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SURVIVORS OF A MILITARY SUICIDE DEATH: EXPLORING DISTRESS AND POSTVENTION PEER SUPPORT

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SURVIVORS OF A MILITARY SUICIDE DEATH: EXPLORING DISTRESS AND POSTVENTION PEER SUPPORT

Jill A. Harrington-LaMorie

A DISSERTATION

in

Social Work

Presented to the Faculties of the University of Pennsylvania

In

Partial Fulfillment of the Requirements for the

Degree of Doctor of Social Work

2011

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Dedication

To my beautiful children, Madeline and Alexander - reach for the "stars", I am here beside you with love, just like you have been there with me.

To all those who have suffered the death of someone in the U.S. military, regardless of their circumstance of death…you are not alone.

To survivors touched by suicide and self-destruction…Where there is despair, hope; Where there is darkness, light (Prayer of St. Francis of Assisi).

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For putting up with me through all the hard work and stress of earning a doctorate. Thank you for being patient with me and still talking my phone calls. Madeline and Alex, you put in just as many hours as I did – thank you for lending me out to PENN for a while. Drew, for your eternal inspiration. Mom, you have always been my rock and my biggest supporter.

"Perfer et obdura, dolor hic tibi proderit olim."
~Ovid

"Taps"

Day is done, gone the sun
From the lake, from the hills, from the sky.
All is well, safely rest, God is nigh.

Fading light, dims the sight,
And a star gems the sky, gleaming bright.
From afar, drawing nigh, falls the night.
Thanks and praise, for our days,
'Neath the sun, 'neath the stars, neath the sky.
As we go, this we know, God is nigh.

Sun has set, shadows come,
Time has fled, we must go to our rest.
Always true to the promises we've made.

Fading light, dims the sight.
And a star gems the sky, gleaming bright.
From afar, drawing nigh. Falls the night.

ABSTRACT

SURVIVORS OF A MILITARY SUICIDE DEATH:
EXPLORING DISTRESS AND POSTVENTION PEER SUPPORT

Jill A. Harrington-LaMorie, MSW, LCSW

Kevin Corcoran, PhD, JD

In the past decade, as the rate of suicides among United States (U.S.) Armed Services members have steadily risen, so too has the number of survivors impacted by military suicide death. When a loved one, friend, family member, or co-worker dies as a result of a suicide, the ensuing shock and trauma -- along with unique issues accompanying suicide bereavement -- may compromise the mental and physical health of survivors. This leaves them vulnerable to a more distressing and complicated grief process. Those bereaved by suicide are at higher risk for completing suicide themselves. Peer support, an acknowledged basis of recovery from mental illness and addictions, has been clinically observed to be widely utilized by suicide loss survivors. Researchers have paid little attention to efficacious interventions for survivors of suicide loss in the general population of the U.S., even less is known about the efficacy of peer support among survivors of a U.S. military suicide death.

In order to assess this gap in clinical knowledge, fifty-two (N=52) survivors of military suicide loss were administered two self-report instruments to evaluate the association between exposure to peer support and perceived distress. This exploratory study with an at-risk bereaved population has yielded a number of new insights and conclusions. Recommendations for clinical practice and future research are discussed.

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List of Abbreviations

AA	Alcoholics Anonymous
AAS	American Association of Suicidology
AFSP	American Foundation for Suicide Prevention
CBT	Cognitive Behavioral Therapy
CDC	Centers for Disease Control and Prevention
COPS	Concerns of Police Survivors
CISD	Critical Incidence Stress Debriefing
DHB	Defense Health Board
DoD	Department of Defense
DSM	Diagnostic and Statistical Manual
DVA	Department of Veterans Affairs
EES	Emotional Support Scale
GED	General Equivalency Diploma
IES/IES-R	Impact of Events Scale/Revised
LGBT	Lesbian, gay, bi-sexual and transgender
LOD	Line of Duty
LOSS	Local Outreach to Survivors of Suicide
MSH	Management Sciences for Health
NASWVA	National Association of Social Workers-Virginia Chapter
NIMH	National Institute of Mental Health
NMFA	National Military Family Association

OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
PNOK	Primary Next of Kin
PTS/PTSD	Posttraumatic Stress/Posttraumatic Stress Disorder
SD	Standard Deviation
SGLI	Serviceman's Group Life Insurance
SPSS	Statistical Package for Social Sciences
SSB	Social Support Behavioral Scale
TAPS	Tragedy Assistance Program for Survivors
WHO	World Health Organization
US	United States
USMC	United States Marine Corps

Introduction

"Every suicide makes this statement: this far, and no further!"
~Edwin S. Shneidman (Roy, 1986, p.4)

Military suicides have enduring impacts on survivors whose "lives are forever altered" (Shneidman, 1972, p.xi). For each person that loses his or her life to suicide, conservative estimates are that six persons close to the deceased are directly affected (AAS, 2010). Whether the death is by direct or indirect acts of self-destruction, suicide is commonly experienced as a sudden, traumatic loss. With each suicide death of a service member, military families, friends, fellow comrades and significant others are profoundly affected emotionally, physically, psychologically, socially, and spiritually in its aftermath.

The suddenness of the loss, frequently experienced in the context of a traumatic and violent self-inflicted death, often intersects with a stigmatizing grief, making survivors of suicide loss more vulnerable to a distressing, isolating and complicated grief process. The literature suggests that survivors affected by suicide loss struggle with more prominent and intense "thematic issues" (Jordan, 2008, p. 680), such as guilt, shame, stigma, social isolation, family relational disturbance, perceived rejection, trauma symptoms, complicated grief and their own suicidality, contributing to a survivor's vulnerability to persistent distress and psychiatric disorders (Cerel, Padgett, Conwell & Reed, 2009).

"The question of how best to help survivors of suicide remains pressing" (AFSP, 2010, p.2). Despite a considerable body of research focused on suicidal behavior and suicide risk, survivors of suicide loss are an understudied population (Cerel, Jordan & Duberstein, 2008; Feigelman & Feigelman, 2008; McMenamy, Jordan & Mitchell, 2008; Parker & McNally, 2008). Even less is known potential treatment and prevention for survivors.

Suicide postvention is described in the literature as services designed to buffer the burden of distress for survivors and ameliorate the impact of the suicide death (Aguirre & Slater, 2010; Campbell, Cataldie, McIntosh & Millet, 2004). Postvention services are aimed at assisting survivors in managing the immediate crisis of the suicide and coping with its long-term consequences. Peer support, an acknowledged basis of recovery from mental illness and addictions, has been observed clinically to be widely utilized by suicide loss survivors; however, there is sparse attention to the study of the efficacy of peer support with survivors of suicide loss as a postvention intervention (Cerel et al., 2009). Furthermore, there is negligible inquiry into its use with sub-groups whose culture has a strong predilection toward peer connectedness, such as members of the U.S. Armed Services and their families.

The following dissertation seeks to inform the literature on military survivors of a suicide loss by examining the role of peer support in buffering survivor distress. This paper will first examine suicide, the impact of suicide loss on survivors and unique issues confronting military suicide loss survivors. Next, the history of peer support in its use with a bereaved population, including suicide loss survivors will be explored. Then, a study is introduced which attempted to address the question: Is there an association between seeking peer support and the level of distress experienced among military suicide loss survivors? Based on the underlying theories of mutual aid, social support, experiential knowledge, helper-therapy principle, social learning theory and the social comparison theory, this study will examine relationships between peer support and survivor distress as an outcome (Salzer and Shear, 2002; Shulman, 2009). It is hypothesized that those who report higher frequencies of exposure to peer support, the independent variable, will report higher score of perceived distress (impact), the dependent variable.

Peer support will be operationalized by scores on the Social Support Behavior Scale, Emotional Support Subscale (SS-B) (Vaux, Riedel & Stewart, 1987), which ascertains the frequency of peer support and its magnitude or intensity, and distress will be operationalized by scores on the Impact of Events Scale Revised (IES-R) (Weiss & Marmar, 1997). Findings from the study will be used to draw conclusions about the impact of peer support on military suicide survivors, as well as clinical populations of suicide survivors at large.

In order to understand suicide as a major world public health problem affecting all sectors of society, including the U.S. Armed Services, we will define the current problem of suicide and its impact from a global, national and U.S. military perspective.

Chapter I
Background

Suicide: The Problem

"Self-destruction occurs in many ways, some obvious, some disguised, but always hastening, in one way or another, one's own death" (Farberow, 1980, p. 15).

Suicide is "the most individual of acts" (Williams, 1997, p. 18) and a complex human behavior killing more humans around the world than "war, terrorist activities, and homicides, combined" (DHB, 2010, p.9). Ranked as the tenth leading cause of death by the World Health Organization, there are close to a million suicide deaths on an annual basis globally (WHO, 2010). Throughout the world a completed suicide occurs every 40 seconds, resulting in 2,700 deaths per day. Suicide yields a mortality rate of 16 per 100,000 internationally and is the third leading cause of death among 15-44 year olds. Suicide rates among this population have increased so drastically they are now the highest at-risk group in a third of all developed and developing countries (WHO, 2010). Furthermore, 20 million individuals attempt suicide each year (WHO, 2010). The WHO has suggested that the problem of "suicide should not be seen as an inevitable cause of premature deaths throughout the world…governments worldwide should work together to find solutions to this growing public health problem" (WHO, 2009, p.1)

In 2007, 34,598 individuals died by suicide in the U.S., making it the eleventh leading cause of death for all ages (CDC, 2010). One suicide occurs every 15 minutes in the U.S., taking the lives of 94 persons a day at a rate of 11.3 suicides per 100,000 (CDC, 2010). However, the problem of suicide may be underscored when considering that there are many whose deaths by drugs, alcohol, single-person motor vehicle accidents, and other forms of sub-intentional self-destruction may also be a form of self-inflicted death (but cannot be confirmed as such).

Suicide affects all countries, cultures, races, gender, religions, ages, and socio-economic groups (WHO, 2010). Although suicide can happen to anyone, there are some groups in the U.S. that are at higher risk than others, there exist age, gender and ethnics disparities contributing to an individual's potential risk for suicide. Men are four times more likely than women in the U.S. to complete suicide, representing 79% of all suicides (CDC, 2010), however women attempt suicide two to three times more often than men, and when successful, use poison as the most common lethal method for ending their own lives (CDC, 2010). It is more common among men to commonly choose violent methods when ending their own lives, such as firearms, hanging, and asphyxiation (CDC, 2010). Firearms are the leading method in the U.S. used to complete suicide across genders (NIMH, 2010).

American Indians and Alaska Natives, ages 15 to 34 years old, face the greatest challenge among racial and ethnic groups at risk for suicide in the U.S. (CDC, 2010). Suicide is the second leading cause of death in the U.S. for this group and American Indians and Alaska Natives have the highest overall rate of suicide deaths per year at 14.3 per 100,000. American Indians and Alaska Native age-adjusted death rates for suicide are 190% higher for suicide than the general U.S. population (MSH, 2010). Comparatively, non-Hispanic whites in the U.S. complete suicide at a rate of 13.5 per 100,000, Asian and Pacific Islanders at 6.2 per 100,000, Hispanics at 6.0 per 100,00 and non-Hispanic blacks, reflecting the lowest rates of suicide at 5.1 per 100,000 (NIMH, 2010).

Suicide is the second leading cause of death among 25-34 year olds and third leading cause of death among 15-24 year olds (CDC, 2010). Senior adults age 75 and older have the highest rates of suicide in the U.S. at 16.0 per 100,000 (CDC, 2010).

There are many factors that put a person at risk for suicide. Some of these factors include, but are not limited to: previous suicide attempt(s); history of depression or other mental illness; substance abuse; physical illness; feelings of loneliness; and a family history of suicide, violence and domestic violence (AFSP, 2010; CDC, 2010; NIMH, 2010; WHO, 2010). There are devastating impacts to survivors who are bereaved by a suicide death. One of these impacts is the exposure to a suicide death of a friend or loved one, putting the survivor at-risk for attempting suicide themselves (Krysinska, 2003).

With more than 34,000 people who die by suicide and over 376,000 individuals are treated in emergency rooms each year with self-inflicted injuries, indicating that suicide is a public health problem in the U.S. (CDC, 2010) There are profound costs associated with suicide, affecting all systems of American Society, from the micro (individual), mezzo (family/community), to macro (broader society) levels. The medical costs and lost wages associated with suicide take their toll on the American Society, with an enormous impact on the healthcare system. There are staggering impacts in terms of services and years of life lost (DHB, 2010, p. 10). The emotional, physical, psychological and social costs of suicide are immense. For those who attempt suicide and survive, there may be serious injuries and physical costs, such as brain damage, organ failure, bodily disfigurement and broken bones. Psychologically, attempters who survive may struggle with stigmatization, emotional difficulties, depression, guilt, anxiety, other mental health impairments, as well as re-attempting. For those who complete suicide, there is a tragic loss of life. For those who are bereaved by suicide, there are profound and devastating biopsychosocial impacts affecting survivors left to cope with the death.

Therefore suicide is a significant cause of preventable death worldwide and a considerable public health and social problem affecting all micro, mezzo and macro systems throughout the world (WHO, 2010), its affects are felt more deeply within certain countries and societies than others, touching some populations and sub-populations more profoundly.

Suicide in the U.S. Armed Forces: An Overview of the Current Problem

"There is a lot we don't know. And we have doubled our rate since 2004…fully a third of those who've committed suicide have not deployed…so there are huge challenges…we've made some progress with respect to eliminating stigma, but we're nowhere close to where we need to be. And I think clearly leaders are responsible."
~ Admiral Michael Mullen, Chairman of the Joint Chiefs of Staff
(National Public Radio, 2010)

Whether in peacetime or at war, military personnel have lost their lives to suicide (Harrington-LaMorie & Ruocco, 2010). "Suicide in the military has existed as long as there have been standing armies"(DHB, 2010, p.11). Historically, suicide rates during peacetime are generally lower than the U.S. civilian suicide rate by 50% to 55% and 20% to 30% respectively (Kang & Bullman, 2008). Currently, with suicide rates rising among all service branches of the U.S. Armed Services, the need to further understand suicide, prevention, intervention and postvention are a vital health and mental crisis faced by the Department of Defense (DoD).

Since the inception of the conflicts in Afghanistan (2001) and Iraq (2003) there has been an alarming rise in the total number and rates of suicide in active-duty armed services personnel (Harrington-LaMorie & Ruocco, 2010). Suicide rates for all services began rising in 2002 with the most common method of death being a self-inflicted gunshot wound (Kang & Bullman, 2008). Forty-one percent of these deaths were recorded as using non-military issued firearms (DHB, 2010).

The highest prevalence of military suicides since 2001 has occurred in males at a rate of 18.2 per 100,000 (DHB, 2010). Caucasian are the most affected racial group, at 17.4 per 100,000, as well as divorced service members (27.6 per 100,000), those under 25 years of age (20.1 per 100,000), and those who hold the rank of E1-E4 (20.1 per 100,000) (DHB, 2010) . Thirty-six percent of all completed military suicides between 2001-2009 had a documented mental health disorder (DHB, 2010). Educationally, service members who had a G.E.D. killed themselves at the highest rate of 20.1 per 100,000 (DHB, 2010).

The U.S. Army and U.S. Marine Corps have had the most deployments and exposure to combat in both Iraq and Afghanistan since the wars began. Currently, both of these service branches have experienced the greatest rise and continual spike in suicide rates.

The annual number of suicide deaths among soldiers on active duty in the U.S. Army, Army Reserve and Army National Guard has steadily grown from 2001 to 2008 (Kuehn, 2009) and continues to rise. Despite efforts to increase programs and improve suicide prevention, the Army's suicide rate continues to climb. Since 2001, the suicide rate in the U.S. Army has risen from 9 per 100,000, below the civilian national average, to 20.2 per 100,000 in 2008, doubling the national average of 11.3 suicides per 100,000 in the U.S. civilian population and tipping over the demographic comparative civilian U.S. rate of 19.2 per 100,000 (Congressional Quarterly, 2010).

The U.S. Marine Corps suicide rate has reached 24 per 100,000, a rate surpassing all other services (USMC, 2010). The suicide rate in the U.S. Marine Corps has nearly doubled in three years, when in 2006 the rate of suicides in the Marines was 13 per 100,000 (USMC, 2010). Completers have chosen methods with increased likelihood of lethality, such as gunshot, hanging, lacerations and asphyxiation. As a result, there is substantial concern for U.S. Marines

attempting suicide and this has resulted in an increase in U.S. Marine Corps suicide prevention efforts and programs. Despite these efforts, death by suicide continues to rise.

The Air Force rate of 15.5 suicides per 100,000 is it's highest since 1995 (Air Force Times, 2009), with the Navy increasingly slowly from that time to a current rate of 13.3 per 100,000 (USN, 2010). According to the *Congressional Quarterly*, in 2009 more military personnel have died by suicide than in the wars in Iraq and Afghanistan that year. Concurrently distressing U.S. Veterans now accounted for 20 percent of the over 30,000 suicide deaths in the U.S. in 2009, with an average of eighteen U.S. military veterans taking their lives every day (Congressional Quarterly, 2010).

The relationship between military service and suicidal behavior remains complex, serving as a protective factor for some and risk factor for others. Protective factors may include pre-enlistment screening, inter-related and social environments in the military, well-developed medical services, sense of belonging and purpose, and organizational cohesiveness (Mahon, Tobin, Cusack, Kelleher & Malone, 2005). Historically some known risk factors include exposure to trauma, access to lethal means, access to marksmanship training, possible selection and self-selection of more aggressive individuals, disconnectedness from support systems, desensitization to death and stigma associated with mental health problems and seeking mental health services (Mahon, et. al., 2005; Selby, Anestis, Bender, Ribeiro, Nock, Rudd, Bryan, Lim & Baker, 2010). These risk factors and recent increases in the military suicide rate suggest that suicide risk is potentially an occupational hazard of military service. There is sparse research on the influences of military service and suicide risk (Selby et al., 2010).

It is known is that the suicide rate of military personnel is rising steadily and rapidly. In addition, the suicide rate of troops exposed to combat in Operation Iraqi Freedom (OIF) and

Operation Enduring Freedom (OEF) has surpassed the general population (Mahon, et al., 2005; Selby, et al., 2010).

In 2009, the vital and critical need to evaluate suicide and suicide prevention in the U.S. Armed Services prompted the DoD to assemble an unprecedented *Task Force on the Prevention of Suicide by Members of the Armed Forces* whose intent was to "provide the Secretary of Defense and DoD leadership with actionable and measureable recommendations for policy and programs designed to prevent suicides by members of the Armed Forces" (DHB, 2010, p. v).

In its findings, the Task Force made seventy-six recommendations pertaining to four focus areas: These focus areas are as follows: Focus Area 1: Organization and Leadership; Force Area 2: Wellness Enhancement and Training; Focus Area 3: Access to, and Delivery of Quality Care; and Focus Area 4: Surveillance, Investigations, and Research (DHB, 2010). In Focus Area 3, the sixty-fourth recommendation of the DHB (2010) Task Force suggests that the DoD:

> provide families with comprehensive emotional support following the death of a loved one by suicide. All those affected, including significant others and battle buddies, should have access to the resources that will help them cope with traumatic grief (p. ES-17).

Access for military families and survivors of a military death, including suicide remains problematic. In 2006, in their statement before the DoD Task Force on Mental Health, The National Military Family Association (NFMA) deemed "persistent provider access problems" as a barrier to care, stating "timely access to the proper providers remains one of the greatest barriers to quality mental health services for service members and their families" (NMFA, 2006, p. 11). Furthermore, access to grief counseling and bereavement services remains a challenge for families of fallen service members. TRICARE, the insurance provider for dependent family

members (spouses, children) of U.S. military service members, currently does not cover grief counseling as a health insurance benefit, even after the recommendation by NMFA that:

> new legislative language governing the TRICARE behavioral health benefit may also be needed to allow TRICARE coverage of bereavement and grief counseling…Targeted grief counseling when the survivor first identifies the need for help could prevent more serious issues from developing later (NMFA, 2006, p. 12).

In addition, access to agencies, providers and mental health counselors trained in grief and trauma counseling is imperative for the health of military service members, their families and survivors affected by a military death. The complex synergy of grief and trauma is an ongoing challenge faced by today's military and a vital factor in the care and the health of the force.

There is a demonstrable need for further research into suicide and suicide prevention efforts as the U.S. Armed Services is faced with the growing rates of suicide among service members and veterans after a decade at war. There is also limited research into impact of suicide on survivors of a military death and effective postvention services, including prevention work with these survivors who are at-risk for completing suicide themselves. Barriers to care for survivors, as well as the education and training of providers in traumatic grief remain problematic.

As the war in Iraq ends and Afghanistan continues, the general public is becoming increasingly more concerned about the health and well being of military families (Cozza, Chun & Polo, 2005) and the broadening effects of their exposure to trauma and grief on the individual and U.S. society. These effects include physical injuries, as well as psychological and emotional wounds, some that heal and those that may never heal (Levy & Sidel, 2007; Tanielian & Jaycox, 2008).

The personal narratives of suicide loss survivors elucidate the reality that the death of a loved one, friend or family member to suicide can be a tremendously painful and life-altering experience for those left behind. The question of whether mourning after suicide is different remains in debate. However, a growing body of empirical and clinical work is beginning to offer evidence that exposure to suicide is frequently associated with many negative sequelae, including an elevated risk for suicide in those exposed (Jordan & McIntosh, 2010). In the next chapter, we will discuss the impact of suicide, why suicide bereavement is considered different and unique challenges facing survivors of a military suicide death.

Chapter II
Survivors of Suicide Loss: The Impact

"Survivors of suicide are the largest mental health casualty area related to suicide"
~Edwin Shneidman (McIntosh, 2003, p. 339)

Suicide Loss Survivors and the Need for Research

Jordan (2008) states that a clear definition of who is a "suicide survivor" has not been define within the field of suicidology and there is no existing consensus definition. In their proposed research agenda for survivors of suicide, the American Foundation for Suicide Prevention states, "a critical question that has long challenged researchers is how many people nationwide can be defined as a 'survivor of suicide' " (AFSP, 2010, pp.1-2). The literature suggests that the decision to be identified as a suicide survivor is one of self-selection (Andriessen, 2009). For the purposes of this study, a survivor of suicide is anyone who has been significantly impacted physically, emotionally, psychologically, socially and/or spiritually by a suicide death.

The number of people affected by suicide grows dramatically when consideration is given to those left in its wake. For each person who dies by suicide conservatives estimates propose that at least six and as many as hundreds of survivors are left behind to grieve and make sense of the death (AAS, 2010; Crosby & Sacks, 2002). Feigelman & Feigelman (2008) state that a recent estimate claims that over 13 million persons knew a person who died by suicide the previous year and one in five were family members. As the suicide rate increases in the U.S., so too do the hundreds of thousands of suicide loss survivors each year.

Despite the large number of suicide loss survivors, research has primarily investigated suicidal behavior and risk factors for suicide (Parker & McNally, 2008). Suicide survivors are an understudied and obscurely understood population (Feigelman & Feigelman, 2008; Jordan &

McIntosh, 2010). Few studies have identified the specific challenges faced by suicide survivors, their efforts to cope and the needs of survivors subsequent to a suicide death (McMenamy, Jordan & Mitchell, 2008). Current understandings of suicide indicate that survivors may be at risk for physical, psychological, social, emotional and bereavements complications, including higher rates of complicated grief and suicide, little research exists about the impact of suicide on survivors and interventions best used to help assist them in repairing their lives (Mitchell, Sakraida, Kim, Bullian & Chiappetta, 2009; McMenamy, et al., 2008; Parker & McNally, 2008). There is even further negligible literature and investigation into sub-populations (AFSP, 2010).

> The question of whether mourning after suicide is different-and, if so, whether the differences are quantitative or qualitative in nature (or both)-remains a challenge to be resolved….there are important definitional issues about survivorship that suicidology and thanatology have yet to address satisfactorily (Jordan & McIntosh, 2010, p.3).

Given the rapid and steadily increasing rates of suicide among U.S. military service members, the rise in the rate of the survivor population continues to mount. With approximately 2,000 reported suicide deaths in the active duty armed services since 2001 (DoD, 2010) and 20% of the 30,000 suicide deaths each year in the U.S. completed by veterans (Congressional Quarterly, 2010), conservative estimates of military and veteran suicide loss survivors reaches into the hundred-thousands.

Suicide Bereavement

Exposure to suicide does not necessarily indicate that an individual will be significantly harmed by the death. For those negatively impacted by a suicide death, the effects can be profound and devastating. The death of loved one, friend or significant other is consistently considered one of life's most stressful events (Stroebe & Stroebe, 1993) and bereavement and

grief following suicide has it own particular challenges for those left in its wake (McIntosh, 1987).

Grief and bereavement following loss through death is a normative human process (Worden, 2009). How each individual responds to loss is a highly individualized and subjective experience. There is no definitive, prognostic response to death; loss and bereavement vary among individuals in their meaning, presence, intensity, frequency, and duration (Bonnano, 2004). Intense emotions, including sadness, anger, longing, guilt, fear and sorrow accompanied by somatic sensations in the stomach, shortness of breath, profound fatigue, agitation, difficulties in swallowing and perceived helplessness are common in the first few weeks and months of grieving. Loss of interest, lack of motivation and social withdrawal are also frequent. However, distress and an adaptive course of adjustment is often a common response to death loss, as is the ability for the majority of survivors to integrate the loss into their lives and accommodate with resilience (Bonnano, 2004; Neimeyer, Burle, MacKay & van Dyke Stringer, 2010). Conversely, research suggests that 10% to 20% of bereaved persons suffer from more complicated grief reactions (Holland, Neimeyer, Boelen & Prigerson, 2008) and those bereaved by suicide are more vulnerable to the cumulative effects of completed suicide, predisposing them to a higher risk of complicated grief and heightened states of distress (Aguirre & Slater, 2010).

Anecdotal evidence suggests that bereavement following suicide is different than mourning other types of deaths (Jordan, 2001; Jordan, scientific evidence in the field when comparing suicide bereavement 2008). However, the scientific evidence in the field when comparing suicide bereavement to bereavement subsequent to other modes of death is mixed (Mitchell, et al., 2009). Over the past 20 years, a large number of studies, using rigorous research methods, such as large group sizes, comparison groups and control for socioeconomic

variables have found little difference between groups bereaved through different modes of death (Barrett & Scott, 1990; Cleiren, 1993; Demi 1984; Farbrerow, Gallagher-Thompson, Gilewski & Thompson, 1992; Grad & Zavasnik, 1996; Seguin, Lessage & Kiely, 1995). On the other hand, research has also indicated that suicide loss survivors experience longer grief related symptoms as well as increased intensity over time (Kovarsky, 1989; Thompson, Futterman, Farberow, Thompson & Peterson, 1993). Some have argued that suicide bereavement is a combination of grief and post-traumatic stress (Callahan, 2000),

Given the conflict in the data and dearth of research, it is critical to note that our understanding about long term affects of suicide on this survivor population is limited (Feigelman & Feigelman, 2008; Jordan, 2001). However, important discoveries in this area are the findings that those bereaved by suicide have a greater prevalence of risk factors (Clark, 2001). The literature conveys that suicide loss survivors demonstrate higher levels of distress in several areas of functioning at some point in their grieving process (McMenamy, et al., 2008) and are prone to complications in mourning, as well as being at higher risk for negative psychological, affective, social, behavioral physiological consequences (Latham & Prigerson, 2004; McMenamy, et al., 2008; Mitchell, et. al, 2009). Distress associated with suicide bereavement can lead to an increased risk of depressive symptoms, anxiety disorders, post-traumatic stress symptoms and poorer self-reported physical health (Mitchell, et al., 2009). Not being prepared for the death predisposes the survivor to a high likelihood of complicated grief (Rando, 1993) and if there was violence associated with the suicide, it also may further be associated with the development of post-traumatic stress disorder and major depression (Kaltman & Bonnano, 2003). Suicide survivors seem to be at an increased likelihood for completing suicide themselves (Jordan, 2008).

As this field of research continues to grow, existing survivor literature suggests that recurrent themes experienced by those bereaved by suicide contribute to a survivor's increased risk for complications in bereavement and suicidality (Aguirre & Slater, 2010; Cerel, et al., 2009; Feigelman & Feigelman, 2008; Jordan, 2001; 2008). Jordan (2001; 2008) contends that suicide bereavement is different and that bereavement for suicide loss survivors is distinct in prominent, recurrent thematic issues.

Influencing Issues in Suicide Bereavement

When a death is from suicide, the pain of the loss is often compounded by overwhelming and intense feelings of blame, guilt, anger, and incomprehension. If the suicide is experienced as a sudden, unexpected loss, adding to a survivor's suffering is the element of shock. Regardless of the mode of self-destruction, survivors are also confronted with the additional burden of stigma that surrounds suicide (Feigelman, Gorman & Jordan, 2009; Houck, 2007).

Suicide loss survivors often compare the distress they experience as being trapped on an endless roller-coaster of emotions, inhibiting their ability to cope with the death and interfering in their grief and healing. The roller coaster of emotions can sometimes include simultaneous paradoxical feelings leading to a conflicted and confusing state for survivors struggling to cope in the aftermath.

Recurrent themes and issues described in the literature which contribute to the subjective experience of suicide loss survivors that differentiate their bereavement process and experience from survivors of other modes of death include: the overwhelming need to answer the question - "why?"; guilt/responsibility/self-blame; perceived rejection/abandonment by the deceased; betrayal; anger; confusion; despair; relief; shame; stigma; social isolation; family disturbances; spiritual/religious/existential crisis; exposure to trauma; and risk of developing complicated

grief, depression and PTSD (Jordan, 2008; Jordan & McIntosh, 2010). Additional struggles accompanied by each of these issues, compounded with an often stigmatizing grief result in a state of heightened distress for survivors, increasing their vulnerability to mental health impairments, complicated grief, and attempting and completing suicide (Aguirre & Slater, 2010).

When a suicide happens unexpectedly and/or traumatically, survivors are exposed to the synergistic influences of both loss and trauma, severely disrupting the survivor's sense of control, shattering their assumptive view of the world and potentially altering their foundational beliefs about the world and their ability to function (Mitchell, et al. 2009: Jordan, 2008).

> "I don't know who I am in this world anymore. I have over-functioned for the sake of my kids, been strong for them, and work all the time running a business which thankfully keeps me too busy to feel anything" ~Surviving Spouse, U.S. Army Reserve Officer, died by suicide at 33 years old, December 2008

The suicide of a friend, loved one or close relationship can unleash upon survivors an "emotional tsunami" (Jordan, 2008, p. 681). Edwin Shneidman, known to be the father of the suicide prevention movement in the U.S. believed that "the person who commits suicide puts his psychological skeletons in the survivor's emotional closet-he sentences the survivors to deal with many negative feelings…it can be a heavy load" (Cain, 1972, p.x).

Described as living in a canyon of "why" (Campbell, 2001), suicide loss survivors often struggle more with questions of meaning making around the death. Because suicide is an act of self-destruction, which violates the fundamental norms of self-preservation, survivors often become encapsulated in trying to answer the question "why did he or she do it?". The need to make sense of the motives and frame of mind of the deceased are major preoccupations for survivors, which can severely inhibit their ability to connect with and work on their grief.

This haunting question of "why" often include questions of responsibility, which can lead to blame, self-blame, guilt and self-reproach. Suicide loss survivors demonstrate higher levels of guilt, blame and responsibility for the death (Feigelman, et al., 2009; Jordan 2001; 2008; Wilson & Marshall, 2010). The survivor's role and responsibility in the death is often self-exaggerated and as Jordan (2008) argues most survivors overestimate their own role in contributing to or failing to prevent suicide. The ensuing guilt is often the result of survivors feeling as if they may have directly caused the suicide through ill-treatment, neglect or abandonment of the deceased. Self-blame results in their perceived inability to anticipate or prevent the suicide.

Guilt and self-blame are particularly difficult if the suicide occurred within the context of an interpersonal conflict between the deceased and the survivor (Worden, 2009).

There are many factors that may contribute to a death by suicide, and some data suggests that 90% of people who die by suicide meet the criteria for a psychiatric disorder (Robins, 1981), however survivors are often unaware of these factors or may minimize them.

The intensity of a survivor's guilt may lead them to the need to feel punished, further influencing self-punishing behaviors, which may lead to societal rejection and isolation. Guilt can also be one of the underlying forces in the need to place blame for the death on oneself or others. Blame can be an effort by survivors to establish control in a very uncontrollable and incomprehensible situation.

Anger is an intense and sometimes confusing emotion for survivors. It may often be the precipitating emotion in the emergence and manifestation of blame for the suicide. A survivor’s anger can have many moving targets, it can be directed toward other family members, friends, co-workers, occupation (e.g., the military), health care professionals, the clergy, God, oneself, and even the person that died. This need to blame, often driven by an intense anger, can cause

severe disturbances in familial and social relationships, further fragmenting and isolating survivors.

Survivors often grapple with guilt and confusion over their anger toward the deceased and the role mental illness may have played in their demise. The uncertainty over "why" the deceased completed suicide can be perceived as a willful rejection, abandonment and act of betrayal to the survivor which may contribute to intense feelings of anger ("How could they do this to me?") and tremendous feelings of low self-worth ("I wasn't good enough to live for.").

Feelings of anger at the deceased are often considered taboo by survivors, so appropriate anger can be coupled with guilt, leading to confusion (Worden, 2009). Feelings of anger toward the deceased are often the most difficult feelings for survivors to reach which sometimes provoke a parallel process of idealizing the deceased (Wertheimer, 2001).

Survivors can find additional pain or solace within their religion regarding the suicide death of a loved one. Sometimes, an existential crisis may develop in the aftermath of a suicide for the survivor. This crisis can lead the survivor to question the very foundations of their way of life and whether their life has any meaning, purpose or value. It can also result in a sense of being alone in the world and contribute to even further isolation for survivors.

Certain religious stigma associated with sin and suicide can further isolate survivors in their grief, limit their support systems and leave them hyper-focused on the perception that their loved one may be doomed to an eternal life in hell (Early, 1992). Conversely, some survivors find support within their religious communities and develop an even stronger resolve in their new or strengthen spirituality.

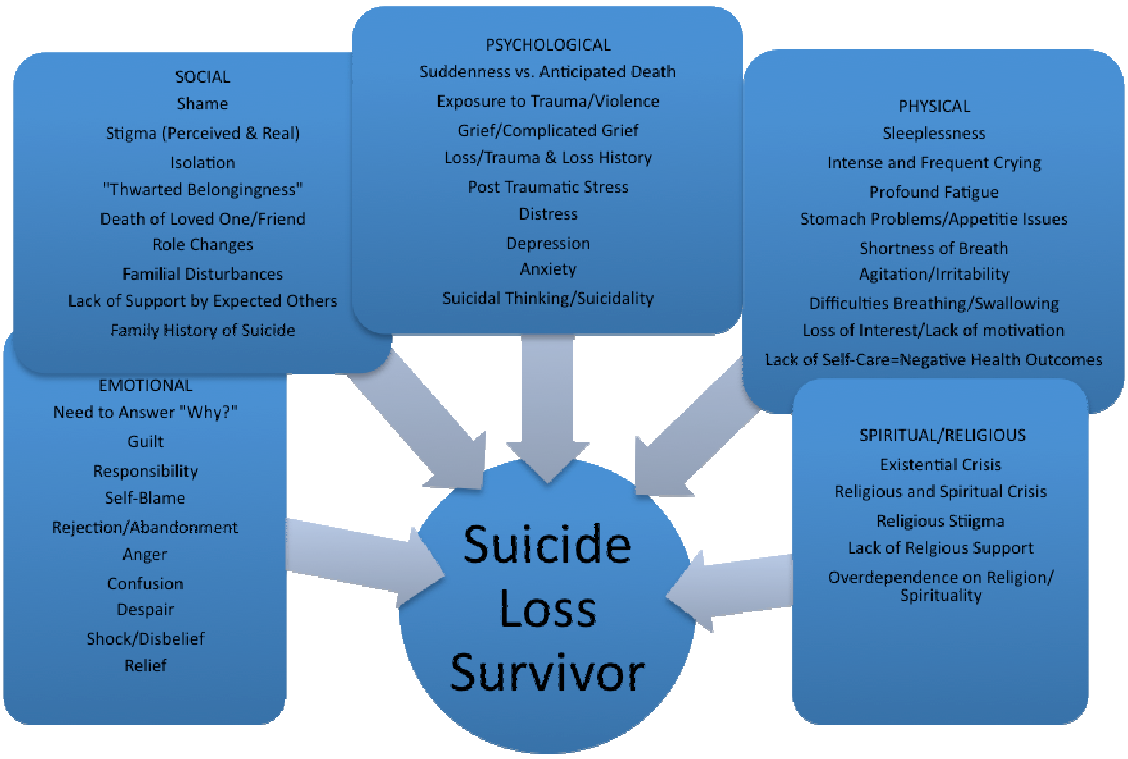
The feeling of relief may come as a surprise to some suicide loss survivors, which may be helpful or hurtful in their healing process as they try and make meaning of the death. Families,

in which there has been a long disruption in functioning due to a member's mental illness, addiction, self-destructiveness and suicidality may feel a certain sense of relief once the disruption is over. These families may have already experienced an emotional distance and sense of separation from this person, who they watched slowly "die" over time. The relief may stem from the survivor's prolonged agony and helplessness as bearing witness to a loved one's suffering. The result may be feelings of relief that both their sufferings have ended. This anticipatory grief and sense of relief is not so different from feelings experience by families bereaved by cancer, dementia or other long-term illnesses (Clark, 2001), nor the feelings of guilt associated with the feelings of relief.

The influence of stigma remains a prevailing, major interfering factor in a survivor's ability to heal and contributes to problems in mourning after suicide. Suicide loss survivors wrestle with both real and perceived feelings of stigma and shame. Feigelman, et al. (2009) state that "the literature on suicide bereavement identifies survivors as highly stigmatized" (p. 591). Informal social disapproval, blame, beliefs/morals/values on suicide, lack of understanding and failed attempts to gain empathy from expected others create greater grief difficulties for suicide loss survivors (Jordan, 2008). Fear of this stigmatization and shame associated with the suicide may influence survivors in keeping the suicide death a secret. This veil of secrecy can be a heavy burden for survivors to carry impacting their ability to fully heal. It can also cause great tension and stress within families (Jordan & McIntosh, 2010).

Finally, stigmatizing reactions only add to the burdens suicide survivors already bear. Many individuals, willingly or unwillingly do not know how to respond to a suicide death or how to support those affected. Survivors often have to educate people in their social networks about how to interact and support them (Feigelman et al., 2009). The quality, measure and type

of social supports survivors receive are instrumental in buffering distress. When supportive responses are missing, this can compound a survivor's grief difficulties. Survivors must navigate a new path, discovering which relationships are helpful and which are toxic. If no helpful relationships exist, survivors are often left alone in a vacuum of self-blame, isolation and shame. This can contribute to what Joiner (2005) calls a sense of "thwarted belongingness" and “perceived burdensomeness”, risk factors for suicide. Aguirre and Slater (2010) contend that trained senior peer survivors, who have shared the tragedy of suicide, can foster a sense of belongingness and begin to help increase self-efficacy to newly bereaved survivors through active postvention outreach programs. Creating a sense of belongingness can act as a protective factor in suicide prevention (Aguirre & Slater, 2010) and serve as a mechanism to link new survivors with suicide support services. With a heightened risk of suffering from PTS/PTSD, complicated grief, familial stress, depression and suicidal thinking, peer support postvention can act as critical short-term and long-term preventative and healing services for suicide loss survivors.



Survivors of a Military Suicide Loss

In the aftermath of a military suicide, as is true with any suicide, it is the survivors who are left to cope under the haunting veil of an often inconceivable question. Coupled with complex factors surrounding a death in the U.S. Armed Services, in addition to the emotional distress and feelings of guilt that generally consume survivors following a suicide, other distinctive issues are often faced by military suicide loss survivors. These multiple layers of compounding complexities, as well as the exposure to the dual burden of grief and trauma, may predispose survivors to a prolonged, distressing and complicated grief process and enduring impairments in their physical as well enduring impairments in their physical, psychological, social and spiritual health.

Based on these factors associated with a death in the U.S. Armed Services and distinctive issues faced by suicide loss survivors, this population should be considered at a high risk for the development of post-traumatic stress disorder, depression, anxiety-related disorders, complicated grief, and suicide (Harrington-LaMorie & Ruocco, 2010). To help understand some of the prominent factors and differences affecting military suicide loss survivors, several areas need explication. These observations of associated issues and complexities surrounding a military death and further, a military suicide loss, have yet to be fully noted in the literature. Therefore, they are based on the clinical observations of the author, who has worked closely with this population.

Complexities of a Military Death

The death of a loved one in the U.S. Armed Services involves complexities unlike those typically experienced in the civilian world (Carroll, 2001; Steen & Asaro, 2006) lending to a potentially prolonged, distressing and complicated grief process for many survivors.

Factors surrounding a death in the U.S. military which may compound the loss and predispose survivors to complications in their grief include: the circumstances of death (which are overwhelmingly sudden and/or violent in nature); geography of the death; age of the decedent; age of survivor/s; condition of bodily remains; their commitment to duty; military casualty and burial rites and rituals; media involvement; death investigations and line of duty investigations; benefits and entitlements: navigating bureaucratic systems of care; and secondary and multiple losses associated with the death (Harrington-LaMorie, 2010).

Acutely grief-stricken and often traumatized survivors, especially if they are the Primary Next of Kin, are instantly confronted with the task of making difficult decisions in the face of complex loss and trauma. The PNOK must navigate through the intricate bureaucratic process

involved with the disposition of the remains of a service member; deal with personal effects of the service member; and attend to a substantial amount of paperwork associated with entitlements for survivor benefits. These tasks often involve multiple systems within the larger macro systems of the DoD and Department of Veterans Affairs.

Interpersonally, the survivor is coping with their own response to the service member's death. Often, they are also having to negotiate a roller coaster of emotions and complex factors within the context of multiple, intrapersonal familial, military and organizational interactions. The aftermath of a military death does not exist in a vacuum, nor does the survivor. The death of a loved one in the U.S. military leaves surviving family members with a coexisting series of crises as well as primary and secondary losses. This is especially relevant for spouses and children who not only lose a family member, but a way of life. The social changes that death may bring to the survivor may come very unexpectedly (Harrington-LaMorie, 2010).

Circumstances of the Death and Condition of Bodily Remains

The manner in which someone dies can have deeply profound and enduring impact on survivors. Since the majority of deaths in the U.S. Armed Services are sudden and/or violent in nature, the psychological and emotional impact of violent death to the survivor is a synergistic experience of both grief and trauma (Neria & Litz, 2004). Bereavement following death by sudden and/or violent means, such as accident, suicide, homicide, increases the survivor's risk for complications in grieving and challenge their fundamental beliefs about themselves and the world in which they live (Currie, Holland, Coleman & Neimeyer, 2007; Doka, 1996; Rynearson, 2006; Worden, 2009).

With military deaths, bodily remains may be fragmented, retrieved bit by bit, never found, or due to circumstance, not viewable. If not viewable or not received by the survivor,

this can further complicate the grief of a survivor and his or her ability to grieve as the survivor can deny or delay the existence of the death. Recent evidence suggests that there may be benefits to being allowed to view a loved one's body after a sudden death (Chapple & Ziebland, 2010). The ability for the survivor to get up close to the deceased affords them the opportunity to orient themselves to the reality of the death and recognize the loss, when bodily remains are not viewable, the survivor is robbed of this opportunity.

Additionally, the circumstance in which a service member dies in the military impacts a wide variety of issues. These include the burial rites they can receive, entitlements and benefits to designated survivors, honors rendered, recognition of service member on memorials and memorial events, inclusion and recognition of survivors in memorial events and survivor membership organizations, media interest and involvement; support and recognition provided by the military community (from a micro level to a macro level); and support and recognition provided by the civilian and veteran communities.

The circumstance of a service member's death has long-term impacts upon a survivor's grief and bereavement experience. How a service member dies can bring with it a community of support from others who honor their loss throughout the years at memorial events or an intense sense of disenfranchisement from the micro level to macro level, which may be real or perceived as a result of deaths which are considered less honorable or dishonorable.

Geography of the Death/Geography of the Survivor

The location of the service member's death can play an important role as to the impact and affects it has on the survivor/s. Service members die under various conditions and in all corners of the world. Many die in the U.S., close to their base/post, or close to home, while others die in foreign lands, sometimes never to be found. One exceptional challenge faced by

military families is that service members spend an extraordinary amount of time away from their families, both primary and extended, due to training, deployments and other operational demands.

When the death occurs overseas, or when the family is geographically separated, such as for married service members, with spouses and children living spouses on or around the base/post where their service member was deployed. Survivors may need to rely on the military community as their primary support system, as most live far away from their families of origin (with the exception of most National Guard and Reserves). The service member was also most likely far away from his or her parents, siblings, family and friends for extended periods of time. Last words and last moments spent together may have been few and far between. Otherwise known as "deployment-delayed" grief, survivors can employ high levels of defense mechanisms to cope and create a subconscious denial that their loved one has died, and rather that they are still "away" on deployment. The reality often hits the survivor, with acute-grief reactions, when the unit returns and the service member is not with them. This delay in grief can often interfere with normative grieving processes for survivors (Steen & Asaro, 2006).

Age of Decedents/Age of Survivors

The majority of deaths of service members are those of young adults between the ages of 18 and 40 (Harrington-LaMorie & Ruocco, 2010). Their survivors are often young adults themselves, including young adult spouses/significant others, parents, siblings and other family and friends. Their children can range from young adults to adolescents and pediatrics, some waiting to be born.

The unexpected, tragic and untimely death of a young adult places the survivor in a position that is out of sync with their developmental phase. Young adult loss presents unique

challenges to survivors. Various factors contributing to this are: (a) a lack of similar others who are experiencing the same loss, (b) an inexperience with previous deaths, especially of that of a spouse or child at a young age, and (c) a limited peer group who can serve as role models to demonstrate how to cope and live with such a traumatic and untimely loss (Walter & McCoyd, 2009).

Distinctive problems plague families of young adult loss. Children may need to be raised by single parents or custodians, family roles may change, identity within the family may change and familial developmental tasks are challenged as they grieve this loss through the life span (Walter & McCoyd, 2009). The grief and loss consequent to the death of a young adult can involve grieving the past, the present as well as the hopes and dreams of a future.

Commitment to Service

Today's U.S. military is an all-volunteer force of men and women, making the choice to enter into the armed services during a time of war. There are multiple reasons why individuals join the military. A predominant theme amongst many is a driving force to commit themselves and their skills to a purpose driven, mission-oriented life in protection, support and defense of the U.S.

The reasons for their commitment to service may be a risk for further complication to the survivor or a protective, healing factor as they grieve. The survivor's viewpoint of the service member's military career is an essential determining factor. In addition, the way in which a survivor views the military's potential responsibility for the service member's death and how the decedent and the survivor have been treated in the aftermath by the military, can also impact the survivor’s grief process.

Death Notification

For many survivors, especially the next-of-kin, their lives are indelibly altered by a knock at the door. The U.S. military formally notifies the primary and secondary next of kin that their service member has died by an official death notification process. The military usually arrives by an official government vehicle, wearing sharply cleaned and decorated uniforms and come in pairs - a notifier and a chaplain.

Receiving and delivering this news is painful and difficult for both the survivor and notification team. However, even with the best training and sensitivity, notifying a family that a service member has suddenly died can be a "primary" traumatic event. When the death is sudden, traumatic and/or violent, the shock of the news can overwhelm the internal resources of the survivor, triggering a variety of individual responses.

The Casualty Officer

The military assigns a casualty officer to be the point of contact for the PNOK for weeks, even months after the death. The core duties and responsibilities for the casualty officer in each branch is essentially the same. They are there to meet the immediate needs of the next of kin; assist the family with the return home of the service member's remains; make funeral and interment arrangements; help the family handle the media; navigate the bureaucratic process; educate the family about benefit entitlements; assist with the inundating amount of paperwork; process benefits claims; and assist with applying for requests for investigation reports (Steen & Asaro, 2006). Once the paperwork is submitted and the last benefit is claimed, the job of the casualty officer is over.

The Casualty Officer is assigned to a family for guidance and support during one of the most difficult and challenging times of their lives. Many military widows, who are far away from their families of origin and without support, rely heavily on their casualty officers for

practical and emotional support. The officers assist the primary next of kin in making complex, major life decisions during a time of intense trauma, grief and confusion. When their role and job is over, sometimes the survivor may experience this as an additional loss and an undeniable finality.

The Immediate Impact to Survivors

The practical and emotional demands on the individual survivor and family who are suddenly notified of a service member's death are extraordinary. From the moment the casualty officer walks in the door, the complex decisions regarding the death begin.

Designated survivors must often deal with the transfer of bodily remains (this can have another layer of distress if the service member dies overseas or far away from home); funerals/memorials/burials (including the military rites and rituals which accompany these); and media involvement (military deaths are often deaths of high public interest).

As with any death of a parent with young children, "what to tell the children" is a struggle for the surviving parent or guardian/s. Because of the circumstances of the death, the condition or lack of bodily remains and coping skills of the surviving parent, some parents may delay relating detailed information to their children and may need assistance in the next few days, weeks, months or years after the death.

> "How do you tell an 8 year old and a 10 year old that their
> dad has made it safely back from Iraq and has taken his own life?"
> ~Surviving Spouse of Major, USMC,
> AH-1W Super Cobra gunship pilot, died by suicide at 40 years old

If the circumstance of the death involves an unattended body (e.g.: a soldier's dead body is found in the house and appears to be a suicide) or warrants further investigation, survivors are also subjected to the burden of a death investigation, which involves more layers of bureaucracy within the military. Death investigations can be prolonged (extended over a year or more); be

chronically re-traumatizing to the survivor; as well as be performed by criminal investigators who may not often work in tandem with victim assistance providers. Part of the death investigation process is to also determine whether the service member died in the line of duty. Line of duty determinations effect benefits and entitlements to survivors.

Immediate complex, life-altering decisions need to be made within hours, days and short weeks following a service member's death. The experts in grief suggest that you do not make any life-altering decisions within the first six months after the death of a loved one or significant relationship (Creagan, 2009). The military is beginning to recognize this best practice suggestion, but often times, survivors, especially spouses are faced with relatively immediate, life-altering decisions on where to move, financial considerations/ monetary benefits, handling personal effects and household goods and schooling for children all within the first three to twelve months after a service member has died, depending upon where they are stationed.

Secondary and Multiple Losses.

The death of a loved one in active duty military service confronts the family member to a series of losses associated with their death. These losses include the actual death, a loss of their way of life and identity associated with this life (e.g.: military spouse, military mom, military child), loss of their housing (if on base/post), and loss of their greater military community. For spouses and children, it is an "involuntary transition" from military family to civilian family. These often, sudden, multiple and compounding losses may bring with them a profound sense of isolation, loneliness and disenfranchisement for the surviving family.

Additional Challenges Facing Military Suicide Loss Survivors

For the survivor of a military suicide death, this profound sense of isolation, loneliness and disfranchisement is often experienced in the immediate aftermath of the death. Although the

military has recently made efforts to confront institutional policies surrounding suicide, there is still stigma that exists, both real and perceived. In addition to the complexities faced by survivors of a military death, suicide loss survivors must contend with additional challenges.

A "Dishonorable" Death: Shame and Stigma

Similar to the culture of police departments, who "subscribe to a myth of indestructibility," (Violanti, 1995, p. 2), viewing suicide as a disgrace to the victim and the profession, as well as a prevailing societal stigma, military suicides are often perceived as "dishonorable deaths". Supported by institutional policies that treat suicide deaths with inequitable difference in terms of memorials, condolences, recognition of service, death investigations, finances, pension rights and entitlements, family survivors are immediately faced with this stigmatization which may bring with it intense feelings of shame, heightening distress and isolating them in their grief.

The confrontation of this stigma exists in the midst of a survivor's struggle to comprehend a self-inflicted death and the accompanying feelings of guilt, blame, self-reproach, feelings of rejection, abandonment, anger, powerlessness, vulnerability and confusion unleashed in the aftermath of a suicide (Jordan, 2001). Social support for survivors may be limited due to the perception of a suicide death in the military as less than honorable or dishonorable. Perceived feelings of shame on behalf of survivors may cause them to self-isolate. Existing cultural stigma may bring with it withdrawal of military community support. Or like many survivors of a suicide loss in general Western society, military survivors often face "a wall of silence" (Feigelman, Gorman & Jordan, 2009) by family, friends and community. Family relationships may be strained or broken apart in the aftermath of suicide, sometimes due to anger and blame seeking behavior. Friends, neighbors and co-workers may naively struggle with how

to be supportive, feel uncomfortable with what to say or have a limited capacity to offer comfort when a death is by suicide. Communally and individually, there are also those who willfully withdraw support as an act of disapproval of this dishonorable death.

In addition to immediate family and friends, another group of survivors, who are often overlooked and suffer in the wake of a military suicide are military peers. Much like police units, where strong familial bonds may be created among service members, military suicides can leave enduring and critical impacts upon their surviving peers. Institutional policies and cultural attitudes further perpetuating stigma surrounding suicide and help seeking behavior in the military, along with a lack of access to effective postvention services can leave military peer survivors at high risk for heightened distress, suicide and the contagion effect (Loo, 1986; Violanti,1995).

Empirical evidence suggests that stigmatization with an ensuing lack of social support by expected others faced by suicide loss survivors is a damaging influence in their healing, intensifying survivor grief difficulties and leaving them at risk for depression and suicide (Mrysinska, 2003; Feigelman, et al., 2009). Research also suggests that survivors who experience greater stigma and complications in their grief have needs in their bereavement and healing that benefit from increased participation in peer support (Feigelman, et al., 2009).

The Violence of the Death

Whether in a war zone, on a ship at sea, in a basic training camp or at home, suicide deaths in the military can happen anywhere. Use of firearms and asphyxiation are the two most common current methods of self-inflicted death among military service members (Kang & Bullman, 2008).

Often times, survivors are exposed to the trauma of finding their loved ones bodies and/or witnessing the death. These deaths can be violent and leave trauma, mutilation or disfigurement to the body. Families are often co-victimized as they become witnesses to the self-inflicted violent death of a family member or are exposed to finding their bodies. Grief and trauma reactions after a violent suicide, especially for those who find the person, can be more intense and complicated. The horror and shock upon discovering the victim can be overwhelming and imprint a permanent image that can remain with the survivor, accompanied by flashbacks, nightmares and intrusive thoughts. These survivors are more likely to develop symptoms of acute traumatic stress, post-traumatic stress disorder and complications in their grief (Jordan, 2008).

> "The kids and I had a great day at Disneyland. When we returned home that evening, we opened up the garage door and found my husband hanging from the ceiling. My daughters actually saw their father first. I couldn't protect them from that."
> ~Surviving Spouse of U.S. Marine Gunnery Sergeant,
> died by suicide at 39 years old

Media

Military deaths are often highly publicized in the media (Steen & Asaro, 2006). Families are frequently co-victimized by the media, as the circumstances of their service member's death is quickly thrust into public view, invading a family's privacy and taking away their choice to disclose the death as a suicide. Survivor's lives and the life and death of their service member become fair game for public scrutiny and consumption.

The media can be an intrusive, unwelcomed and uninvited guest during an extremely traumatizing time for survivors. From the death scene, to the funeral and beyond, the media may not exercise objectivity or sensitivity while attempting to cover a story about military suicide. Survivors, who may not be ready or willing to share their stories may be directly confronted by

the media at a time of immense vulnerability and pain. Media coverage of a military service member's suicide can be exploitative and sensationalistic, furthering contributing to a survivor's sense of stigmatization and shame.

How to handle the media, learning what information to share and if an individual is willing, ready and capable to expose themselves to the media is an additional challenge of military suicide loss survivors.

Memorials & Recognitions

The U.S. military has not instituted any policies on how units or commands should memorialize service members who die by suicide, especially those who die by suicide on the battlefield. Memorial services are handled on a case by case basis. Some suicide memorials have no noticeable difference, others more prominent.

The military does make distinctions between suicides in combat and other war-related deaths. The families of those who die of combat and non-combat related deaths while serving in a warzone receive letters of condolence from the U.S. President. The families of military suicides, do not. Units or commands may choose to inscribe the names of the suicide fallen on their unit war memorials, many do not include them. Recent controversy has been provoked among some commanders in the U.S. Army who contend that suicide is dishonorable, while the Vice Chief of the U.S. Army, has ordered that memorial services for battlefield suicides should be the same as any battlefield death (Washington Post, 2010).

The effects of this type of non-recognition of service stigmatization, referred to by survivors as going from "hero to zero" and the perpetuation of the reinforcement of suicide in the military being a dishonorable death reaches far beyond the U.S. Armed Services. State, local and federal war memorials may not list combat-related suicides. Organizational or community

programs for veterans or families fallen service members may not include outreach to any or all military suicide loss survivors. Veterans or military-related membership organizations may not offer membership privileges to military suicide loss survivors. Recognition pins or other medallions of recognition may not be provided to family survivors of military suicide. Survivors must be confronted on a yearly basis with the effects of this dishonorable death stigmatization with the passing of each U.S. National holiday which honors veterans, service members and fallen service members.

Line of Duty and Death Investigations

A Line of Duty (LOD) determination is an administrative tool used by the military commanders to determine a service member's duty status at the time an injury, illness, disability or death is incurred. On the basis of the LOD determination, the service member may be entitled to benefits administered by their service branch, or exposed to liabilities. The key link is between the injury, illness, disability, or death and the service member's duty status.

One way to determine this link is through the death investigation process. Suicides in the military usually involve extensive investigation. Deaths investigations are conducted to determine or confirm the cause of death as well as identify the circumstances, methods and contributing factors surrounding the event. These investigations are performed by criminal investigators who often treat the scene and those involved as part of a criminal process. Investigators are not known to work in tandem with victims assistance providers, who can provide specialized skill in working with victims of trauma.

Death investigations can take months or years to complete. They may involve crime scene photos, crime scene descriptions, extensive interviews, search of personal effects and property, seizure of personnel effects and property, review of service records, autopsy photos, re-

interviews, and other chronically invasive measures. Families are often subjected to continual re-opening of the wound during the death investigation process as they struggle to make sense of their own grief and loss in the aftermath of their service member's suicide.

There may be feelings of intense anxiety centered around waiting for the report and the outcome of the death investigation which assists the command in determining the LOD. If deaths are not considered to be LOD, then benefits are effected. Many suicides are determined to be LOD deaths and some are not.

Pensions/Insurance/Entitlements

Suicide deaths in the line of duty receive the same burial rites as all military deaths. Pensions and entitlements become affected when deaths are deemed as a willful act of misconduct. Designated survivors may not receive the service member's survivor benefit plan, dependent's indemnity compensation or other entitlements. Service member's group life insurance (SGLI) is payable to the designated beneficiary, regardless of the circumstance of death, with some exclusions. When it comes to private life insurance, policies are often subject to the two year suicide clause, which will not pay out a life insurance premium to designated beneficiaries if the policyholder dies by suicide in the first two years of opening up the policy.

For service members who die by a combat-connected suicide death, families often struggle to find information and receive extra entitlements and tax benefits on the local, state and federal level designated specifically for war-related deaths.

Mental Illness/Help-Seeking/Blame

The military represents a highly cohesive subculture whose members tend to "take care of their own" (Hall, 2008). "The whole culture of the military is that you don't talk about feelings or emotions" (Marshall, 2006, p. 32). Coupled with research which suggests that 90%

of people who die by suicide meet the criteria for a psychiatric disorder (Robins, 1981), this can be a fatal combination.

There still exists a stigma both institutionally and within the subculture of the military regarding help seeking and mental health care. In a dominant culture whose ethos revolves around stoicism and invincibility, there are both real and perceived barriers to seeking help with personal problems (Hall, 2008). In a culture that promotes strength, service members often struggle with identifying and seeking help for their psychological, emotional, practical and personal problems. Concerns center over being perceived as weak, losing the confidence of others, and being treated differently, resulting in a direct correlation to one's ability to perform, effecting their reputation and career (Hall, 2008).

A big concern for service members and their families is whether or not seeking help for mental health related issues will be documented on a service member's record and threaten their career and/or ability to be promoted (Hall, 2008). Many times families will subvert the system and seek care outside of the military. They also fear that disclosing concerns to their service member's command may come with reprisal as well as create a betrayal of trust between the service member and their family. In some cases, service members and their families have sought help within the system and have been challenged with multiple barriers that impede care.

The high operational and occupational stress of military work and the constant transitional life style can be overwhelming. Even with the increased efforts in suicide prevention by the DoD, many military families suffer in silence, fearful of the stigma of mental illness and seeking help (Hall, 2008).

The stigma of mental illness, fear of help-seeking, frustration with barriers to care and feelings of helplessness are factors which contribute to families withdrawing from support

systems prior to the suicide (Harrrington-LaMorie & Ruocco, 2010). The added stigmatization of suicide can further isolate survivors, cutting them off from support systems, both in the military and civilian communities. This can contribute to a severe interference in a healthy grieving process, complications in grief and their own risk for the development of biopsychosocial problems, including a higher risk for suicide.

In the aftermath of suicide, familial disturbances can be created or exacerbated over feelings of anger and the need to ascribe blame. Suicides can leave a division in families, with members spinning off with their own anger, guilt, blame and sorrow (Harrington-LaMorie & Ruocco, 2010). In the aftermath of a suicide death in the military, often times a common intersection of family survivors, friends, extended family, the media, the military and the community is the displacement of real and perceived anger and blame (Harrington-LaMorie & Ruocco, 2010).

Survivors are often blamed for the suicide and frequently feel others blame them (Cerel, et al. 2008). They often do not feel free to mourn because they encounter reactions from others who assign blame to the deceased for causing the survivor's suffering.

These additional challenges and risk factors faced by military suicide loss survivors may result in an unwillingness to gain social support and involve others in the grief process, thus reducing the likelihood that survivors will seek help (McIntosh, 1993). It is estimated that only one in four suicide survivors seek help (Aguirre & Slater, 2010). However, when survivors do seek help, peer-facilitated groups are the preferred model (Feigelman & Feigelman, 2008).

The following is an exploration of the types of peer support programs available and what is currently known about their efficacy.

Chapter III
Peer Support

"Narrative heals personality changes only if the survivor finds or creates a trustworthy community of listeners for it." (Shay, 1994, p. 188).

There is widespread indication that social support can buffer the effects of bereavement (Stewart, Craig, MacPherson, & Alexander, 2001). Peer support has been noted to be a widely-utilized and effective model of healing for suicide loss survivors (Feigelman & Feigelman, 2008).

Peer support can take the form online-chat, one-to-one peer mentor, peer-facilitated support groups and suicide survivor support seminars. And more, in order to best understand how survivors of many differing forms of trauma and life-stressors, especially the bereaved and suicide loss survivors, have benefited from the distinctive perspectives that have come from sharing with those who have journeyed "all-in-the same boat" (Yolam &Leszcez, 2005), it is important to explore the history, theories and concepts underlying peer support, models, benefits, limitations and its efficacy.

The History of Peer Support Starts with the Self-Help Movement

The self help movement is “arguably both the most exciting and least recognized resource for improving public health in the United States” (Humphreys & Ribisl, 1999, p. 322) and has been described as a key component in the recovery process of illness and resilience in health (Mead & Copeland, 2000). It is estimated that one in five Americans participate in some form of peer-led/self-help support group each year and a grossly underestimated 25 million have done so in their lifetimes (Substance Abuse and Mental Health Services Administration, 2008).

There are peer-led/self help groups for cancer, addictions, LGBT community, diabetes, suicide, children with disabilities, heart disease, bereavement as well as every other psychosocial and health related issue in the U.S. (Humphreys & Ribisl, 1999). These groups have been successful in facilitating psychological adjustment, promoting recovery from traumatic experiences, prevention, education, companioning the alienated, recognizing the stigmatized, supporting disenfranchised groups, and aiding in extension of life for individuals with chronic and life threatening illness (Cohen, 2000).

Peer-led/self-help groups, fueled by the benefit of the mutual-aid system, are the oldest and most wide-ranging of the peer support types (Solomon, 2004). Mutual support transpires when individuals provide emotional support to one another, allowing open expressions of feelings and an ability to empathize with one another (Shulman, 2009). This expression of empathy assists in healing for both the giver and receiver of support.

> In the practice of mutual aid, which we can retrace to the earliest beginnings of evolution, we thus find the positive and undoubted origin of our ethical conceptions; and we can affirm our ethical progress of man, mutual support-not mutual struggle-has had the leading part (Kropotkin, 1955, p. 300).

Mutual aid among people is older than recorded history, therefore a brief, contemporary overview of this support movement in the U.S. will be discussed. The development of contemporary peer-led groups is linked with the 1935 founding of Alcoholics Anonymous (AA) (Brown, Shepherd, Wituk & Meissen, 2008). AA is a model for hundreds of other peer-led/self-help groups which are non-hierarchical direct democracies that avoid advocacy (Makela, 1996). Newer expressions of peer-led/self-help organizations emerged in the decades following World War II (Katz, 1981). Katz and Bender (1976) observed:

> organizations of parents of children ill or handicapped by a particular physical or mental problem were the first to surface after World War II; they were quickly

followed by a multiplicity of special-purpose groups that probably reached a crescendo in the 1960s" (Katz & Bender, 1976, p. 277).

In the 1960's, disease-specific groups rapidly grew in size and locations (Katz & Bender, 1981). The use of peer-led/self-help groups became a popular choice in the promotion of recovery among "consumers" of services who began to view the traditional health system, at times, as destructive and disempowering (Brown, Shepherd, Wituk & Meissen, 2008). The major growth of groups occurred during the Vietnam War and in tandem with the civil rights and women's movements especially during and after the 1970s; both challenged bureaucracies and traditional authority (Borman, 1982). The socially stigmatized, disenfranchised, ill and like minded people began to band together collectively across all levels of socioeconomic classes in pervasive areas of the country (Katz, 1981).

There was little interest and research by U.S. social scientists into the investigation of peer-led/self-help up until the 1970's (Katz, 1981). The first empirical study of any aspect of peer-led/self-help, was recognized by social scientists Volkan & Cressey's (1963) paper on the group Synanon and the use of peers in drug rehabilitation. The paper focused on Synanon's use of former drug users as peer role models and helpers in the treatment and recovery of addicts. Immediately following this work, Riessman (1963), a social psychologist, expanded on Volkman & Cressey's (1963) findings and created the concept known as "helper therapy". This concept postulates that both the helper and helpee of mutual aid gain positive psychological benefits from the dual, mutual process of support (Riessman, 1963).

In the 1970's, four seminal works created the foundation for research on the peer-led/self-help movement in the U.S. These include: Caplan & Killilea, (1976); Gartner & Riessman, (1977); Katz & Bender, (1976); and Lieberman & Borman, (1979). And with this the 1970s and 1980s saw an upsurge of peer-led/self-help groups in the U.S. (Katz, 1981). One widely

accepted interpretation in the literature is that peer-led/self-help groups were a response to industrialization and the breakdown of traditional support systems, such as the family and the local community (Katz, 1981). At the same time, peer-led/self-help groups were seen as empowering the ordinary citizen against professional and bureaucratic machines.

The movement burgeoned in the 1970's and by the mid-1970's, people with histories of serious mental illness began to gather around the country and lobby collectively for reforms in mental health care and against the discrimination associated with mental illness they had encountered (Brown, Shepherd, Wituk & Meissen, 2008) . The consumer driven, peer support, survivor movement mushroomed as consumers of services began to become stakeholders and participators in their own care and recovery (Davidson, Chinman, Kloos, Weingarten, Stayner & Tebes, 1999). By 1976, there were an estimated 500 national peer-led/self-help oriented organizations with half a million separate groups in North America, involving several million member-participants (Katz, 1981).

By the 1980s, individuals who saw themselves as consumers of services, began to organize peer-led/self-help groups, advocacy groups and peer-run services with a different goal than just as an alternative source of treatment and recovery model to traditional medical and mental health care (Kurtz, 1997). Instead, consumer's view of traditional medicine was that it was necessary, and demanded a participatory role in health and mental health policy-making (De Sousa & Leung, 2002). Gradually, they gained access to policy making and advisory committees. With this, peer run services expanded, peer-led/self-help groups grew and many of these services incorporated or gained 501 (c) 3 status as non-profit organizations (Kurtz, 1997) . These organizations continue to have a strong grassroots basis and political lobby. With the unprecedented expansion of peer-led/self-help groups in the 1980s, support systems such as self-

help clearinghouses were established in North America. These clearinghouses, which are still in existence today, provide information and referral services linking the public with existing groups and assist groups to develop (Humphreys & Ribisl, 1999).

In the past twenty years, with advancements in technology and the invention of the world wide web, a new trend appeared: online peer-led/self-help support groups, chat rooms and other forms of peer-led support interface (White & Madara, 2002). This technological advance has helped to facilitate communication between people at great distances and allowed people to access help from home (White & Madara, 1997). People with special physical, emotional and psychological needs can now easily have access to groups without travelling great distances (Oka & Borkman, 2000). Limitations of online groups include those who cannot afford internet services, as well as those who have difficulty understanding the technology.

The impact of current changes in health care, such as managed care, on peer-led/self-help group is unknown (Dennis, 2003). Health promoting strategies continue to be reinforced in the current health-care system (Dennis, 2003), while spiraling costs of healthcare have demanded professionals consider all avenues of care. "Recognizing that health professionals alone are unable to address evolving health needs, consumers have brought the self-help movement into the center stage in the health care arena" (Dennis, 2003, p. 322). Humphreys & Ribisl (1999) contend that with the current health and mental health needs of the public, the high cost of healthcare and advancements in technology, there are great potential public health benefits of partnership between the health sector and peer support groups and programs.

The Differences Between Self-Help and Mutual Aid

Although peer support has its origins in the self-help movement, it is important to differentiate the meanings of the words "mutual aid" and "self-help". Borkman (1999) notes

that researchers of self-help groups have had difficulty over the years with the terms self help, mutual aid, mutual aid group, self help group, support group, and associated words that articulate the same concept.

There is a major distinction between "self-help" and "mutual aid". Borkman (1999) states that self-help is:

> an individual's taking action to help him or herself, often drawing on latent internal resources and healing powers within the context of his or her lived experience with an issue or predicament…Self-help includes do-it-yourself techniques such as self-help books or tapes in an independent educational process. (pp. 4-5)

Mutual Aid, on the other hand, is the underlying reciprocal process that occurs when individuals join together to support one another either emotionally, socially, or materially (Borkman, 1999). Mutual aid, therefore is an interdependent, interpersonal relational process between two or more people. Self-help groups rely on the mutual-aid system of support in order to be effective, however, any person can partake in their own self-help.

Concept and Definition

The concept of peer support is simple, yet powerful. It is based on the belief that people who have faced, endured and overcome adversity in their lives can offer hope, encouragement, advice and possibly counsel to others facing similar circumstances (Davidson, Chinman, Sells & Rowe, 2006). It is been defined as a system of giving and receiving help founded on the key principle of respect, shared responsibility, and mutual agreement of what is helpful (Mead & MacNeil, 2006). Peer support is social emotional support, often joined together with practical support, which is mutually offered or provided by peers who share a similar health, mental health or social condition in which the primary goal of this support is to bring about a desired social or personal change (Solomon, 2004).

Underlying Theories

At the root of all peer support programs is the reciprocal process of mutual aid, offered through social support. Kropotkin (1903) was the first to elaborate on mutual aid theory. An evolutionary theorist and sociobiologist, Kropotkin (1903) expanded upon Darwinism and the notion of natural selection by asserting that mutual aid, in the face of common environmental threats, was a significant factor in the survival of the species.

Kropotkin (1903) observed the role of mutual aid in both modern and primitive human societies, stating

> the mutual aid tendency in man has so remote an origin, and is so deeply interwoven with all past evolution of the human race, that it has been maintained by mankind up to the present time, notwithstanding all vicissitudes of history (p.145).

Shulman (2009) describes ten dynamic principles underlying the benefits of mutual aid between support groups: (1) the "all-in-the same-boat" phenomenon": this is an understanding gained that there are others who share similar problems, concerns, feeling and experiences. Participants can learn they are not alone; (2) the ability to discuss a taboo area: this happens because the safe culture of the peer group allows members to challenge stigma and shame; (3) mutual support: group members provide emotional support to one another, creating an environment where there can be an installation and maintenance of hope (Yalom & Leszcez, 2005); (4) individual problem-solving: this is when members of the group can help one another learn how to cope and solve problems. They can receive help for themselves while lending it to another (Feigelman & Feigelman, 2008); (5) sharing data: participants have learned through their life experiences and have accumulated knowledge which they can share with on another; (6) the dialectical process: is the process when the group can act as a sounding board for one

another, agreeing with views and challenging and offering differing views; (7) mutual demand: this is when group members place demands and set expectation on personal behavior from one another; (8) rehearsal: this is where the group becomes a place where new ideas and skills can be tried; (9) developing a universal perspective: this a process within the group in which members begin to view their own problems in perspective, alleviating the burden of assigning all the blame to oneself; (10) the strength in numbers phenomenon: is when group members learn that they can take on difficult tasks through knowing they have a group for support.

Peer support is a form of social support, where the bi-directional nature of mutual aid is clearly illuminated. Salzer and Shear (2002) describe five theories that underlie peer delivered services and why peer-led/self-help groups have been considered to be helpful to both peer receivers and peer givers of support. The five theories include: social support, experiential knowledge, helper-therapy principle, social learning theory and the social comparison theory.

Social support is at the heart of peer support and refers to the availability of friends, family, people we know who can be relied on for physical, emotional and practical support (Silverman & Murrow, 1976). Social support provides a greater sense of community, a greater sense of love, self-worth and value (Schwarzer & Leppin, A. 1991). In terms of its functional value, social support can have a main effect on various outcomes, or it can interact with the experience of stress. Research has demonstrated that supportive relationships help buffer stress and add to positive adjustments during challenging times and adversities (Schwarzer & Knoll, 2007). As such, it is a critical component in the assessment of overall well-being. The primary types of social support delivered in peer support are: emotional support (self-esteem, attachment, reassurance); instrumental support (material goods and services); and information support (advice, guidance and feedback) (Solomon, 2004).

The process of experiential knowledge in peer-led/self-help groups distinguishes them strictly from being educational groups by virtue of the emphasis of sharing similar experiences with others (Borkman, 1976; Shubert & Borkman, 1994). By sharing similar experiences with others members learn that their reactions are normal and appropriate (Coates & Winston, 1983). Many peer-led/self-help groups exist for people who face stigma. For these members, the validation provided by peers is thought to normalize the experience and reduce feelings and attitudes of stigma (Figley & Nash, 2006). The commonality among group members provides them a unique support system, a group with whom they can gain understanding, feel attached with and a sense of belonging (Harris & Larsen, 2007).

Social learning theory is the theory that people learn in their social environment through observing other's behaviors (Rotter, 1954). This theory incorporates aspects of behavioral and cognitive learning. Behavioral learning assumes that people's environment cause people to behave in certain ways (Bandura, 1977). Cognitive learning presumes that psychological factors are important for influencing how one behaves. Social learning suggests a combination of environmental (social) and psychological factors influence behavior (Bandura, 1977). Social learning theory outlines requirements for people to learn and model behavior: attention, retention (remembering what one observed), reproduction (ability to reproduce the behavior), and motivation (good reason) to want to adopt the behavior (Bandura, 1997). The process of shared experiential knowledge in peer-led/self-help plays a credible role in social learning among group members. Peers who have positively endured a life adversity can act as successful role models who may be able to demonstrate and share coping skills that may result in positive behavior changes on the part of other peer members (Salzer and Shear, 2002). Peers who acquire

knowledge through this social support may gain confidence in their own coping skills, gain hope about their own future and enhance their own sense of self-efficacy (Salzer and Shear, 2002).

As discussed earlier, Riessman (1965) was the first to describe the helper therapy principle in an attempt to explain the therapeutic effect for both people in the "helper" and "helpee" relationship within self-help groups. Peer support services offer individuals the opportunity to help themselves by helping others (Solomon, 2004). According to this principle, in the process of helping another member, the helper gains an increased sense of self-efficacy, making the relationship mutually beneficial and instilling a sense of competence (Solomon, 2004). At a time when self-esteem may be challenged, the opportunity to help other people may increase positive feelings about the self. The expectation is that peers will be able to provide sound advice, useful firsthand knowledge and coping skills. Members, in both the helper and the helpee positions have correlated positive perceived benefits of group involvement as well as improved psychological well being (Maton, 1988).

Lastly, peer-led/self-help groups provide opportunities for social comparison. The social comparison theory (Festinger, 1954) is the idea that there is an active drive within individuals to look to outside images in order to evaluate their own opinions and abilities. This theory explains how individuals evaluate their own opinions and desires by comparing themselves to others (Festinger, 1954). In times of uncertainty, stress or trauma, people compare themselves with others and evaluate their feelings, coping and capabilities (Figley & Nash, 2006). Comparisons to similar others may normalize this experience for them as well as learn that others endure similar problems as well as share the same concerns, fears, anxieties, expectations and hopes (Wills, 1981).

Besides self-evaluation, there are other reasons people engage in social comparison. People also compare themselves to improve their situations. Solomon (2004) notes this improvement is achieved by a sense of optimism gained by peers interacting with others who are perceived to be better than them. It offers to the peer, in an upward comparison model, something to strive toward, with an incentive to build skills and gain hope in the process (Solomon, 2004). Conversely, self esteem enhancement is thought to be accomplished by downward comparisons, in which the social comparison is made to those in worse circumstances, enabling one to put into perspective how bad things could potentially be and feel lucky or fortunate about their own circumstance (Wills, 1981).

Models of Peer Support

There are four general models of formalized peer support described in the literature (Davidson, et. al., 1999; De Sousa & Leung, 2002; Katz & Bender, 1976; Schubert & Borkman, 1994; Solomon, 2004). They are presented here.

The peer-led/self-help group model is the oldest and most pervasive form of peer support (Solomon, 2004). The predominantly cited definition of peer-led/self-help groups is that of Katz and Bender (1976):

> Self-Help groups are voluntary, small group structure for mutual aid and the accomplishment of a special purpose. They are usually formed by peers who have come together for mutual assistance in satisfying a common need, overcoming a common handicap or life-disrupting problem, and bringing about desired social and/or personal change. The initiators and members of such groups perceive that their needs are not, or cannot be, met by or through existing social institutions. Self-help groups emphasize fact-to-face social interactions and the assumption of personal responsibility by members. They often provide material assistance, as well as emotional support; they are frequently "cause"-oriented, and promulgate an ideology or values through which members may attain an enhanced sense of personal identity (Katz & Bender, 1976, p. 9).

The role of the professional in peer-led/self-help groups has emerged as a somewhat clouded area and the distinction is clouded by the fact that mental health professionals and

community organizations often assist self-help groups with logistical support, consultation, referrals, and education (Cohen, Gordon, Underwood, Gottlieb & Institute, 2000). Mental health providers may assist in the beginnings of peer-led/self-help groups until a leader surfaces (Solomon, 2004). With the creation and expansion of the internet, some face-to-face self-help groups have also transformed or been initiated as online support groups. Extinguishing the face-to-face element as a requirement of participation (Solomon, 2004).

The "consumer" or peer-run services model is a model in which services are planned, performed, governed and appraised by peers (Davidson, et. al, 1999; De Sousa & Leung, 2002). Paid employees of the program do not expect and are not allowed to receive support or other assistance from those served by the program (Solomon, 2004). They usually aim to provide a supportive setting and are more administratively formal in the interactions with the peers they serve (Solomon, 2004). These programs have a large number of volunteers and small number of paid staff (Figley & Nash, 2006). They differ in size and in regard to the disposition of services provided. Examples include: crisis services, drop-in centers, employment services, clubs, educational services and non-profit organizations.

Another peer support model is that which peers are incorporated as part of a mental health team or are "peer employees" (Solomon, 2004). This is where peers work as providers of support and are hired into traditional mental health positions or conventional positions as identified peer employees (De Sousa & Leung, 2002). Examples of peer positions include peer counselor, peer companions, peer advocates, peer case managers and peer professionals. An advantage to this model is that peers can work as visible role models as well as influence how policy is crafted and clinical services/support programs are delivered.

The workplace embedded peers model is often used in workplaces where the normal demands of a job can put an employee at risk of developing a physical or psychological injury (Robinson, 1990). Careers in the military, police force and firefighting are examples of where this model is often employed (Figley & Nash, 2006). In this model, designated employees received specialized training to help fellow employees support and counsel a professional colleague if a critical incident or trauma occurs on the job (Mitchell, 1988). The peer does not share the same disability or suffering, what they share in common is the same occupation (Mitchell, 1988). Critical incident stress debriefing and critical incident stress management programs use this model, often times pairing up peer mentors and mental health professionals to provide debriefings, stress management and follow-up support to affected employees (Robinson, 1990).

Peer Support and the Bereaved

Bereavement and the use of peer-led/self-help groups in working with the bereaved has been an area of interest to clinicians since the late 1960's. It began when Kubler-Ross (1969) published her book on death and dying which brought discussions of the subject matter into the open (Silverman, 2004). One of the first documented peer-led/self-help groups formed for bereaved parents in the U.S. was "Compassionate Friends" (Lieberman & Borman, 1979). Started in Coventry, England in 1969, the first group formed in the U.S. in the fall of 1972 (Lieberman & Borman, 1979) and has grown tremendously since its inception. Multitudes of bereavement peer-led/self-help groups have developed and grown throughout the U.S. and the world from the 1970's until today. Groups dedicated to general loss, loss specific to relationship type, and circumstance of the death have been the most prevailing (Howarth & Leaman, 2001).

The primary model of peer support in this discussion will focus on peer-led/self-help, as they are one of the most widely engaged forms of support by the bereaved (Howarth & Leaman, 2001). "Self-help complements, but more often replaces 'expert' approaches to grief" (Howarth & Leaman, 2001, p. 403). It has been postulated that these groups are often seen as less intrusive ways for the bereaved to help make sense of their grief, feel less isolated and lonely share social and practical support with peer groups members, enable individuals to replace initial feelings of despair with a more positive inner representation of the deceased, as well as explore past and continuing relationships with their dead loved ones (Howarth & Leaman, 2001).

In the past several decades, the peer support movement has gained significant attention and has witnessed an expansion of interest in the kind of help that returns the control to the consumers or recipients of help (Davidson, Pennebacker, & Dickerson, 2000). As in all areas of special interest, those who are bereaved, have discovered and rediscovered the value of learning from peers with similar experiences, reaching out to help peers in need and the benefits derived from mutual support.

"The loss of a loved person is one of the most intensely painful experiences any human can suffer" (Bowlby, 1980, p. 7) and is an example of one of the most stressful life events for survivors. People who undergo stressful life events, characteristically orient themselves to seek out similar peers who are able to help them integrate their new identities and serve as role models or teachers (Figley & Nash 2006). The bereavement peer-led/self-help movement has been the human reaction to seeking out peer based social support in the face of unbearable loss, stress and human suffering.

The current bereavement literature, under systematic review, has yielded few reliable conclusions to guide treatment (Forte, 2004). "For all forms of intervention…and all attempts to

diminish grief per se, no consistent pattern of treatment benefits has been established across all well-designed experimental studies" (Forte, 2004, p. 11). However, for the past few decades, researchers evaluating the effects of peer-led/self-help groups have discovered the important benefits of participation (White & Madara, 2002).

A subset of leading self-help effectiveness studies have emerged in the bereavement literature in reference to peer-led/self-help groups. These studies include differing relationships to the deceased and focus primarily on longitudinally comparing self-help participants to non-participants (White & Madara, 2002).

Vachon's (1980) landmark study of peer support interventions for widows participating in a "widow-to-widow" peer support program concluded that women who participated in the study, after 12 months, compared to non-participants, reported having improved facilitated adjustment in relationship with themselves as well as in their relationships with others (Vachon, 1980).

Videka-Sherman and Lieberman (1985) compared the effects of peer support/self-help groups to psychotherapy as an intervention for parents who lost a child. The study sample included primarily white females and compared those who received psychotherapy services to those who attended a Compassionate Friends (CF) bereavement self-help group after the loss of a child. Results reported from CF participants included increased comfort in discussing their bereavement as well as reduced self-directed anger. Participants receiving psychotherapy did not report having these effects. In this study, CF members that had group involvement also reported an increased sense of control, happiness, self-confidence as well as decreased anxiety, guilt, anger and isolation (Videka-Sherman & Lieberman, 1985).

Lieberman and Videka-Sherman (1986) also compared the impact of self-help groups on the mental health of widows and widowers who had participated in the bereavement peer-led/self-help support group THEOS for over a period of one year. Results from participants of this study demonstrated that members who had formed social relationships with other group members and spent time together outside of the group experienced less psychological distress and improved psychological functioning than non-members and those members who did not form such relationships (Lieberman & Videka-Sherman, 1986).

Marmar and Horowitz (1988) compared brief psychotherapy to mutual help groups treating the conjugally bereaved. Women seeking treatment for grief after the death of their husbands were randomly assigned to professional psychotherapy or peer-led/self-help groups. Results drawn from this study suggested that peer-led/self-help groups and psychotherapy were comparative in their therapeutic impact (Marmar & Horowitz, 1988)

Caserta and Lund (1993) studied bereaved older adults, their intrapersonal resourcefulness and the effectiveness of self-help groups on this resourcefulness. One major conclusion from the study was that participants of self-help, with initial levels of low interpersonal and coping skills, experienced less depression than non-participants (Caserta & Lund , 1993).

Stewart, Craig, MacPherson and Alexander (2001) found that elderly people who participated in peer-led/self-help groups were more satisfied with the available social support and experienced diminished needs and increased positive affect.

Gradually throughout the past few decades, research studies have begun to investigate models and interventions in working with the bereaved. In the study of death, loss and grief, the most influential factor in how one copes with loss is tied to their relationship with the deceased:

relationship (spouse, child, parent, sibling); length of the relationship; role the deceased occupied; strength of the attachment; and degree of the dependency (Borman, 1982).

Peer-led/self-help groups have formed in the past thirty years to address the unique and specific needs of survivors in relation to their deceased loved one (Gehlert & Brown, 2006). All types of groups have formed including groups specific to: relationship to the deceased (spouse/parent), age of survivors (young widow/ers), mass trauma (9-11/TWA Flight 800) occupation of the deceased (fallen police and firefighters), as well as many groups which circumstance (suicide/homicide) of the death plays a major factor in survivor loss and healing (Gehlert & Brown, 2006).

The need for groups specific to trauma and mass trauma has risen in the aftermath of world violence, including the September 11th attacks, terrorism and the global war on terror (Walsh, 2007). The development of these specific groups is consistent with one of the main underlying processes of peer support that people who undergo stressful life events, characteristically orient themselves to seek out similar peers who are able to help them integrate their new identities and serve as role models or teachers (Figley & Nash, 2006). Findings have supported the special value of peer support/self-help groups and have confirmed their positive impact on the bereaved (Silverman & Murrow, 1976; Lieberman & Borman, 1979; Vachon et. al, 1980; Videka-Sherman & Lieberman, 1985; Lieberman & Videka-Sherman, 1986; Marmar & Horowitz, 1988; Caserta & Lund; 1993; Webb, 2004; Stewart, Craig, MacPherson & Alexander, 2001). Future implications for research should include attention to how multiple cultures view death and grieve as well as multi-cultural approaches to care (Silverman, 2004).

In the trauma and bereavement field, increasing recognition has been made to the intertwining of trauma, loss and grief (Walsh, 2007). In traumatic bereavement, the use of multi-

dimensional interventions and strategies of support, involving a multi-systematic approach, have proven effective in decreasing the high risk of a pathological grieving process while fostering resiliency in posttraumatic recovery (Walsh, 2007; Webb, 2003; Zinner & Williams, 1999).

U.S. Military Death Specific Bereavement Support

As previously discussed, U.S. service member deaths are overwhelming sudden, traumatic and/or violent in nature. These deaths often shatter the assumptive world of survivors (Doka, 1996; Steen & Asaro, 2006; Weeks & Johnson, 2000), challenging their fundamental beliefs about themselves and the world. Survivors struggle in the aftermath, confronted with the dual burden of grief and trauma, the agony of trying to make sense of the death, as well as repair their lives.

U.S. military deaths also bring along with them complexities that may not be widely experienced in the civilian community (Steen & Asaro, 2006; Walsh, 2007; Weeks & Johnson, 2000). These young survivors, who experience and negotiate through these complexities, share commonalities that may be only be validated through the unique understating of other survivors (Weeks & Johnson, 2000). These complexities may include: violent and traumatic nature of the death, geography of the death, media attention (negative or positive) given to a service connected death, coping with deceased's commitment to duty, condition of bodily remains and how bodily remains are handled, non-existence of identifiable bodily remains, rite and rituals associated with military casualties and burials, complying or countering with the military culture and hierarchy, death investigations to determine survivor benefits, benefit entitlements, navigating the intensely bureaucratic system in regard to benefits and the sudden, re-traumatizing, "involuntary discharge" from the military community/way of life to civilian community (Steen & Asaro, 2006; Weeks & Johnson, 2000).

The loss of a young adult loved one presents complexities and developmental challenges not typically seen in older adulthood. One specific challenge is a limited peer group, who may lend support to buffer the stress of grief, as this young adult group typically has had a narrow experience with death and is limited in their repertoires of coping (Golan, 1981).

As we have reviewed, the history and efficacy of the peer-led/self-help movement has been based on a foundation of social support offered by those who have shared in a common experience. History has taught us that groups of disenfranchised, traumatized, ill or those discriminated against have banded together to heal, advocate for and support one another while becoming stakeholders in their own care.

In following with this tradition, a mutual aid group, called TAPS (Tragedy Assistance Program for Survivors) emerged in the early 1990's, as a peer based emotional support program for anyone who had lost a service member in active duty military service (Weeks & Johnson, 2000). TAPS was started by a military widow, Bonnie Carroll, who had lost her husband in an airplane crash and in the face of her own trauma turned to other recently widowed military spouses for support (Weeks & Johnson, 2000). In this mutual process of aid, she discovered the "tremendous insight for the value of peer support in a specific loss experience" (Weeks & Johnson, 2000). Turning toward other highly successful peer support programs, "like Mothers Against Drunk Driving (MADD), Concerns of Police Survivors (COPS), Compassionate Friends, and Gold Star Wives," (Weeks & Johnson, 2000, p. 177), Mrs. Carroll formed TAPS in 1994 as the first non-profit providing peer based emotional support for survivors of active duty U.S. service member deaths. The program was designed to provide support to all survivors, regardless of relationship to the deceased, circumstance of the death or geography of the death (Weeks & Johnson, 2000). Prior to the existence of TAPS, the peer programs for survivors of

military deaths were mainly for widows. The focus of these groups were primarily networking and advocacy for government entitlements. The long-term psychosocial emotional support component did not exist, especially for disenfranchised groups, such as siblings, parents, significant others and sometimes even children (Weeks & Johnson, 2000). One of the primary missions of TAPS was to provide an unprecedented, national survivor network who could connect, and support one another in their grief through peer based programs. These programs include: peer-led self-help groups, one to one peer support, online support groups, good grief camps for children and national survivor seminars (Weeks & Johnson, 2000).

In 2005, TAPS began to see an increase in the number of survivors of military suicide seeking grief and trauma support services (Harrington-Ruocco, 2010). A preponderance of these survivors had experienced stigma, isolating them in their grief and causing a major interference with a healthy grieving process. With no formal support programs for suicide, TAPS began to build a military suicide peer support program. As survivors began to reach out to TAPS, it became evident that their exposure to traumatic bereavement and specific issues related to a military death required specialized services in addition those already offered by TAPS (Harrington-LaMorie & Ruocco, 2010). It is also became apparent that this subculture of military families, which is a highly-relational, peer-oriented culture, could benefit from increased social support and peer-led programs (Harrington-Ruocco, 2010).

Peer Support Postvention for Suicide Loss Survivors

"Postvention is Prevention for the next generation"
(Shneidman, 1972, p.x)

Shneidman (1972) coined the term postvention, in divergence to prevention, to clarify the actions and interventions employed after a suicide to help survivors such as family, friends and

co-workers. Because suicide loss survivors are at risk of increased vulnerability to complicated grief, post-traumatic stress disorder, depression, heightened distress and increased risk of completing suicide, postvention was conceptualized as a natural extension of prevention. The aim of suicide postvention serves a dual purpose of assisting suicide loss survivors through the grief process and preventing suicide in future generations. Research suggests that suicide loss survivors often demonstrate an increased risk for suicide between 2 and 10 times that of the general population (Aguirre & Slater, 2010).

Suicide postvention models may include programs and services for survivors, postvention analysis, and evaluation. Postvention analysis may include psychological autopsy and review of suicide notes. Postvention programs and services, may include but are not limited to: critical incidence stress debriefing, outreach to survivors, individual mental health therapy and social support/peer based support programs for survivors.

As previously discussed, risk factors such as complicated grief, stigma, shame, self-blame, societal norms and isolation often result in a heightened state of distress for survivors. These risk factors, which also can be compounded by exhaustion and a loss of energy (Dyregrov, 2002), result in an unwillingness to involve others in the grief process, as well as reducing survivors capability and likelihood that they will initiate help-seeking (McIntosh, 1993).

Research has found that individuals who had experienced a traumatic event were two to three times more likely than a control group to perceive barriers to request medical health services and even higher barriers for mental health services (Amaya-Jackson, Davidson, Hughes, Swartz, Reynolds, George & Blazer, 1999). It is estimated that only one in four suicide loss survivors seek help. This increased stress and isolation can result in psychache for the survivor, a known trigger of suicide (Aguirre & Slater, 2010).

Suicide loss survivors reaching out for support is a barrier to care and given the risk of this population suffering from increased mental health distress, physical distress, complicated grief and the heightened risk of suicide, Cerel and Campbell (2008) have suggested that active postvention models may be effective in linking survivors to services and resolving acute problems before they become chronic. Multiple and prolonged stressors such as these degrade a person's quality of life and contribute to social isolation and feelings of hopelessness. Cerel and Campbell (2008) also describe active postvention as a "unique concept" (p.31) that begins outreach to survivors as close to the time of death or notification as possible. This active postvention model identifies and outreaches services to suicide loss survivors, whereas the passive model approach requires the survivor to seek out support for themselves. It is still unclear whether it is more helpful for suicide loss survivors to present earlier for support/treatment (Cerel & Campbell, 2008), however research suggests that 65% to 88% of survivors have found participation in suicide postvention services helpful (Aguirre & Slater, 2010).

The most frequently available and suggested form of suicide postvention support are peer support groups (Aguirre & Slater, 2010; Feigelman & Feigelman, 2008). In addition, contact with other survivors, through support groups and other peer based emotional programs seem to be a highly valued resource of care for survivors (Dyregrov, 2002; Jordan, 2008; Wilson & Marshall, 2010).

As previously discussed, theories underlying peer support, such as mutual aid, social support, experiential knowledge, helper-therapy principle, social learning and social comparison are helpful in providing a foundation to understand why peer support may be an effective intervention for suicide loss survivors. Peer support can be described as the social, instrumental,

or emotional support that individuals sharing the same life challenges or circumstances can provide to each other in a reciprocal fashion.

Recurrent themes in the existing suicide survivor literature including risk for developing PTSD, shame due to stigma, feelings of abandonment and rejection, the need to answer the question "why", complicated grief, existential crisis and self-blame can lead to an increased sense of real or perceived isolation for survivors, resulting in a heightened state of distress and increased vulnerability to attempting and completing suicide. Often, losing a loved one to suicide is a significant negative life event, creating the need for social support, however due to prevailing societal attitudes toward suicide and the shame and stigma which continue to encircle survivors, suicide survivors are at worst confronted with social animosity, indifference or tepid reassurance. Family disturbances exacerbated or created in the aftermath of a suicide further isolate survivors who often feel they have no one who can identify with them or understand their experience. This lack of social support creates an environment of stress and isolation for survivors.

To counter that, peer based programs can provide the necessary social support which can buffer against increased distress, reduce isolation, decrease psychological morbidity, create a sense of belongingness and act as a potential protective factor against a survivor's own suicide risk. Suicide loss survivors may uniquely benefit from peer based support programs for some of the following reasons:

a. The "All-in-the-Same Boat" Phenomenon: individuals impacted by suicide learn they are not alone. From the beginning there is a clear linkage of a common experience. Survivors can feel they are in safe environment where they can begin to tell their story among those who have shared a common experience and have a unique

understanding of the complexities of being a suicide loss survivor. Survivors can feel free to be themselves with other who "get it". The feeling of being with similar others and that "I am not alone" can have a powerful healing effect.

b. Normalization: One of the most significant and helpful benefits a suicide survivor can gain from peer support is the realization that a wide range of thoughts, feelings, cognitions, behaviors and physical reactions are normal, given the situation. The feelings of shock, isolation, stigma, confusion, trauma, loss of one's belief system, anger, guilt, self-blame and confusion are typical responses to suicide loss and a shared experience among survivors. This roller coaster of emotions, shared among peers, validates the survivor's experience and reassures them they are not alone. It also helps them to understand that these responses are a normal part of suicide loss and not a pathological response.

c. Providing a safe culture: Peer support programs for suicide survivors provide a safe culture where survivors can feel free to discuss taboo areas. They can discuss circumstances around the suicide, such as difficulties with mental illness, substance abuse, addictions, marital problems and infidelity, sexual issues and problems with the law they may have experienced with the deceased and not feel judged. Feelings of anger, rejection, abandonment and/or relief may be validated. The sharing of their stories among those who "get it", allow survivors to challenge stigma and shame associated with suicide. They can take risks, unburden their secrets and diminish their sense of isolation and feelings of guilt.

d. Modeling: Those who have managed through their suicide loss with resilience can be an installation of hope and model new and effective coping skills for other survivors,

especially the newly bereaved. Senior peer survivors who can be positive supports provide a "like selves" model of recovery offering hope, empowerment, and enhanced self-esteem. The modeling of resilience teaches survivors that they have the capacity to deal with, overcome, learn from or even be transformed by life adversities.

e. Monitoring: Another benefit is monitoring suicide survivors for complications in their bereavement and suicide risk. Peers, who may be very knowledgeable of suicide risk factors and more intuitive to those feelings and symptoms can be key frontline responders in suicide prevention. Suicide loss survivors, who often suffer from the fear that they may too complete suicide themselves, may be more inclined to reach out to another peer for crisis support. Because of their shared experience, appropriate peer supporters can be vital assets in the prevention of suicide among survivors. Suicide postvention initiatives should acknowledge their value and provide them with tools, training and access to allow them to be available sources of solace and hope for survivors in crisis.

f. Education and Advocacy: Peer support programs provide resources to assist in educating survivors regarding the nature of suicide and suicide bereavement. They share knowledge on where to find support and help. Suicide loss peer groups also become advocates for suicide education, prevention, political advocacy and research funding. Peer groups and programs allow survivors to find strength in numbers and band together for support. Education, advocacy and awareness raising by suicide loss survivors help decrease feelings of stigma and isolation and increase feelings of empowerment.

g. Meaning Making: Making sense of a suicide death, especially for those bereaved by suicide, can be a long, complex, difficult and emotional journey. That prevailing question of "why" may be one that suicide loss survivors may or may not ever find resolution. Those involved in suicide peer support programs have the opportunity to share their story among others who have "sat in the same chair" and mutually support one another as they search for meaning. Recent evidence suggests that those who engage as peer supporters found their own personal healing through offering support to another survivor (Barlow, Waegemakers, Schiff, Chugh, Rawlinson, Hides & Leith, 2010). The peer supporters gained a positive benefit from sharing their lived experienced and understanding of their situation with others going through a similar situation. They felt useful and helpful in providing those individuals with coping strategies and hope. Peer supporters believed they were making a constructive difference in another survivor's life, which helped them to make positive meaning out of a negative life event (Barlow, et. al) and engendering a feeling of interconnectedness (Aguirre & Slater, 2010). This evidence supports Riessman's (1963) helper therapy concept which postulates that both the helper and helpee of mutual aid gain positive psychological benefits from the dual, mutual process of support. This can promote growth through the positive transformation of a negative life adversity.

Peer support programs also have their challenges. Some of the more predominant criticisms of peer support programs are that they can traumatize survivors; they can re-traumatize participants and peer supporters; peers can be overwhelmed by the grief of others; peer workers are inadequately screened, supervised and trained; peers have uncertainty about what are

appropriate boundaries and how to set and maintain them; peers over-personalize their work and become over-involved; issues with confidentiality; peer programs foster dependency; peer programs set unrealistic expectations of their peer workers; peer programs do not encourage or train self-care, ensuring high rates of compassion fatigue and burnout among peer workers; peer programs lack record keeping; fall prey to founder's syndrome; and peer support programs may not recognize their ineffectiveness with certain individuals and refer them for more appropriate services (Powell, 1985; Block, 2004; Dyregrov & Dyregrov, 2008; Patti, 2000; Tindall &Black, 2008).

Despite these challenges, peer support is acknowledged as an effective and widely used postvention resource by suicide loss survivors, yet the research is sparse (Clark, 2001; Jordan & McIntosh, 2010). Our knowledge and understanding of the impact of suicide, suicide bereavement and how to best help survivors repair their lives is just beginning. Current research has begun to demonstrate the value of peer support programs for suicide loss survivors (Barlow, et. al, 2010; Feigelman & Feigelman, 2008). Even so, continued research is needed to better comprehend how suicide peer support programs work, their applicability, accessibility, availability, their efficacy and who is best helped by them (Barlow, et. al, 2010; Cerel et al., 2009; Feigelman & Feigelman, 2008).

In addition to a lack of understanding about the efficacy of peer support, a much neglected area of research within the overall suicide loss community are the special needs of individuals who belong to certain sub-groups, occupations and cultures. With the rising rates of suicide in the U.S. Armed Services, and a fast growing demographic of military suicide loss survivors, we can only speculate about the impact of suicide on these survivors and healing postvention supports.

To this end, a study was conducted to explore the effectiveness of exposure to peer support and perceived levels of subjective distress on survivors of a U.S. Armed Services suicide death. We will now discuss the methodology employed in this study.

Chapter IV
Methodology

Research Design

A survey research design was conducted in order to learn more about military suicide loss survivors' level of distress and peer support. A self- report questionnaire was developed to include three instruments. Two are theoretically the dependent variables of social support and includes, namely the availability of Emotional Peer Support (EPS), and the Frequency receiving the Emotional Peer Support (FEPS); both measures were adapted from the Social Support Behaviors Scale (Vaux, Riedel, & Stewart, 1987; in Fischer and Corcoran, 2007). The EPS ascertains the availability of emotional support from friends and family members, from "no one" to "most peers", which the frequency determine whether the emotional support occurred "not at all" to "often", both using a 5-point scale.

The third instrument was the Impact of Events Scales-Revised (IES-R) (Weiss & Marmar, 1997), which is theoretically considered the independent variable of distress resulting from the suicide such that the greater the distress the greater peer support. Demographic information was also ascertained. Given the non-existent research on this population, this study provided survivors with the opportunity to respond to the research question regarding perceived levels of distress and exposure to and frequency of peer support after a military suicide death. Procedures and instrumentation are described here.

Research Question

1. Is there an association between distress (i.e., scores on IES) and the availability of emotional peer support (i.e., scores on the EPS) and frequency of peer support (i.e., scores on the FEPS) in survivors of suicide death by a U.S. Armed Service member?

Hypothesis Number One

H_1: It is hypothesized that there will be an association between the availability of emotional peer support, as defined by scores on the EPS measure, and the levels of distressful impact of a traumatic event, as defined by total scores and subscale scores of the Impact of Events Scale -Revised (IES-R) (Weiss & Marmar, 1997).

. H_o: It is hypothesized that there is no relationship between reported levels of exposure to emotional peer support and levels of distress.

Hypothesis Number Two

H_2: It is hypothesized that participants who report higher scores on the frequency of emotional peer support, as defined by scores on the FEPS scores, will report higher scores on the distressful impact of the suicide death, as defined total scores and subscale scores of the Impact of Events Scale -Revised (IES-R) (Weiss & Marmar, 1997).

H_o: There is no relationship between reported levels of the frequency of emotional peer support and the perceived levels of distress from the impact of a traumatic event.

Participants and Procedures

This study sought participation from adult military suicide loss survivors, ages 18 and older. Application to perform this research was submitted to the University of Pennsylvania Institutional Review Board (IRB). Upon IRB approval and with the appropriate permission from TAPS, the study was conducted during the TAPS national suicide survivor seminar at the Hilton,

Mission Bay, San Diego, California, October 9-10, 2009. Using convenience sampling, participants were recruited to voluntarily participate. This cross-sectional study used a non-random, convenience sample for survey data collection. Thus, by definition there was no comparison group. Two-hundred and fifty adult military suicide loss survivors attended the seminar and were made aware of the research being conducted. Of the 250 adult survivors attending, all were invited to participate. Fifty-seven responded, five had surveys were incomplete, and thus, N=52 were included in this final analysis.

Recruitment

Convenience sampling was used to inform and recruit participants for this study. To ensure an adequate sample size of 50 participants, there were three waves of recruitment during the seminar. The first recruitment wave was established through creating awareness of the research, and the research table via a flyer that was placed at the registration desk and inserted into each participant welcome packet. The flyer described the study's purpose and goals, eligibility criteria, location at seminar where research was taking place, contact information for both the principal investigator and the student, as well as the statement of IRB approval (appendix). The second recruitment occurred via an announcement of the research study at the general session of the seminar by the conference chair. The third recruitment occurred during duplicate repeat announcements on the first and second days of the seminar.

Inclusion/Exclusion Criteria

Criteria for inclusion were as follows: (a) all participants must be 18 years of age or older, (b) were at least 6 weeks post the death of their loved one/friend/significant other and (c) were impacted by the suicide death of a U.S. Armed Service member. Survivors could be of any relationship to the deceased.

Exclusion criteria included (a) if participant was under the age of 18, (b) those less than 6 weeks post the death of their loved one/friend/significant other and (c) those not impacted by the suicide death of a U.S. Armed Service member.

Data Collection

Data collection was in-person at the TAPS National Suicide Survivor Seminar. A research table was set up in a strategic location next to the seminar registration table. It was attended and monitored by the student investigator. The student investigator was available at all times during seminar hours for questions regarding the study. Blank surveys were left in a box on the table for those who elected to self-select to participate and were also handed out by the student investigator to those interested in participating. A covered drop-box was left on the table, under constant supervision for participants to drop-off completed surveys by the end of the seminar.

Instrumentation

Theoretical Dependent Variable

Emotional Support

The measurement of peer support was adapted for this study from the Emotional Social Support (ESS) subcale (ESS; Vaux, et al. 1987), which emphasizes the availability of social support from friends and family when the individual needs help. This study adapted the alternative from friends and family to “peers” and left the definition undefined. The SSB tool was developed to "tap supportive behavior enacted in the face of some known stressor" (Vaux, et al., 1987). According to Fischer and Corcoran (2007), the five subscales have been confirmed through factor analysis and that this scale is an important measure for the study of social support networks. Overall norms for this SSB are not available because the measure was tested in the

context of a particular stimulus problem condition (Fischer & Corcoran, 2007). Only the emotional peer support subcale was included in this study. The ESS scores has very good internal consistency, with reported alphas that exceed .85, however data on stability is not available (Fischer & Corcoran, 2007). It also has good concurrent validity (Fischer & Corcoran, 2007).

Each of the 10 items of the EPS included a question about "how often has this occurred" which using a 4-point likert scale with scores from "not at all" "rarely" "sometimes" to "often." For both the EPS and the FEPS higher scores reflect more peer support and scores potentially could range from 1 to 5 and 1 to 4 respectively.

The EPS and FEPS are conceptually the dependent variables as it is theoretical relationship is that more distress due to the death will result in more need for social supports and, in turn, the obtainment of it. This research does not allow this to be tested if the differences in peer support are due to the magnitude of distress, and thus must remain theoretical.

Theoretcial Independent Variable

Impact of Events Scale-Revised

Distress was measured using the Impact of Events Scale-Revised (IES-R). The IES (Horowitz, Wilner & Alvarez, 1979), is one of the most widely utilized self report measures within the trauma literature (Weiss & Marmar, 1997). The scale was revised in 1997, after being criticized as not comprehensively measuring PTSD as defined within the DSM (Joseph, 2000). The goal of the revision was to improve the efficacy of the IES and its applicability to the DSM symptomatology for PTSD (Beck, Grant, Read, Clapp, Coffey, Miller & Palyo, 2008). The IES-R is a revised version of the original 15-item IES (Horowitz, Wilner, & Alvarez, 1979) and

contains 7 additional items related to hyperarousal symptoms of PTSD. These items match directly to 14 of the 17 DSM-IV symptoms of PTSD.

The IES-R (Weiss & Marmar, 1997) is a 22-item scale that assesses subjective distress caused by traumatic events. Respondents are asked to identify a specific stressful life event and then denote the level of distress this event caused them in the past seven days. Items are rated on a 5-point scale ranging from 0 (*not at all*) to 4 (*extremely*). Scale scores are formed for three subscales, which reflect "intrusion" (8 items), "avoidance" (8 items) and "hyperarousal" (6 items), showing a high degree of intercorrelation, *rs* = .52 to .87 (Creamer, Bell & Failla, 2003). Scores range from 0 to 88 and subscale scores can also be analyzed for the Intrusion, Hyperarousal, and Avoidance subscales. The higher the score the higher amount of subjective distress is experienced. According to Beck, et. al (2009), the IES-R has previously reported high levels of internal consistency (Intrusion: Cronbach's alpha = .87-.94; Avoidance: Cronbach's alpha = .84-.87; Hyperarousal: Cronbach's alpha = .79-.91). Test-retest reliability ranged from .89 to .94 with similar internal consistency and test-retest values having been reported with a Japanese translation of the IES-R (Beck, Grant, Read, Clapp, Coffey, Miller & Palyo, 2008).

From the current study, the internal consistency using Cronbach's co-efficient alpha was .93 for the total scale score. The intrusion subscale had an acceptable internal consistency (alpha = .83). The avoidance subscale had a very good reliability estimate with an alpha of .89. The hyperactivity subscale had good reliability with an alpha coefficient of .86.

As advanced from the theory, the hypothetical relationship is that more distress results in more peer emotional support and the frequency of obtaining. Again, however, the independent – dependent relationship is not tested with this study.

Moderating Variables

The moderating variables, as self-reported on the survey questionnaire, include information on the survivors and information on the decedent. Survivor information included age and gender. Decedent information included date of death (time since death) and their age at death.

Human Research Protection

This study was approved by the University of Pennsylvania Institutional Review Board prior to recruitment. Although the risks of completing this survey research were deemed minimal, the vulnerabilities of a traumatically bereaved population were accounted for, as well as the best supports and protection of study participants.

The following measures were in place to help provide additional support or crisis care to those participants who were at-risk during or after completing the survey: (a) a psychological first aid team, staffed by trained peer mentors and mental health professionals were available 24/7 at the seminar to all participants, (b) three crisis hotlines, including a local San Diego crisis hotline were included on the cover-sheet of the survey (Appendix) and (c) the student investigator, who is also a licensed mental health professional, provided her contact information and was continuously available to all survey participants.

Informed Consent

An information sheet, rather than an informed consent, regarding the peer support was recommended by the IRB (Appendix). The information sheet explained the following in regard to voluntary participation in the study: (a) introduction and purpose of study, (b) what is involved, (c) confidentiality, (d) risks of participating, (e) benefits of participating, (f) compensation, (f) primary investigator and student investigator contact information, and (g)

explanation of voluntary participation. Signature was requested on this form, but not required for participation.

Data Analysis

Quantitative data were analyzed using Statistical Package for Social Sciences (SPSS) version 17.0. Descriptive statistics including mean, standard deviation and range were determined for the study variables. The hypothetical relationship between the independent variable, the dependent variable and the moderating variables were tested with Pearson correlation coefficients. In the event of a moderating effect, differences and associations were tested co-varying the variance due to the moderating variable.

Chapter V
Findings

This chapter presents the findings of the study. First the descriptive statistics will be presented and the sample will be described. A discussion of the research questions and the study's findings will then be presented including describing the data analysis procedures, the results of the analysis and their significance.

Sample description

Data were collected from fifty-seven participants (n=57); however, five were excluded from the final analysis due to four of the surveys being incomplete and one survey not meeting the inclusion criteria. The analytic sample was 52 family survivors of a military suicide. Seventy-nine percent (n=41) of the respondents were female and the remaining 21% (n=11) were male. Ages of participants ranged from 20 to 78 years old with the mean age of 48.03 and the standard deviation is 13.8 years.

Stated dates of death ranged from 4/21/1988 to 7/23/2009. The average date of death was February 2007, with 23% of the total sample having died from suicide in the 2007. Participants were interviewed an average 37.09 months after the suicide death. The ages of the deceased were reported as ranging from 19 to 58 with the mean age, $\bar{x} = 30.8$ years old and a standard deviation of 12.2 years.

The sample demographic were compared to Beck, et. al (2008)., samples of patients with and without Post Traumatic Stress Disorder. These data are displayed in the following table.

Table 1 Demographic information and Impact of Event Scale-Revised (IES-R) scores for participants with

diagnosable post-traumatic stress disorder (PTSD+) and no PTSD (PTSD-) (Beck, Grant, Read, Clapp, Coffey, Miller & Palyo, 2008), compared with Current Study Sample

Note. Values in parentheses are standard deviations.

	PTSD+ (n = 98)	PTSD - (n = 84)		Study Sample (n-52)
Age	42.9 (10.98)	42.7 (13.84)	n.s	48.03 (13.8)
Gender (%female)	54.8%	72.6%	n.s..	79%
IES-R Intrusion	1.9 (.85)	1.1 (.88)	.0001	1.9 (.69)
IES-R Avoidance	1.7 (.85)	1.2 (.88)	.0001	1.8 (.98)
IES-R Hyperarousal	2.2 (.94)	1.3 (1.02)	.0001	1.8 (1.1)

While the study sample was slightly older then this the normative samples, the current sample is clearly similar to the patients with PTSD, with the exception of having slightly lower scores for the hyperarousal subscale. The study sample also had noticeable higher scores on intrusion, avoidance, and hyperarousal. From this comparison it is evident that the sample has a considerable degree of PTSD, most likely at the clinically diagnosable level.

Hypothesis Testing

There are two major hypotheses for this study. Hypothesis One states that there will be an association between scores on the EPS and the distress due to the suicide death, as defined by total scores and subscale scores of the Impact of Events Scale -Revised (IES-R) (Weiss & Marmar, 1997). Hypothesis Two maintains that participants who report higher frequencies of emotional peer support as defined by scores on the FEPS scale will report higher scores of perceived distress.

Pearson correlation analysis (r) was performed to demonstrate the relationship between reported scores on the peer support measures and scores on the IES-R. Pearson's r indicates that there is a significant association between EPS and total scores on the IES-R, $r = .304$, $p < .001$. Therefore, there is a significant relationship between these two variables and we can reject the

null hypothesis that states there is no relationship. There is a positive correlation (.30) that demonstrates that as research participants report a more distressful impact there was an increase in their emotional peer support. As scores on perceived distress (impact of a traumatic event) increased, so did scores on emotional peer support.

Pearson's *r* of .42, $p < .01$, also indicates that there is significant positive relationship between frequency of emotional peer support and total scores on the IES-R. This positive correlation shows that as the perceived levels of distress due to the suicide increases there is a greater frequency of obtaining peer support. With a p-value of less than .01, we reject the null hypothesis which asserts that there is no relationship between reported levels of higher frequencies of emotional peer support and higher levels of perceived distress and accept the alternative that participants who report more distress also have more frequent emotional peer support.

These findings support and confirm the study's two hypotheses. They confirm that there is an association between perceived levels of distress due to a suicide death and peer support. They also support that as reported levels of distress (impact of a traumatic event) increase so does the frequency of obtaining emotional peer support. Both the first and second hypotheses were supported

The Impact of the Moderating Variables

Survivor Moderating Variables

Age

There is an inverse correlation $r = -.39$, $p < .01$, between age and IES scores, suggesting that there is a greater impact with younger respondents then older respondent. There is no association between age and the EPS scores, $r = -.19$, $p = .21$. For age and FEPS score the

correlation was also not significant, $r = -.27$, $p = .10$. This means that as age goes up there is no significant association between age and the support one receives.

Gender

When we look at IES-R, we have 11 men with an average score of 32.3 (SD=12.9). There are 39 females and their average score is 43.2 (SD=18.4). When you compare those scores it gives you a $t = -1.84$, which is trend toward significance, $p=.07$. Females are not significantly different from men, however, there is a trend toward significance. Women seem to have a slightly greater impact than men on the impact of the suicide death. However, males and females do not different when it comes to the availability of support, $t=.18$, $p=.86$, or the frequency of obtaining emotional support, $t = -.71$, $p=.49$, means that this difference occurs by chance.

Decedent Moderating Variables

Date of Death (time since death)

The moderating variable, date of death is in fact the time since death. The recent the death did correlate with the IES scores. The more recent the death, there is a greater impact, $r = .27$, $p < .05$. This indicates that the more recent the death, the greater the impact, and perhaps supports the notion that time does heal.

The date of death (time since death) does not have an impact on EPS scores, $r = .17$, $p < .05$ or the FEPS scores, $r = .14$, $p < .05$. The amount of support they get is independent from the date of the death.

Age at Death

How old the person was who died did not have an association between impact, $r = -.031$, $p < .05$, with the availability of emotional peer support, $r = .025$, $p > .05$, or frequency of support $r = .029$, $p > .05$. The age of the deceased does not moderate the impact and social support variables.

Subscales

The hypothetical relationships were also tested for each of the three subscales of the IES-R: avoidance, intrusion, and hyperarousal.

The subscale analyses evidenced that scores on the intrusion subscale (M=1.89, sd=.69) were significantly associated with scores on both EPS scores (r=.28, $p < .05$) and the frequency of seeking support (r=.42, $p < .01$). Scores on the subscale avoidance had a mean of 1.83 and a standard deviation of .98, and scores were slightly correlated with support scores (r=.29, $p < .05$) and lesser so for the frequency of seeking support ($r = .28$, $p < .08$). And finally, hyperarousal scores (M = 1.82 and sd = 1.1) were not correlated with support (r=.21, p = .15), but scores were correlated with the frequency of support (r =.40, $p < .01$).

In general, these findings support the hypothetical relationship between the impact of the suicide death and support, although with these more refined definitions, the support for the hypothesis is stronger for the frequency of seeking support then support itself.

The impact of the moderating variable, date of death (i.e., how recent the death), was associated with hyperarousal ($r = .31$, $p < .05$), however there was no association with either intrusion or avoidance scores ($r = .24$, p = .09 and $r = .14$, p = .32, respectively). This suggests that the more recent of time since death loss fades for its impact on one's avoidance and intrusion, but has a more lasting impact on hyperarousal.

Chapter VI
Limitations and Discussion

Limitations

The findings of this study must be regarded as preliminary. The sample was a convenience sample drawn from a group of individuals who were attending a military suicide loss survivors peer support seminar. It is impossible to generalize these findings to all survivors, especially since the samples excludes a significant section of the suicide loss survivor population who may have never been aware of, attended or received peer support. Sample selection may be an important source of bias in the present study. One of the most challenging methodological issues in suicide loss survivor research is sample selection and bias and the need to address it in intervention research (Jordan & McIntosh, 2010). In addition, the demographics of the sample are not representative of the diversity of the population of the United States and focus even more narrowly on a sub-group, which may have cultural issues influencing these variables. The sample was over three-quarters female and over half were parents of the deceased. The dominance of women is to be expected since the majority of the U.S. military are men which would account for a larger of group of widows participating in the study and thus increasing the female percentage. It was also overwhelmingly comprised of military families and/or those exposed to military lifestyle and culture.

One other confounding variable within the sample includes the length of time since the suicide death, with a mean length of 37.9 months. Given the variability in time since loss, retrospective data can be questioned. All of these factors limit the generalizability of the findings.

Another limitation to this study is its design, which involved a cross-sectional, self-report survey of U.S. military suicide loss survivors. There was no possible follow-up with respondents

and more significantly there was no comparison group. It is impossible to generalize how other survivors of suicide loss would have responded to the survey questionnaire. Hence, no assertion can be made that the responses on this questionnaire are unique to all suicide loss survivors.

Moreover, it would not be unlikely to find similar levels of distress in a sample of other types of sudden, traumatic loss survivors. Likewise, because there were no pre and post-test measures of perceived distress, there is no way of knowing whether there is a casual relationship between perceived levels of distress and peer support. Therefore, can only suggest that there is a relationship between the two variables, but cannot assert that one variable caused a change in the other variable. Because our variables are theoretical we can only suggest that there is a relationship between perceived levels of distress and peer support and provide our theoretical assumptions about this correlation but cannot demonstrate, based on these findings that peer support increases or decreases distress or vice versa.

Additionally there were limitation related to the questionnaire itself. Some of the questions pertained to support services offered by the military and Department of Veterans Affairs. Considering that some of these survivors, based on their relationship to the deceased, status to the deceased and demographic location may not be entitled to or have access to these services. Therefore, the reliability of this data can be questioned. Furthermore, participants were asked to recall feelings of perceived distress in the last seven days, which make it impossible to determine at what intervals or how chronically they have experienced these levels of distress since the suicide death. It is unclear whether these reported scores of perceived distress have been apparent since the suicide death and for how long they have remitted, resurfaced or persisted. The findings can only indicate the present perceived levels of distress during the week

leading up to the military suicide seminar, in which the anticipation of this event could also be a contributing effect. Therefore, the reliability of some of these data may be questioned.

Lastly, the wording of some of the questions were not clearly understood by respondents, leaving room for ambiguity. For example, a question was asked about peers giving "encouragement". There was difficulty to distinguish whether peers were giving "encouragement to do something" or just were "encouraging". An example of a survey statement includes, "I do not understand this question, so I will modify." Given all the design issues above, the reliability of some of the data may be questioned.

Discussion

The primary purpose in this present study was to examine the correlation between military suicide loss survivor's perceived levels of distress (impact of a traumatic event) and peer support. In addition, a secondary aim of the study was to add to our knowledge of self-reported perceptions of both survivor exposure and utilization of peer support and distress after the suicide death of a U.S. Armed Service Member. By exploring the association between these two variables, this study aimed to determine whether military suicide loss survivors with high levels of perceived distress sought peer support and peer support opportunities. It also examined the relationship between the four moderating variables, survivor age and gender and the decedent's date of death (time since death) and their age at death, and their impact on the perceived levels of distress and peer support.

This exploratory study of military suicide loss survivors has yielded some interesting initial findings. Results of the current study indicated that there is significant positive relationship between high levels of perceived distress (impact of a traumatic event) and peer support. The data also suggests that survivors of military suicide loss with high levels of

perceived distress tended to seek peer support. Furthermore, participants reported that as levels of perceived distress increased the tendency to access peer support opportunities also increased.

The study also found that date of death (time since death) and age of the survivor moderated perceived distress (impact of a traumatic event), meaning that the younger the survivor and the more recent the time since the death there is an association with greater distress. Women were not significantly more impacted then men after a U.S. military suicide death, however a slight difference showed a trend toward greater possible significance for women. A survivor's age and the date of the death (time since loss) had no significant correlation with exposure to peer support or the frequency of obtaining peer support. Getting peer support and the amount of peer support is independent of age and time since the death. Also, how old the person was who died was not significantly associated with impact and social support variables.

In comparison to Beck, et. al (2009), the normed sample of patients with and without PTSD, results from study indicate that participants had a significant degree of PTSD symptoms, with high scores on intrusion and avoidance scores. When testing the hypothetical relationships for each of the three subscales of the IES-R, avoidance, intrusion and hyperarousal, the PTSD symptoms of both intrusion and avoidance, correlated with a higher need for EPS and frequency of obtaining peer support. Hyperarousal was related to higher frequencies of obtaining peer support. Thus, even as a narrow measure these elements strongly support the hypotheses that survivors who report high levels of distress consequent to a U.S military suicide death are likely to seek peer support services and obtain peer support more frequently. Finally, results of the study also suggest that the more recent the suicide death the more survivors may suffer from symptoms of hyperarousal.

The previously reviewed literature has supported the premise that suicide loss survivors may be at risk for a multiplicity of psychological, social, and physical complications in their bereavement, including heightened states of distress and elevated rates of complicated grief and suicide (Aguirre & Slater, 2010; Knight 2006; Latham & Prigerson, 2004). Suicide loss survivors also demonstrate higher levels of distress in several areas of functioning at some point in their grieving process (McMenamy, et al., 2008). The present findings were consistent with the previously reviewed literature.

Although very little research exists about the impact of suicide on survivors and interventions to best help assist them in repairing their lives (McMenamy, et al., 2008; Mitchell, Sakraida, Kim, Bullian & Chiappetta, 2009; Parker & McNally, 2008), clinical observation and a scant amount of research has suggested that peer support has an especially compelling appeal to suicide loss survivors and is widely-utilized (Dyregrov, 2002; Feigelman et al., 2008; Feigelman & Feigelman, 2008; Wilson & Marshall, 2010).

In addition to finding a significant positive relationship between perceived levels of distress (impact of a traumatic event) and peer support, the results of the current study indicate that those participants reported high levels of perceived distress reported that they also obtained significantly higher levels of peer support then those with lower levels of reported perceived distress. Thus supporting the concept that those bereaved by suicide seek out peer support in an effort to help them cope in the aftermath, especially if they are highly distressed.

Suicide loss survivors, similar to survivors of other types of sudden traumatic deaths, are more prone to trauma symptoms and are at increased risk for the development of PTSD. Jordan (2008) contends that the comorbidity of PTSD symptoms may lend to a more complicated bereavement process for survivors while Aguirre & Slater (2010) add that PTSD is a contributing

factor to a survivor's heightened state of distress, increasing their vulnerability to suicide themselves. The literature also supports that persons with PTSD are at higher risk for suicide (Kotler, Iancu, Efroni & Amir, 2001). Participants in this study had a significant degree of clinical PTSD symptoms, including avoidance, intrusion and hyperarousal. This finding is particularly noteworthy given the scant research on PTSD in suicide loss survivors and effective interventions for those suffering from the dual burden of loss and trauma. The literature suggests that forms of social support, such as peer support, reduce suicide risk (Kotler, Iancu, Efroni & Amir, 2001), and may be protective against PTSD and complicated grief in the bereaved (Vanderwerker & Prigerson, 2004).

The data regarding the relationships between age and time since loss are supportive of the potential role that a survivor's age may influence their level of distress and the impact on coping given how recently the suicide death has occurred. This is consistent with Walter & McCoyd's (2009) observation that young adults who suffer the death of a young adult may be presented with unique challenges, such as lack of previous experience with death that may provide them with learned coping skills. The findings from the study did support that those who suffered a death more recently were significantly more distressed.

These findings imply that those who have suffered the suicide death of a U.S. Armed Services Member are at an increased vulnerability to heightened distress and the development of post-traumatic stress, which may increase their risk of suicide. It is clear that those who suffer from heightened levels of distress when bereaved by suicide seek out and obtain peer support more frequently. This lends to the notion that social support may buffer distress and act as a protective factor for suicide loss survivor's own risk of suicide.

Chapter VII
Conclusions and Implications for Future Research

Conclusions

Peer-led support, fueled by the reciprocal process of mutual-aid, is one of the oldest, most pervasive and widely utilized forms of help in the U.S. As an acknowledged basis of healing for millions of Americans, it has been recognized to facilitate psychological adjustment, promote recovery, aid in the extension of life for individuals with chronic and life-threatening illness, reduce isolation, de-stigmatize, assist in education, prevention and reduce stress. There is wide spread indication that social support buffers the effects of bereavement and that peer support is a highly sought after and utilized form of healing for suicide loss survivors.

The U.S. has been engaged in a Global War on Terror for the past decade - the longest war in American History. With only one-percent of the U.S. population comprising the total volunteer force of the U.S. Military, troops have been deployed and re-deployed multiple times to meet the operational tempo and required demands of a large scale war with a small scale force. The burden carried by those who choose to serve, in any capacity, takes a sacrifice and sometime a toll on military service members and their families. One observed consequence has been an increased rate of suicide across all branches of the U.S. military. In addition to service members already falling within a high-risk age group for suicide, exposure and repetitive exposure to stress and trauma associated with service in these wars, has left service members and their families struggling to contend with invisible psychological wounds. As the rates of suicide increase, so do the number of survivors left in the aftermath, who themselves become at risk for the rippling wounds of post-traumatic stress, physical impairments, complicated grief and suicide.

To address this growing public health crisis, the Department of Defense and Department of Veteran's Affairs have increased research, programs and services to address suicide awareness and prevention. However, there has yet to be similar organizational response to postvention. Given the rising rates of military and veteran suicides and the concern by the D.O.D and DVA for the health of the force, veterans, and the care of their families, what remains to be done in their prevention efforts is postvention. As Shneidman recommended as early as 1972, postvention is prevention. Shneidman (1972) pointed out that postvention support for those exposed to a suicide death, especially that of a loved one, friend or co-worker, is a natural extension of prevention of suicide. This is due to a survivor's increased vulnerability to stigma, shame, isolation, guilt, complicated grief, depression, heightened distress, PTSD - all possible contributors to their risk for suicide.

This study highlights the unrecognized additional casualties of a suicide casualty in the U.S. military, the family survivors, demonstrating the need to identify military suicide loss families as trauma victims and to provide effective, programmatic attention for their care. Much like other military family programs that are designed to help families deal with the effects of trauma, (eg., domestic violence, sexual assault, addiction, combat injury), military suicide loss survivors should be afforded equivalent military professional family support, victims assistance and case-management services. Casualty "care" for the family should be inclusive of the care for the psychosocial impact of a service member's death in addition to the established assistance with practical matters.

Given suicide loss survivors increased risk for PTSD, complicated grief and suicide, there remains a tremendous need for research to better understand the needs and unique challenges of survivors and what helps them in their healing. Understanding that certain occupations and sub-

groups may have higher rates of suicide and unique cultural issues that exist within those occupations, research into these sub-groups and specific understandings of these communities can further illuminate their particular needs and help provide for culturally-competent, informed care.

An important finding of this research is that those who have suffered a military suicide death commonly sought peer support by other survivors of suicide as postvention support. This lends backing to a premise of peer support, which contends that this type of help is appealing and helpful because those who share a similar experience can provide a better understanding community that can help ease the pain. For suicide loss survivors, peers can be successful models of coping, provide mutually reassuring and supportive responses, assist each other to move beyond the isolating sadness of loss, promote hope, foster resilience, model adaptation and demonstrate to each other how to integration suicide loss in their lives. This study also sheds light on the issue on whether suicide loss survivors may be prone to symptoms of PTSD, as the sample clearly demonstrates clinically significant symptoms of PTSD and supports the theory-base that effects of trauma may depend greatly on whether those affected can seek comfort, reassurance and safety with others. The study further suggests that the perception of supportive relationships may buffer the effects of traumatic events. Those with higher levels of distress, theoretically, may also seek and obtain these relationships from similar others more often to mitigate theses symptoms of trauma. For military suicide loss survivors, they may seek these specific military suicide peer programs to orient themselves toward similar peers who are able to help them integrate their new identities and serve as role models as a response to a stressful and traumatic life circumstance (Figley & Nash, 2006). Like most suicide loss survivors, and possibly even more so in the military, embarrassment, shame and stigma play such a prominent

role in a survivor's bereavement process, finding others who can provide the safety of an understanding environment where taboos can be discussed may be an important part in a why survivor's seek peer support. Because military suicide loss survivors tend to be younger in age then those bereaved in general society they may lack a similar peer group (young widows, younger adult mother/fathers, young adult siblings) with whom they can share their experiences, struggles and resiliency as a community. This may also theoretically play a role in why suicide loss survivors seek each other out. They may also provide to each other a unique understanding of the culture, lifestyle and challenges of the U.S. military and the shared experience of the impact of a service member's death, which others in the civilian and general community may not be able to experientially understand. It is important not to lose sight that as the number of U.S. military suicides increase so do survivors left in their wake, contributing to a significantly rising portion of the population of the U.S. A recognized population by mental health professionals at high risk for mental health difficulties, including suicidal behavior. Similar to the general population, there may be stigma and societal norms regarding suicide that may create barriers for survivors, which may contribute to why only a portion of survivors will seek help. A lack of understanding of where to access appropriate and effective services may also be a contributing factor.

The present research has demonstrated that military suicide loss survivors with higher levels of distress tend to seek out emotional peer support and do so by seeking emotional peer support opportunities more frequently as postvention support consequent to the suicide death of a U.S. service member. Younger survivors (18-40) and those who experienced the death more recently exhibited higher levels of distress, increasing their susceptibility to complicated bereavement, PTSD and suicide. In alignment with Cerel and Campbell's (2008) Active

Postvention Model, the proactive reaching out to military suicide loss survivors as close to the time of death or notification as possible by peer support providers may prove to be an effective, postvention service buffering distress and preventing suicide in those bereaved by the suicide of a family member in the U.S. military. An active postvention model proposed by Cerel and Campbell (2008) begins at the scene of the suicide or at notification with the family and includes first responders and a Local Outreach to Survivors of Suicide (LOSS) Crisis Team, in which the trained, peer support providers play an essential role. The LOSS team provides support services to the survivors and referrals to support services, including peer support programs. Given that early distress may be a contributing factor toward complications in bereavement and suicidality, early, effective postvention care may buffer against this distress, mitigate psychological and physical harm as well as prevent survivor suicide.

Implications for Future Research

While preliminary in nature, this pilot data suggest directions for some future research. First, a traditional medical model of service delivery that assumes distressed individuals find their way to needed services is quite likely insufficient in the case of suicide loss survivors (and probably to survivors of most other sudden, traumatic deaths). Campbell et al. (2008) proposed an Active Postvention Model of services that greatly facilitates the process of accessing needed services by new survivors. As indicated by this study, individuals who suffered a suicide death more recently reported feeling more distressed. Helping survivors find the help they need much earlier in the grieving process may also serve to reduce the isolation, stigma and trauma often experienced after a death by suicide. Studying suicide loss survivors early in their bereavement process prospectively may help gain a better understanding of their initial risks and support needs as well as give a 360 degree view of the long-term trajectory of suicide bereavement. In

the context of a military suicide death, this may be extremely helpful in understanding if there are unique complexities and issues of care more specific to a military suicide loss population. Much like police suicides, it is unfortunate that survivors of a military suicide must not only cope with their own grief and trauma but also with potential negative reactions from the deceased's military peers, the military, the veteran community and the public. Often, family survivors of a military suicide are avoided and abandoned more rapidly then those of service members who die of other causes. This is typically due to the shame and stigma still associated with this "dishonorable death" which is displaced upon the surviving family, often innocent victims. The military suicide postvention crisis team has the potential to provide a supportive set of conditions in reducing psychological distress and a sense of understanding and recognition for the survivor.

In addition, since a suicide loss survivor is defined as anyone who has been impacted by a suicide, the military needs to look at defining fellow service members, especially those peers, members of the unit, the military community and others which served with that service member as survivors. These fellow service members are also at risk of suffering from the signs and symptoms of distress and bereavement resulting from the suicide of a known or fellow service member, especially if they witnessed the death or found the body. Postvention programs, much like those used by the civil service, such as police and fire departments, include critical incidence stress debriefing (CISD), counseling support and peer support for fellow officers and firemen. They too are at a great risk of distress and grief as well as an increased risk of suicide and the contagion effect.

Secondly, because we cannot assert a casual relationship from this study, it would be recommended to perform an interventional study of peer support and ascertain pre and post-test measures to establish effect. This cross-sectional survey data does not enable us to identify the

chain of casual forces between perceived distress and peer support. This remains a mission for future longitudinal study.

In addition to pre and post measure testing and longitudinal study, a qualitative understanding of what is potentially helpful or harmful about peer support and when and how in their bereavement process survivors may find it most effective would help illuminate our understanding about the nature, the quality and the timeliness of peer support through the experiential voice of suicide loss survivors. The current study can only make theoretical assumptions about why survivors may be obtaining peer support. It cannot assert causation, only correlation, so it is unknown whether high frequencies of peer support may be causing distress. The caution about re-traumatization and the deleterious effects of peer groups is an important concern of researchers and clinicians (Cerel et al., 2009).

There are also many different types of peer support programs offered to military suicide loss survivors, e.g. support groups, online chat, one-to-one mentoring, retreats. It would be worth further investigation to tease out which type of peer support survivors find most effective and why? Also, to compare the utilization and helpfulness of peer support to other forms help, such as professional mental health counseling, meditation programs, trauma-informed therapies, CBT, complicated grief therapy, etc.

Given the clinically significant levels of distress reported in this sample, these findings suggest a great need for further work to investigate the psychiatric sequelae of the loss of a U.S. service member in the family to suicide and the possibility of an increased risk for the development of PTSD, depression, complicated bereavement, suicide and other conditions in survivors. In differentiating these symptoms, their intensity and their impact, service delivery, including evidence-based practice interventions can be designed to provide the best informed

care. This study of the intersection of trauma (acute and post traumatic stress) and grief would greatly contribute to the growing body of literature on traumatic bereavement as well as inform clinician care, which may include the use of trauma therapies in conjunction or separate from grief therapy and counseling. Use of comparison groups of other sudden, traumatic deaths (i.e.: homicide survivors, accidents, terrorist attacks, KIA, acute heart attack/stroke) would highlight the differences or similarities between these groups and contribute in answering the question, "Is suicide bereavement different?" (Jordan, 2008).

Finally, the use of these findings have broad implications to all surviving family members of U.S. military deaths. Since the majority of U.S. Military deaths are sudden, traumatic and violent in nature, the exploration of the use and helpfulness of peer support and distress, among family survivors of all circumstances of death (KIA, accident, homicide, kidnapping, IED, illness) should be explored to help understand and aid this traumatically bereaved population and potential cultural factors that may influence their gravitation toward peer support.

The present research has demonstrated the potential value of peer support to military suicide loss survivors. More research is needed to understand how peer support programs work, their benefits, their risks/harms, identification of who is best aided by peer support or alternative interventions.

Since social workers play a fundamental role as one of the largest groups of mental health providers in the DOD and DVA health systems, as well as being the largest groups of providers of mental health care in the U.S (NASWVA, 2011), additional training and education should be considered in working with suicide loss survivors and their unique and complex challenges. Findings from this study and future information gained from the study of military suicide loss survivors can help further our knowledge in designing services that provide evidenced-based,

effective, and compassionate care for families and survivors affected by the suicide death of a U.S. Armed Service Member. This information as broad implications for all those caring for individuals experiencing the death of a significant other, friend or loved one to suicide.

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