989).

Groups for Children and Adolescents

Children and adolescents can benefit from most of the same advantageous conditions that are generated by adult therapy groups (Clouser, 1986; Robertson & Mathews, 1989), and the group model, with some modifications, is effective in the

prevention, intervention and postvention of suicidal behavior in children and adolescents (Robertson & Mathews, 1989). Children express much of themselves through play, and therapeutic groups that include variations of play activities are extremely productive for children who may have difficulty expressing themselves verbally. Activities, such as the use of art, storytelling, poetry and drama, have been successfully combined with a behavioral format to (a) teach children appropriate ways to deal with destructive thoughts; (b) promote social, problem-solving and coping skills; and (c) elevate self-esteem through the use of reinforcement and reward systems (Clouser, 1986; Stiles & Kottman, 1990).

Developmental counseling groups. Groups can be used to reduce the occurrence of self-destructive behavior in children and adolescents. Fairchild (1986) promotes the use of school-based prevention-oriented developmental counseling groups to facilitate (a) self-awareness, (b) interaction with the environment, and (c) assimilation of positive and efficacious methods of coping with internal and external pressures. The major goals of these groups are to (a) enable students to develop self-responsible behaviors; (b) identify personal resources; and (c) develop strategies for coping with potential life crises. Students are invited to join these groups and select the topics they wish to discuss. The group format is generally a function of the maturity of the group members. Older adolescent groups are given more

responsibility for the content and process of the group, and leaders usually need to provide more structure for younger groups of children.

Groups for children and adolescents dealing with divorce-related issues. Goldman (1986) and others have designed a school-based group intervention program for children and adolescents who are experiencing feelings of anxiety, anger, loss and rejection that are frequently associated with the crisis of divorce. These time-limited (meetings occur once a week for 50 to 75 minutes over a 6 to 12 week period) activity groups collaborate with administrators, faculty and parents, and have a positive impact on the creation of constructive changes for children and their family systems. The goals of these groups include (a) provision of a safe environment where children can develop skills that will enable them to adjust to family changes; (b) reduction of feelings of isolation and shame; and (c) emphasis on supportive aspects of the school environment. Students are referred to these groups by counselors, teachers, administrators and other school personnel, and an effort is made to keep groups as age-homogeneous as possible. The author states that participants who have experienced a recent (i.e., within two years) family transition benefit most from the short-term group intervention format, however, the group model is also offered to students who have long-standing school-related difficulties, and have experienced no recent family change.

At the onset of the group, children are given a journal and encouraged to write about their concerns and feelings. This behavior creates a sense of continuity between sessions. To introduce the concept that each child is a unique individual, participants are given a photograph of themselves to place on the cover of the journal. Photographs are also used as part of the group's termination process, and members are given a picture of the entire group during the group's farewell party.

Activities that involve art, play and drama are used to facilitate discussion about divorce-related issues, and to encourage group members to work through conflicting emotions (e.g., guilt, rage, despair, feelings of abandonment). Goldman (1986) provides an example of the group structure and the types of interventions used at each session.

■ First session: Drawing of good and bad changes. The concept of change is introduced and discussed, and participants are asked to draw a picture of a good change, and of a bad change, and present these picture to the group.

■ Second session: Feeling charades. Children are given a card with a feeling written on it (e.g., happy, sad, angry, jealous) and are encouraged to act out this feeling until it is guessed by other group members.

■ Third session: Family change drawing. Various issues that surround family change are introduced to the group, and children are asked to draw pictures that depict a good change

and a bad change that occurred within their families over the past year.

■ Fourth session: Family wish drawings. Participants are asked to draw and share a picture that discloses something they wish would change in their families over the next year.

■ Fifth session: KKID Radio Broadcast. A mock radio broadcast (question and answer format) facilitates the discussion of the children's concerns about issues related to separation and divorce.

■ Sixth and seventh sessions: Visitation skits. The group is separated into two groups and each subgroup is asked to write and develop two skits that pertain to good and bad noncustodial parental visitations. After the skits are presented, the group leaders help children think of changes that might produce a more pleasant visitation situation, and ways the children might facilitate those changes.

■ Eighth session: True-false game. The group leaders present prepared true-false statements to group members to (a) assess what participants have learned about divorce; and (b) address unresolved issues.

■ Ninth session: Coping skills diplomas. During the last group meeting, children are given a diploma that has a coping skill written on it. An example of a coping skill could be "When your parents are fighting, you can visit a friend, ride your bike, read a book, or go outside and play ball".

Individual evaluations are conducted one month post-termination to evaluate the participants' subjective response to the group, discuss specific school and family problems at a greater depth, and offer further assistance to the child and his or her family. The author recommends that an additional follow-up interview be performed approximately nine to ten months following the group intervention to reassess the risk of the child, and if necessary, make referrals to appropriate treatment programs.

CHAPTER V

CONCLUSION

SUMMARY

The purpose of this thesis is to (a) summarize a sample of the literature that pertains to suicidal behavior; (b) explore the ameliorating factors of the group treatment approach for people who experience suicide-related issues; (c) provide information and models for special suicide-related groups (intervention and postvention); and (d) discuss age-specific variations of suicidal behavior.

Suicide Intervention Groups

Suicide is the ninth leading cause of death in the United States and the populations most at risk for suicidal behavior are children, adolescents, and adults, age 65 and older. The studies reviewed indicate that the act of killing oneself is rarely precipitated by a single factor. The phenomenon of suicide is considered to be a process, and suicidal behavior is the result of a culmination of the interaction among various psychological, behavioral, environmental, social and situational factors. Variables that are proposed to contribute to the incidence of suicide include (a) social conditions and practices; (b) family factors (e.g., conflict,

impaired communication, abuse, history of suicide); (c) genetic disposition; (d) individual circumstances; (e) personal motivation; (f) developmental stage; and (g) depression.

Depression is identified as the major predictor of suicidal behavior, and the emotional and behavioral features of depression (e.g., feelings of low self-esteem, helplessness, hopelessness and despair; external locus of control; dependency; inadequate coping and problem-solving skills; poor communication skills; withdrawal) (a) increase the probability of negative experiences (e.g., rejection, isolation, and a reduced social support network); and (b) reduce the ability to generate workable solutions to problems and adopt effective ways to cope with life events.

The group therapy approach is recommended as a treatment modality for persons who are depressed and/or suicidal. It is further suggested (Asimos, 1979; Frey, et al., 1983; Hipple, 1982) that a short-term, homogeneous, open group format better suits the special needs of people who have suicide-related issues. The benefits of this group approach are many and include (a) reduction of feelings of loneliness, isolation and hopelessness; (b) satisfaction of the need to belong, to be accepted, to give and receive love, and to be socially integrated; (c) opportunity to disclose concerns and receive feedback; and (d) provision of an arena where members can learn and practice new effective ways to communicate,

problem-solve, cope and adapt to life situations. In addition, suicide-related groups can supply a support system, reduce resistance to treatment programs, and treat a greater number of persons who are at risk for suicide.

Leaders of suicide-related groups should be thoroughly trained in (a) psychological assessment; (b) the basic theories of group counseling; (c) the fundamental principles of group dynamics; (d) the processes and procedures of group work; and (e) the application of these maxims to therapeutic work with persons who are suicidal and/or depressed.

The primary goal of short-term intervention-oriented group therapy is the confrontation and prevention of suicidal ideation and destructive behaviors in group members. Subsequent goals include (a) reduction of stress; (b) encouragement of self-disclosure; (c) encouragement of self-responsibility and self-management; (d) enhancement of self-concept; (e) consideration of future goals; (f) development of external support systems; and (g) motivation of clients in the pursuit of extended therapy.

Suicide Postvention Groups

The literary reports indicate that suicide attempts and completions may adversely effect the lives of over twelve million Americans annually. Yet, postvention is a seriously neglected component in the field of suicidality. The majority of studies reviewed propose that the most difficult type of bereavement is mourning a death by suicide because (a) the

loss is premature and unexpected; and (b) social stigma, which is generally attached to the death by suicide, aggravates the problems of survivors.

Survivors of suicide, in comparison to survivors of other types of death, typically experience a more encompassing distress reaction (e.g., shock, horror, intense shame, excessive guilt) to the death. In addition, people who encounter a suicide frequently have a history to dysfunctional family relationships, impaired communication systems, emotional or cognitive disturbances, experiences of separation and loss, and based on these past experiences, may develop inadequate coping mechanisms that shape their strategy of response to a traumatic event, such as a death by suicide. Factors that have a mediating impact on the grieving process include (a) the quality and type of relationship between the survivor and the deceased person; (b) the reserve of coping skills available for the survivor; (c) the circumstances surrounding the death; (d) the social support system available to and used by the survivor; (e) the age and gender of both the survivor and the decedent; and (f) the cumulative losses and stressors experienced during the adjustment period (Constantino, 1989; Valente, et al., 1988; Wroblewski, 1984).

Suicide survivors have a tremendous need to communicate their feelings, yet because of social stigma, they may avoid discussing the suicide with natural sources of support. Family and friends may feel threatened by the suicide, and may

(a) be unable to reach out and comfort the survivor; (b) discourage discussions about the suicide; (c) attempt to blame the survivors; or (d) completely ignore the cause of death. Group postvention is a therapeutic procedure that allows the grieving survivors to discuss and ventilate their emotions, receive emotional support from people who share a similar experience, work toward the resolution of the bereavement process, and achieve positive growth.

Age-Specific Variations for Suicide-Related Groups

Adults who are older. Research indicates that adults, age 65 and older, comprise the population group with the greatest risk for suicide completion. This risk for suicide is positively correlated with increase in age, and men and women over age 75 commit suicide three to four times more often than younger adults. Moreover, many professionals propose that the seriousness of the risk of suicide is vastly underestimated because of misdiagnosis and underreporting practices (Saul & Saul, 1988).

According to the available literature, the major factors that are related to suicidal behavior in adults who are older are (a) lowered self-efficacy (e.g., diminished perception of control over life events, reduced freedom of choice, decreased personal effectiveness); (b) separation and loss (e.g., loss of professional and social status, reduced income, death of family and friends, impaired physical and mental capabilities, loss of home, diminished self-esteem); and (c) depression.

It is projected that about 12% to 18% of people who are older have a clinically significant depression, and older adults, who are depressed, have a much higher risk for suicidal behavior. Effective treatment is imperative for this population because even episodes of minor depression can present a life-threatening situation (Achte', 1988; Kermis, 1986).

The literature demonstrates that groups are an excellent and practical method of providing mental health services for adults who are older. This population is often isolated and lonely, and groups provide peer experiences, social contact, and opportunities to receive feedback, and share beliefs, information and feelings. In addition, groups (a) restore a sense of mastery and competence; (b) help repair injuries to self esteem; (c) decrease depression; (d) allow the grieving process to occur in a supportive environment; and (e) facilitate adaptation to life's changes through the acquisition of problem-solving and coping skills.

Children and adolescents. Many professionals believe that suicide is now the leading cause of death in younger populations. Moreover, the studies reviewed reveal that the current trend for childhood and adolescent suicide is an increased number of attempters and more attempts by younger children. The fact that the probability of a completed suicide is significantly increased among adolescents who have attempted suicide compounds the seriousness of this problem.

Research has been unable to identify specific factors that cause suicidality in younger populations, but has demonstrated that certain variables, when presented in a cluster of symptoms, are significantly correlated with childhood and adolescent suicide. These variables include (a) separation and loss (e.g., divorce, death); (b) family history (e.g., conflict, destructive communication, neglect, abandonment); (c) developmental and maturation processes; (d) environmental pressures; and (e) depression.

Children and adolescents benefit from most of the same advantages offered by adult therapy groups, and the group model, with some modifications, is an effective method of providing mental health services for younger populations. Groups that incorporate play activities, such as art, storytelling, poetry, and drama are appropriate for children, and when combined with a behavioral format (a) teach children effective ways to deal with destructive thoughts; (b) promote productive social, problem-solving and coping skills; (c) facilitate discovery of self; and (d) elevate self-esteem.

IMPLICATIONS FOR FUTURE STRATEGIES OF INTERVENTION

The escalating incidence of suicidal behavior in the United States, especially the dramatic increase in rates among children, adolescents and adults who are older, suggests that the traditional model of intervention (i.e., individual approach) inadequately addresses the problem.

Durkheim (1951) concluded that the greatest deterrent to suicidal behavior is a sense of involvement and identification with other people. Despite the fact that extensive research findings demonstrate that groups provide a sense of integration and belonging, and that clinical reports attest to the positive benefits of the group therapy approach for people with issues related to suicide, the majority of professionals who work with people with suicide-related issues are reluctant to form groups with people at high or moderate risk for suicide. The credibility of group counseling for people with issues related to suicide will be strengthened by the initiation of methodologically sound and replicable research that investigates specific group therapy models, methods of treatment, and provides clear and concise information about the outcomes of the study.

1. There is a need for the reassessment of current perspectives on suicide prevention, intervention and postvention treatment programs, and the development of more precise, effective and practical methods of responding to people who have issues related to suicide.

2. There is a need for education and training about the signs and symptoms of suicide, and the provision of referral sources for individuals (e.g., nurses, doctors, paramedics, police, school personnel) who have contact with people in the community. These training programs should include components that emphasize variations within specific populations.

3. There is a need to increase the availability and quality of existing treatment programs.

4. There is a need to establish more effective programs in primary and secondary prevention programs. For example, suicide education programs in the schools may not be the most effective method for suicide intervention, prevention and postvention. Schools could work conjointly with community health professionals to establish prevention and intervention groups for adolescents.

5. There is a need for studies that research the distinctive factors related to suicidal behavior in different population groups, and for the organization of prevention and intervention groups that specifically address the needs of high risk groups (e.g., children, adolescents, adults who are older).

6. There has been much research that focuses on the investigation of the causes of suicide, and not enough research that determines the practicality and effectiveness of therapeutic approaches for people with suicide-related issues.

7. There is a need for comparative studies of different treatment modalities (e.g., individual, group, family) for suicide prevention, intervention, and postvention programs. Objective research that emphasizes the clinical experience and examines the long range impact of therapy may facilitate the willingness and courage to incorporate different methods of

treatment. Wherefore, such research can empower counselors to confidently select a more effective mode of therapy, devise an appropriate strategy for treatment, and experience a more positive outcome from the therapeutic process.

8. There is a need for qualified training programs for counselors who work with people who have suicide-related issues.

9. There is a need for master and doctorate level programs to provide instruction on group theory and intervention, and offer a group practicum component.

10. There is a need for graduate programs in counseling and psychology to include programs that focus on the facilitation of groups for special (e.g., suicide prevention, postvention) populations. In addition, graduate students should be taught interventions that are appropriate for age-specific groups.

11. There is a need for more literature that discusses group therapy as an alternative intervention for special populations.

RESEARCH-RELATED COMMENTS

It would certainly be reassuring for mental health professionals if the assessment of the potential for suicide was guaranteed by a reliable instrument that could accurately predict whether a person, would, at some time in the future, attempt to commit suicide. Even the development of a standardized test that could identify clients who are at

immediate or near risk for suicide would reduce the feelings of overwhelming anxiety that counselors often experience when they attempt to make a reasonable prediction of whether their client is at high risk for suicide. Unfortunately, such instruments do not exist, nor are they likely to be developed in the near future.

There are many problems tied to the research of a phenomenon such as suicide. Once a suicide occurs, the subject can no longer supply information about the factors that precipitated the event. One might consider performing a psychological autopsy with the assistance of friends, family, and other people who might be able to furnish knowledge about the decedent. These structured interviews might render pertinent information about the pre-death psychological and behavioral status of the deceased person, and details about his or her family history, but these data might be contaminated by (a) the bereavement response to the suicide; (b) family feelings of shame and self-recrimination; (c) social stigma; and (d) the tendency of the family to conceal certain facts about the suicidal death. Furthermore, the facts surrounding the suicide might not be available to family and friends because the majority of people who commit suicide are ambivalent about their desire to die, and this decision is usually finalized when they are alone and experiencing a period of severe psychological distress. Ultimately, the climax of the suicide process is most likely

the result of a lifelong culmination of the interaction among various psychological, behavioral, sociocultural, environmental and situational experiences. The greatest obstacle to the accumulation of accurate data about possible causes of suicidal behavior is the difficulty encountered when an attempt is made to measure the elusive, unique and intricate nature of the human experience.

Another alternative is to gather information from a sample of people who have attempted suicide. The problem with this approach is that this sample may not accurately represent the targeted population (i.e., people who will complete suicide). It is likely that only those people who seek mental health assistance will be interviewed, and that an unrepresentative percentage of this sample of individuals who have attempted suicide may be different in significant ways from those who have completed suicide. In addition, each person's experience is unique and the reasons for suicide are extremely complex. The risk of suicide can vary greatly with individual factors, such as age, gender, developmental stage, current emotional state, environmental stressors, sources of support, motivation, coping and problem-solving skills, and a multitude of other variables.

Furthermore, there are many complications in developing an instrument that can accurately predict the probability of suicidal behavior. For example, a test used to identify persons at risk for suicide should have two important

components: sensitivity and specificity (Murphy, 1988). The percentage of times the test accurately identifies a targeted behavior is the sensitivity of the test. The test should also be able to rule out cases in which the condition is absent. The percentage of cases correctly identified as negative is the test's specificity. A third variable that can determine the accuracy of the test is the relative frequency of the condition being investigated. When the condition has a low rate of occurrence, the probability of the test identifying false positive data or false negative data, increases. For instance, the rate for suicide in adolescents is 13.1 per 100,000. Although this figure denotes that the incidence of suicide in this population is dangerously high, the base rate for suicide is too low to produce accurate predictions of behavior. Depending on the sensitivity and specificity values of the instrument, either numerous adolescents would be identified as being suicidal when they were not (false positive), or a substantial number of adolescents would be identified as being without risk, when in fact, they were at high risk for suicide (false negative) (Murphy, 1988).

The studies which have unsuccessfully attempted to determine any statistically significant predictor of suicidal behavior, have substantially contributed to the current base of knowledge about suicidal behavior. Research needs to build on this existing groundwork about the psychosocial, philosophical, biological, and cultural aspects of suicide,

and aggressively pursue new hypotheses that will assist in methods of assessment and the formation of potent prevention, intervention and postvention programs. At present, this wealth of information has established certain characteristics that are common to suicidal behavior. When these distinct elements are presented together, the potential for suicide increases. All of the factors that are correlated with suicidal behavior should be explored during the assessment of clients who are suspected to be suicidal. The group facilitator should be knowledgeable about these symptoms, employ a systematic and thorough strategy for assessment, and be acutely alert to certain characteristics that mandate initiation of a crisis intervention tactic.

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