Commander's Message

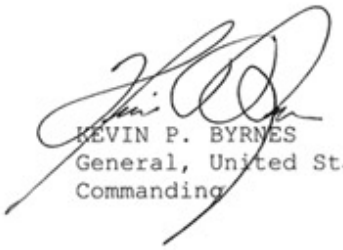
This pamphlet provides commanders and leaders a comprehensive guide to assist with their suicide prevention efforts. It contains the most current, proven suicide prevention measures from leading Army, Department of Defense, and civilian suicide prevention authorities.

We all realize the inherent stress and burdens placed upon our Soldiers. What defines us as an Army is our compassion and commitment to individual physical, spiritual, and mental fitness.

We must always be aware of potential triggers and warning signs of suicide, and we must be vigilant and increase our awareness to recognize those Soldiers, family members, and Department of the Army civilians who might be at risk for suicidal behaviors.

All leaders, whether officers, noncommissioned officers, or civilians, should create an atmosphere of acceptance and support that encourages help-seeking behavior for those requiring professional counseling.

Soldiers and civilians alike should learn that seeking help is a sign of strength, courage, and personal maturity!



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***TRADOC Pamphlet 600-22**

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Personnel - General

LEADERS GUIDE FOR SUICIDE PREVENTION PLANNING

Summary. This pamphlet serves as a guide to United States Army Training and Doctrine Command (TRADOC) commanders and leaders for TRADOC implementation of the Army Suicide Prevention Program.

Applicability. This pamphlet applies to all elements under the control of Headquarters, TRADOC.

Suggested improvements. The proponent of this pamphlet is the Office of the TRADOC Surgeon. Send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) through channels to Commander TRADOC (ATBO-M), 60 Ingalls Road, Fort Monroe, VA 23651-1032.

Availability. This publication is available only on the TRADOC Homepage at http://www.tradoc.army.mil/Publications.htm.

Unless otherwise stated, when the masculine gender is used, both male and female are included.

Contents

***This pamphlet supersedes TRADOC Pamphlet 600-22, 30 September 1985.**

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Chapter 1
Introduction

1-1. Purpose. The purpose of this pamphlet is to provide a guide to TRADOC commanders and leaders to implement the Army Suicide Prevention Program.

1-2. References. Related publications are listed in appendix A.

1-3. Explanation of abbreviations. Abbreviations used in this pamphlet are explained in the glossary.

1-4. Overview.

a. Suicide is not a pleasant topic because it is an intentional act resulting in a person's death. It strikes at the heart of underlying moral, religious, and ethical principles. It is the denial of a human being's basic need (self-preservation), and contradicts the value of human life. For many, suicide is more shocking, more revolting, and more unacceptable than almost any other cause of death.

b. On average, more than 30,000 Americans die by suicide each year. Suicide is the ninth leading cause of death in the United States, and the third leading cause of death for Americans aged 15 to 24.

c. Unlike information on suicide mortality, there is no single primary data source for suicidal behaviors. Suicidal behaviors encompass a broad range of acts, including suicidal attempts, gestures, threats, and suicidal thoughts. Some estimate suicidal behaviors are one hundred times as frequent as completed suicides. One-fourth of those who survive a suicidal behavior require medical and/or psychological intervention to prevent further suicidal acts and possible death. The lack of lethality of the suicide act or thought does not undercut the serious nature of the "suicide" action (see app B for additional information).

d. The U.S. Surgeon General publicly declared suicide a serious public health threat, while launching a national effort entitled "A Call to Action" to develop strategies to prevent suicide and the suffering it causes. This was a historic first: recognition at the highest levels of government that this country could no longer ignore or deny the significant numbers of Americans that kill and harm themselves each year, and the trauma these events have on the survivors.

e. For a number of reasons, suicide is less of a problem in the Army than in the civilian population. This has a lot to do with the specific requirements for "fitness for duty." Self-selection and intake-selection factors limit the number of individuals that are at risk for suicide. Alcohol and substance abusers, and people with serious aggressive or antisocial behavior (conditions that are strongly associated with suicide) are unlikely to select a military career or, if they do, stand a good chance of being denied enlistment.

f. Although the military suicide rates are lower then rates among comparable age, sex, and racial groups in the general population, military suicide rates are higher than expected. Suicide ranks as the third leading cause of death for soldiers, exceeded only by accidents and illnesses.

g. All through the 1990's, five-times as many soldiers (an entire battalion) committed suicide than were killed by hostile fire. During the first year of Operation Iraq Freedom (OIF) (2003-2004) the Army lost more soldiers to suicide than ever experienced in any previous hostile environment.

h. Consequently, the U.S. Surgeon General chartered an OIF Mental Health Advisory Team (MHAT) to assess OIF-related mental health issues and provide recommendations to the OIF medical and line commands. One of their most important findings was the Army needs to increase behavioral health intervention training for soldiers in order to reduce the risk of in-theater suicide.

i. The MHAT assessment showed soldiers who were trained in maintaining psychological well-being or in suicide prevention were significantly more likely to endorse counseling and to assist fellow soldiers in seeking and getting mental health help. An additional MHAT finding was all soldiers needed training awareness on the availability of mental health services and how to use them. This education facilitates early intervention and decreases stigmas associated with asking for and receiving professional mental health help.

(1) Of the soldiers who committed suicide over the past 10 years:

(a) Seventy-six percent had serious problems in their intimate relationship.

(b) Sixty-three percent communicated their intentions to kill themselves.

(c) Fifty-three percent gave clear indication of depression at the time of their death.

(d) Forty-three percent had work-related problems.

(e) thirty-two percent had substance abuse problems.

(f) twenty-three percent had financial problems.

(g) sixteen percent had legal problems.

(h) seventy percent had multiple problems.

(2) Despite these facts, only 20 percent of these soldiers received treatment from the mental health care system prior to their death.

(3) It is important to know relevant myths and facts about suicide because these can influence people's attitudes toward suicidal individuals and toward taking action on their behalf. Specifically, many myths contain rationalizations that can prevent people from taking action when they suspect or are confronted by someone who is at risk for suicidal behavior. Table 1-1 provides further information on suicide myths and facts.

Table 1-1
Suicide myths and facts

	MYTH	RATIONALIZATION	FACT
1.	Most suicides occur with little or no warning.	If you cannot see suicide coming, there is nothing anybody can do.	Most people communicate warning signs of how they are reacting to or feeling about the events that are drawing them toward suicide. These warning signs—or invitations for others to offer help—come in the form of direct statements, physical signs, emotional reactions, or behavioral cues. They telegraph the possibility that suicide might be considered as a means to escape pain, relieve tension, maintain control, or cope with a loss.
2.	You should not talk about suicide with someone who you think might be at risk because you may give that person the idea	It is best just to avoid it altogether.	Talking about suicide does not create nor increase risk—it reduces the risk. The best way to identify the intention of suicide is to ask directly. Open talk and genuine concern about someone's thoughts of suicide is a source of relief and often one of the key elements in preventing the immediate danger of suicide. Avoiding the subject of suicide can actually contribute to suicide. Avoidance leaves the person at risk feeling more alone and perhaps with even less energy to risk finding someone else to be helpful.
3.	People who talk about suicide do not do it.	There is no need to get involved with people who talk about suicide.	People who attempt suicide usually talk about their intentions, directly or indirectly, before they act. Four out of five people who commit suicide talk about it in some way with another person before they die. Failing to take this talk seriously is suspected of being a contributing cause in many deaths by suicide.

	MYTH	RATIONALIZATION	FACT
4.	Non-fatal acts are only attention-getting behaviors.	These behaviors can either be ignored or punished.	For some people, suicidal behaviors or "gestures" are serious invitations to others to help them live. If help is not forthcoming, there is an all too easy transition between a desperate invitation to receive help and a conclusion that help will never come—between little or no intent to die and a higher intent to die. Punishing suicidal thoughts or actions as if they were an improper way to invite help from others can be very dangerous. Punishment often has the opposite effect to that which is desired. Help with problems, as well as help in finding other ways to ask for that help, is far more likely to be effective in reducing suicidal behaviors.
5.	A suicidal person clearly wants to die.	There is no point in helping. They will just keep trying until they complete suicide.	Most suicidal people are ambivalent about their intentions right up to the point of dying. Very few are absolutely determined or completely decided about ending their life. Most people are open to a helpful intervention, sometimes even a forced one. The vast majority of those who are suicidal find a way to continue living.
6.	Once a person attempts suicide, they will not do it again.	There is no need for concern now; the attempt will be cure enough.	Although it is true that most people who attempt suicide do not go on to kill themselves, many do attempt again. The rate of suicide for those who have attempted before is 50 times higher than that of the general population: 50% of successful suicide victims have attempted suicide previously.
7.	A suicidal person's need is so great that I cannot possibly make a difference.	They need more than I can provide so only a specialist can help.	There are as many reasons for suicidal behaviors as there are people who engage in them. In terms of finding general rules that apply to all people, suicide is very complex. However, understanding and responding to suicidal behavior in a particular person does not require deep understanding of the motivation or circumstances of the suicidal feelings. All that is required is paying attention to what the person is saying, taking it seriously, offering support, and getting help. Many persons are lost to suicide because this type of emergency first aid and immediate support was not offered or available.

	MYTH	RATIONALIZATION	FACT
8.	If a person was depressed (for example, withdrawn and lacking motivation) and suddenly seems to feel better, the danger of suicide is over.	They are better. I will not have to talk to them about suicide or keep my eye on them.	The outcome of feeling better can go two ways: 1) full recovery as one would hope; or 2) increased risk because the emotional conflict over living or dying was resolved in favor of death. Also, a person who is severely depressed may not have the energy to kill themselves: a lifting depression may provide the needed energy or give clarity to the perceived hopelessness of continuing with life. Or, resources may withdraw prematurely and not provide the support necessary for continued progress. Open and direct discussion of suicide is the only way to determine which of these directions applies.
9.	Improvement following a suicidal crisis means that the suicidal risk is over.	Again, everyone can relax and not have to deal with the issue of suicide again.	Many suicides occur following "improvement." Suicidal feelings can return. For at least three months following a suicide crisis, be particularly attentive to the individual. Professionals generally will see patients frequently during this time to assess them for increasing levels of depression, hopelessness, or anxiety.
10.	Once suicidal, a person is suicidal forever.	There is no way to help eliminate suicidal feelings or help the person return to regular duties after a suicidal episode.	Most suicidal crises are limited in terms of time, and will pass, if help is provided. However, if emotional distress continues without relief, and help is not provided, the risk remains for further suicidal behavior. Professional help should be obtained after which the individual can usually resume normal activities.

j. The Department of Defense (DOD) takes a community approach to suicide prevention and awareness.

(1) The key principles of DOD's suicide prevention program are:

(a) Leadership.

(b) Community involvement.

(c) The reduction of stigma associated with seeking help.

(2) The University of Rochester, New York, performed a 6-year study (2003) on the successful United States Air Force suicide prevention program. The Air Force program validated the DOD principles and demonstrated the inter-connectedness of many stressors that affect people, and the importance of enhancing protective factors while decreasing risk factors.

Chapter 2
Suicide Prevention

2-1. Leadership.

a. The role of Army leadership in suicide prevention cannot be overemphasized. Military leaders monitor and protect those under their command. A military leader can more effectively promote and sustain protective factors in the military than in civilian settings. Quality leaders endorse, advocate, authorize, and even mandate suicide prevention as a priority. It is important for all commanders and leaders to recognize that mental wellness is part of the triad of overall individual fitness (along with physical and spiritual fitness). All leaders should:

(1) Promote a climate of mutual "Buddy Care" among all military personnel. This is an environment where no one has to go it alone. This web extends to all soldiers, and includes showing interest, whether it involves making sure soldiers drink enough water on runs, to concern for personal and family issues. We are our brother's keepers! Buddies DO NOT ignore buddies in emotional distress and DO NOT try to bury problems presented to them! Buddies DO express concern, and DO intervene when necessary to save a Buddy's life! (See app D.)

(2) Pay attention to warning signs and respond to those who need help. If anyone suspects or knows that a fellow soldier, family member, or anyone else is troubled, they should provide or get help for them.

(3) Be aware that heightened stress, Uniform Code of Military Justice (UCMJ) actions, relationship problems, and impending holidays can trigger inappropriate coping behaviors in vulnerable individuals. Leaders should pay close attention to the personal needs of their people, and be on the lookout for signs of stress.

(4) Communicate in words and actions, that it is not only acceptable, but a sign of strength, to recognize life problems and get help to deal with problems constructively.

(5) Support and protect those courageous people who seek help early, before a crisis develops.

(6) Strongly promote and reward help-seeking behaviors in soldiers.

b. Soldiers enter the Army with varying resiliency levels to handle stress, anger, and the conflicts often associated with intimate personal relationships (see app C for additional discussion on protective factors and resiliency). Many lack coping abilities, decisionmaking skills, and other key competencies which enhance their personal protective factors and help them effectively deal with the stress of the military environment. These competencies are the combined result of genetic disposition and environmental and developmental influences. Not all soldiers can adequately handle the stresses of military service or life in general, especially if they are already predisposed to psychiatric disorder. The majority of all suicides are due to some form of psychiatric disorder (with depression being the most common).

c. The baseline mental health of our inductees may be less than optimum, so a successful suicide prevention program requires proactive identification, targeted education/intervention, and ongoing mentoring by unit leadership. This intervention will assist soldiers in avoiding some of the normal pitfalls leading to mental health dysfunction and subsequent early attrition. These pitfalls include:

(1) Premature marriage.

(2) Premature parenthood.

(3) Excessive debt.

(4) Substance abuse.

(5) Dysfunctional and/or inappropriate behaviors resulting in UCMJ.

(6) Authority difficulties.

(7) Inability to form positive, supportive relationships.

(8) Excessive time demands relative to time management skills.

(9) Childhood conflicts. Problems acute and unresolved from childhood (relating to parents and/or siblings).

(10) Disparity between expectations and the reality of Army life.

d. Early referral is critical. Soldiers who are struggling or in distress may feel they should be able to master things alone. Hearing directly from a figure of authority that getting help is a priority--not only for the soldier but for the unit--can make a big difference. Commanders and supervisors are in a powerful position to dispel concerns about seeking help from mental health providers.

e. When a soldier is aware he is having problems, self-referral is the intervention with the highest probability of the best outcome for the soldier and the unit. Early self-referral may eliminate the need for more "costly" interventions. However, soldiers may not seek mental health treatment for themselves because they mistakenly believe their—

(1) Symptoms are not associated with a mental health disorder.

(2) Symptoms can be self-treated.

(3) Diagnosis could stigmatize them.

(4) Treatment will not help.

(5) Depression is not serious.

(6) Symptoms are due to personal weakness rather than illness.

(7) Self-referral could destroy their career.

f. Commanders and leaders should always support soldiers in crisis and refer them to a behavioral health specialist and/or their unit chaplain whenever they identify significant or suspect—

(1) Performance changes.

(2) Change in work relationships and family friends.

(3) Substance abuse problems (any).

(4) Financial difficulties.

(5) Changes in physical health occur.

(6) Emotional and anger symptoms.

(7) Legal difficulties.

(8) Disciplinary actions.

g. These warning signs or “red flags” demonstrate the potential for suicide or suicidal behavior. With or without a current threat of suicide, people with the above signs or symptoms need assistance (for more information see app F). Unfortunately, regardless of how accessible help is and how strongly leaders encourage self-referral, many soldiers struggling with serious behavioral health or substance abuse issues simply will not seek help on their own. In these cases a commander's options are:

(1) Command-directed mental health evaluation.

(2) Command-directed evaluation by Army Substance Abuse Program.

(3) Emergency referral to The Center for Mental Health Services.

h. Commander-directed referrals are appropriate when the commander needs answers to any of the following questions:

(1) Are the member’s behaviors due to a mental health problem?

(2) Should this individual’s security clearance status be maintained?

(3) Are duty restrictions appropriate?

(4) Is cross-training appropriate?

(5) Is this individual suitable for continued service in the Army?

i. Command programs should always emphasize keeping soldiers employed at their fullest potential. The goal is self-improvement, and the best way to achieve this goal is for the soldier to self-refer early. When a soldier is in a "life crisis," the chain of command ensures the soldier not only receives the proper crisis intervention, but that the problem is fully resolved. The command involvement continues until there is assurance that the crisis or disorder is resolved.

2-2. Community.

a. The three "Cs" of community (connectedness, communication, and caring) define the human condition. Humans evolved in small, highly connected extended family groups. Once a person leaves home to join the military, it is essential that the military community create those interpersonal bonds connecting us to each other. Without these connections, soldiers may quickly consider suicide as the only way to end their psychic pain and suffering.

b. Since mental disorders frequently can cloud one's judgment, soldiers suffering from a mental disorder may be unable to appreciate the seriousness of their problem; they must rely upon others ("the community") for assistance. In extreme cases, this may mean escorting someone in crisis to what, for them, is lifesaving help.

c. Each member of the TRADOC community is accountable. We cannot turn our backs because we do not want involvement. This is a shared responsibility for the general welfare of all TRADOC members. We should demonstrate a competence in confronting situations threatening the safety and well-being of the community. Every member of the TRADOC community should be able to identify people having difficulty coping with life events, and they should know how to get those individuals help.

d. The Army structure affords a network of multidisciplinary agencies and caregivers unequaled in civilian life. They are available 24/7 and at no cost to the soldiers. It is a comprehensive program, linking the efforts of an integrated system of chaplains and professionals from mental health, family support, child and youth services, health and wellness centers, and family advocacy. They all work together and take responsibility for prevention. Table 2-1 provides an overview of community resources that can assist in suicide prevention. For additional training resources refer to appendix F.

Table 2-1
Suicide prevention resources

Program Elements	Specific Resources
Awareness Education	▪ Headquarters messages. ▪ Annual Suicide Prevention training. ▪ Applied Suicide Intervention Skills Training (ASIST) for leaders, drill sergeants, civilians. ▪ Command leadership.
Life Skills Training	▪ Alcohol and drug abuse prevention training. ▪ Stress management training. ▪ Anger management training. ▪ Communication and conflict resolution training. ▪ Army Community Services financial training. ▪ Chaplains Family Life Training.
Leadership Training	▪ Senior program briefs. ▪ Suicide prevention training in Initial Military Training, Noncommissioned Officer Education System, Officer Education System.
Counseling/Treatment Services	▪ Family service centers. ▪ Chaplains. ▪ Mental Health Services at clinics and hospitals.
Protecting the Survivors of Suicide within Commands and Families	▪ Sensitive family support by Casualty Assistance Team members. ▪ After-suicide interventions by leaders. ▪ Critical incident stress debriefings for survivors.

2-3. Stigma.

> "*It's clear that we need to remove the stigma associated with the diagnosis of a mental illness, and educate all people about depression and generalized anxiety disorder so they can recognize symptoms and distinguish transient, circumstantial moods or feelings from a more serious mental health problem. We must help people recognize when it's time to seek professional help, and then, let them know that with care, their illness can—and should—remit."*
>
> Michael Faenza, Master of Science in Social Work,
> President and Chief Executive Officer,
> National Mental Health Association

a. According to 2003 data from the U.S. Department of Health and Human Services, an estimated 22 to 23 percent of the U.S. population experiences a mental disorder in any given year. However, nearly half of these individuals do not seek treatment, partly because of the shame associated with mental illnesses in our society. Over the past 10 years, more than 50 percent of the soldiers who committed suicide in the Army were suffering from a mental disorder

at the time of death. It is estimated that less than 10 percent of the soldiers sought mental health assistance in treating their depressive disorders.

b. Why do people, to include soldiers, find mental illness so unacceptable?

(1) *Fear of violence*. Some people believe that individuals who suffer from mental illness are violent. The basis of this myth is caused by inaccurate and outdated cultural myths portraying people with mental illness as aggressive and violent. In reality, people with a mental illness are usually anxious, fearful of others, and passive. Aggression can be a problem for a small minority of people with mental health problems that—

(a) Are not taking medication.

(b) Habitually abuse drugs and/or alcohol.

(c) Have a history of violence towards themselves or others.

Otherwise, statistics show people with mental illness are less violent than the general population, and tend to be the victims of violence instead of instigators of violence.

(2) *Fear of criminal intentions*. People with psychiatric disorders are no more likely to commit crimes than the general population. However, left untreated, mental illness can become progressively more severe and mentally ill people may inadvertently end up in jail.

(3) *Fear of the unknown*. People often fear what they do not understand, and when they do not understand, they often make wild guesses. Some cultures believe mental illness is the work of evil spirits, while others believe bad blood, poisons, or lack of moral integrity cause mental illness. As people understand more about the brain and the biological causes of brain disease, these harmful beliefs are quickly fading.

(4) *Aversion to illness*. Today we define "mental illness" as a disease just like epilepsy, Parkinsonism, or diabetes. But changing the definition to a disease treated by physicians still does not erase all the negative feelings. The public still has a very strong aversion to hospitals, disease, and doctors (especially mental health hospital doctors).

Consequently, there are millions of people throughout the country not seeking medical help because they believe that mental illness should be a "secret." Others believe there is a shame surrounding mental illness so they wait until they break down completely before getting help. Many feel that if their leader(s) found out that they were treated by a mental health professional, that it would harm their career. Others are embarrassed or view seeking help as a sign of personal weakness, or they feel so helpless and hopeless that they believe no one can help them.

c. The stigma associated with mental health care in the civilian community takes on added significance in the Army. In addition to worrying about their embarrassment and their careers, soldiers have the concern that their commander will discover that they received mental health treatment. Commanders have a legitimate "need to know" about the mental and physical capabilities of their soldiers in order to safely and efficiently carry out their mission, but many

soldiers feel they cannot acknowledge depression in their lives without risking detriment to their careers. For these soldiers, they will delay or never seek help; they feel the Army culture demands a "No Fear," "Suck it up!" "Bite the Bullet" mentality. In reality, not getting help is much more likely to damage a soldier's career. Commanders should always reinforce the personal courage it takes to seek mental health help, and that seeking "treatment" will not affect a soldier's military career.

d. Clearly, for the Army's suicide prevention campaign to be effective, we must all reduce the actual and perceived stigma of seeking mental health counseling. Leaders at all levels can reduce this stigma by—

(1) Not inadvertently discriminating against soldiers who receive mental health counseling.

(2) Supporting confidentiality between the soldier and their mental health care provider.

(3) Reviewing policies and procedures that could preclude soldiers from receiving all necessary and indicated assistance.

(4) Educating all soldiers, family members, and civilians about anxiety, stress, depression, and their treatment.

(5) Increasing behavioral health visibility presence in soldier area (using the Combat Stress Control tactics, techniques, and procedures).

(6) Encouraging help from mental health providers without it being considered "treatment"—similar to critical incident stress debriefings.

(7) Reinforcing the "power" of the buddy system in helping each other in times of crises.

e. Suicide has occurred since the beginning of recorded history, with attitudes toward it varying from the condemnation of the early Hebrews to the tolerance of the ancient Greeks and Romans. Our best hope for prevention of suicide lies in education, focusing on the ability to recognize soldiers who need mental health help, reducing the stigma associated with mental illness, and supporting soldiers to seek the treatment they need. Edwin Schneidman, Ph.D., founding president of the American Association of Suicidology, stated: "Human understanding is the most effective weapon against suicide. The greatest need is to deepen the awareness and sensitivity of people to their fellow men."

Appendix A
References

AR 600-85
Army Substance Abuse Program (ASAP)

DA Pam 600-24
Suicide Prevention and Psychological Autopsy

DA Pam 600-70
A Guide to the Prevention of Suicide and Self-Destructive Behavior

TRADOC Reg 600-17
U.S. Army Training and Doctrine Command (TRADOC) Risk Reduction Program

TRADOC Supplement 1 to AR 600-85
Army Substance Abuse Program (ASAP)

Appendix B
General Questions about Suicide

B-1. What is suicide? Suicide is the deliberate and self-inflicted ending of a person's own life. Suicidal behavior includes:

- Serious suicidal thoughts or threats.
- Self-destructive acts.
- Attempts to harm, but not kill oneself.
- Attempts to commit suicide.
- Completed suicide.

B-2. Why should we know about suicide? Anyone may be in a position to stop a person who is considering suicide. Most suicides and suicide attempts are reactions to intense feelings of loneliness, worthlessness, helplessness, hopelessness, and depression. People who threaten or attempt suicide are often trying to express their desire to communicate and ask for help. With the professional help that is available to those who experience these feelings, many suicide attempts can be prevented.

B-3. Why do people commit suicide?

a. Why do people kill themselves? Psychological pain is a basic ingredient of suicide. Suicide is seldom a result of joy or happiness; rather, negative emotions lead to suicide. Suicidal death is often considered as an escape from psychological pain. Psychological pain is the hurt or ache that affects a person's mind and spirit (the pain of excessively felt shame, guilt, fear, anxiety, loneliness, and the pain of growing old or dying in pain are examples).

b. To understand suicide, we must understand suffering and psychological pain. People who complete suicide feel driven to it. They feel that suicide is the only option they have remaining.

(1) The primary source of severe psychological pain is frustrated psychological needs. These needs include the need to succeed, to achieve, to affiliate, to avoid harm, to be loved and appreciated; and to understand what is going on in their life.

(2) When an individual completes suicide, they are often trying to blot out psychological pain that comes from defeated or frustrated psychological needs "vital" to that person. For practical purposes, most suicides tend to fall into one of four categories of thwarted psychological needs:

(a) Problems with self-image related to frustrated needs for affiliation.

(b) Lack of control related to the needs for achievement, order, and understanding.

(c) Problems with key relationships related to grief and loss in life.

(d) Excessive anger, rage, and hostility.

B-4. What are some stressful situations (precipitants) that can trigger suicidal behavior in the military? Certain events have been found to precipitate suicide in vulnerable individuals. These are not causes of suicide; rather, they are events that occur just before an attempt or completion of suicide. Like straws that break the camel's back, they are stresses that push someone already vulnerable due to a psychiatric condition, personal coping style, or accumulation of stressful events. These include:

- A bad evaluation report for an enlisted soldier or officer.
- The break up of a close relationship.
- Drug or alcohol abuse.
- Reunion with family upon return from long field training exercise or an isolated tour.
- Leaving old friends.
- Being alone with concerns about self and family.
- Financial stressors.
- New military assignments.
- Recent interpersonal losses.
- Loss of self-esteem/status.
- Humiliation.
- Rejection (for example, job, promotion, boy/girlfriend).
- Disciplinary or legal difficulty.
- Suicide of a friend or family member.
- Discharge from medical or mental health treatment.
- Discharge from the military service.
- Retirement.

B-5. Who commits suicide?

a. More people die from suicide than from homicide in the United States. In 1997, 30,535 Americans took their own lives. In contrast, 19,491 were homicide victims. On average, 84 Americans commit suicide each day, with more suicides than homicides each year since 1950. In 1997, suicide was the eighth leading cause of death in this country. It was the fourth leading cause of death among 25- to 44-year-olds.

b. Suicide is a serious problem among young people. Between 1980 and 1997, the rate of suicide increased 109 percent for 10- to 14-year-olds and 11 percent for 15- to 19-year-olds. Suicide was the third leading cause of death for 15- to 24-year-olds in 1997. That same year, a nationwide survey of high school students found one-fifth had seriously considered suicide, and 1 in 13 had attempted it during the previous year.

c. Most successful suicide victims are males. In 1997, males accounted for 80 percent of all suicides in the United States. Among 15- to 19-year-olds, boys were five times as likely as girls to commit suicide; among 20- to 24-year-olds, males were seven times as likely to commit suicide as females. Although more females attempt suicide than males, males are at least four times as likely to die from suicide.

B-6. What is depression and hopelessness?

a. Depression is a psychological state that may be caused by personal loss, heredity, or body chemistry. For the depressed, hopeless person, life may seem unbearable and the person loses interest in all activities and "withdraws from life." Depressed people see things in a very negative way and have a difficult time generating effective ways of dealing with problems.

b. Hopelessness is a spiritual/relational issue. Often it stems from feeling disconnected from a higher power and/or others. The connection people have with a higher power is spiritual in nature and provides a key link in their ability to withstand grief and loss. The presence of faith, in an individual, creates a resilient world view and may enable that person to rebound from the most severe disappointments of life.

B-7. What are common symptoms of hopelessness and depression?

a. Symptoms of hopelessness:

(1) Believing all resources are exhausted.

(2) Feeling that no one cares.

(3) Believing the world would be better off without you.

(4) Total loss of control over self and others.

(5) Believing death is the only way out of the pain.

b. Symptoms of depression:

(1) Difficulty concentrating or remembering; decreased attention, concentration, or ability to think clearly (such as indecisiveness).

(2) Loss of interest in, or enjoyment of, usually pleasurable activities.

(3) Loss of energy or chronic fatigue; slow speech and muscle movement.

(4) Decreased effectiveness or productivity.

(5) Feelings of inadequacy or worthlessness; loss of self-esteem.

(6) Change in sleep habits—the inability to sleep or the desire to sleep all the time.

(7) Pessimistic attitude about the future; negative thinking about the past.

(8) The inability to respond with apparent pleasure to praise or reward.

(9) Tearfulness or crying; feeling "blue."

(10) Recent change in weight; poor appetite, with weight loss or weight gain.

(11) Recurrent thoughts of death or suicide.

(12) Decreased sex drive.

(13) Anxiety.

B-8. Are most suicides caused by one sudden traumatic event? A sudden traumatic event may precipitate or hasten a decision to commit suicide, but it is unlikely the only cause. More likely, other contributing events and feelings have occurred over a period of time.

Appendix C
Protective Factors and Resiliency

C-1. General.

a. Ultimately the prevention of suicide is best accomplished by enhancing supports (community) and individual strengths since (1) not all risks are identified or reliably associated with suicide in individual cases; and (2) not all stresses are avoidable.

b. Research is beginning to identify resiliency and protective factors that can moderate the impact of stress or psychological dysfunction on an individual. The presence of these factors can

prevent a variety of ineffective behaviors including violence, substance abuse, and suicide, even in the presence of stressful events or environments.

C-2. Resilience.

a. Resilience describes the process and outcome of successfully adapting to difficult or challenging life experience, especially highly stressful or traumatic events. Resilience is an interactive product of beliefs, attitudes, behaviors, and physiology that helps people fare better during times of crises and recover more quickly following it. It involves the way an individual views and engages the world, the availability and quality of social resources, and specific coping strategies.

b. Resilient people are optimistic, believe in their own capabilities to produce effects, have a sense of mastery, sense of coherence, and are hardy. They believe they can influence the course of events in their lives and accept change as a part of life. Resilient people:

(1) Take a step back to solve a problem before reacting to the problem.

(2) Break up big tasks into smaller ones and address smaller, more notable tasks.

(3) Rely on their own resources.

(4) Take a break from problems to relax.

(5) Seek help from others.

(6) Keep things in perspective.

(7) Get involved with their community.

C-3. Protective factors. There are two categories of protective factors that can lessen the risk of suicide: personal protective factors and environmental protective factors. They include good problem-solving skills; reasonable expectations and an ability to tolerate failure and move forward to new challenges; social acceptance; support from others; and unit cohesion.

a. Personal protective factors:

(1) Easy temperament.

(2) Previous experience with self-mastery, problem-solving, and crisis resolution.

(3) Optimistic outlook.

(4) Social/emotional competence.

(5) High self-esteem and self-worth.

(6) Decisionmaking/problem-solving skills.

(7) Sense of personal control, self-efficacy.

(8) Sense of belonging to a group and/or organization.

(9) High and realistic expectations.

(10) High resiliency.

b. Environmental protective factors:

(1) Strong family relationships.

(2) Models of healthy coping.

(3) Encouragement of participation.

(4) Opportunities to make significant contributions.

(5) Available social supports.

(6) Available helping resources.

(7) Healthy spiritual/religious affiliation.

(8) Cultural and religious beliefs against suicide and in support of self-preservation.

For each of the factors above, there may be specific actions to take to build an environment that respects and promotes emotional health, and supports individual and unit readiness (see table C-1).

Table C-1
Protective factors and how to promote them

Level	Protective Factor	How to Promote Factor
Individual	Sense of control/effective coping skills/ optimistic outlook.	• Keep the focus on succeeding and accomplishing the mission. • Provide life skills training. • Remind others of their own success, competency, and mastery.
Peers	Acceptance and support.	• Promote unit cohesion and camaraderie. • Recognize achievements.
Community/ Command	Social support/ positive attitude about getting early help.	• Promote social involvement. • Make it known that helping resources exist. • Handle problems early. • Offer user-friendly access to helping resources. • Emphasize it is okay to get help. • Work to destigmatize counseling and mental health care. • Communicate clear message against suicide.

Appendix D
Suicide Help Card and Buddy Pledge

D-1. Help card. See the example in figure D-1 for the "Soldier's Suicide Prevention Help Card" and "Battle Buddy Pledge."

Side 1 **Side 2**

Soldier's Suicide Prevention Help Card	Battle Buddy Pledge
If someone you know: ▪ **Threatens suicide.** ▪ **Talks about wanting to die.** ▪ **Shows a change in behavior, appearance, or mood.** ▪ **Abuses drugs, alcohol.** ▪ **Deliberately injures themselves.** ▪ **Appears depressed, sad, withdrawn.** **You can help:** ▪ **Stay calm and listen.** ▪ **Let them talk about their feelings.** ▪ **Be accepting; do not judge.** ▪ **Ask if they have suicidal thoughts.** ▪ **Take threats seriously.** ▪ **Do not swear secrecy--TELL SOMEONE.** **Get help. <u>YOU CAN'T DO IT ALONE</u>.** **CONTACT YOUR:** ■ **Chaplain or Behavioral Health Clinic.** ■ **Primary Care Manager.** ■ **Company/Battery/Troop 1SG or CO Commander.** ■ **Local Emergency Room.**	**I am an American Soldier. Each day I serve I renew my pledge to duty, loyalty, respect, selfless service, honor, integrity, and personal courage. My nation and my unit can depend on me. I will not let them down. In war and in training for war, I depend on my Battle Buddy to advise, protect, and support me. I pledge to my Battle Buddy my scared honor to do all in my influence to keep us always ready to deploy, fight, and win.** **I understand that reporting the risk of self-harm does not violate my Buddy's confidentiality. I will do all I can to protect the safety and well-being of my Battle Buddy.** **I pledge to recognize mutual respect, caring, and support as vital to the readiness of my unit. I pledge to keep open the lines of communication about circumstances of all types, including self-destructive thoughts and behaviors.** **I acknowledge there is no circumstance or problem too great for a person to overcome with help. It is not a sign of weakness to seek help; it is a sign of strength to recognize that help is needed.**

Figure D-1. Content of Help Card

D-2. Use. Produce help cards for handouts to soldiers. Duplicate the information on the front and back of cards as shown.

Appendix E
Identifying "High Risk" Soldiers

E-1. Warning signs. Research shows that most people who contemplate suicide give clues to their intentions. Be alert for the following danger signals:

- Previous attempts—this may indicate that the person is at a high risk to try again.
- Threats—which are often followed by suicide attempts. Take all threats seriously.
- Depression and hopelessness—be aware of the symptoms of depression and hopelessness.
- Changes in personality or behavior—such as sleeplessness, lost weight, or a tendency to withdraw. This may be associated with a UCMJ action, a relationship problem, a financial problem, and or increased use of alcohol.
- Preparations for death—such as quickly putting affairs in order, giving away personal possessions, or acquiring a means to commit suicide (such as a gun, rope, or knife).

E-2. Initial response for all personnel.

a. If you suspect that someone is at risk for suicidal behavior (because you have witnessed some of the warning signs mentioned above, or because the person has confided suicidal thoughts or plans to you), your job is to obtain help for them. You and/or the suicidal person may be concerned about them getting into trouble or having a negative mark on their record, or you may be concerned about the victim being angry with you. But these concerns do not compare to the consequences of failure to take action when it is indicated (that is, their possible death). It is better to overreact than underreact.

b. If you can, talk with the person about your concerns of their possible suicide or self-harm, and then get help. If you do not feel that you can confront the person, bring your concerns to the most immediately available proper authority, such as the platoon sergeant, platoon leader, the chaplain, or the company commander.

c. What NOT to do:

(1) Do not assume the person is not the suicidal "type."

(2) Do not keep a deadly secret. Tell someone what you suspect.

(3) When speaking with someone that you suspect is at risk for suicidal behavior:

(a) Do not act shocked at what the person tells you.

(b) Do not argue or try to reason.

(c) Do not debate the morality of self-destruction or talk about how it might hurt others. This may induce more guilt.

(d) Do not analyze the person's motives (for example, "You just feel bad because...").

(e) Do not try to shock or challenge the person (for example, "Go ahead and do it." This only works in the movies!).

Appendix F
Training Resources

F-1. Training aids. Suicide prevention training and awareness education is the cornerstone on which the success of each unit's program will rest. The following training aides and resources will assist unit commanders in their suicide prevention training:

a. The U.S. Army Center for Health Promotion and Preventive Medicine (USACHPPM) Resource Manual. The USACHPPM developed an excellent Suicide Prevention Resource Manual complete with lesson plans and slides. The electronic version of this manual is available at http://chppm-www.apgea.army.mil/dhpw/Readiness/suicide.aspx.

b. Applied Suicide Intervention Skills Training. Founded as a partnership in 1983, Living Works Education is a public service corporation dedicated to providing suicide intervention training for front-line caregivers of all disciplines and occupational groups. The Living Works objective is to register qualified trainers in local communities, who in turn prepare front-line gatekeepers with the confidence and competence to apply first-aid suicide intervention in times of individual and family crises. The ASIST "T-2" training includes how to make proper suicidal risk estimation and, if required, applying a proven model on establishing a personal contract with the suicidal individual until that person can receive professional help. The purpose of ASIST is not to produce personnel qualified to diagnose mental disorders or treat suicidal individuals, but rather provide the immediate first aid for those individuals until they are handed over to a trained, professional mental health care provider, or member of the chain of command. It is by far the most widely used, acclaimed, and researched program of its kind in the world. The Army Chaplaincy uses the ASIST training program to educate leaders at Army installations. The impact on workshop participants is considerable. For more information on Living Works, visit their website at www.livingworks.net; E-mail living@nucleus.com; or phone (403) 209-0242.

c. Training support packages. Suicide Prevention Training, PSDS0001, version 1, 1 Jan 2003; 082-E91-0022, Identify the Signs and Symptoms of Suicide Risk; 805D-203-1102, Identify Suicide Risk Factors; and 081-831-9018, Implement Suicide Prevention Measures.

F-2. Web sites.

a. Suicide prevention: http://www.metanoia.org/suicide/.

b. Statistical information:

(1) National Center for Injury Prevention and Control, Injury Fact Book, 2001-2002 (http://www.cdc.gov/ncipc/fact_book/26_Suicide.htm).

(2) National Center for Health Statistics - statistics on suicides by year, age, etc. (http://www.cdc.gov/nchs/fastats/suicide.htm).

(3) National Institute of Mental Health -- facts and statistics by category and other information (http://www.nimh.nih.gov/suicideresearch/consortium.cfm).

(4) World Health Organization -- facts and statistics (http://www.who.int/en/).

c. Prevention research and grief support.

(1) American Foundation for Suicide Prevention -- prevention information and links (http://www.afsp.org/index-1.htm).

(2) American Association of Suicidology -- links, national support groups, and crisis centers (http://www.suicidology.org/).

(3) Latest technical information on suicide (http://www.suicide-parasuicide.rumos.com).

d. Information on depression and other brain illnesses.

(1) National Mental Health Organization (http://www.nmha.org/).

(2) National Alliance for the Mentally Ill (http://www.nami.org/).

(3) Mental Health Network -- information on mental health disorders and treatment (http://mentalhelp.net/).

(4) United Stated Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, National Mental Health Information Center -- calendar, catalog, and publication information (http://www.mentalhealth.org/).

(5) Mental Health InfoSource -- detailed information on all symptoms and disorders (http://www.mhsource.com/).

(6) American Psychiatric Association (http://www.psych.org/).

(7) American Academy of Child and Adolescent Psychiatry (http://www.aacap.org/).

(8) National Institute of Mental Health (http://www.nimh.nih.gov/).

(9) National Depressive and Manic Depressive Association (http://www.ndmda.org/).

(10) Psycom's Depression Central (http://www.psycom.net/depression.central.html).

(11) Beat Depression (http://www.seeq.com/popupwrapper.jsp?referrer=&domain=beatdepression.com&direct=true).

(12) Mental Health Information (http://www.mentalhealth.com/).

F-3. Family support. In this time of high operational tempo and long deployments, many families are under additional stress and concern for their loved ones overseas. For families experiencing problems, help is available through their local family support center. Army Community Services and the Army Chaplaincy provide support during times of transitional stress. Combat Stress Control Teams, Family Support Groups, Community Counseling Centers, Family Life Centers, the Family Advocacy Program, Army Emergency Relief, the Exceptional Family Member Program, and Community Mental Health provide support in special needs situations. Child Development Centers and morale, welfare, and recreation programs provide relational services for family members as well as for single soldiers. Chapel programs offer spiritual, religious, and relational support to soldiers and family members.

Glossary

ASIST	Applied Suicide Intervention Skills Training
DOD	Department of Defense
MHAT	Mental Heath Advisory Team
OIF	Operation Iraqi Freedom
TRADOC	United States Army Training and Doctrine Command
UCMJ	Uniform Code of Military Justice
USACHPPM	U.S. Army Center for Health Promotion and Preventive Medicine

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OFFICIAL:

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/signed/
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