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CHILDREN BEREAVED BY SUICIDE

Evaluation of a Group Intervention

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Foreward

This research was commissioned by the Daughters of Charity Child and Family Service as a direct result of the increasing demand for support for children bereaved by suicide following the death of a close family member by suicide. Following on from a number of referrals across the service to the family centers it was agreed that a consistent and group work approach was required to support these children and their families. Family workers got together with other agencies to explore best practice in the area and to develop a template for children bereaved by suicide.

After the template was finalised the bereavement group was set up with children from different areas of the city attending. As well as assessing the effectiveness of this intervention being measured in this report; a longitudinal follow up on three of the families after four years was also completed.

The findings indicate that the attendance at the group had a positive long term impact on the children and that the provision of the suicide specific group was an effective intervention for the children and their families. Although the group was a small group of five children; their experiences and feedback from both the children and their families has been very helpful to the service. The group allowed the children space to make sense of their experience and to express themselves with a group of children with a similar experience. The children reported feeling less isolated, having their own space and being able to laugh and enjoy life again. In the future areas to develop include having mixed gender facilitators and to have a reconnection event to support the new friendships that developed as well as having more fun events. This report reaffirms the work carried out with the children bereaved by suicide and the children are continuing to attend across the service and receive support as part of a generic family centre service.

Many thanks to all the family centre staff who facilitated the group, to the steering group committee for the bereavement service especially Dr. Ella Arensman and Sr. Margaret Joyce.

Thanks also for Dr. Angela Veale, School of Applied Psychology, University College Cork for researching and writing the report as well as completing the longitudinal follow up research.

I hope this report will direct and influence the work with families bereaved by suicide to ensure a positive outcome to the therapeutic support work that is ongoing throughout the service.

Geraldine O'Hara.

Senior Manager, Daughters of Charity Child and Family Service.

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Executive Summary

1. This report describes a longitudinal evaluation of a therapeutic groupwork intervention for children aged 8-12 years bereaved by the suicide of a parent or relative, offered through the Daughters of Charity Child & Family Service. In 2001, a steering group on suicide prevention was established by the Northern Area Health Board. A primary recommendation of the group was that a specialist service for children bereaved by suicide should be established as an urgent priority.
2. Empirical evidence now strongly indicates that parental suicide is a risk factor for offspring mental health difficulties and even suicide. Research findings suggest that suicide bereaved children were more likely to experience anger and shame and less acceptance of the death, one year after bereavement than non-suicide bereaved children. Age at bereavement by suicide is emerging as a significant predictor of later emotional and behavioural problems as recent research findings show that parental suicide affects children more profoundly than young adults (Wilcox et al, 2010; Sørensen et al., 2009).
3. Group participants included 4 boys and 1 girl aged 8-12 years. The Daughters of Charity's Children's Bereavement Group met weekly for 1.5 hours from September-December 2007 over 11 weeks. A child-centred evaluation was carried out that involved pre- and post- intervention interviews and further follow up six months and four years post-completion.
4. On the Child Behaviour Checklist, pre-intervention scores indicated that 80% (n=4) of children exhibited scores within a clinical range for emotional and behavioural problems. Total competence scores (activities, school and social competence) were similar to normative sample scores for 80% of children. These findings are similar to those found by Pfeffer et al. (1997, 2000) and others when working with referred samples of suicide-bereaved children who typically showed difficulties with depression/anxiety and behaviour problems but normative social competence. Post-intervention, 1 child (20%) was within the clinical range for internalising and total problems. All were scoring within the normal range for total competence. At follow up six months, 1 child (20%) was within the clinical range for internalising problems and all children were within the normal range on their total (overall) problem behaviour score. At four year follow up with three participants, total problem scores were within the normal range.
5. A function assessment elicited information on tasks that children found more difficult since the bereavement and this included visiting places, thinking of and missing the person that died, getting up in the morning, school, football training, special occasions, going to the graveyard. Over time, they rated that many of these tasks became easier although special occasions and going to the

graveyard remained somewhat difficult.

6. It appears that overall, the number of people in children's networks was not affected greatly by suicide but children reported that the quality of relationships; feeling able to talk about the relative that died; or in particular to talk about suicide, was impacted upon within these relationships.
7. The most important contribution of the groupwork for children and parents was the opportunity for children to talk with other children who were bereaved through suicide and to feel they are not alone. This has made it easier for parents and children to talk about the suicide of their loved one at home, and with other important people outside the home.
8. Four years on, some of the former group participants have taken leadership roles in their schools by working with teachers and mental health professionals to set up projects or organise talks on suicide, suicide bereavement and suicide prevention. Thus the project has had an unanticipated multiplier effect in reaching children affected by suicide.

Introduction

This report describes a longitudinal evaluation of a therapeutic groupwork intervention for children aged 8-12 years bereaved by the suicide of a parent or relative, offered through a community-based child and family service, the Daughters of Charity Child & Family Service in partnership with Console. In 2001, a steering group on suicide prevention was established by the Northern Area Health Board. Three working groups were established to focus on the prevention of suicide amongst the general population, high risk groups and the provision of support following suicide. A primary recommendation of the group was that a specialist service for children bereaved by suicide should be established as an urgent priority.

In September 2004 the Daughters of Charity Child and Family Services and the Northern Area of the Health Services Executive initiated a pilot project to conduct a needs-assessment of children bereaved through suicide and, informed by this, to develop a support service. A Bereavement Therapist was employed to conduct this needs analysis. In 2006, a bereavement support service was established. This service offered individual work, family work, couple, sibling and group work to suicide-bereaved children aged up to 18 years and to their families in the Dublin area. This is the context in which this groupwork intervention for suicide-bereaved children was developed.

In Ireland, there are no statistical records available on the number of children who are bereaved annually through suicide of a family member. However the National Strategy for Action on Suicide Prevention 'Reach Out' Report (2005) noted that Ireland has experienced one of the fastest rising suicide rates in the world and that this has been most striking in men, and young men in particular, aged 19 -54 years of age. What is often overlooked is that many of these men are fathers or brothers and thus increasing numbers of children are experiencing bereavement of close family members, in particular fathers, through suicide. Little is known of the developmental impact on children of experiencing a family bereavement through suicide. A small but growing literature is asking if the experience of grief after a suicide loss is different in important ways from other losses, and if so, how can this inform the development of appropriate support services?

I. Child suicide survivors: The impact of bereavement by suicide?¹

Empirical evidence now strongly indicates that parental suicide is a risk factor for offspring mental health difficulties and even suicide. Early studies sought to understand the impact of bereavement by suicide. Pfeffer et al. (1997) described the characteristics of 22 children aged 5-14 years from 16 families bereaved by the suicide of a family member within a year of bereavement. The suicide victim was a father in 50% of cases, followed by a mother (25%) and a brother or sister (18% and 7% respectively). Compared against a normative community sample, child survivors of suicide had higher rates of depression and anxiety (internalising symptoms), and poorer levels of social maladjustment, especially regarding academic competence and spare-time functioning. Findings indicated that 25% of families had children who reported clinically significant symptoms of depression, 40% of families had children who reported moderate symptoms of post-traumatic stress disorder (PTSD) and 31% of families reported at least one child with recent suicide ideation. Approximately half of surviving parent(s) had significantly higher levels of psychological distress, especially anxiety and depression, than community norms. Parents own functioning was an important factor mediating child outcomes (positive parenting, parental depression). Child-level factors (efficacy of coping, inhibition of emotional expression, and fear of abandonment) were also significant.

More recent studies have attempted to understand whether children bereaved by suicide have different needs, experiences or outcomes compared to children bereaved due to other causes. Cerel et. al (1999; 2000) found that suicide bereaved children were more likely to experience anger and shame (grief-related emotions) and less acceptance of the death one year after bereavement than non-suicide bereaved children. They found no differences between the groups on sadness and suicidality. Cerel & Roberts (2005), in a large scale health survey of a nationally representative sample of adolescents aged 11-21 years in the US, found that of their sample of 5,918 adolescents and their caregivers, 1.2% experienced a family member's death by suicide in the past year. Suicide-bereaved adolescents were more likely than their peers who had no such experience to report behaviour problems including emotional distress, marijuana use, binge drinking and suicidal ideation and attempt. In spite of this, bereavement by suicide did not have a significant independent effect on school grades or parental reports of parent-child connectedness, implying adolescents were demonstrating some resilience and competence. Based on their findings the authors concluded that adolescents who have experienced suicide deaths in the family show

1 The following databases-EBSCO, PsychINFO; Psychology & Behavioural Sciences Collection; PsycArticles; & Medline were searched for peer reviewed papers published from 1995-2009 that included the words 'child', 'suicide', 'bereavement' 'parent', 'family'; and 'impact', 'intervention', 'group', 'support', or 'evaluation'.

high levels of at-risk behaviour and “*must now be considered a risk that can be the focus of intervention*” (p.15).

Pfeffer et al. (2000) compared outcomes within 18 months of parental death for 16 suicide-bereaved children with 64 age-matched cancer-bereaved children (age range 6-13 years). The results found that suicide-bereaved children reported higher levels of depressive symptomology than cancer-bereaved children, however for both groups, levels of symptomology was comparable with a normative sample. Brown et al. (2007) compared 24 suicide bereaved children and adolescents from 15 families with 302 children from 186 families who lost a parent from all causes other than suicide (homicide and accidents) and found no significant differences between the groups on child or family functioning. However a recent large-scale population study demonstrated offspring who have experienced parental suicide are at greater risk of psychiatric disorders and suicide compared to offspring of parents who died from accidents and other causes (Wilcox et al., 2010). Children who lost a parent to suicide were three times more likely to committ suicide than those living with parents. Age at which bereavement occurs is a significant predictor of future distress; child and adolescent offspring are at threefold greater risk for suicide but not young adults (Wilcox et al, 2010; Sørensen et al., 2009). This suggests there may be an interaction between developmental period and suicide bereavement that is not well understood but is potentially critically important to understand.

There is a small literature that has examined the consequences of suicide for family and social networks. This literature suggests that the *experience* for children of bereavement by suicide may be different in important ways to other forms of bereavement. Cerel et al. (2008) found that a death through suicide in a family affects communication processes within the family and between the family and their extended networks in profound ways. Distortion of communication processes may occur around the issue of blame, “overtly expressed or covertly communicated through non-verbal cues and social withdrawal, straining and even rupturing the cohesiveness of a family” (p. 39). The development of secrecy around the cause of death also has a deleterious impact on communication and on social networks, and family members are most likely to hide the cause of death from children. A third observed communication pattern can be social ostracism and self-isolation by suicide survivors. Taken together, these distortions of communication patterns may create a cycle of avoidance, misunderstanding and social distance between surviving family members and their broader social networks of friends, relatives, colleagues that can complicate grief and mourning. Jordan (2001) argues that it is the social processes and the impact suicide has on family systems that make the subjective experience of grief after a suicide loss quite different from other losses. Dyregrow et al. (2003) found self-isolation was by far the best predictor of psychosocial distress following a family suicide. Cvinar (2005), in a review of the literature, argues suicide has an effect on families that transcends the immediate loss through the mediating effect of

stigma and “this individual or societal stigma introduces a unique stress on the bereavement process that sometimes requires...intervention.” (p 14).

A child-centred exploration of the experience of suicide-bereavement is for the most part absent in the literature. Provini, Everett & Pfeffer (2000) found that adult relatives of suicide victims frequently go through a process of questioning the reasons for suicide/self-blame and avoid talking about it for fear of being overwhelmed. This has an impact on their role as parents as they have an additional responsibility of helping children understand and process the loss.

The tasks for children in restoring functioning and social competency may be different to that of adults, and this is an unexplored area in the literature. ‘Sense-making’ or the capacity to construct an understanding of the bereavement is a mediating variable between a violent death, including suicide, and complicated grief symptomatology (Currier, Holland & Neimeyer, 2006). Given children’s emotional and cognitive developmental status, this may have particular resonance for children.

In summary, what lessons can be drawn from the literature reviewed above with respect to the development of appropriate interventions for children bereaved by suicide?

Firstly, parental or familial bereavement through suicide is not a homogenous experience for children and not all children bereaved through suicide need intervention. We are developing a clearer picture of what experiences and factors at a child-level, parent-level and within the broader family system place children at risk or poorer outcomes following suicide and factors that may promote resiliency (Brown, 2007). Positive parenting or poor parental coping, depression or anxiety emerges as important in relation to the nature and extent of child bereavement difficulties. Child-level factors such as inhibition of emotional expression has been significantly linked to children’s internalising and externalising problems (Brown, 2007). Family communication processes, especially around blame and secrecy can be sources of dysfunction in family systems with long terms impact on grieving and healing, particularly for children (Cerel et al., 2008). Parental suicide during childhood or adolescence is a particular risk factor for poor mental health (Wilcox, 2010).

These give us important theoretical tools to understand how interventions might sensitively target the experience of children and parents experiencing difficulties in dealing with the loss through suicide to promote resiliency and prevent poor long-term outcomes.

II. Child suicide survivors: Efficacy of interventions

Therapeutic groupwork is a relatively new methodology for working with children bereaved by suicide. There may be concerns about the appropriateness of bringing children together to talk about suicide as well as concerns about

retraumatisation, enhancing rumination about suicide and 'Do no harm'. Therapeutic groupwork holds out the possibility of offering children a different 'space' to deal with bereavement through suicide compared to individual counselling. Moore & Freeman (1995) argue that as grief is a normal rather than pathological psychological reaction to death, community-based support groups offer an appropriate response. Pietila (2002) argues talking about bereavement in a group is an utterly social action and can function to take grief out of an inner (isolated/isolating) space into a social space where people can find understanding, a sense of mutual acceptance and togetherness.

An interesting group intervention study for children bereaved through the suicide of a relative (parent or sibling) was carried out by Pfeffer et al. (2002). Families were identified from medical examiners' lists of suicide victims over a three year period. Children with diagnosed psychiatric disorders were excluded so participants represented a community-based sample. Children were randomly assigned to two groups in which 75 children from 52 families were assigned to a treatment group and 39 children from 27 families were assigned to a waiting list/control group. Children attended 10 weekly 1.5 hour sessions and their surviving parent/caregiver attended separate but simultaneous sessions. Children's groups consisted to 2-5 children grouped by age. Theoretical concepts of attachment (Bowlby, 1980), responses to loss, and cognitive coping (Lazarus & Folkman, 1984) informed the intervention and main themes focused on children's understanding of and responses to the death of a parent or sibling, unique feature of suicide, loss of personal/environmental resources and psycho-educational components of concepts of death, what is suicide, why people commit suicide and problem-solving skills. Findings demonstrated greater reduction in anxiety and depressive symptoms for children receiving the intervention than for non-intervention children. Furthermore, for the non-intervention group, anxiety at outcome was greater and depression levels similar to that at initial assessment. In the intervention group, children whose pre-intervention anxiety and depression scores were rated as clinically significant had anxiety and depression scores below clinically significant levels at post-intervention. A limitation in the study was there was a significant dropout of children assigned to the waiting-list/control group (75%) compared to the intervention group (18%) but the findings offer cautious support for the efficacy of groupwork interventions.

Mitchell et al. (2007) conducted a support group intervention for children aged 7-13 years bereaved by suicide of a parent at an outpatient psychiatric clinic in the United States. Six to eight children attended an 8 week bereavement support group. Their report is a descriptive account of the groupwork sessions and offers no evaluation of mental health or competency outcomes. They found it was important to consider a child's readiness to engage with groupwork. Participants expressed appreciation for the realisation they are not alone and other children experience similar thoughts and feelings. The session goals focused on expression of feelings, instilling hope, understanding the act of parental suicide and children's experiences of

grief, interpersonal learning, an integration of conflicting feelings towards the parent who had died, and managing the group ending. Their observations were that the group helped children comprehend what suicide is and why it can happen, that it enhanced children's coping skills to cope with the death, and facilitated effective communication but noted "future research designed to evaluate the effectiveness of survivors of suicide support groups with children are desperately needed" (p 13). Hollander (2001) also makes a case for the need for more evaluation, in particular to monitor for 'do no harm' or any negative outcomes.

III. The groupwork intervention

This intervention was developed in response to requests from children and parents attending the Daughters of Charity Family Centres for bereavement support in the aftermath of suicide, in particular to suicide within the family and the sense of isolation children voiced about being "the only ones this happened to". A suicide-specific bereavement group for adolescent girls bereaved through suicide by a parent was run in 2005. It consisted of ten sessions and was in response to requests from adolescents to meet other young people affected by suicide. The Suicide Bereavement Therapist noted that feedback from the group was very positive and it seemed to be meeting a real need:

All of the young people who attended that group spoke about how helpful they found it to be able to talk about their feelings and thoughts with other young people who 'understood' as a result of having lost someone through suicide. It was important to them that all the members of the group had lost a family member to suicide and expressed the belief that a death to suicide is different from other types of death. The reason given by them for this was that they understood each other and that other people who had not lost someone to suicide tended to judge the suicidal act. Some of the girls attending the group had never been able to tell to another young person that their parent had died through suicide. Some of them had never met another young person who had bereaved someone through suicide. (Suicide Bereavement Therapist, Daughters of Charity Child & Family Centres).

The groupwork template for children aged 8-12 years was devised by a Daughters of Charity Child & Family Service working group, supported by a child psychotherapist from Solas (Barnados Bereavement Service), a member of the team from the Bereavement Service Temple Street Children's hospital, Deora Counselling and a psychotherapist from Console. The groupwork model was informed by recommendations arising from the Barnados project "*Talking with children bereaved by suicide*".

Participants

Group participants included 4 boys and 1 girl aged 8-12 years. Children were from families already attending the bereavement support service following the death of a family member by suicide.

The Eleven Week Sessions of the Children's Bereavement Support Group

The Daughters of Charity Children's Bereavement Group met weekly for 1.5 hours from September-December 2007 over 11 weeks. Groupwork was facilitated by a Child & Adolescent Psychotherapist and two Family Workers. Sessions were facilitated by two facilitators or three facilitators, with most sessions having three facilitators present. This enabled children to do individual activities within the group, supported by a facilitator and balanced with whole group activities.

Sessions were structured to progressively explore the bereavement experience, moving to memories of the loved ones and finally a focus on the future. Each session began with lighting a candle. In the first session, children were told this was to help them to think about the person they had lost. Various activities were used to involve children in the groupwork activity including art activities, physical activities, worksheets, reflective activities, and mindfulness practice.

Session 1 Introductions and why we are all here.

The introductory session sought to establish a safe, therapeutic space. The ritual of lighting the candle was introduced to the children, children used artwork to explore their hopes and fears and then they were given a box to decorate and children were told this box is for them to keep their work in during the group. This box took on the identity of a 'memory box' that children took home with them at the end of the groupwork.

Session 2 Why I'm here? Sharing and being connected

The goal of sessions to was to allow children to express 'what brings me to this group'. The session reaffirmed discussions of the previous week that everyone in the group has lost someone through suicide. Children were invited to write or draw something that represented why they are coming to the group. A core exploration was 'connectedness' and this was created through creative and physical exercises that explored themes of helping each other, safety, sharing of experiences, differences and support.

Session 3 All about me-changes in my life since the death

This session focused on the fact that all children had recently lost someone through suicide and the aim of the session was to explore what had changed in their

lives. Using a story of ‘The river’, participants used collage, drawing and painting to explore their feelings and changes.

Session 4 How the family has changed

Following on from the previous session, the objective of this session was to help participants understand how the family had changed as a result of suicide-bereavement and to look to other family members to receive support and help.

Session 5 My story of the death

In week 5, groupwork focused on exploring and reflecting on each participant’s story of the death, what they were doing when they heard the person died, who told them, the history behind the death. Children worked individually, supported by the facilitators and also in the group. Mindfulness exercises (breathing exercises, bodyscans) helped children focus on and manage emotions.

Session 6 The funeral

This session focused on thinking about the funeral, if children went to it, if they didn’t, memories of the occasion or what they would like to know. Questions such as ‘what happens to people when they die?’ were raised and explored.

Session 7 & 8 Questions we have and what happens after death?

The group were invited to put forward what questions they have and the sessions explored why people die by suicide and why do people kill themselves. The discussion raised lots of issues as to why people died by suicide. These were written on a big piece of paper. It had been planned to devote one session to this topic but given the needs of the group, a decision was made to devote a second session to this topic. Session 8 focused on ‘Why suicide?’ and exploring answers to this.

Session 9 Memories of loved one

The aim of this session was to explore, reflect and look at memories about the person who died.

Session 10 Affirmations, coping mechanisms and hopes for the future

Session 10 aimed to develop self-esteem by helping participants to look at affirmations, hopes and coping skills and to instilling hope for the future.

Session 11 Reflection on the group and ending

Reflection and ending. This session addressed questions such as ‘What have I learnt about bereavement over the last eight sessions? How am I feeling now that the group is coming to an end? Who will I turn to for support?’

Week 12 (post-intervention)

Ending celebration – Children and facilitators went ice-skating and for a meal.

IV. Research Methodology

Participants included all children and their parent(s) attending the groupwork intervention. Informed consent forms were signed by parents and by children. Children were told that we wanted to learn about their experiences of the project, and any ideas they may have for making the project better. This information would be used to inform people who may want to help other children bereaved by suicide. Parent(s) and children were interviewed three times; pre-intervention, immediately post-intervention and six months post-intervention. Four years post intervention, parental interviews and the Child Behaviour Checklist was carried out with three parents and three of the children (now adolescents) took part in a focus group discussion.

Participants

Child	Age	Gender	Bereavement	Time bereaved	Individual counselling	Pre-	Post-	Six Month+	+ 4 years
A	8	Male	Father	4 years	Yes	√	√	√	√
B	10	Female	Father	1 year	Yes	√	√	√	√
C	10	Male	Sister/Brother	4 years & 2 years	Yes	√	√	√	–
D	12	Male	Uncle	1 year	Yes	√	√	√	√
E	9	Male	Father	1 year	Sibling counselling with brother	√	—	√*	–

*Michael-final interview completed one year after completion of groupwork.

Research methodology with children

A child-centred methodology was developed to evaluate the groupwork with child participants. We chose to avoid using pre-determined research instruments with

children as it could be experienced as disempowering and uninteresting. Instead, we developed an approach that would elicit goals children saw as personally in terms of areas of functioning they felt were affected by the suicide of their relative.

Questions the research sought to address were as follows:

- (1) What was children's experience of the groupwork intervention?
- (2) What areas of functioning did children feel were impacted by the suicide of a loved one and did the groupwork help them develop competency or skills to manage better in those areas?
- (3) How isolated/connected did children feel to their supportive networks; specifically, what were the number, quality and strength of relationships children had with significant people in their lives?

Research methods included asking children to talk, in their own words, about their experiences of the group.

Function assessment using construct elicitation methods

A construct-elicitation method was used to identify with children the areas of functioning they hoped would change as a result of participation on the group. The objective of this method was to develop a personally relevant instrument to learn from children about areas of functioning in their lives that have been impacted as a result of being bereaved through suicide.

Social network & strength of relationship questionnaire

The social network & strength of relationship questionnaire is designed to assess the number, quality, and strength of relationships children have with significant people in their lives. Children are asked to name the people they have most contact with each week. They then identify the relationship of that person to them (sibling, friend, relative etc.) and whether the person lives at home with them. Once they have completed this list, children are asked to rate the quality of the relationship by assigning each person a number (1=bad, 2=half/half, 3=good). A question was asked: 'Who can you talk to' about the person bereaved by suicide?

Semi-structured interview. Post-intervention and at follow up 6 months later.

Children were asked some specific questions about the group such as What was your experience of attending the group? What did you like best about attending the group?

What did you find difficult about attending the group? What would you tell another boy, about your age that lost someone they love through suicide, about the group? Would you advise him to attend the group? Is it easy or difficult to talk about your (parent(s)? best friend? Significant relatives? Has this changed since the group began?

Sentence completion exercise

- “Things I liked about coming to the group were.....”
- “Things I did not like about coming to the group were....”
- “Something I miss now that the group is over is.....”
- “One thing that could have made the group better would be”
- “What I hope for the future is”

Methodology with parent(s)

- (1) Semi-structured pre-, post- and follow-up interview schedules were carried out with parent(s) (see Appendix C)
- (2) Social competence and behaviour- Child Behaviour Checklist

Parental reports of the children were obtained with the Child Behaviour Checklist (CBCL), a measure that yields *T* scores for scales of children’s competence and behaviour problems (Achenbach, 1991). The CBCL yields a Total Competence comprised of scores for specific competencies in activities, school, and social domains. It also yields a Total Behaviour Problems score, comprised of two broad subscales for internalising and externalising behaviours. These are comprised of specific subscales for internalising behaviours (anxious/depressed; withdrawn/depressed; somatic complaints) and externalising behaviours (rule-breaking behaviour and aggressive behaviour. Normal and clinical ranges of *T* scores are identified for selected sub-scales.

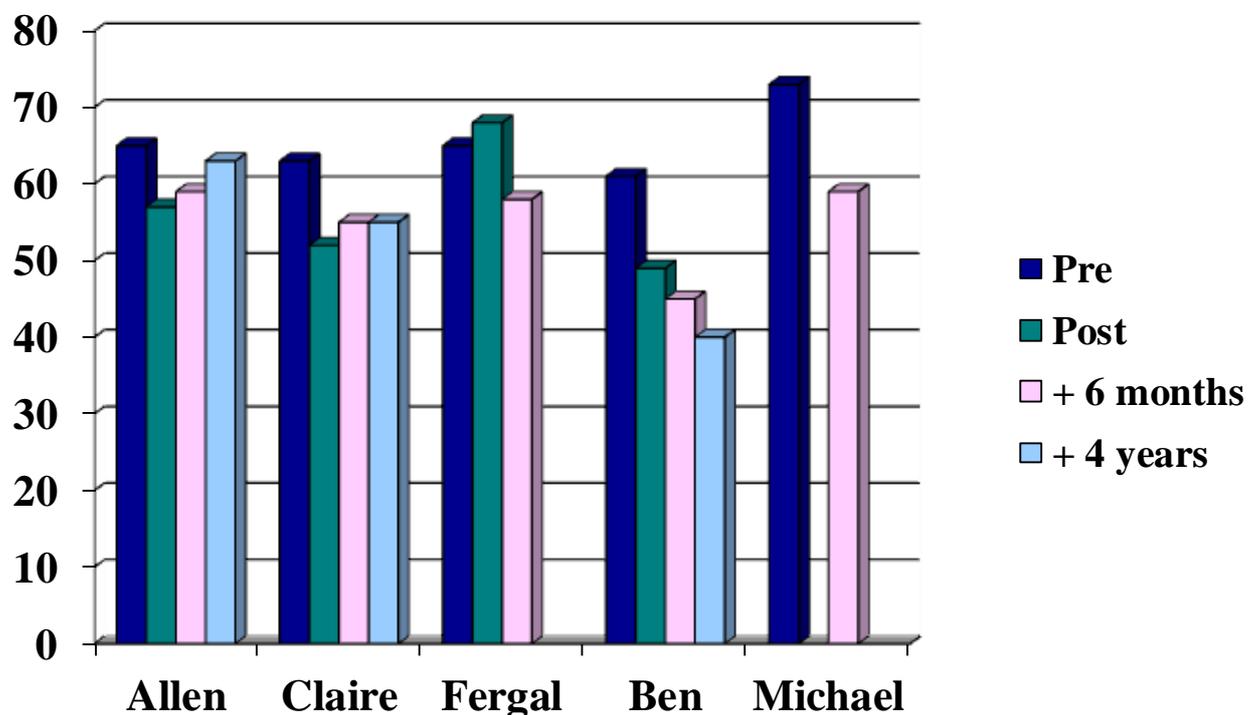
Control group

It was planned to also include a control group/waiting list matched by sex and age but this proved difficult. Two children were interviewed as part of this control group but subsequently dropped out and it was not possible to conduct three-month or follow-up interviews.

V. Results

Social competence and behaviour The Child Behavior Checklist 4-18 years was used to examine children's competence and behaviour problems. This is a widely used mental health scale standardised on American children and adolescents in the early 1990's. Raw scores were converted to age-standardised scores known as T-scores, in which the mean T-score is 50 and for Total Problems, Externalising Problems and Internalising problems, T-scores less than 60 are considered in the normal range, 60-63 represent borderline scores and scores greater than 63 are in the clinical range (Achenbach, 1991). Figure 1 summarises the Total behaviour problems T scores for the five group participants. In the period from pre- to post- test, 75%, or three of four children interviewed showed evidence of a reduction in behaviour problems. One child demonstrated slightly higher symptomology at the post-test phase. At the follow-up interviews, six months after the completion of the groupwork intervention, all children showed decreased behaviour problems compared to base rates.

Figure 1: Summary of Total behaviour problems for all participants at Pre-, Post- and follow-up 6 months & 4 years later (T scores less than 60 in the normal range; 60-63 borderline; more than 63 considered to be in the clinical range).



These results are now examined in greater depth.

Figure 2: Summary of Total behaviour problems for David at Pre-, Post- and follow-up 6 months & 4 years later (*T scores less than 60 in the normal range; 60-63 borderline; more than 63 considered to be in the clinical range*).

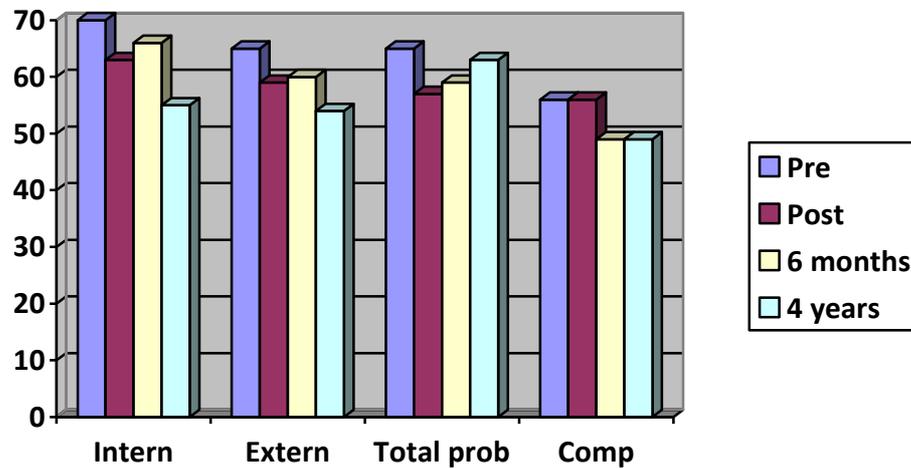
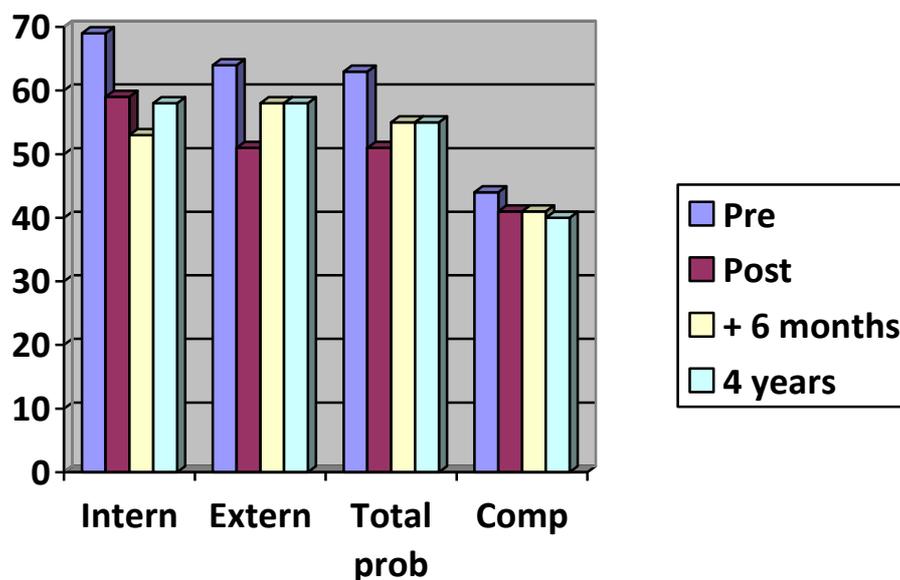


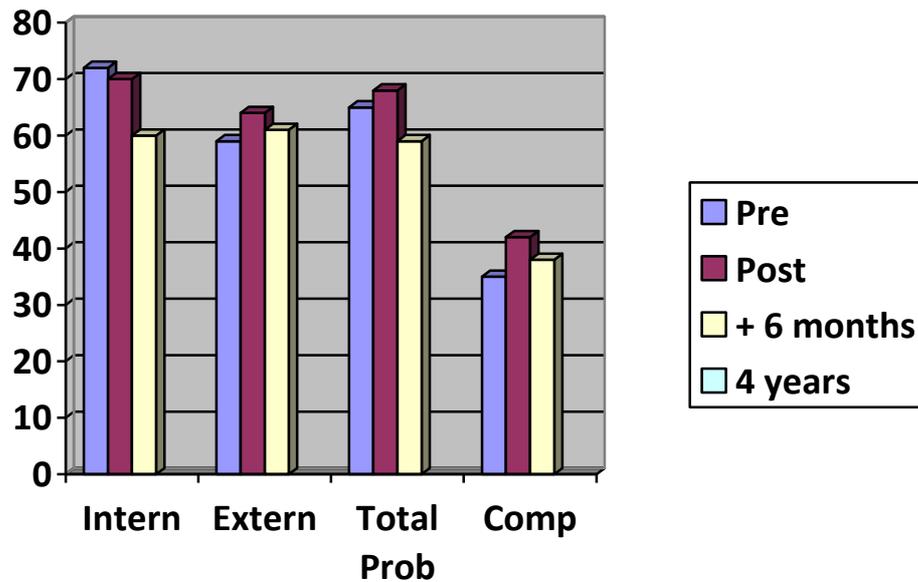
Figure 2 summarises the CBCL behaviour sub-scales for David, suicide-bereaved by his father. It demonstrates that David fell within the normal range for competence and was in the clinical range for internalising, externalising and total behaviour problems preceding the group intervention. Following the groupwork, internalising problems were in the borderline clinical range but within the normal range for competence, externalising problems and total behaviour problems. Six months post-intervention, there was a slight increase in internalising and externalising problems, with internalising problems measuring within the clinical range.

Figure 3: Summary of Total behaviour problems for Anne at Pre-, Post- and follow-up 6 months and 4 years later (T scores less than 60 in the normal range; 60-63 borderline; more than 63 considered to be in the clinical range).



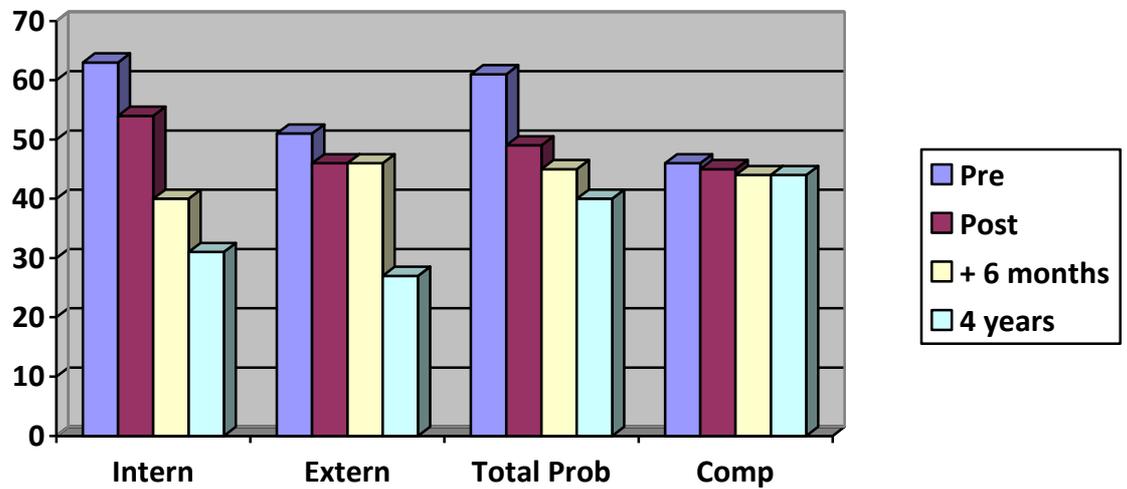
CBCL scores for Anne, who lost a father through suicide, scored within the clinical range for internalising problems, and within the borderline clinical range for externalising and total behaviour problems pre-intervention. Competence and behaviour problem scores at post intervention and again at follow-up are within the normal range.

Figure 4: Summary of Total behaviour problems for Fergal at Pre-, Post- and follow-up 6 months and 4 years later (T scores less than 60 in the normal range; 60-63 borderline; more than 63 considered to be in the clinical range).



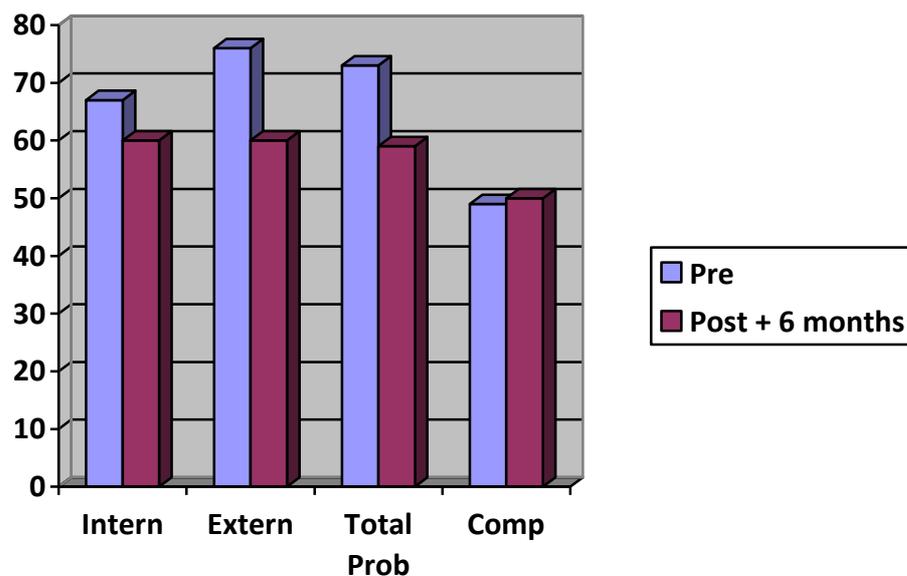
The CBCL profile of Fergal, bereaved by a brother and sister through suicide, scored in the clinical range on internalising and total behaviour problems pre-intervention. Post-intervention, scores on internalising, externalising and total problems were in the clinical range. At six months follow-up, internalising and externalising were within the borderline clinical range and competence and total problems were within the normal range.

Figure 5: Summary of Total behaviour problems for Ben at Pre-, Post- and follow-up 6 months and 4 years later (*T scores less than 60 in the normal range; 60-63 borderline; more than 63 considered to be in the clinical range*).



Ben lost an uncle through suicide and exhibited internalising and total problem behaviour scores within the borderline clinical range pre-intervention. Post-intervention, at 6 months follow-up, and after 4 years, CBCL scores were similar to normative sample scores.

Figure 6: Summary of Total behaviour problems for Michael at Pre-, Post- and follow-up 6 months and 4 years later



Michael lost his father through suicide. Pre-intervention, his profile indicates competence within the normal range but significant internalising, externalising and total behaviour problems. It was not possible to conduct a post-intervention assessment. At one year follow-up after the group intervention, there is considerable change evident and internalising/externalising problems were just within borderline clinical range. Competence and total behaviour problem scores were within normal range.

Summary

Pre-intervention scores indicated that 80% (n=4) of children were within the clinical range; 60% were within the clinical range for externalising problems, 40% were within the clinical range for total problems. Total competence scores (activities, school and social competence) were similar to normative sample scores for 80% of children. These findings are similar to those found by Pfeffer et al. (1997, 2000) and others when working with referred samples of suicide-bereaved children who typically showed difficulties with depression/anxiety and behaviour problems but normative social competence. Post-intervention, 1 child (20%) was within the clinical range for internalising and total problems. All were scoring within the normal range for total competence. At follow up six months, 1 child (20%) was within the clinical range for internalising problems and all children were within the normal range on their total (overall) problem behaviour score. At four year follow up with three participants, total problem scores were within the normal range.

VI. Function Assessment Scales

Results of the Child Behaviour Checklist suggested that on competence in school, social areas and general activities, most children were scoring within the normative range at all time periods. We explored areas of functioning that children identified as having been specifically affected by bereavement through suicide.

Table 6: Function assessment results: tasks or competencies children experienced as more difficult following bereavement by suicide.

Task or activity (Construct named by one participant)	Task or activity (Construct named by two participants)
Helping at home with his brother	School
Visiting places my Da has brought me	Football/Football training
Getting up in the morning	Special occasions/ Christmas/ Deceased persons birthday
Going back to the house where relative died by suicide	Going to the graveyard
Seeing cousins whose father died	Missing dad
Talking to cousin	Going to the graveyard
Getting along with Dad	
Thinking of dad	
Knowing dad	

David identified ‘School’, ‘Helping at home with my brother’ and ‘Football training’ as three areas of functioning that had changed for him since the bereavement. He noted school and football were ‘a little difficult’ pre-intervention but were not difficult at post-intervention and six month follow up. ‘Helping his brother at home’ remained ‘a little difficult’ at all three time periods. His mother noted that his relationship with his brother had deteriorated significantly since the bereavement.

Tasks identified by Anne as more difficult since bereavement included ‘Special Occasions’ (moderately difficult), ‘Going to the Graveyard’, ‘Missing Dad’, ‘School’ and ‘Visiting places my Da brought me’ (a little difficult). Interestingly, at the pre-intervention interview, she said that school had become easier since her Dad had died but that she did not know why that was, but perhaps the focus provided by school was helpful. Anne felt that tasks such as special occasions, going to the Graveyard and Visiting places my Da has brought me were ‘a lot’ more difficult immediately post-intervention. This was just before Christmas so those tasks were probably particularly difficult at that time of year. At 6 month follow up, she reported “Going to the graveyard is easier than it was, talking about my Dad is easier, and going to places my Dad brought me is a bit easier”. The researcher asked if she felt this was due simply to the passing of time or if it had anything to do with attending the group, she responded “Going to the group, because I had a chance to talk about things”.

Fergal identified ‘Special occasions’, ‘Getting up in the morning’ and ‘Football’ as tasks he found a little harder since experiencing bereavement through suicide. He missed his brother and sister, and talked of the things they used do with him such as

take him out for his birthday or take him trick or treating. He misses them more at these times, especially Christmas and on their birthdays. At the post-intervention interview, he said one of the things he noticed since the intervention was that he feels sad and cries more since he started attending the group and crying is moderately hard. He clarified that “It is easier not to cry, its harder to cry”. Six months post-intervention, he found getting up in the mornings to be still a little difficult but had no difficulty with managing special occasions or going to football.

Ben identified the following tasks as more difficult since bereavement: ‘Going to the Graveyard’ (moderately difficult), ‘Going back to house where relative died by suicide’ (very difficult), ‘Seeing cousins whose father died’ (a little difficult) and ‘Talking to cousin’ (a little difficult). At the post-intervention interview, he noted that Going the Graveyard was a little difficult Going to the house, talking to his cousin, and seeing cousins whose father had died presented no difficulty as he and his cousin attended the group and after-school classes together. At 6 months follow up, going to the graveyard remained a little difficult, but seeing his cousins whose father died, talking to his cousin and going back to the house where his relative died by suicide presented no difficulty.

Michael identified ‘Getting along with Dad’, that meant in his words, that “He is no longer there to get along with; Dad is no longer there to do the things I used to do with him, and that that thinking about dad makes me sad”- was moderately difficult. ‘Missing Dad’ was a little difficult and ‘Thinking of Dad’ was something that he rated as ‘often can’t do’. ‘Knowing Dad’, he identified as somewhat easier. At the post-intervention interview, he said he has talked a lot about Dad since he died and that he knows everything about him and is happy about this. At follow up, he noted that “Thinking about my Dad is easier”.

Summary: The function assessment allowed children to talk about their experience of bereavement and identify the areas of functioning where their experience of bereavement affected them personally. At post-intervention and follow up interviews, most children reported that things had gotten easier in many of the areas they identified although special occasions were still often hard.

Social network & strength of relationship questionnaire

The social network and strength of relationship questionnaire sought to look at the quantity and quality of children’s social and emotional relationships. The average number of people in children’s weekly social network at pre-intervention, post-intervention and + 6 month follow-up respectively was 11.6, 13.25, and 13 people with a range of a minimum of 7 people to a maximum of 19 people.

Table 7: Total individuals in children's social network

Size of Social Network	Pre-intervention	Post-intervention	Follow up
David	9	11	9
Anne	7	14	11
Fergal	12	12	18
Ben	19	16	17
Michael	11	---	10

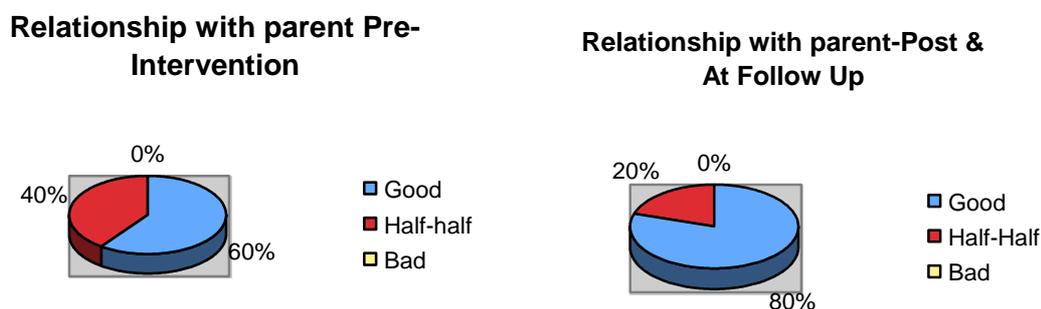
In general, children reported more relatives than friends in their networks (surviving parent(s), sibling(s), uncles, aunts, grandparents, and cousins).

It appears that overall, the numbers of people in children's networks were not affected greatly by suicide but children reported that the quality of relationships and feeling able to talk about the relative that died, or in particular to talk about suicide, was impacted upon within their relationships.

- *Is there anyone you find it easier to talk to since the group ended?*
 - **Everyone**
 - *Your relationship with your Ma since-better, the same, worse?*
 - Better.
 - *Why?*
 - Because I can tell her stuff about my mother and sister, and stuff like why did my sister kill herself and all, stuff like that. And my Ma said stuff like, that she was sad over my brother doing it, she missed him and all.
 - *Do you think your Mam finds it easier to talk to you?*
 - Yeah.
 - *Does it make you happy or sad that you can talk to your Mam about it?*
 - Happy.
 - *Do you think it makes your Mam feel happy or sad ye can talk about it?*
 - Probably happy, yeah.
 - *Before the group, were you able to talk to your Mam about it?*
 - No
 - *Would you say it has gotten easier or harder?*
 - **Easier**
- (Fergal, Post-intervention)

Children were to rate the *quality* of each relationship. Figure 6 displays the results for parent(s).

Figure 6: Relationship with parent(s) pre-, post-intervention and at follow up.



At pre-intervention, 60% described their relationship with parent(s) as good and this had increased to 80% at post-intervention and follow-up. No child reported a bad relationship with a parent. Overall, children reported good relations with parents but more difficult relationships with siblings. This may have implications for services working with children bereaved by suicide.

VII. Qualitative accounts of children and parent(s)

Concerns, hopes and expectations of parent(s) and children

At pre-intervention interview, the most common concern of parent(s) was that their child was withdrawn or keeping a lot of things ‘inside’. They saw the group as a place where children might get support, in particular to get a sense that they are not isolated and they are not the only child that experienced bereavement through suicide. Qualitative accounts support the findings on the Child Behavior Checklist of raised levels of internalising problems (depression) and some externalising problems (anger, aggression).

What are your concerns for your child and your hopes of what he or she may gain through the group?

“I feel that he can get very withdrawn, extremely sensitive. ...he keeps things to himself”.

“He was crying a lot and upset...He will be changing school (primary to secondary) –(we are) worried about the effect it may have on him, how he’ll cope”.

“Her deepness, she is very deep, looks like a sad child and I never know from one end of the day to the next what she is thinking... (*Hopes?*) That it will bring her out more in herself, she is a mixer but she is kind of on the outside...I hope she comes out of herself... That she will be happier at home, she never looks happy”.

“Depends-... His fiery temper worries me. He bangs doors and doesn’t like people to make jokes at him”.

“I worry that (my child) will feel that if life or situations get tough for him, that suicide will become an option for him”.

Children identified their primary expectation was that the group would be a place where they could talk with other children that had lost someone in their family through suicide. In a preliminary group meeting, one child told the other children he expected they would be “talking about anything, talking about the people in our family that died”. Another noted he was “hoping to have fun and to get along with the other kids”. One child said “talking about it” (the suicide) was the hardest thing about the loss of his father through suicide and that this is what he expected to be doing. One child, when asked what he hoped to get from attending the group, said he didn’t really know and didn’t really mind. In their interviews and drawings, there was a sense of ‘readiness’ to engage with the group and that the children wanted to talk about the death and what they had experienced.

Experience of attending the group: Parent(s) perspective

Parents of all five children reported that they felt attending the group was a positive experience for their children.

From the start, (my child) felt he was isolated and alone, even on the first night, the introduction session, he was like a totally different child. I thought he would stand behind me...within the first 10 minutes, he was like a totally different child, he was the first one up to talk, got all the kids out and they were all playing and it was like he let out a deep sigh of relief, ‘Oh god, I’m not on my own’ and I think that was great for him. For me, that was one of the biggest things, he knew he wasn’t the only child that was going through this. (Parent of David)

She really, really enjoyed the group. It kept her going from week to week. She constantly reminds me that the group was on Thursday, and would say things like ‘I wonder what we will be doing next week. (Parent of Anne)

It’s the first group that he’s been at that seemed to go to the depths of what they went through and he seemed to come out of it fine. (Parent of Fergal)

Parents of one child who had lost an Uncle through suicide reported that in the initial weeks, they had concerns that he was “very down” when he came back and considered withdrawing him from the group. Their concern was twofold: firstly, as he had not experienced the intensity of loss as other children of an immediate family member, that it generated thoughts and anxiety he had not previously felt regarding the safety of his own family. Secondly, his cousin was in the group and so he was not only dealing with his own grief about his Uncle but also supporting his cousin in his bereavement. However by the fourth week, they deemed he was managing ok, their concerns lessened and they felt overall the group was a positive and beneficial experience.

All the children and facilitators spoke of the ritual of lighting the candle at the start of the session to help them to think about the person they had lost as very important symbolically. One child spoke of it as the highlight memory of the sessions (Ben). Facilitators and children all described the middle sessions as difficult, but also as a time when the group really ‘bonded’. Facilitators reported that the facilitation

style changed from working with the group to supporting individual work within the group, while also helping children bring it back to the group.

The group 'seemed' more connected at sessions 4, 5 and 6. These sessions were difficult sessions to facilitate as they were quite heavy sessions and felt very heavy for the facilitators...The children seemed to need more individual input during these sessions. At times during these sessions some of the children became detached from the focus of the session and acted out and needed more individual support. (Suicide Bereavement Therapist).

"I think initially at the start it was great for him, he seemed to come out of himself... According as the weeks went on it got very intense because I think in one of the sessions they were talking about the funeral and at the time when (his father) died, I know I got it wrong but I didn't let the children attend the funeral so I excluded him from funeral. I know he got very, very angry after one of the sessions because all the other kids had attended the funeral and he hadn't and it brought out anger issues with him but I don't think he's glad about that but I was because it was making him sort of realise different things and talk about things a bit more". (Parent).

It was very good really. He got to go into detail about how his Da died and how he found him. It was good for him to open up, he wasn't a talker, and he was the one that found his Dad. He went in on himself. He wouldn't talk about what he saw or felt. It was good for him to talk about it. It would get me upset-I couldn't talk about it. (Parent).

Children also noted that they found the middle sessions of the group difficult. One child stopped attending for two sessions, but all others maintained their attendance.

Sometimes I couldn't remember stuff and sometimes I had to write down things and I could not remember and that was hard. Like things about the day of the funeral, and memories and all that stuff. (Anne).

In the middle it was hard, and then it was easy. I didn't really talk out loud but when we'd go into our corner and write it down, that was easier. Hard weeks....found it hard to talk about why they commit suicide...but yea, it was ok. (Ben).

One child said he found the group neither good nor bad but that he liked talking and playing with the other children. Another child found it hard to express any concrete reactions to the group.

Facilitators also talked about how they had to consider and reflect on the impact of what might happen within the group for the child/family outside the group.

Secrets were 'broken' in the group. One child ...had been told at the time that if the Gardai were given this 'real' information he would have to give evidence during the inquest so ...a story around the death was developed. In the group he told the 'real' story and this seemed to really help him. (Suicide Bereavement Therapist).

Overall, the group experience was a positive one good experience, according to all five child participants and their parents.

"Thinking about my Dad was easy-write down good memories, I liked making new friends, having a laugh, drawing. Nothing was difficult". (David).

Children's views on the groupwork impact

Three children reported positive changes in their lives and they attributed this change in part to having participated in the groupwork intervention.

Did it help?

A bit, It helped me to get along without me Da, so didn't have to keep thinking about him.Its easier to cope with Da and to get along with everyone.(Six month follow-up, Michael)

I find it easier to concentrate in school.

And at home? It's changed that I can talk to my Mam more but other things are the same. (Post-interview, Anne)

Going to the graveyard is easier than it was, talking about my dad is easier, school is a bit easier, and going to places my dad brought me is easier. (Six month follow-up, Anne)

How are things now? Everything fine-sometimes I talk with my Da but not really any more. Is it that you don't feel the need to? Ya. (Six month follow-up, Anne)

Two children described things as feeling "the same" at post-interview and follow-up.

"The group didn't help much... It doesn't help to *understand* why people commit suicide'... Feel the same, nothing's changed. Everything's the same, everything has stayed the same.

I: Can you tell me what stayed the same? What was it that didn't help-or what might help you with?

C: To understand more...

I: About what?

C: About why people commit suicide.

(David, post-interview)

For some children, they noted that there were things they were able to do within the group that was still difficult outside the group.

Is it easier to talk about suicide now, compared to in September? No, not really. It's easy to talk about it in the group but I can't talk about it to my friends in school. (post-interview, Anne).

At follow-up interview, she reported it was getting easier to talk to people about the suicide of her father.

I think... after the group, I felt I could talk to people - before the group, I bottled things up and never really talked about my Da but since group finished I've been talking to people more and saying how I feel. (Six months follow-up interview, Anne).

The "good stuff" about the group mentioned by many or all children included that they made new friends, that they had to write down good memories, had a chance to have a laugh, draw and they enjoyed the activities. It seemed important that if a child did not want to be 'on task', there was space to be in the room to engage/disengage as needed.

"We wouldn't just have to sit down and listen, could play with toys" (Post-interview, David)

Best thing about group? Talking about family and about Dad. *Bad/worst thing?* Nothing. (Follow-up, Ben)

What would you tell another child about the group?

It was very helpful. It helped you to get over it 'cause you talking about it more.

It helped me, yeah. I don't know why. (Follow-up, Michael)

It seemed important to all children that all children in the group were suicide-bereaved.

If the group was mixed (according to bereavement) – it would have been different, they wouldn't understand that the one they loved that died, they wouldn't understand about suicide.

(Anne, Follow-up)

Everyone had lost someone through suicide. If it was for other reasons, like accidents, it would be all sorts of things, it would have been different. (Ben, post-interview)

All children liked the last day where they went ice-skating and had a meal afterwards. This is useful to reflect on as it created a 'normalised' space for the children to spent time together but not thinking about their experiences.

In their time-line exercises at follow-up interview, all children drew graphs which placed their present well-being as at a low point before the group work, that increased over the time of the group work, and either remained high, or dipped up and down according to special occasions (birthdays, Christmas). All five children depicted the 'wellbeing' line as being at a higher level than before the groupwork began.

Sentence completion exercise

Things I liked about coming to group were...

... talking to kids who know what I'm going through and all the art and talking about stuff and memories and all

...meeting people

Things I did not like were...

... the stuff that I can't remember.... stuff that are hard to think about, to remember.

... taking up my time

Something that I miss about the group is...

...seeing everyone cause I don't see them anymore.

...not seeing the people that much

One thing that could make the group better...

...if more girls were there.

...a longer break

What I hope for the future is...

... to maybe see them again, and just talk more and not keep things bottled up and be positive.

.... to be good at football, to meet the group again.

Impact of attending the group on children- Parents' perspectives

At post-interview, four out of five parents noted that they felt the group had had a positive impact on their child and one parent reported that it she had not observed any significant change. At follow-up interview, all parents reported that their children were doing better, compared to pre-group intervention. Two children continued to receive individual support once the groupwork intervention was completed.

The biggest change noted by the parent of Anne is her daughter began smiling and even laughing more:

I have noticed a difference in her. She is after laughing for the first time in twelve months...big change, she's after been laughing; for the last couple of weeks, and I put it down to the group cause she was in individual counselling. She has an understanding that she's not on her own now, because she has been in the group". (Post-interview, parent, Anne).

Any noticeable behavioural change? "The smiling thing, the laughing thing, a lot of people noticed that. When she laughs, she has a real good hearty laugh. She really laughs. She hadn't at all. You'd have probably got a smile but not a laugh the way she used to laugh...I think she's relaxing a bit more. She doesn't seem as tense. She used to be quite tense and worked up. She seems a little bit more relaxed. (Follow-up, parent, Anne)

The parent of Michael feels her son is less angry and distraught and that she has noticed a lot of changes in him. She has concerns for her youngest son and was hoping that he would also have a chance to attend a similar group.

It was very good for him... It helped him cope with his feelings and how he felt. He was very angry, very quiet, and unable to talk about his feelings.... He was very distraught and angry. It helped him realise why his dad died and how he died. It helped him with funerals. Anytime he sees a funeral, he talks about his Da. Before, he was able to talk about it but not in as much detail. He explains it to his brother who is 6, he's the wise one. It helped him deal with his feelings. His brother is still very confused regarding why his Da is not here. He seems wise. The best thing I did was that I brought (my child) here. (referring to individual and groupwork) (Follow-up, parent, Michael)

The parent of David noted that her son seemed able to open up more and to be more emotionally expressive.

There he had a chance to talk about things and I know he opened up more in the group than he would to me anyway. He puts a big 'blank' up around me, he gets very angry... but sometimes it can be hard. He talked about the night it happened a bit more, the night we found (his Dad). I'd never force him to talk about it; he'd bring it up himself. Now like that, it would be a three or four minute conversation then he'd go onto something else, or he'd see something in the newspaper about suicide and he'd bring it up; or Sean would say something-has no memories but would say something about the night, and David would say no, it wasn't like that...anything that gets David talking is positive in my book. He keeps it all in, so anything that gets him talking is good. (Post-interview, parent, David)

I think he is a little more emotional. He would get frustrated and wouldn't cry no matter how much you see he wanted to, I find he's crying much easier now, than what he was before. I prefer that it's a way out...he's letting it out, whereas before I could see he was holding it all here, I could see it on his face, but no matter what, I'm not crying....now cry a lot more easier...sounds horrible, like to see my child crying, but he's releasing it when he gets upset or angry over something...and hugging, he's gone mad into hugging -like he'll run up to me for nothing and say 'give me a hug'...before, he wouldn't do that. (Follow-up, parent, David)

The parent of Fergal reported at the post-intervention interview that they had not noticed any change in their son as a result of attending the groupwork. At follow-up six months later, it was reported that he was doing a little better although he said found school and some things about everyday life difficult. However he loved

playing with friends and was out with friends a lot. His parent noted small progress and “Yea, it’s very slow”.

I don’t really know if it has (helped) or hasn’t. It sort of finished and that was it. I don’t really know-it’s hard to say. I don’t actually know what the group was doing with him. As regards Fergal, in himself, he was still quite teary-the least thing that you would say to him, he still is...He went and he came home and that was it, and it finished. (Follow-up, parent, Fergal).

For Ben, parents said an important reason he attended the sessions was to support his cousin. They felt that, after their initial concerns had settled, that they felt the group was helpful to him in talking to people about his Uncle’s suicide but they noted they particularly noted a positive impact for his cousin.

Most beneficial outcome?

It would be the isolation, that he’s not isolated, that he is not on his own, there are other people. It was a place for him to open up and be able to talk about it because he doesn’t really at home. (David, parent, follow-up)

To talk about the funeral. We never really talked about it. What with the way (bereaved) was. He saw him hanging. I wasn’t able to talk about it. It was very good. Made him realise he can talk about things like that. (Michael, parent, follow-up)

Groupwork versus individual counselling

Four of five parents expressed the view that there was “added value” to groupwork over individual work for their children.

I think the changes are down to the group sessions, that she is not on her own, that other children are in the same situation. She came out of herself more in the group sessions. She is back doing individual work but when she was in the group session, she said she ‘can’t wait, can’t wait’, she was always talking about it....After the individual sessions, I’d say ‘How did you get on?’, ‘Fine’. I think it was the realisation ‘It wasn’t just me, other people have this (suicide-bereavement) as well’; a sense that it’s natural to be like this- that would be main thing, realising she wasn’t on her own. (Anne, Parent, follow-up)

Compare groupwork versus individual work? It was the group that made a difference, for the kids, they all going through the same thing, they had lost someone to suicide –other kids knew how it was for him. (Michael, Parent, follow-up)

Request for more information about group sessions and feedback

A common theme in post- and follow-up interviews was that parents would have liked a little more information about what was to be covered in the sessions each week. In a number of cases, children did not talk about what had happened in the sessions at home and this resulted in parents feeling excluded/feeling they were not

sure what was being talked about so as to understand how to interpret their child's behaviour. In fact, according to facilitators, parents were given this information at the start of the intervention. Perhaps it needs to be given in a different format. Some parents also said they would like some feedback on how their children engaged with the work, how they were getting on in the sessions and from the research. All said they felt they could have gone and talked to the Suicide Bereavement Counsellor at any time.

'Do No Harm'?

At all interviews, all parents and children were asked if they had any concerns about the groupwork, if they had observed any negative impact on their children? And specifically if they had any concerns about children working in a group to talk about and discuss the suicide of a loved one. Parents of one boy who was suicide-bereaved by an Uncle mentioned they had some concerns in the first weeks but after that, they had no further concerns. All parents said they had observed no negative impact. All parents said they had no concerns about children partaking in groupwork on suicide-bereavement; on the contrary, they felt it was very important that children had a chance to have this discussion with peers that were similarly bereaved.

I: Do you have any concerns that it may have done harm?

No, it never did any harm, I know that myself. (Follow-up, parent, Fergal).

I'm afraid around the issue of suicide that especially now, if you push it under the carpet,... I don't think it's right to hide it, it's a huge part of society today, and I'd rather the boys know and be aware, I know they are aware of the devastation that is left behind but that it's not just us, it happens to other people, because I don't want it to become an option for either of them two, want things to be open and more talked about". (David, Parent, Follow-up)

Summary: The most important contribution of the groupwork appears to be the opportunity for children to have very supported engagement with peers who had experienced bereavement through suicide. The hardest sessions for children, facilitators and parents were those sessions that focused in the details of the suicide, the sense-making work of trying to understand why people kill themselves and dealing with the emotions of isolation, anger and grief. All children completed the groupwork which is an indicator that they found this work challenging but manageable. The facilitators, in their feedback, highlighted the importance of debriefing and supervision in supporting them to manage the trauma present in the sessions for children and also for themselves.

VIII. Four years on.

Four years after completion of the group, parents and children were contacted to find out how they were getting on. Three parents completed a Child Behaviour Checklist and took part in an interview. Three former child participants attended a focus group discussion. In one family, Mum feels David is doing really well at the moment and really enjoying secondary school. She said David felt very lost and confused at the time of the group intervention and meeting other children who had dealt with suicide helped with this. She said it was different to meeting people who had lost a parent due to illness as there is such a taboo around suicide. David meeting others and becoming aware that others were in a similar position to himself meant he didn't feel as lost. The group gave Mum and David the opportunity to talk and as such she felt the group was beneficial for them both. It meant it became easier for David to talk about suicide and his dad's death. Mum put it another way saying if David hadn't taken part in the group she feels things would be a lot different now as he may not talk about it. She said beneficial from the point of view of how they can talk about it at home. In the years since the group they still talk now about David's Dad and suicide and she believes this is a result of the group. The previous day was Fathers Day and they went to the grave. When Mum mentions going to visit the grave David will say yeah, that's fine. He knows if it is a birthday or Fathers Day they will be going and often brings it up first. He will talk about his dad and is fine on these days. She is concerned that he might think suicide would be an option if things aren't going well. He can get angry and finds it hard to express why. Mum believes there are definite long term benefits for both herself and David. They can talk and at the time they really needed something to help them. When she mentioned the group to David recently he responded positively and she believes the time is a fond memory for him.

Mum described how Anne is doing really well and getting on great in school. Mum said she would have no concerns at all about Anne and feels she is getting on really well. She remembered that Anne was initially reluctant to go to the group but from the first session really enjoyed it. Her mother said Anne didn't know how to feel at the time and meeting other children of the same age at that time helped her see there are others going through it and that suicide is something she can talk about with others. Mum feels that at the time Anne was at an age where the group was particularly important and played a big role in helping Anne talk about what had happened. She thinks the group has had a long term positive impact. Mum is involved in fundraising for Pieta House and taking part in the Darkness into Light walks held annually. Anne has now become involved, organising fundraising events for Pieta in her secondary school. She has put together a committee of four of her friends and this will now be an annual fundraising event in the school organised by Anne. She has also asked the school to organise a speaker to come to the school to give a talk on dealing with suicide which they are organising. She said her younger daughter is now coming up to the age Anne was when she took part in the group. She said it would be great if this daughter could attend a similar project as Anne and

wishes it was an ongoing project for any child who needs it as she feels it was so beneficial for their family.

Ben's parents also noted that he is doing well and enjoying school. He is aware of suicide and talks about it. He has become active in school on suicide prevention.

In the focus group discussion, two of the group participants told of how they have taken leadership roles in their schools and among their peers on suicide, suicide bereavement and suicide prevention. One of the group has linked up with Headstrong and Dr. Tony Bates, raised funds and set up a programme in transition year running a drop-in space in the school for young people that have been affected by suicide or to gain support if they are having problems. Another participant has taken an active role on suicide awareness and suicide prevention in her school. The group intervention is arguably having a multiplier effect as these adolescents now reach out to their peers and mobilise adults to engage with them on suicide-awareness and suicide-prevention interventions. This was an unintended but very interesting outcome. All three former participants said they found the intervention very positive and timely, that it gave "space for yourself" and all still had their memory boxes from that time. Reflecting back on the group, they said they would have liked to have had a male facilitator (all facilitators and the researcher were female) and would have liked and organised reconnection event some time after the group ended.

IX. Conclusion

This report has described the experience and outcomes for children who participated in a group intervention for children bereaved by suicide. Children experienced the group as a forum where they could talk about their experiences with peers who had also experienced bereavement through suicide. All five participants scored within a clinical range for total behaviour problems on the Child Behaviour Checklist at pre-intervention assessment. Post-intervention, 1 child (20%) was within the clinical range for internalising and total problems. All were scoring within the normal range for total competence. At follow up six months, 1 child (20%) was within the clinical range for internalising problems and all children were within the normal range on their total (overall) problem behaviour score. At four year follow up with three participants, total problem scores were within the normal range and some of the former group participants have taken leadership roles in their schools by working with teachers and mental health professionals to set up projects or organise talks on suicide, suicide bereavement and suicide prevention.

A limitation of the study is the small sample size and also the lack of a control group. It is not possible to say if the changes observed are due to the intervention or simply the passing of time. However qualitative information indicates that the groupwork supported emotional expression, enhanced family communication processes around the suicide, allowed secrets to come out and the real narrative to

unfold, and gave children a space to ask questions about suicide and engage in sense-making. These are processes associated with promoting resiliency and acting coping in suicide-bereaved children (Brown, 2007; Cerel et al., 2008). The evidence compiled here indicates that groupwork has “added value” compared to individual counselling for children bereaved by suicide as children and parents report that peer-interaction reduced isolation and stigma, supported children in their griefwork and enhanced communication and family relationships.

X. Recommendations

1. This groupwork intervention for suicide-bereaved children was experienced as timely and valuable in helping children cope with suicide-bereavement by both parents and children. This groupwork approach for suicide-bereaved children should be further developed as an intervention for suicide-bereaved children. .
2. The template for this groupwork intervention was developed and implemented by an experienced child psychotherapist. Any future development of groupwork interventions for suicide-bereaved children needs to ensure facilitators are suitably qualified to safely manage traumatic material for children and families. Children noted they would have liked a male and female facilitator (gender balance) if possible.
3. Parallel support sessions should be implemented for parents in their role as parents, with other parents or caregivers that are caring for children bereaved by suicide. Parents and children said they would ideally like such sessions to be offered a few times over the course of the intervention rather than every week.
4. More information about the content of sessions should be made available to parent(s) in advance of each weekly session.
5. Consideration should be given to decisions on whether to include relatives (e.g. cousins or siblings) within the same groupwork intervention, and it was the view of facilitators that it might be better to place children related to the bereaved person in different groups, so they could engage in their own process in the group.
6. The intervention template could be reviewed to consider if it is possible to support children more in the middle sessions that they reported as finding difficult. A possibility is to include an external, fun-based activity outside of the formal sessions where children meet to do something normative for their ages (the ice-skating was one such activity that all children enjoyed).
7. Some feedback mechanism be developed for parents as a formal completion of the intervention.

8. One child requested a longer 'break-time' during each session so they had more time to talk and have fun with each other in an unstructured way.
9. Supported debriefing for group facilitators should be a regular part of the groupwork structure.

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