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TAPS Suicide Postvention Model™: A comprehensive framework of healing and growth

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ABSTRACT

The TAPS Suicide Postvention Model™ is a three-phase approach to suicide grief that offers a framework for survivors and providers in the aftermath of a suicide. This framework proposes guidance on how to build a foundation for an adaptive grief journey and creates a research-informed, proactive, intentional pathway to posttraumatic growth. The Model follows the Tragedy Assistance Program for Survivors' peer-based model of care and has supported more than 16,000 military suicide loss survivors over the past decade. The Model is applicable to anyone grieving a suicide loss or coping with any associated trauma.

Incidents of suicide in the United States rose 35 percent between 1999 and 2018, making suicide America's tenth leading cause of death (Hedegaard et al., 2020). Yet despite this and other ample reminders that suicide is a growing public health issue, there is still far too little focus on the impact these deaths have on family members. Cerel et al. (2019) demonstrated that some 135 people are affected by every suicide death, while Harrington-LaMorie and Ruocco (2011) found that these survivors are at increased risk for anxiety-related disorders, posttraumatic stress, complicated grief, depression, and suicide.

The suicide problem in the military and the veteran community is especially pernicious. The suicide rate among veterans was 50 percent higher than that of non-veteran adults after adjusting for age and sex (Department of Veterans Affairs, 2018). And while suicide rates in the military are more or less on par with national averages, an alarming number of these deaths occur in places where loved ones, friends, and colleagues may be exposed. Pruitt et al. (2017) showed that almost 77 percent of all suicide deaths of active duty service members occur either at the service member's personal residence, in the barracks, at the home of friends or family, or at the workplace or a job site, making the impact on survivors of these losses particularly acute (p. 107).

For more than a decade, the *Tragedy Assistance Program for Survivors* (TAPS) has made postvention care to survivors of military and veteran suicide loss a core focus of its mission. The TAPS Suicide Postvention Model™—a three-phase approach to care developed to support these survivors and the subject of this article—is broadly applicable to anyone grieving the death of a loved one to suicide.

TAPS

TAPS is a 501(c)(3) not for profit organization in Arlington, Virginia, that cares for grieving military families. It was founded in 1994 by Bonnie Carroll, an Air Force officer and newly bereaved military spouse, whose experience navigating the aftermath of her Army husband's death left her feeling more could be done for other survivors grieving the loss of a military loved one. Today, 26 years after its founding, TAPS has brought comfort, hope, and healing to more than 90,000 bereaved survivors. Of those, some 16,000 have come to TAPS grieving a death by suicide. Indeed, an average of seven bereaved survivors of suicide loss come to TAPS every day seeking support and services. Suicide loss survivors now represent the majority of all new TAPS survivors.

In 2008, TAPS began to observe an increase in the number of military *suicide loss survivors* seeking grief

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support. It soon became apparent that specialized programming for this population was needed. Referrals for newly bereaved suicide loss survivors were increasing, as were inquiries from longer term survivors who had been coping in solitude for years with no support, services, or direction. Newly bereaved survivors expressed the need for support regarding issues that were traditionally outside the scope of other military loss survivors. Longer term survivors often sought out services and self-referred to TAPS because they still felt "stuck" or "alone" in their grief, even in cases in which many years had elapsed since the deaths of their loved ones. Many of these individuals had never been able to connect to peers who understood the nature of their loss. Many felt disenfranchized in their grief or had experienced additional challenges, such as trauma, that were never addressed or even acknowledged (Harrington-LaMorie & Ruocco, 2011).

Therefore the question for TAPS became how to meet the particular demands of this population. The answer was the development of suicide-specific programming that focused on stabilizing survivors before integrating them into more general grief work. TAPS set out to provide an emotionally safe environment where suicide loss survivors could connect with one another and engage in tailored postvention programming. Over time, survivor testimonials, first-hand observations, and facilitator feedback suggested that these efforts were proving effective in achieving the goal of stabilization and were furthermore likely to be preventive in nature.

TAPS recognized that addressing suicide loss's complicating factors was not the whole picture, that an effort to promote an adaptive grief trajectory for survivors required offering them a roadmap to navigate their bereavement. Survivors' input provided momentum for TAPS as it worked to build a comprehensive suicide postvention program based on best practices in grief, trauma, and postvention. The authors propose that by connecting programming, peers, services, and resources that specifically addressed their needs in an organized way, suicide loss survivors were able to learn adaptive grieving strategies that could bolster posttraumatic growth.

This article introduces a conceptual framework for supporting and caring for suicide loss survivors called the TAPS Suicide Postvention Model™. The purpose of this article is to discuss how the Model was conceived, developed, refined, and implemented as well as to demonstrate how care providers can utilize this approach.

Suicide and postvention

Suicidology and suicide postvention

Suicidology is "the study of suicide, its causes, and its prevention, as well as the behavior of those who threaten, attempt, and/or die by suicide" (Stumpf Patton, 2012). Suicide *postvention* is a concept that emerged in the 1970s, largely through the efforts of leading suicidologist Dr. Edwin Shneidman, who first coined the term. Berkowitz et al. (2011) echo Shneidman in defining postvention as "planned interventions with those affected by a suicide death that would facilitate the grieving process" (p. 157). Shneidman began his early work in the field as a clinical psychologist and researcher for the Veterans Administration (VA). In 1949, he first became involved with suicide through outreach efforts—what now would be considered postvention work with military survivors—to widows whose husbands had died by suicide while wards of the VA hospital (Shneidman, 1996).

Other pioneers in the field of postvention made progress in the exploration, adaptation, and implementation of postvention protocols as a necessary modern tool of psychological and emotional support to survivors. In their review of the literature on interventions with suicide loss survivors, Jordan and McMenamy (2004) contend that postvention efforts can potentially prevent future mental health distress, including subsequent suicides. Campbell et al. (2004) demonstrated that "active postvention" dramatically reduced the time between a death by suicide and a survivor's decision to seek emotional grief support (p. 30). Their study also showed that survivors are a valuable source of referral to those who are newly bereaved.

In under half a century, postvention has gone from being an esoteric idea in a nascent field of study to an indispensable, best-practice approach to caring for suicide loss survivors.

Suicide and complicated grief

Research shows that people exposed to a death by suicide are at increased risk for suicide, mental health disorders, addiction, and reclusiveness (Pitman et al., 2014). This is because suicide-related bereavement presents survivors with unique challenges that may inhibit them from embarking on an adaptive grief journey. Suicide loss brings with it many factors that can complicate the grieving process. Examples include trauma, stigma, blame, guilt, abandonment, conflicts

with faith, anguish over the need to understand why, and challenges talking about the death to children. Because every death by suicide exposes an average of at least 135 people (Cerel et al., 2019), the need for quality postvention care could not be more critical.

The TAPS Suicide Postvention Model™ is intended to provide a roadmap for anyone grieving the loss of a loved one to suicide as well as a guide for professionals who support or treat suicide loss survivors.

TAPS Suicide Postvention Model™

The *TAPS Suicide Postvention Model™* is a three-phase approach to suicide-related grief or trauma that can stabilize survivors, military units, and organizations in the immediate aftermath of a suicide death. The Model provides guidance on how to navigate an adaptive journey of grieving and establishes a pathway toward intentional posttraumatic growth. It is a framework that helps guide survivors to face developmental stages of grief, emotional milestones, significant dates and holidays, and subsequent loss or trauma. It also provides professionals with a framework for approaching a therapeutic relationship with suicide loss survivors.

The three major phases—Stabilization, Grief Work, and Posttraumatic Growth—are sequentially ordered to conform to a "typical" grief progression. (Phases may be revisited out of order so that issues that resurface in the later phases of the Model can be addressed.) Each of the three phases is broken into three distinct tasks. However, the tasks are not intended to be completed in a linear, chronological order.

Phase I: Stabilization

The first phase of the TAPS Suicide Postvention Model™ is *Stabilization*. This phase represents the period immediately following the death of a loved one to suicide—the first hours, days, weeks, and months following the loss, when emotions are all-consuming, concentration is hyper-focused on the details of the death, answers are elusive, and the feeling of grief is intense and seemingly insurmountable. The goal of Stabilization is to mitigate risk and promote healing by intentionally focusing on these specific areas. If needs are not immediately assessed and identified in this phase, then the deleterious effects of the loss may continue or reemerge. (Note that although Stabilization is the first phase of the Model, it may be revisited later if necessary.)

Stabilization is the most critical phase from a safety and wellness standpoint. It entails the need for the highest level of care when working with the bereaved. For many survivors of suicide loss, risk factors for suicide are present, numerous, and serious. People who have lost someone to suicide are at higher risk of attempting and dying by suicide themselves (Pitman et al., 2016). Professionals, caregivers, providers, and other family supporters should be very engaged with survivors during this period and extremely attentive to matters of safety. For survivors who are either geographically isolated or for those who may withdraw and separate themselves from support systems, proactive outreach may be required.

Task 1. Assessment for mental health concerns, suicide risk assessment, and referrals

When someone dies by suicide, the death causes a ripple effect that can significantly impact immediate family, loved ones, friends, neighbors, colleagues, military comrades—anyone with a connection to the decedent. Suicide is a devastating and stress-inducing event that elicits extreme emotional responses and psychological challenges in people impacted by the death.

In this task, it is important to identify mental health issues and suicide risk in survivors so they may be connected to professional care, when appropriate. Stroebe and Schut (1999) posit that understanding "adaptive versus maladaptive coping" can improve accuracy in predicting health outcomes, thereby enabling the reduction of risk in people who are vulnerable (p. 198). TAPS staff are trained to explore coping strategies and to use various intervention skills like Applied Suicide Intervention Skills Training (ASIST) (LivingWorks, 2020) and Crisis Response Planning (CRP) (Bryan et al., 2018) to assess risk and the need for professional care. Special care is taken to connect survivors with professionals versed in military culture, bereavement, and suicide risk.

Task 2. Trauma assessment and referral

Losing someone to suicide is a life-changing event for most who experience it. Learning about the sudden death of a loved one can leave survivors with symptoms of posttraumatic stress, particularly if they are exposed to or even become aware of the death's graphic details. Family members are more likely to experience symptoms of posttraumatic stress when the suicide occurs by violent means and the family member either witnesses the death or discovers the body

(Young et al., 2012). This level of trauma elevates the risk for mental health issues, struggles with addiction, trauma-related symptoms, and suicidal ideation or behaviors (Jordan, 2008).

The majority of TAPS suicide loss survivors who sought additional trauma-informed care report (when asked) that their trauma was either overlooked or not discussed at all by providers during their initial assessment of needs. Regehr and Sussman (2004) note that "it is imperative that mental health professionals respond with approaches that do in fact assist to relieve suffering and do not carry the risk of elevating symptoms" (p. 290). Therefore assessing for trauma is critical. Survivors who experienced severe trauma related to the death have also reported that they felt alone and hesitated to talk to others about what they were going through for fear of causing emotional harm or additional trauma in others. Beyond surviving family members, it is important to recognize that there are likely others who knew the deceased and have experienced significant grief or trauma (or both). Peers, roommates, colleagues, first responders, and others should not be overlooked as a population requiring assessment for trauma and grief related to the event.

Trauma and grief often co-exist and should be identified and treated separately. While bereavement care involves remembering the deceased, processing emotions, and building new relationships with lost loved ones, trauma treatment is more focused on the effects of a patient's exposure to "horrifying and life-threatening events" (Regehr & Sussman, 2004, p. 289). Grief is the normal, natural reaction to loss. But suicide loss survivors often mention that their grief after suicide was drastically different than grief from other losses they experienced. While people's psychological responses to loss vary widely, suicide-related trauma often causes a severe impediment to the grieving process, but may not be identified as trauma. For survivors who endured trauma in connection with the death, the manifestation of the associated symptoms may be unfamiliar and misunderstood. This is as true for the bereaved as it is for those supporting them. This unfamiliarity can be confusing and overwhelming, leading some survivors to find themselves seeking ways to self-regulate in potentially harmful ways, such as through alcohol and drug use. Identifying trauma and connecting survivors to appropriate professional care to treat symptoms and increase coping skills is an essential component of stabilizing suicide loss survivors.

Task 3. Assess, identify, and stabilize all suicide-specific issues

Feelings such as guilt, shame, anger, rejection, and even relief can be complicated and confusing emotions for survivors. These complex emotions may make it difficult for survivors to find the right kind of support to help navigate them. Feigelman et al. (2008) found that family and friends were not a helpful support system following a suicide loss. Bartone et al. (2018) showed that one of the most crucial components of successful peer-to-peer support is matching survivors whose loss experiences are as similar as possible. For example, a surviving parent of a military suicide loss should be matched with a parent peer who has also lost a military child to suicide. Connecting survivors to peers of similar experience can normalize emotions and validate the need to seek additional care. Addressing these issues in a compassionate, intentional way and proactively connecting like survivors, may help this population navigate these emotions and put them on a constructive trajectory of healing.

In addition to specific emotions, there are issues related to suicide that, if not addressed, can complicate the grief journey and increase risk. While it is beyond the scope of this article to review all of the suicide-specific issues that may arise, it is helpful to examine several examples. One of the most prominent challenges that besieges survivors of suicide loss is an all-consuming need to understand why their loved one died in this manner (Sands et al., 2011). Survivors may perseverate on every interaction they had with the deceased before the suicide took place. They wonder what they did or did not say that may have contributed to the death. Many survivors feel the need to become investigators, sifting through all available information gathered from suicide notes, archived computer data, phone records, social media posts, and communications with other family members or friends. They labor to find clues to help them understand exactly how this could have happened.

This process can lead survivors to uncover new or alarming details of their loved ones' lives. They may unmask secrets like affairs, debts, legal problems, or addiction to alcohol, drugs, gambling, or pornography. These discoveries can compound the pain and confusion they are already experiencing and can reinforce feelings of self-doubt. The revelations can cause survivors to internalize notions that they should have known better, should have done something, or should have realized sooner how much pain their loved one was in. The unmasking of secrets can cause

attachment ruptures that increase feelings of rejection, fear, and anger in the bereaved. It is not uncommon for survivors to go on to question their instincts, struggle with trust, and wonder whether they ever truly knew the person who died.

For survivors, the lingering question of "why" their loved one died by suicide is often intertwined with a ruptured attachment. Researchers who have studied complicated grief (CG) and attachment propose that grief can become complicated if there is a "failure to integrate information about the death of an attachment figure into an effectively functioning secure base and/or to effectively re-engage the exploratory system in the world without the deceased" (Shear et al., 2007, p. 1).

By addressing issues present before the death as well as those that arose because of the death, Stabilization may support healing attachment wounds. During the Stabilization and Grief Work phases, survivors explore and work on healing the wounds that resulted from these relationship issues. As they acquire new insights into the suicidal mind and theories about why people die by suicide, survivors may come to understand suicide as a complex, multi-factored event and that the death of their loved one may have been attributed to a mix of stressors, illness, injury, and/or psychological pain. This can help reconstruct a new, different representation of their loved one and how that relationship relates to self (Bowlby, 1979), thus helping to repair and reform a new, more secure attachment that promotes a survivor's healing and growth.

Understanding what those in crisis may have endured prior to dying by suicide is also valuable in helping survivors shift from guilt and anger to understanding. Many people who die by suicide struggle with profound psychological pain before taking their lives. Behaviors that seemed out of character for the deceased person may have been an attempt to numb or avoid his or her inner turmoil—their actions the reflection of a state of mind rather than a statement about the depth of their love or the content of their character. The suicidal mind is often dark and narrow. *Suicide attempt survivors* report—and research supports—that they often experience self-blame for their pain, feel like a burden to others, and may have convinced themselves that everyone would be better off without them (Joiner, 2005). Gaining a new perspective can help survivors move, for example, from feeling deliberately abandoned to instead recognizing that their loved one may have believed there were no other options or that they believed, in their state of mind at the time, they were solving a problem. This kind of reframing can help achieve reconciliation or forgiveness and ultimately reestablish positive memories so that the lives of deceased loved ones are not defined by their final moments, but by how their lives were lived. Feelings of empathy and forgiveness can help mitigate negative emotions and assist survivors in moving toward more soothing self-talk about the event.

An issue that commonly beleaguers surviving spouses or caregivers is how to talk to their children about suicide. Survivors are often not equipped with the language or information that allows them to do this. Adults understandably wish to protect children from confusion, pain, and sorrow. Telling children that someone they love died by suicide may be the most difficult thing a parent ever has to do, especially at a time when they feel least equipped to handle it. Losing a loved one to suicide often ruptures one's worldview. Beder (2005) points out that "when the assumptive world is shattered by loss, the guidelines with which the self navigates the world can be overturned" (p. 259). When one's internal compass is compromised it may be difficult to trust previous confidence in decision-making and parenting. This can leave a surviving parent or guardian vulnerable to misinformation and potentially harmful advice. Offering support and guidance based on best practices and recommendations from professional experts can help parents navigate this challenge and provide a healthy foundation for the way forward in collective family grief.

Children need guidance and support in discussing suicide, especially with friends, teachers, and other adults. Helping children find their words or giving them permission to say, "I am not ready to talk about it," even to adults, can decrease anxiety and offer a sense of control. Practicing phrases like "My mom died by suicide," "My dad died, and I am really sad," or "My brother struggled with posttraumatic stress and took his own life," can help children navigate their grief, better communicate what they are feeling, and identify what they need from adults.

Challenges around one's relationship with faith, spirituality, or religion following suicide loss is yet another common struggle. After any death, especially one that is sudden and traumatic, there may be ambivalence about faith and belief systems. Research demonstrates that survivors exposed to a violent death have increased levels of complicated spiritual grief (CSG) than do survivors of other, more natural deaths (Burke & Neimeyer, 2014). Unlike other kinds of

death, suicide has been considered by some religions to be an unforgiveable sin, thereby denying the deceased entrance into heaven. This kind of messaging, whether delivered directly by a faith leader or already cemented in the mind of a survivor from a lifetime of exposure to such teachings, can have a devastating impact on the healing process. Burke et al. (2019) developed a three-factor model for CSG that highlights estrangement from spiritual community, insecurity with God, and disruption in religious practices as three areas that may complicate grief. Given these three factors, survivors may make decisions about funerals, memorial services, and obituaries that are influenced by stigma, misinformation, and fear rather than by a supportive, informed community. Helping survivors express their concerns, talk openly about their beliefs, or perhaps connect to a faith community that provides a comforting, healing message, can be among the most important interventions in the Stabilization phase of the Model.

When all the predominant issues are assessed, identified, and supported, survivors should have a stable foundation to rebuild their families and integrate grief into their lives. Suicide loss survivors who are stigmatized, disenfranchized, or insufficiently treated may withdraw, disengage, or cope by self-medicating or behaving in a self-destructive way, thereby putting them at elevated risk for suicide. With proper outreach, assessment, and stabilization, suicide loss survivors can work through and resolve complex issues, which leads to connection, healing, and growth.

Phase II: Grief Work

People grieve because they love. Grief is not a time-limited event with a beginning and an end but a process that lasts a lifetime. As an expression of love, grief may change, evolve, or lessen in intensity over time, but it will invariably resurface again and again.

In the *Grief Work* phase of the Model, TAPS intentionally focuses on integrating grief into survivors' lives in ways that can renew their relationships with the deceased and help them to embrace grief as love. In this phase, the focus is largely on what Stroebe and Schut (1999) call "loss-oriented" coping, the processing of emotions related directly to the loss. However, this phase also assists survivors in "oscillating" between a focus on the loss itself and the process of dealing with immediate everyday issues of life that are impacted by the loss, or what the authors term "restoration-oriented" coping (p. 213). This is not to say that the work of grief happens only during this phase, but Grief Work does intentionally focus on integrating grief into one's life in a constructive way.

Task 1. Move away from the cause of death

When a loved one dies by suicide, a common response from survivors is to become hyper-focused on the details and questions surrounding the death. In the military, there is an especially strong focus on the manner of death and related circumstances. For example, medals, special ceremonies, and honors are conferred on those who die while serving on deployments. What are often viewed as "heroic" deaths are commemorated with perpetual honors. As a result, details of the death, as well as the days, weeks, and months leading up to them, can come to define the entire life. Military suicide loss survivors often fear that the manner in which their loved ones died will be the defining feature that is remembered and that their service and sacrifices will therefore be forgotten. The process of Stabilization should help survivors come to terms with the circumstances surrounding the death and move toward healing. This begins with remembering the life lived instead of the final moments and details connected with the death. Helping survivors reconnect with the love and the life will also open survivors up to grief. Providing a rhythm for what grief may look like—for instance, establishing a routine or learning skills to manage it—can help survivors move toward the grief instead of away from it.

Task 2. Incorporate grief by finding a rhythm

Grief is among the most profound of human experiences. Grief can be heart-stopping, all-consuming, and totally unpredictable—just like love. It can also feel foreign and difficult to navigate when one lacks the tools to do so. *Grief waves*—also referred to as grief bursts or surges of emotion—can inundate survivors at any time, often when they are least prepared for them. The fear of being ambushed by grief may result in avoidance and withdrawal from others, which can lead to a myriad of other problems.

The Model encourages survivors to decrease avoidant behavior by recognizing physical, emotional, and psychological triggers related to grief and embracing them. Finding a *grief rhythm* can help survivors manage the ebbs and flows of their grief. The process involves identifying grief waves as love, embracing the emotions that come with them, and finding safe spaces to express them. Grief can be expressed in any

number of ways, including crying, exercising, yelling, writing, singing, and many other activities. After releasing these emotions, mourners may feel extremely fatigued, requiring rest or other forms of support like a hug. They also may feel emotions such as relief or resolve, which can help them return to activities.

Helping survivors talk to others, including employers, about their grief and what they may need during the day can give survivors a sense of control and decrease anxiety. Moving toward the grief—allowing oneself to experience it and recover—can actually decrease the intensity and time that is otherwise consumed by avoiding the emotions that are often too painful to address.

Task 3. Form a new relationship with the deceased

Survivors often believe that because their loved ones are no longer physically present, all is lost and there is nowhere to redirect the love they feel. But the love does not die, and it can endure. Through his Two-Track Model of Bereavement, Rubin (1981) shows how a bereaved individual may transform his or her attachment to the deceased and establish new forms of an ongoing relationship. TAPS's own work with survivors has demonstrated that relationships can shift from being largely physical or proximal to being those where memories and attachments to their loved ones are restored and reinforced.

Klass et al. (1996) termed the ongoing attachment to the deceased after a loss as a "continuing bond." It is important for survivors to understand that relationship renewal is a possibility given the concept that love and a continuing bond to the deceased does not die. Offering avenues to stay connected to the deceased can help heal attachment wounds and reconstitute a new and different relationship. There are also circumstances in which survivors may not want to continue a connection with the deceased (perhaps when relationships have been strained or in cases of domestic or intimate partner violence), but in these cases, support should be provided so survivors may move forward in ways they feel most comfortable and safe.

It is also common for survivors to feel strong spiritual connections to their loved ones. Perhaps they experience signs or report communications from the afterlife. Religious messaging about this kind of communication as well as fear that people will think they are unstable or delusional, often keep survivors from talking about these experiences. Giving survivors a safe, accepting space to talk about these connections can provide an immense amount of validation and healing. Encouraging survivors to be open about creating and maintaining these relationships to their loved ones through a spiritual connection, whether in the form of signs, dreams, prayers, meditation, letter writing, or just talking to their loved ones, can provide immense comfort, peace, and hope.

Phase III: Posttraumatic Growth

The *Posttraumatic Growth* phase describes a possible positive outcome of an adaptive grief journey. It follows a period when many of the complicating factors around suicide loss have subsided, been mitigated, or come to some level of resolution or reconciliation. In their pioneering work on posttraumatic growth, Tedeschi and Calhoun (1996) introduced a Posttraumatic Growth Inventory (PTGI) to measure a survivor's progress in the areas of appreciation for life, relationships with others, new possibilities in life, personal strength, and spiritual change. The TAPS Suicide Postvention Model™ is similarly designed to help survivors in each of these five areas.

The TAPS Suicide Postvention Model™ employs concepts of "problem-focused coping," which has been associated with higher posttraumatic growth in survivors regardless of length of time since their loss (Drapeau et al., 2019). Problem-focused coping involves "seeking information about the source of stress, seeking assistance from others, and/or engaging in activities to reduce stress" (p. 200). At this point, survivors will have worked through many of the grief-related tasks and have found coping mechanisms for many of their stressors. Their focus should be shifting away from their past pain and toward their lives ahead. In this phase, the Model aims to help survivors learn to live intentionally and with purpose in honor of their loved ones.

Task 1. Find meaning from the loss

Finding meaning after a loss by suicide not only provides an opportunity for growth but also healing. Research shows that an inability to make sense of a loss can predict complicated grief, while greater meaning-making over time is associated with alleviation of the same symptomatology (Holland et al., 2010). More recent research supports this by suggesting that the traumatic impact from loss, which usually results in negative psychological outcomes, can be decreased and even removed for survivors who are able to make meaning out of the experience (Bellet et al., 2018). Therefore when survivors believe they are ready, they should be encouraged to explore possibilities for life

transformations or to re-channel their grief into instruments for good. Survivors can be guided to explore a range of pathways that helps them discover meaning from their loss and reshape their own identities—with a deeper sense of connection, newfound purpose, and new direction. Examples include mentoring fellow survivors, facilitating support group forums, or speaking to audiences for awareness and prevention purposes. Some survivors may even go on to work professionally in the field as clinicians, experts, or authors.

Task 2. Tell and share the story in a hopeful, healing way

During the Posttraumatic Growth phase, survivors can be guided to revisit, reconsider, and rewrite the stories they once told themselves (and others) about the loss by incorporating new insights and wisdom they have gained along their journeys. Neimeyer and Sands (2011) identify two forms of narrative processing that survivors confront. One is the event story of the death; the other is the back story of the relationship with the deceased. Once the story of the death event has been stabilized, the new narrative can focus on the back story, which will work to secure attachment and a continuing bond (Neimeyer, 2012). That means being true to oneself and the memory of the deceased but also authoritative, compassionate to themselves and their loved ones, and, above all, hopeful. For example, one's storyline might change from "It's my fault. I should have seen the signs…" to a more realistic, comforting message like "I did the best I could with the information I had at the time," "I am using my tragedy to save other lives," or "I live my life now in honor of my loved one."

If survivors decide that, as part of their posttraumatic growth, they would like to tell their stories publicly, it is important to ensure that the storytelling process is safe and strategic for the survivors as well as for the audiences being addressed (National Action Alliance for Suicide Prevention, 2020). TAPS is often called upon to help survivors when they are considering sharing their stories in public forums. Sharing one's story in a group or public setting is quite different than doing so one-on-one with a peer. It involves the added responsibility of providing for the emotional safety of one's audience, so it is critical to add a level of care that provides safe guidance for the audience while still focusing on care for oneself. There are periods during the grief journey when survivors may need to revisit Stabilization tasks, and this may be a good time to pause their efforts at helping others and redirect focus to their own well-being.

Task 3. Discover a new appreciation for life

When suicide loss survivors are supported and eventually emerge from the dense fugue state of grief, when emotional numbing begins to subside, they can begin to reevaluate the terrain of their lives. They may even find that their lives are more authentic and enriched than they had been prior to their loss. Hibberd (2015) describes this specific meaning-making, which focuses on how valuable one sees life, inwardly and outwardly, as "life significance." At this point in the journey, survivors often relate that life seems more valuable. They experience a deeper sense of connection to others—increased empathy, patience, and compassion—so it can be useful and productive to help them develop ways of giving back to others. Embracing this newfound appreciation of their own lives can be extremely healing and is more likely to increase the chances for an adaptive grief journey. In other words, living a purposeful and authentic life can be a profound way to continue the bonds and honor the memory of the deceased loved ones.

Lessons learned from employment of the TAPS Suicide Postvention Model™

The authors propose that the TAPS Suicide Postvention Model™ is a viable approach to supporting those whose lives have been impacted by suicide and that it offers valuable insight in efforts to prevent future suicides. Here are five of the most critical lessons TAPS has learned:

Lesson 1. Postvention is a critical component of a comprehensive suicide prevention strategy

Until recently, response to suicides primarily involved suicide *prevention* education that emphasized heightened awareness of risk and warning signs. However, offering only prevention-focused training may inadvertently increase feelings of shame and guilt and even increase risk at a time when survivors are most vulnerable. This is especially concerning given that Jordan (2017), in a wide-ranging review of the empirical evidence, found that exposure to a family member's suicide appears to increase the chances by at least two to three times that a survivor will also die by suicide.

By contrast, the TAPS Suicide Postvention Model™ proactively attempts to decrease risk by

promoting protective factors such as a sense of belongingness and connectedness as well as addressing risk factors such as untreated trauma and mental health issues. Additionally, it is critical during the Stabilization phase to ask clearly and directly about suicide risk and then connect at-risk survivors to appropriate resources. The authors propose that a postvention approach should be included in any comprehensive suicide prevention strategy.

Lesson 2. Suicide loss is a uniquely challenging grief journey

Traditional approaches to addressing grief may not be helpful for those who have lost someone to suicide. Jordan (2014) points to substantial evidence that "survivors may experience high levels of psychiatric morbidity, social alienation and stigmatization, and longer term mental health consequences" (p. 350). TAPS's work providing bereavement care for military loss survivors over 25 years supports this observation. Suicide loss survivors may need additional, specific programming to stabilize their special issues so they can better integrate with, and grieve alongside, survivors of other forms of loss. The authors contend that it is therefore crucial to have a model specifically designed to meet the unique needs of these survivors. The TAPS Suicide Postvention Model™ was developed out of this gap in support.

Lesson 3. Peer-based support is one of the most important factors in helping suicide loss survivors

From an analysis of interviews with experts in peer support, Bartone et al. (2018) identified best practices for effective peer support programs, finding that they should be "easily accessible; confidential; provide a safe environment; use peer supporters with similar shared experiences to clients; select peer supporters carefully; partner with professional mental health providers; train peer supporters thoroughly; and provide care and monitoring for peer supporters" (p. 555). The TAPS Suicide Postvention Model™ employs all eight of these peer support practices throughout its application.

Suicide can leave survivors feeling overwhelmed, ashamed, and alone. The authors propose that connecting with others who have experienced a similar loss can mitigate negative emotions and build relationships that offer comfort and hope. Peer-based support is a bridge to professional care—like mental health and trauma care—with longer term survivors modeling the possibility for healing to the newly bereaved. There is also a reciprocal benefit (Castellano, 2012) for long-term survivors as they realize how far they have progressed and that their lessons learned on the lookback are equally valuable to others.

Lesson 4. Combining peer-based support and clinical care offers a best practice approach to traumatic loss

Trauma, mental illness, and addiction are complicating factors often associated with suicide loss that can go overlooked. Assessments for risk, mental health, and trauma are essential components of stabilizing survivors following a death. The TAPS Suicide Postvention Model™ recommends incorporating needs assessments for specific professional care during intake interviews with newly bereaved survivors. When necessary, staff refer new survivors to one or more partner organizations in a network of clinical care that complements TAPS peer-based support. This combination of peer and professional bereavement support is a key feature of the TAPS Suicide Postvention Model™. One study of suicide loss survivors who received care from both peers and professionals suggests a strong correlation between the two, "with one or the other awakening greater desires for self-knowledge through interaction with counselors and/or with other survivors" (Feigelman & Feigelman, 2011, p. 68). The synergy from this coupling, the authors found, works equally well regardless of whether survivors choose to engage in counseling or support groups first.

Partnerships seem to be the key to the success of this approach, so TAPS works closely with leading organizations in mental health and trauma to provide the most comprehensive care to survivors. For example, since 2017 TAPS and Boston's *Home Base* program have partnered on a two-week *intensive outpatient treatment program* (IOP) to treat TAPS suicide loss surviving spouses and parents who had suffered trauma associated with their loss. In most cases, the survivors had either witnessed the death of their loved ones or had discovered their bodies. The IOP put these survivors through a mix of intensive clinical therapy and group bonding activities that focused on mitigating the effects of posttraumatic stress (PTS) and complicated grief (CG). The peer-to-peer aspect of this treatment was supported and enhanced by a team of TAPS *peer professionals* before, during, and after the direct clinical treatment. (TAPS peer

professionals are survivors with lived experience who also possess professional training, education, and experience in the fields of mental health, suicidology, and bereavement.) A study led and published by Home Base clinical psychologists Ohye et al. (2020) revealed that after completion of the IOP, surviving spouses reported experiencing significant improvement in their satisfaction with, and "perceived ability to participate in," social roles (p. 4). The authors postulate that this improvement may be due to the group support and cohesion the survivors experienced during and following their treatment.

The authors contend that it is this very combination of TAPS peer-based support and professional, clinical care that weaves the safety net this population usually requires.

Lesson 5. Suicide loss provides a unique opportunity for posttraumatic growth

TAPS's work with suicide loss survivors has suggested they are uniquely positioned to achieve posttraumatic growth, especially when they are supported with specialized resources, services, and strategies. TAPS now counts more than 500 peer mentors who are using the lessons learned from their own losses to support new suicide loss survivors.

Suicide loss survivors often have a desire to make meaning out of what seems like a senseless death. This population can thrive, with multiple opportunities to engage in various types of growth, when given a roadmap like that which this Model provides. TAPS offers many paths to make meaning through prevention, intervention, and postvention initiatives. The authors also encourage and support the concept of living one's life "differently" in honor of a loved one.

TAPS often hears the following sentiment from long-term survivors: "Of course I would trade everything to get my loved one back. But there are so many positive changes in my life that would not have happened if they had not died." Some survivors express guilt about these newfound feelings, but they are referring to the depth of connections they have made, the appreciation of life they have gained, and the realization that they are stronger than they once thought.

Conclusion

For more than a decade, TAPS has been on the front lines of suicide postvention efforts to support military families grieving deaths by suicide, as well as using lessons learned on the lookback to save countless lives through suicide prevention efforts. In addition to bereaved families, TAPS works alongside the military community and the veteran population, both of which have provided unique insights into suicide loss survivorship and the ways in which healing, hope, and growth are possible.

The TAPS Suicide Postvention Model™ is broadly applicable to anyone grieving the loss of a loved one to suicide and is also applicable to other traumatic, complicated losses. The Model was developed by survivors, for survivors in order to address the unmet needs of this population, and the authors encourage its use as a pathway to decrease risk and promote healing and growth. This Model can benefit all survivors—and their supporters—by helping them better understand the survivor experience and how to approach their journeys in a more intentional way.

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