

SUICIDE PREVENTION

A RESOURCE MANUAL FOR THE UNITED STATES ARMY

PREPARED BY

**THE U. S. ARMY CENTER FOR HEALTH PROMOTION
AND PREVENTIVE MEDICINE**



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INTRODUCTION

This manual replaces the previous USACHPPM Suicide Prevention: A Resource Manual for the United States Army dated 2000. This manual will focus on suicide prevention only and there are separate manuals for suicide intervention and postvention. This manual is valid only for CY 2007 and will be updated annually. All accompanying slides and graphic training aids will be available for downloading at the USACHPPM web page, <http://chppm-www.apgea.army.mil/dhpw/Readiness/suicide.aspx> .

HISTORY

Dr. David Satcher, Surgeon General of the United States, declared in 1999 that suicide is a serious public health threat, so he launched a national effort to develop strategies to prevent suicide and the suffering it causes. The Army followed his direction and in December 1999, the Chief of Staff of the Army directed a review of the Army Suicide Prevention Program. In 2000, the Army G-1, the Army Office of the Surgeon General (OTSG), and the Office of Chief of Chaplains (OCCH) completed a review and determined that the program was basically sound but needed to emphasize greater leadership involvement and offer more advanced training. In 2001, the Army implemented the Suicide Prevention Campaign Plan that emphasized prevention and intervention measures, directed commanders to take ownership, and synchronized and integrated resources at installation level. In compliance with the need for more advanced training, the Army G-1 funded intervention training in 2002 by contracting with Living Works and initiated the Applied Suicide Intervention Skills Training (ASIST) workshops with accompanying computer interactive computer disk. In 2005, the Army G-1 funded Question, Persuade, Refer (QPR) workshops Army-wide to provide an additional resource in suicide prevention awareness and intervention training.

With the advent of combat operations in Afghanistan and Iraq, completed suicides in theater increased during 2002-2006. To assess Soldiers' mental health issues and look at their suicide prevention programs, OTSG deployed Mental Health Assessment Teams (MHAT) from 2003 - 2006 to the OIF/OEF Theaters. The 2005 MHAT report verified that suicide prevention training was being conducted at specific intervals during the deployment cycle, primarily conducted by Unit Ministry Teams (UMT) with occasional assistance from behavioral health assets. The report also discovered that there was a decrease in Soldiers' perception of the adequacy of suicide prevention training.

The latest national suicide data reported by the Centers for Disease Control and Prevention (CDC) was released in February 2006 and contains data from 2003. The CDC reported that 31,484 people in the United States died by suicide in 2003 and estimated suicide attempts for 2003 at 787,000. The national suicide rate for 2003 is 10.8 per 100,000. Since 1994, the rate has fluctuated from 12.0 to 10.7. Research reveals that 90% of those individuals who committed suicides had a Diagnostic and Statistical Manual of Mental Disorders, 4th. Edition (DSM-IV) diagnosis. It also shows that men are four times more likely to commit suicide while women are three times more likely to attempt suicide.

The Army suicide rate for 2005 was 13.0 which is higher than the 2003 civilian rate but lower than the civilian demographically-adjusted rate of 19.9. The Army suicide rate has varied from 9.2 in 2001 to 15.8 in 1985. Eighty-eight Soldiers committed suicide in 2005 with one case still pending. As of 20 December, 77 Soldiers had killed themselves in 2006 with 18 cases still

pending. Eighty-nine percent (89%) of those deaths are from the Active Component (AC), 42% were either deployed or had deployed within 12 months.

ARMY SUICIDE PREVENTION PROGRAM

Suicide Prevention is a commander’s program and the responsibility of every leader. It is a required training for Army Soldiers and civilian employees but the frequency of this training is not specified, so the commander can be creative and implement training that is based on internal factors. It is highly recommended for family members, but not required. AR 600-63 states that this training can come from UMT or behavioral health personnel, or the best choice would be a collaborative effort from the different disciplines. Leaders, gatekeepers, and UMT members will receive more advanced training, and behavioral health professionals shall provide the technical expertise for this training.

The Army Suicide Prevention Program (ASPP) is defined in AR 600-63 and it involves the entire military community as the Garrison Commander will establish a Community Health Promotion Council (CHPC). The CHCP ensures that suicide prevention activities are carried out in accordance with the AR 600-63. The Garrison Commander designates a Garrison Suicide Prevention Program Coordinator to synchronize and integrate unit and community-based programs and activities. The current strategies designate layers of responsibilities for commanders, leaders, and the CHCP.

SUICIDE PREVENTION STRATEGIES

	LEADERS (L) COMMANDERS (C)	CHCP
DEVELOP POSITIVE LIFE COPING SKILLS	<ul style="list-style-type: none"> • Encourage and support programs (L) 	<ul style="list-style-type: none"> • Ensure programs are promoted and advertised
ENCOURAGE HELP-SEEKING BEHAVIOR	<ul style="list-style-type: none"> • Create positive command climate (L) • Eliminate negative policy (C) • Monitor access to services and programs (C) 	<ul style="list-style-type: none"> • Increase visibility and accessibility to local helping agencies • Monitor use of helping agencies • Coordinate with local programs
RAISE AWARENESS AND VIGILANCE TOWARDS SUICIDE PREVENTION	<ul style="list-style-type: none"> • Ensure training for all Soldiers/DA employees (C) • Coordinate training for leaders (C) • Ensure supervision and assistance to those in crisis (L) • Ensure training for UMTs (L) 	<ul style="list-style-type: none"> • Ensure training of all installation gatekeepers • Identify events that increase the risk of suicide and take appropriate measures
SYNCHRONIZE, INTEGRATE AND MANAGE THE ASPP		<ul style="list-style-type: none"> • Implement suicide prevention strategies and objectives • Establish policies and procedures for the ISRT • Create subcommittee(s) as needed
CONDUCT SUICIDE SURVEILLANCE, ANALYSIS AND REPORTING	<ul style="list-style-type: none"> • Stay aware of the problem of suicide behavior, track any demographic trends, and identify any potential event that has raised the level of risk (L) 	

Suicide Awareness Training For Soldiers

Lesson Plan Advance Sheet

Title: Suicide Prevention/Awareness

Time: 60 minutes

Target Audience: This training is designed for all E1-E4 Army personnel and equivalent civilian personnel in small groups only. Any group larger than company size is not recommended. There is separate training for leadership.

Mission Statement: The Army Suicide Prevention Program is based on trained and ready personnel at all levels.

Terminal Individual Objective: Personnel will understand the importance of taking care of self and taking care of buddies.

Learning Objectives

Participants will be able to:

Understand the basics of mental health and spiritual health.

Encourage help seeking behavior for self and others.

Know what to do if an individual is suicidal.

Know about support resources and programs

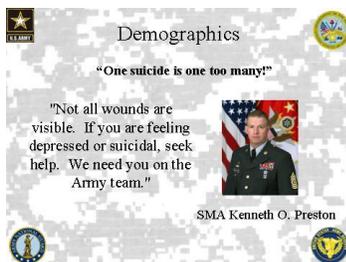
Soldier Preparation: None

Instructional Procedures:

Soldiers normally do not like PowerPoint! Minimize the slides as much as possible and also minimize the amount of your comments. Guide the audience to discover the information on their own via discussion. You will need the capability to play a DVD that has good resolution and good audible. You should rehearse your AV equipment before the training to ensure compatibility. Location of the training is also very important. Suggestions include dayrooms, conference rooms, chapel, theater, etc. If you split up into groups for the vignettes, determine ahead of time how the groups will be split up.

Instructor Note: Each slide has 1) script or 2) general, spiritual, and behavioral health talking points. The presenter may use the script or may use the talking points as guidelines. Recommended presenters include chaplains, senior NCO chaplain assistants, or behavioral health providers. Keep in mind that the introduction of a very sensitive topic requires an equally sensitive approach. You must assume that the class will include people who have been touched by a suicide, and some class members who have seriously contemplated or attempted suicide. Care must be given in discussing this topic. Also, you will seek to motivate members of the unit to become concerned for the well-being of others. Chaplains can certainly speak from their own faith traditions, but need to remember to be inclusive of the different beliefs of the audience. Chaplains also need to openly advocate behavioral health as a resource. Behavioral health providers need to openly advocate spirituality and religiosity as resiliency factors. This briefing will be more effective if both providers are present during the briefing.

1. Negative filter: The Soldier views all of his life including daily activities through a negative filter. Soldiers might attribute a benign glance from a fellow Soldier as a look of anger or view a simple mistake such as misplacing keys as a sign that he/she is truly a failure in life.
2. All-or-nothing thinking: The Soldier sees things in black and white categories. If the relationship fails, the Soldier sees himself/herself as a failure and as the sole reason for the break-up.
3. Overgeneralization: The Soldier sees a single negative event as a never-ending pattern of defeat. If the Soldier's relationship ends, he/she may think that all future relationships will fail, too.
4. Disqualifying the positive: The Soldier disregards any positive experience, and maintains negative beliefs even if they are contradicted by everyday experiences. A Soldier may fail to find any positive about his/her relationship or about his/her current status, if newly single even if several members of the opposite sex express interest in a relationship.
5. Catastrophizing: The Soldier exaggerates the importance of negative events. If a relationship fails, the Soldier might assume that the failure will now affect all aspects of life, will affect ability to be promoted, and will cause a loss of friends. It is important to help the Soldier identify his/her automatic cognitive distortions and beliefs and then work with the Soldier to create healthier, more rational cognitions and beliefs.



Slide 3 Demographics

Script: *Bottom line up front, Soldiers are committing suicide and we must find a solution to decrease the number of suicides. For the next hour, we will collectively look at preventing Soldiers from attempting suicide. In the past, suicide prevention briefings have included several slides on demographics. This presentation only has one such slide, has only two main points, a few vignettes for*

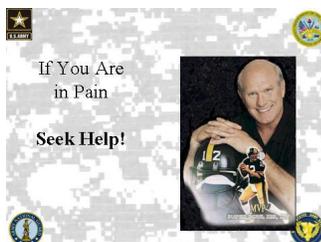
discussion, and then concludes with a contest. Key point here is that Soldiers are killing themselves and one suicide is too many!

Talking Points

General: Soldiers are killing themselves and one suicide is too many!

Spiritual: Emphasize the importance of spiritual health, connectivity with a faith community, and a relationship with God.

Behavioral Health: Focus on coping mechanisms that exist within the Army and ask Soldiers to think about their own personal coping mechanisms. Help Soldiers identify ways that they have coped with difficulties in the past (e.g., social support from buddies/family/friends, counseling, writing a letter, talking to a friend, etc.) and ways that they might cope in the future.



Slide 4 If You are in Pain, Seek Help!

Setup: Play DVD chapter entitled "Servicemembers".

Script: *Suicide is not an option for Soldiers. If you are suffering from unbearable pain, I will do everything in my power to help you. Please do not hurt yourself. Give me a chance to help you survive you in this difficult period of your life. Terry Bradshaw finally sought help with his pain. He is the winner of four Superbowls and eight AFC*

championships, author of five books, starred in several movies, and has even recorded six records. Terry was enthusiastic and willing to discuss his battle with depression in an interview

with the Army. Bradshaw has been ridiculed and criticized for his openness on this topic. The Warrior Ethos statement, “I am disciplined, physically and mentally tough” tells us that if there is a physical or mental hindrance, then we must fix it. If you break your leg, get it fixed. If you are suffering from emotional or mental pain, then as with the broken bone, get it fixed! Please listen to this ten minute portion of the thirty minute interview. If anyone wants to order their own free copy of the full interview, it can be ordered from the CHPPM suicide prevention website.

Talking Points

General: Football legend Terry Bradshaw agreed to speak to Soldiers about his battle with depression and the stigma of seeking help. He is the winner of four Superbowls and eight AFC championships, author of five books and he has even recorded six records. Here is a ten minute clip of that interview.

Spiritual: Terry is very open about his faith in God and his relationship with his church. Spirituality is an invaluable ingredient in his battle with this disease. Make sure the Soldiers know they can come to you for help, that you care, and that suicide is not an option.

Behavioral Health: Soldiers should be aware of the signs of depression:

1. Persistent sad mood
2. Difficulty concentrating
3. Sudden change in appetite or weight (loss or gain)
4. Difficulty sleeping (too much or too little)
5. Feelings of guilt
6. Feelings of hopelessness
7. Persistent fatigue and/or loss of energy
8. Loss of interest in pleasurable activities
9. Irritability



Slide 5 If Your Buddy is in Pain, Help!

Script: The Warrior Ethos statement “I will never leave a fallen comrade” refers to helping a buddy in mental distress also. A very large number of suicides could have been prevented by an attentive buddy. Helping a buddy takes courage and accepting help is a sign of strength.

Talking Points

General: A very large number of the completed suicides in the Army could have been prevented by a caring buddy.

Spiritual: Soldiers need to take care of each other and rid any thoughts of survival of the fittest. Almost all religions adhere to some form of Christianity’s Golden Rule, or the Categorical Imperative of Immanuel Kant. The Golden Rule basically states that we should treat others as we would want to be treated. Its universality is demonstrated by the following table:

Universality of the Golden Rule

Christianity	<i>So in everything, do to others what you would have them do to you, for this sums up the Law and the Prophets</i>
Confucianism	<i>Do not do to others what you would not like yourself. Then there will be no resentment against you, either in the family or in the state</i>
Buddhism	<i>Hurt not others in ways that you yourself would find hurtful</i>
Hinduism	<i>This is the sum of duty; do naught onto others what you would not have them do unto you</i>
Islam	<i>No one of you is a believer until he desires for his brother that which he desires</i>

	<i>for himself</i>
Judaism	<i>What is hateful to you, do not do to your fellowman. This is the entire Law; all the rest is commentary</i>
Taoism	<i>Regard your neighbor's gain as your gain, and your neighbor's loss as your own loss</i>

Behavioral Health: Ask Soldiers to think about times when they have helped a buddy and when they have been helped by a buddy. Emphasize that helping a buddy takes courage and that accepting help is a sign of strength and indicates a desire to feel better.



Slide 6 Intervention - ACE

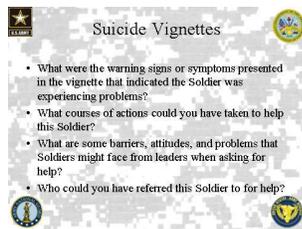
Script: *This is not a difficult mission but it is most important. Key points are to confront your buddy, keep your buddy safe, and to take your buddy to the nearest available resource. Never leave the individual alone and do not be afraid to directly confront the Soldier with questions such as: Are you going to hurt yourself, Are you thinking about suicide, etc. As long as you demonstrate true concern for their wellbeing, you cannot say the wrong thing. Doing nothing is not an option.*

Talking Points

General: Emphasize that it is okay to ask the question and to never leave the person alone as help is sought.

Spiritual: Chaplain should emphasize the UMT's availability immediately after this presentation and all other times.

Behavioral Health: Encourage Soldiers to become acquainted with their Behavioral Health professionals and inform Soldiers how to access care.



Slide 7-12 Suicide Vignettes

Setup (1 or 2): 1. Divide the Soldiers into small groups and hand out printed copies of each vignette and request that each group share their discussion of the questions listed on Slide #5.

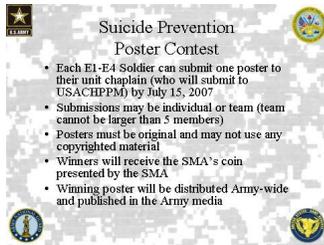
2. Display or hand out the questions and discuss each vignette in the large group setting.

Script: 1. *Please look at the vignette that was handed to your group and respond to the questions for each vignette. Pick a leader from each group to report back to the large group.*

2. *Let's look at each vignette and address each of the questions that I have passed out (or displayed).*

Talking Point

General: Each slide has recommended warning signs embedded in the notes of the slide (risk factors are listed also, although Soldiers should be more focused on warning signs). The trainer should attempt to get the Soldiers to discover this information on their own. Soldiers are certainly allowed to discover signs not listed, but the trainer's goal is to at least guide the audience to discover the listed signs.



Slide 13 Poster Contest

Script: *The Army is very serious about preventing suicide and we want to encourage your assistance in this mission. Each E1-E4 Soldier may submit only one poster that focuses on suicide prevention. Contest rules are displayed before you.*

Talking Point

General: Encourage the Soldiers to electronically submit their poster to the USACHPPM web site and include AKO contact information along with unit chaplain information. Posters may be submitted until 15 July 2007 and the winners will be announced 31 July 2007



Slide 14 Lieutenant Dan (Gary Sinise)

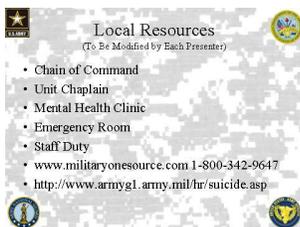
Script: *Actor Gary Sinise, who played LT Dan in the movie Forest Gump, volunteered to offer this announcement to all DOD personnel. Gary has traveled all over the world to speak to military members, providing musical entertainment and encouraging us all. He delivered this public service announcement at Fort Leonardwood, MO on June 5, 2006. Please listen to this three minute talk.*

Talking Points

General: Actor Gary Sinise (LT Dan from Forest Gump) volunteered to offer this announcement to all DOD personnel. This public service announcement was delivered at Fort Leonardwood, MO on June 5, 2006.

Spiritual: Emphasize the phrase “that you persevere, that you stay alive”. This is from a Greek word “Hupomeno” which is used in Christian scriptures, particularly in the Pauline epistles. It is also used by James, the bishop of Jerusalem, as Jerusalem was in devastation and about to be destroyed. He wanted all Christians, despite the persecutions and violent times, to not lose hope, to keep on enduring. Encourage the audience to repeat this word and use it as a motto or mantra when in difficult times.

Behavioral Health: Emphasize the sentence, “The difficulties and dangers that you face are so abnormal that they’re more than a human being is designed to handle.” Discuss the importance of talking to other Soldiers about what he/she is feeling. It is likely that the Soldier’s buddies are feeling the same way and are experiencing the same difficulties and struggles. Talking to each other strengthens bonds and shows that you care.



Slide 15 Local Resources

Please modify this slide so that it tells Soldiers what the resources are for your situation.

Suicide Awareness Training for Army Leadership

Lesson Plan Advance Sheet

Title: Suicide Prevention/Awareness

Time: 120 minutes

Target Audience: This training is designed for all NCOs, staff officers, and Commanders. It is recommended the leadership presentation be provided to all brigade, battalion or company leadership personnel in small groups only. Any group larger than brigade size leadership is not recommended. This is training for the unit leadership. Soldiers' training is separate.

Mission Statement: The Army Suicide Prevention Program is based on trained and ready personnel at all levels.

Terminal Individual Objectives: 1) Leadership will learn to minimize suicidal behavior among your Soldiers. 2) Be able to identify earlier warning signs of suicidal behavior. 3) Be able to identify necessary services required to address Soldier's suicidal behavior.

Learning Objectives:

Participants will be able to:
identify signs or symptoms of suicidal behavior;
learn about where to turn for help; and
identify at least two sources of available help.

Unit leadership Preparation: None

Instructional Procedures: PowerPoint, DVD, Handouts

Instructor Note: Each slide has general, spiritual, and behavioral health talking points. Although they can be used as script, the talking points are guidelines for the presenter to adapt to their own style. Recommended presenters include chaplains, senior leadership chaplain assistants, or behavioral health providers. Keep in mind that the introduction of a very sensitive topic requires an equally sensitive approach. It must be assumed that the class will include people who have been touched by a suicide, and some class members who have seriously contemplated or attempted suicide. Care must be given in discussing this topic. Allow participants a chance to talk about their attitudes, and their experiences that underlie them. You are not expected to change any attitudes; however, you may facilitate awareness among the participants about their own attitudes. When leadership has an awareness of their own personal attitudes, it allows opportunity for learning and growth that may foster more concern for Soldier's emotional well-being. Hence, leadership attitude awareness may result in securing appropriate services for Soldiers who exhibit suicidal behavior. The best time to have this dialog could be at the beginning of the presentation or after viewing the Terry Bradshaw interview. Your primary mission is to motivate leaders to become concerned for Soldier's well-being. Chaplains can certainly speak from their own faith traditions, but need to remember to be inclusive of the different beliefs of the audience. Chaplains also need to openly advocate behavioral health as a resource. Behavioral health providers need to openly advocate spirituality and religiosity as

resiliency factors. This briefing will be more effective if both providers and senior command are present during the briefing.



Slide 1 Suicide Prevention: **Leaders in Action** Play DVD chapter (Lt Dan Band Tour) or some other song that focuses on relationship destruction and suicide as personnel enter the room (Other songs, CD or DVD, may be substituted – a full list can be found at http://en.wikipedia.org/wiki/List_of_songs_about_suicide).

Talking Points

General: Suicide is not an acceptable option for the US Army. Army Strong includes mental and spiritual strength along with physical strength. The goal of the Army Suicide Prevention Program (ASPP) is to minimize suicidal behavior among our soldiers. This goal is founded on the premise that many suicides are preventable. If the Army is vigilant, aware of and appreciates the significance of these danger and warning signs, and knows how to properly intervene, suicide behavior will be minimized. **It is recommended that the presenter provide a personal experience on dealing with someone who was suicidal.**

Spiritual: Spirituality looks outside of oneself for meaning and provides resiliency for failures in life experiences. Religiosity adds the dimension of a supportive community to help one deal with crises. Both embed themselves in a relationship with God, or a higher power, that provides an everlasting relationship. Bottom line, Soldiers should not base their reason for living in another human being!

Behavioral Health: When Soldiers feel depressed and sad, they can become trapped in a cycle of negative thoughts and beliefs. They may experience a variety of cognitive distortions such as:

1. Negative filter: The Soldier views all of his life including daily activities through a negative filter. Soldiers might attribute a benign glance from a fellow Soldier as a look of anger or view a simple mistake such as misplacing keys as a sign that he/she is truly a failure in life.
2. All-or-nothing thinking: The Soldier sees things in black and white categories. If the relationship fails, the Soldier sees himself/herself as a failure and as the sole reason for the break-up.
3. Overgeneralization: The Soldier sees a single negative event as a never-ending pattern of defeat. If the Soldier's relationship ends, he/she may think that all future relationships will fail, too.
4. Disqualifying the positive: The Soldier disregards any positive experience, and maintains negative beliefs even if they are contradicted by everyday experiences. A Soldier may fail to find any positive about his/her relationship or about his/her current status, if newly single even if several members of the opposite sex express interest in a relationship.
5. Catastrophizing: The Soldier exaggerates the importance of negative events. If a relationship fails, the Soldier might assume that the failure will now affect all aspects of life, will affect ability to be promoted, and will cause a loss of friends.

Leaders can help a Soldier to identify his/her cognitive distortions and beliefs by playing the objective observer i.e., a leader can help clarify and objectify the Soldier's thoughts. This is best done by engaging and listening to Soldier's concerns.

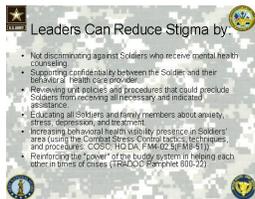


Slide 2 Bottom Line for Leaders Talking Points

General: It is important that leaders create a command climate that encourages Soldiers to seek help when it is necessary.

Spiritual: Leaders who view their leadership as more responsibility versus more power are better leaders. The lives and well being of a leader's subordinates are now in that leader's hands. FM 6-22, paragraph 10.32 states that leaders should "Ensure Soldiers with serious issues have access to mental health professionals if necessary". Paragraph 10.36 adds, "The Army has implemented a comprehensive mental health recovery plan for all returning Soldiers to counter post-traumatic stress disorder. Sound leadership, unit cohesion, and close camaraderie are essential to assure expeditious psychological recovery from combat experiences".

Behavioral: Soldiers are under stress. Sometimes Soldiers experience extreme stress that may lead to suicidal thoughts or behavior. The leader needs to establish a command climate that acknowledges this fact that Soldiers are under stress, and if they need help it will receive leadership's approval. "Earlier treatment leads to faster recovery" (Battlemind). After this introduction, suicidal behavior should be explained. Suicidal behavior includes: completed suicide; non-fatal self-injurious events where the individual's intent was to die (attempt); and the risk of death without the intent to die (gesture) and suicidal ideation including thoughts of, or fascination with death.



Slide 3 Leaders Can Reduce Stigma By:
Talking Points

General: The MHAT 2 report indicated that "among Soldiers who screened positive for depression, anxiety, or PTSD, 53% reported that their unit leadership might treat them differently, and 54% reported that they would be seen as weak." Such evidence suggests that Army personnel

continue to sanction the stigma of "help seeking," which ultimately acts as a barrier for access to preventive and stabilizing care. Leaders at all levels can reduce this stigma by: (refer to slide). Information for this slide was taken from TRADOC Pamphlet 600-22.

Spiritual: Soldiers will respect a leader who cares about subordinates much more than a leader who only cares about self. Leaders must recognize the importance of team, and that a team is only as valuable as its weakest link. When a Soldier is perceived by leadership to be weak, it is that leader's responsibility to strengthen that Soldier. If the injury is physical, then it is appropriate to send that Soldier to receive medical care. If the injury is mental, then it is still the leader's responsibility to send that Soldier to receive medical care.

Behavioral: Stigma refers to a cluster of negative attitudes and beliefs that motivate, inadvertently, Soldiers and leaders to fear, reject, avoid, and discriminate against military and civilian personnel with mental illnesses. Stigma is widespread in the Army. Stigma leads to Soldiers and leaders to avoid and often discriminate against Soldiers who are experiencing personnel emotional problems. It leads to low self-esteem, isolation, and hopelessness for the Soldier who has a mental illness. It deters the Soldier from seeking care. Responding to stigma, Soldiers with mental health problems internalize others attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment. When Soldiers fail to seek help when it is necessary, the general outcome is emotional degeneration leading to poor work performance and suicidal behavior. As more Soldiers seek help and share their stories with buddies and relatives, compassion will be the response, not ridicule.



Slide 4 Who Commits Suicide?

Talking Points General: In United States, suicide is the 11th leading cause of death with a rate of 10.8 per 100K.

-Suicide was the 3rd leading cause of death for youth ages 15 to 24 in 2001.

- Males are four times more likely to die from suicide than females.
- Suicide rates are highest among young white males.
- Females reported attempting suicide three times more often than males.

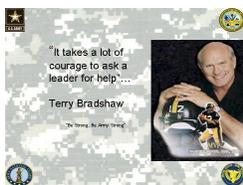
Additional Army Demographics:

- During CY 2006, Army had 91 confirmed suicides with a rate of **18.5 per 100 K**.
- Gender: 12 % were females and 88 % were males.
- Deployment Status: 12 % were post deployed; 30% were deployed; and 58% were non-deployed.
- Marital Status: 62 % were single and 38 % were married.
- Race: 79% were white; 18% African Americans; and 3% were Asian.
- Method: 74% were by firearms; 10% were by hanging; 6% were by Asphyxia; and 6% were by OD.

Spiritual: Remember that rates and data represent human beings, someone's son or daughter. All religious writings emphasize the importance of compassion toward fellow human beings, and leadership has even greater responsibilities.

Behavioral: The main reasons why Soldiers commit suicide are because of Psychological pain. Suicide is usually the result of intense negative emotions. 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). Soldiers may use their death as retaliatory abandonment i.e., killing self to "get back at" a person who abandoned him or her. Finally, Soldier may use their death as self-punishment a way to torturing/killing self in order to atone for guilt/shame. Soldiers who feel they are driven to suicide think that death is the only means to relief the Psychological pain.

Again, leaders must promote a climate of mutual "Buddy Care" among all Soldiers. Buddies can identify fellow comrades who are suffering psychological pain. The Army should be an environment where no one has to go it alone.



Slide 5 "it takes a lot of courage to ask a leader for help"...

Talking Points

General: Football legend Terry Bradshaw agreed to speak to Soldiers about his battle with depression. During the interview, he suggests that leaders be more understanding and compassionate when Soldiers request help with their problems. Here is about a ten minute clip of Terry Bradshaw speaking

directly to leaders.

Spiritual: Terry is very open about his faith in God and his relationship with his church. Spirituality is an invaluable ingredient in his battle with this disease.

Behavioral Health: Again, the stigma associated with mental health care take on significance in the Army. Not only do Soldiers worrying about their embarrassment and their careers, Soldiers are also 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 behavioral health help, and that seeking "treatment" will not affect a Soldier's military

career. “Early care protects careers and marriages” (Battlemind). Leaders must reduce the actual and perceived stigma of seeking mental health counseling.



Slide 6 About the Video

Talking Points

General: The trainer should facilitate a ten minute group discussion on the questions presented on the slide. The trainer can conclude and re-enforce the conversation by quickly presenting the signs of depression and hopelessness discussed below.

Spiritual: Emphasize the resiliency of religiosity, and more important spirituality. Religiosity provides a caring community that offers additional support. Spirituality connects one to God, who provides hope and unconditional love. Spirituality also emphasizes the importance of life and the connectivity to God strengthens one’s ability to deal with the stressors of life.

Behavioral: Leaders should be aware of the signs of depression and hopelessness.

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 Soldiers see things in a very negative way and have a difficult time generating effective ways of dealing with problems.

Soldiers who experience clinical depression will have two or more of the following signs:

1. Persistent sad mood
2. Difficulty concentrating
3. Sudden change in appetite or weight (loss or gain)
4. Difficulty sleeping (too much or too little)
5. Feelings of guilt
6. Feelings of hopelessness
7. Persistent fatigue and/or loss of energy
8. Loss of interest in pleasurable activities
9. Irritability

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. Soldiers who experience a sense of hopelessness will have the following signs:

1. Believing all resources are exhausted.
2. Feeling that no one cares.
3. Believing the world would be better off without them.
4. Total loss of control over self and others.
5. Believing death is the only way out of the pain

Depression can be effectively treated by medications and psycho-therapy.

Suicide Prevention Training Tip Card

Talking Points

General This training tip card should be provided at the beginning of the training. It is recommended not to provide a complete brief on this card. Participants are encouraged to use the card as a reference when discussing the vignettes. The card is hip pocket size.

Spiritual: Emphasize the importance of caring for your fellow human being, summed up by all religions to be one of our greatest missions.

Behavioral: FYI: Research shows that most people who **contemplate** suicide give clues to their intentions. Be alert for the warning signs and common risk factors. These warning signs or "red flags" demonstrate the potential for suicide or suicidal behavior. With or without a current threat of suicide, Soldiers with the above signs or symptoms need assistance. When a combination of these warning signs is presented, the commander should immediately be concern, and refer Soldier to the Chaplain or behavioral health for assistance. Risk factors are those things that increase the probability that difficulties could result in serious behavioral or physical health. The risk factors only raised the risk of an individual being suicidal it does not mean they are suicidal. The presence of these factors only raises the risk. 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 may need to be personally involved by command directing the Soldier to services. The emphasis is on keeping Soldiers employed at their fullest potential. 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.

It is important for all army personnel to have an awareness of potential triggers and warning signs of suicide in order to properly intervene and recognize those Soldiers and buddies who are at risk. It is believed that anyone may be in a position to stop a fellow Soldier who is considering suicide. Most suicides and suicide attempts are reactions to intense feelings of loneliness, worthlessness, helplessness, hopelessness, and depression. Soldiers 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.



Slides 7 – 12 Suicide Completion Vignettes / Questions

Setup (1 or 2): 1. Divide participants into small groups and hand out printed copies of each vignette and request that each group share their discussion of the questions listed on Slide #7.

2. Display or hand out the questions and discuss each vignette in the large group setting.

Script: 1. Please look at the vignette that was handed to your group and respond to the questions for each vignette. Pick a leader from each group to report back to the large group.
2. Let's look at each vignette and address each of the questions that I have passed out (or displayed).

Talking Point

General: Each slide has recommended warning signs embedded in the notes of the slide (risk factors are listed also, although participants should be more focused on warning signs). The trainer should attempt to get the participants to discover this information on their own. Participants are certainly allowed to discover signs not listed, but the trainer's goal is to at least guide the audience to discover the listed signs.



Slide 13 What Leaders can Do

Talking Points

General: Leaders are responsible for their personnel and play a vital role in preventing suicide. Leaders must know their people, units and be aware of the resources available to assist Soldiers. Trainer could remind leaders that advocating a climate that

supports the early identification of problems and early referral for treatment will help maintain a healthy climate. This portion of the training can best be managed by a senior leader. If the unit's senior leader is willing to talk about leadership, it is highly recommended that they lead the discussion on this portion of the training. The senior leader may use the slides to facilitate discussion or use their own material.

Spiritual: Chaplains and Behavioral Health personnel need to be available to Soldiers and leaders. Our behavioral health and chaplain professionals need to get out of their offices! Leaders need to develop relationships with these help professionals and refer their Soldiers to get the help that they need.

Behavioral: Leaders should not assume the person is not the suicidal type. The leaders should take Soldier's problems seriously. They should never ignore Soldier's problems. When speaking with someone that is suspected at risk for suicidal behavior, the leader should not act shocked at what the Soldier tells them, argue or try to reason, debate the morality of self-destruction or talk about how it might hurt others. This may induce more guilt. The suicidal Soldier should never be left alone until help is secured. Soldiers should never be humiliated or embarrassed about their situation. Leaders must take proactive measures to ensure that this never happens to a Soldier who is in trouble.



Slide 14 What Leaders can Do (continue)

Talking Points

General: The trainer should provide the participants with some information on how to talk to a Soldier who is suicidal. Use the information provided under the behavioral section for your talking points.

Spiritual: Leaders are often afraid that they will say the right thing. It is hard to say the wrong thing if one is demonstrating compassion and seeking to help the Soldier. Soldiers must have the confidence to go to their leaders about personal issues as well as professional issues, and without fear of condemnation.

Behavioral: First, share your concern for their well-being.

- Be honest and direct.
- Use open-ended questions such as: "How are things going?" or "How are you dealing with...?"
- Listen and pay attention to both their words and emotions.
- Repeat back what they say using their own words.
- Express concern about them and a willingness to help. People who are thinking about suicide are shocked to find out how many people care about them.
- **Ask directly about thoughts or plans for suicide.**
- If someone tells you they are suicidal, it is often a plea for help. Ensure the **Soldier gets immediate assistance** (Chaplain or Behavioral health).
- **Find someone to stay with the Soldier. Do not leave them alone.**
- Realize that each person is unique, and that there is no standard approach to managing a Soldier who is experiencing problems (Treat each Soldier with the utmost respect and regard).
- This is not the time to embarrass, criticize, or demean an individual who is experiencing emotional difficulties.

Get your Soldier help quickly and you will get them back quickly!



Slide 15 How to Refer

Talking Points

General: Responsibility always rests with unit leadership. Any Soldier referred to Military Behavioral Health care does require commander’s involvement. The unit leadership is encouraged to be involved in order to facilitate appropriate care for their Soldier.

Spiritual: Chaplains and assistants should always accompany their Soldier to seek intervention – do not just send them. Make sure that Soldiers know how to contact the chaplain 24 hour hotline.

Behavioral: Responsibility always rests with unit leadership **Emergency** referrals take place when there is threat to life and lethality is imminent or severe, The commander is encourage to consult with a behavioral healthcare provider or other healthcare provider, if behavioral health is not available. A Soldier who needs immediate intervention should be escorted immediately to the Emergency Room, Behavioral Health, Aid Station, or the Chaplain.

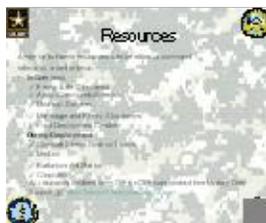


Slide 16 How to Refer (continue)

Talking Point

General: Non-Emergency referrals take place when there is no immediate threat to life and there is lack of lethality. The commander should consult with a chaplain or behavioral health care provider. If command directed to behavioral health, the counsel Soldier is given a

copy of the command referral (DoDD 6490.1). The Commander and /or leader should observe Soldier’s rights to see SJA and IG. It is recommended that the Soldier is escorted to behavioral health with a command referral memorandum.



Slide 17 Resources

Talking Point

General: The Army structure affords a network of multidisciplinary agencies and caregivers. 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 behavioral health,

family support, child and youth services, health and wellness centers, and family advocacy. They all work together and take responsibility for prevention. The trainer should emphasize local resources during this part of the presentation.



Slide 18 Concluding Remarks

Talking Points

General: Actor Gary Sinise (LT Dan from Forest Gump) volunteered to offer this announcement to all DOD personnel. This public service announcement was delivered at Fort Leonard wood, MO on June 5, 2006.

Spiritual: Emphasize the phrase “that you persevere, that you stay alive”.

This is from a Greek word “Hupomeno” which is used in Christian scriptures, particularly in the Pauline epistles. It is also used by James, the bishop of Jerusalem, as Jerusalem was in devastation and about to be destroyed. He wanted all Christians, despite the persecutions and violent times, to not lose hope, to keep on enduring. Encourage the audience to repeat this word and use it as a motto or mantra when in difficult times.

Behavioral Health: Emphasize the sentence, “The difficulties and dangers that you face are so abnormal that they’re more than a human being is designed to handle.” Discuss the importance of talking to other Soldiers about what he/she is feeling. It is likely that the Soldier’s buddies are

feeling the same way and are experiencing the same difficulties and struggles. Talking to each other strengthens bonds and shows that you care.



Slide 19 Summary

Talking Points

General: The trainer is encouraged to briefly summarize key points of the presentation. The trainer may conclude final remarks from one of the following areas.

Spiritual: Chaplains need to emphasize that suicide is not an option. The Soldier needs to know that the chaplain does care about each and every Soldier, and that the chaplain is readily available 24 hours a day.

Behavioral: A number of suicides can be prevented in the Army by:

- Securing appropriate interventions for those **at risk**;
- Minimizing **stigma** associated with accessing behavioral health care;
- Leaders **knowing** and **caring** about their Soldiers;
- Leaders constructively **intervening early** on in their Soldier's problems;
- Leaders paying close attention & providing constructive interventions to those Soldiers **facing major losses** from legal, marital, occupational or financial problems.



Slide 20 Questions

Suicide Awareness Training for Deployed Soldiers

Lesson Plan Advance Sheet

Title: Suicide Prevention/Awareness

Time: 60 minutes

Target Audience: This training is designed for all deployed Soldiers. Soldiers should have received a more formal training before deployment, so this briefing will serve as a refresher training.

Mission Statement: The Army Suicide Prevention Program is based on trained and ready personnel at all levels.

Terminal Individual Objective: Personnel will understand the importance of taking care of self and taking care of buddies.

Learning Objectives

Participants will be able to:

Understand the basics of mental health and spiritual health.

Encourage help seeking behavior for self and others.

Know what to do if an individual is suicidal.

Know about support resources and programs

Soldier Preparation: None

Instructional Procedures: PowerPoint, DVD, Handouts

Instructor Note: Each slide has general, spiritual, and behavioral health talking points. Although they can be used as script, the talking points are guidelines for the presenter to adapt to their own style. Recommended presenters include chaplains, senior leadership chaplain assistants, or behavioral health providers. Keep in mind that the introduction of a very sensitive topic requires an equally sensitive approach. It must be assumed that the class will include people who have been touched by a suicide, and some class members who have seriously contemplated or attempted suicide. Care must be given in discussing this topic. Allow participants a chance to talk about their attitudes, and their experiences that underlie them. You are not expected to change any attitudes; however, you may facilitate awareness among the participants about their own attitudes. When leadership has an awareness of their own personal attitudes, it allows opportunity for learning and growth that may foster more concern for Soldiers' emotional well-being. Hence, leadership attitude awareness may result in securing appropriate services for Soldiers who exhibit suicidal behavior. The best time to have this dialogue could be at the beginning of the presentation or after viewing the Terry Bradshaw interview. Your primary mission is to motivate leaders to become concerned for Soldiers' well-being. Chaplains can certainly speak from their own faith traditions but need to remember to be inclusive of the different beliefs of the audience. Chaplains also need to openly advocate behavioral health as a resource. Behavioral health providers need to openly advocate spirituality and religiosity as

resiliency factors. This briefing will be more effective if both providers and senior command are present during the briefing.



Suicide Vignette #1

PVT Smith was a 22 year-old single, black male who was three months into his first deployment. While surfing MySpace.com, he learned that his deployed girlfriend was involved in another relationship. After that, PVT Smith began to abuse alcohol. One evening, PVT Smith refused to go to the gym with his buddies, which was unusual. That night, PVT Smith shot himself to death.

Can you list the warning signs?

Given that you know PVT Smith, and are aware of his distress, which of the following would be the best response.

1. Wait and see how things go because it's not a good idea to interfere in another Soldier's personal matters. He might get angry.
2. If I knew about his girlfriend problems, I would talk to him to see if he was alright. I would ask him if he felt suicidal. If he said yes, I would escort him to see the commander.
3. Because of his alcohol abuse, I would inform the Platoon SGT that something was troubling PVT Smith i.e., he was drinking too much. I would suggest that the Platoon SGT talk to him.





Suicide Vignette #2



SPC Rodriguez was a 27 year-old, single, Hispanic male, who had previously deployed to both Iraq and Afghanistan. SPC Rodriguez recently received an Article 15 resulting in loss of pay and rank. His commander referred him for a lateral transfer and cross training. It was known that SPC Rodriguez was very frustrated and angry about the command referral and reassignment to a new unit that was deploying in a week. Ordinarily, he was very quiet and introverted, but had a good rapport with other platoon members. He was a “video gamer” who spent more time gaming and less time with friends. SPC Rodriguez was missing for 2 days before he was discovered dead by a buddy. SPC Rodriguez had hanged himself in the basement of his quarters.

Can you list the warning signs?

Given that you know SPC Rodriguez, and are aware of his distress, which of the following would be the best response.

1. Two deployments are tough. He probably received the article 15 for complaining about going on another deployment. I prefer not to be involved with someone who received an article 15. He was probably trouble.
2. In our unit, we keep good track of our unit personnel. If someone is missing, we look for the Soldier immediately to see if he or she is okay.
3. Realizing that SPC Rodriguez is a quiet person, I would talk to him after the transfer to see if he was alright. Given all his issues, I would recommend that he speak with the Chaplain.



Suicide Vignette #3



PFC Morgan was a 19 year-old, single, white male, 11B, who had deployed twice to Iraq with significant combat exposure. PFC Morgan had difficulties learning new Soldiers’ skills. Because of his slowness, he was often ridiculed by peers and leadership. Everyone believed that he accepted the treatment as good natured ribbing. Prior to his death, he gave away some personal belongings. About one day before his death, he also told a buddy that he had “had enough.” This was interpreted as simple frustration. PFC Morgan was found dead in his car by carbon monoxide poisoning.

Can you list the warning signs?

Given that you know PFC Morgan, and aware of his distress, which of the following would be the best response.

1. If I had known he was angry about being “teased”, I would talk to him to see if he was alright. I would ask him if he felt suicidal. If he said yes, I would convince him to see a behavioral health provider in the morning. After he made a commitment, I would tell him that I would pick him up the next day.
2. In the Army, people are always joking with each other. That’s how we all deal with the stress. If you can’t handle the ribbing, you should get out of the Army.
3. When I heard that he had had enough, I would immediately ask him if he was thinking of suicide. If he said yes, I would stay with him, and inform the chain of command. I would never leave him alone until he saw a helping provider.





Suicide Vignette #4



SPC Rhodes was a 25 year-old, single white female, 91 W, who has deployed three different times: twice to Iraq and once to Afghanistan. During a current deployment, her TMC experienced a mass casualty in which SPC Rhodes watched several Soldiers from her unit die. She was neither well-liked nor disliked by others. She frequently talked about her boyfriend back home and their plans to marry. About a week before she died, she received a letter from her boyfriend indicating that he wanted to terminate their relationship. SPC Rhodes was discovered in her bunk dead from drug overdose.

Can you list the warning signs?

Given that you know SPC Rhodes, and are aware of her distress, which of the following would be the best response.

1. "Dear John or Dear Joan" letters are common during deployments. It is best to wait and see how a Soldier will respond to such a letter. You don't want to ask intrusive questions unnecessarily because the Soldier could get angry.
2. If I had known about her boyfriend problems, I would have asked one of her girlfriends to talk to her. Girls relate better to each other. She would never tell a guy if she was suicidal.
3. Both the mass casualty and the lost of her boyfriend were concerns. I would talk to her to see if she was alright. As her buddy, I would make sure she talked to either the unit Chaplain or COSC team about her losses.



Suicide Vignette #5



SGT Jones was a 34 year-old, married white male, 13B, who was 6 months into his first deployment. SGT Jones received a verbal counseling for not following proper risk assessment procedures which may have led to combat casualties. He declined mid-tour leave. One week before his death, he received an Article 15 for falling asleep while on guard duty. SGT Jones shot himself to death using his own military weapon.

Can you list the warning signs?

Given that you know SGT Jones, and are aware of his distress, which of the following would be the best response.

1. Being in a war zone, he should have lost his stripes. Falling asleep on guard duty is unacceptable.
2. It was apparent that SGT Jones had issues. I believe that another NCO should talk to him to see if he is alright. This is NCO business.
3. Leadership should have recognized that it is not usual for an NCO to get an article 15. SGT Jones must have been experiencing personal problems. I would have recommended that he talk to behavioral health.



Leaders Vignette



Suicide Vignette #5

CPT Garcia was 25 year-old, married Hispanic male, who was a dedicated career officer. He has deployed two times since the beginning of the war in Iraq. His unit is preparing for another deployment. CPT Garcia is highly regarded by leadership. Recently, his spouse informed him that if he deploys again she will divorce him. His immediate commander has noticed changes in his mood and behavior e.g., occasional angry outburst and sadness. CPT Garcia appeared pre-occupied and tired. His commander has decided to take action and counsel CPT Garcia.

What actions should his immediate commander take?



Gary Sinise Public Service Announcement

I am extremely honored that I was invited to speak to the brave and dedicated Soldiers of our great nation. Today I want to convey just how grateful I am for your service, your sacrifice, and your love of Country. You are deployed all over the world, separated from your families, and often placed in life-threatening situations. You're making sacrifices that most Americans will never fully understand, and I just want you to know how extremely proud I am of you.

I have a specific purpose for addressing each of you today. It is my desire that you persevere, that you stay alive, and that you are able to overcome all of the monumental challenges that are being thrown at you. The difficulties and dangers that you face are so abnormal that they're more than a human being is designed to handle. I am asking each Soldier to get to know your fellow Soldiers and care for each other as you would for a member of your own family. Each Soldier has someone back home that loves and needs that Soldier. They expect that someone will take care of their loved one. That someone may very well be you. Soldiers do not abandon Soldiers. Just as LT Dan had Forrest, we all need that amount of loyalty and encouragement. The doctors could fix the physical scars of LT Dan, but it took loyal and dedicated friends to help heal the emotional wounds.

When family members send their loved ones into harms way to defend this great Nation, they do so with the understanding that leaders will ensure that their family members are honored, respected, and cared for. Your commitment to preserve the freedom that we all enjoy has not gone unnoticed – so I honor you, I admire you, and I salute you.

RESOURCES

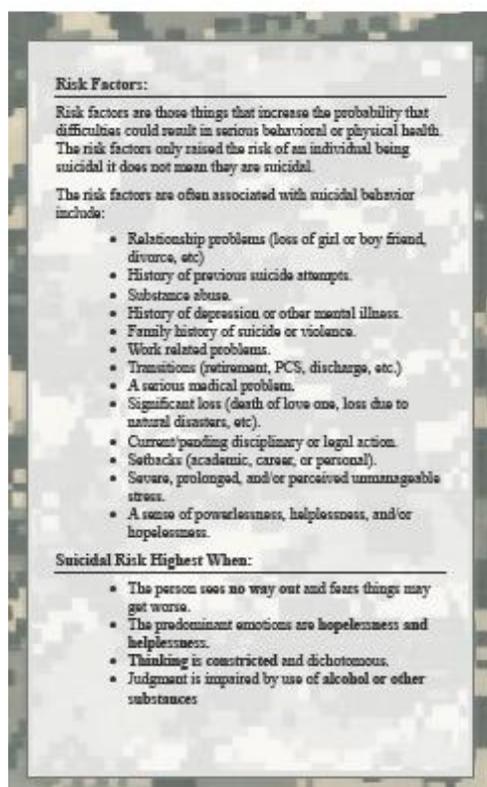
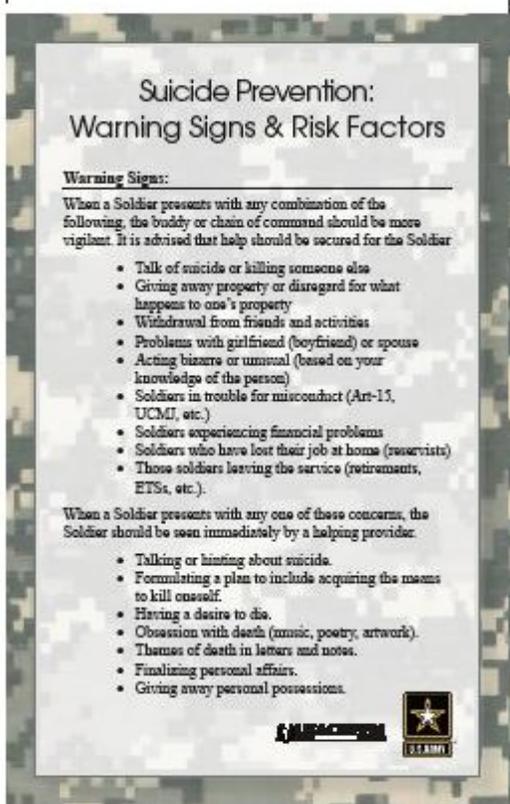
The following GTA's are available at http://chppm-www.apgea.army.mil/hio_public/orders.aspx

TG 240 - COMBAT STRESS BEHAVIORS
TG 241 - COMBAT OPERATIONAL STRESS REACTION (COSR) (BATTLE FATIGUE)
TG 242 - COMBAT OPERATIONAL STRESS REACTIONS (COSR) PREVENTION: LEADER ACTIONS
TC1 - HELPING A SOLDIER/BUDDY IN DISTRESS
TC2 - COPING WITH STRESS IN STABILITY AND SUPPORT OPERATIONS
TC3 - HELPING A SOLDIER IN DISTRESS - LEADER'S HIP POCKET TRAINING GUIDE
TC4 - HELPING A SOLDIER IN DISTRESS - LEADER'S HIP POCKET TRAINING GUIDE
TC5 - PROVIDING SUPPORT TO SOLDIERS IN DISTRESS - BUDDY AID
TC6 - COPING WITH DEPLOYMENT SEPARATION
TC7 - HOW TO FACE THE INJURED AND DEAD
TC8 - COPING WITH DEPLOYMENT SEPARATION – PARENTS AND CARE-GIVERS
TC9 - SLEEP MANAGEMENT AND SOLDIER READINESS - A GUIDE FOR LEADERS AND SOLDIERS

The following products can be downloaded at <http://chppm-www.apgea.army.mil/dhpw/Readiness/suicide.aspx>

Targeting Suicide Brochure
Suicide Helpcard

Suicide Prevention: Warning Signs and Risk Factors



Suicide Prevention Training Leaders TIP Card

Suicide Prevention Training Tip Card

This card is to be used as a training aid for the Soldier's and leadership's Suicide Prevention awareness briefs.

Most suicides and suicide attempts are reactions to intense feelings of:

Loneliness - is an emotional state in which a person experiences powerful feelings of emptiness and isolation. Loneliness is more than just the feeling of wanting company or wanting to do something with another person. Loneliness is a feeling of being cut off, disconnected from the world, and alienated from other people.

Worthlessness - is an emotional state in which a person feels low, and they lack any feelings of being valued by others.

Helplessness - is a spiritual/relational issue. It often stems from feeling disconnected from a higher power or other people. Connection with a higher power and other people is a key to helping individuals to withstand grief and loss. This connection allows individuals to rebound from most severe disappointments of life.

Helplessness - is a condition or event where the Soldier thinks that they have no control over their situation and whatever they do is futile such as repeated failures, receipt of a "Dear John or Dear Joan" letter, etc.

Guilt - is a primary emotion experienced by people who believe that they have done something wrong.

Depression:

Depression - is diagnosed when one of the following two elements is present for a period of at least two weeks: depressed mood or inability to experience life pleasures. If one of these elements is identified, depression is diagnosed when five symptoms from the list below are presented over a two-week period.

- Feelings of overwhelming sadness and/or fear, or the seeming inability to feel emotion (emptiness).
- A decrease in the amount of interest or pleasure in all, or almost all, daily activities.
- Changing appetite and marked weight gain or loss.
- Disturbed sleep patterns, such as insomnia, loss of REM sleep, or excessive sleep (Hypersomnia).
- Psychomotor agitation or retardation nearly every day.
- Fatigue, mental or physical, also loss of energy.
- Intense feelings of guilt, helplessness, hopelessness, worthlessness, isolation/loneliness and/or anxiety.
- Trouble concentrating, keeping focus or making decisions or a generalized slowing and memory difficulties.
- Recurrent thoughts of death (not just fear of dying), desire to just "lay down and die" or "stop breathing", recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.
- Feeling and/or fear of being abandoned by those close to the individual.

For some individuals, a combination of many factors may cause depression. For others, a single factor may trigger the illness. Depression often is related to the following:

- Imbalance of brain chemicals called neurotransmitters - Changes in these brain chemicals may cause or contribute to clinical depression.
- Negative thinking patterns - People who are pessimistic, have low self-esteem, worry excessively, or feel they have little control over life events are more likely to develop clinical depression.
- Family history of depression - A genetic history of clinical depression can increase one's risk for developing the illness. But depression also occurs in people who have had no family

- **Difficult life events** - Events such as the death of a loved one, divorce, financial strain, history of trauma, moving to a new location or significant loss can contribute to the onset of clinical depression.
- **Frequent and excessive alcohol consumption** - Drinking large amounts of alcohol on a regular basis can sometimes lead to clinical depression. Excessive alcohol consumption is also sometimes a symptom of depression.

Warning Signs:

When a Soldier presents with any combination of the following, the buddy or chain of command should be more vigilant. It is advised that help should be secured for the Soldier

- Talk of suicide or killing someone else
- Giving away property or disregard for what happens to one's property
- Withdrawal from friends and activities
- Problems with girlfriends (boyfriends) or spouses
- Acting bizarre or unusual (based on your knowledge of the person)
- Soldiers in trouble for misconduct (Art-15, UCMJ, etc.)
- Soldiers experiencing financial problems
- Soldiers who have lost their job at home (reservists)
- Those soldiers leaving the service (retirements, ETSs, etc.).

When a Soldier presents with any one of these concerns, the Soldier should be seen immediately by a helping provider.

- Talking or hinting about suicide.
- Formulating a plan to include acquiring the means to kill oneself.
- Having a desire to die.
- Obsession with death (music, poetry, artwork).
- Thoughts of death in letters and notes.
- Finalizing personal affairs.
- Giving away personal possessions.

Risk Factors:

Risk factors are those things that increase the probability that difficulties could result in serious behavioral or physical health. The risk factors only raised the risk of an individual being suicidal it does not mean they are suicidal.

The risk factors are often associated with suicidal behavior include:

- Relationship problems (loss of girl or boy friend, divorce, etc.)
- History of previous suicide attempts.
- Substance abuse.
- History of depression or other mental illness.
- Family history of suicide or violence.
- Work related problems.
- Transitions (retirement, PCS, discharge, etc.)
- A serious medical problem.
- Significant loss (death of love one, loss due to natural disasters, etc.)
- Current/pending disciplinary or legal action.
- Self-hatred (academic, career, or personal).
- Severe, prolonged, and/or perceived unmanageable stress.
- A sense of powerlessness, helplessness, and/or hopelessness.

Suicidal Risk Highest When:

- The person sees no way out and fears things may get worse.
- The predominant emotions are helplessness and hopelessness.
- Thinking is constricted and dichotomous.
- Judgment is impaired by use of alcohol or other substances.




References

The following references acknowledge the responsibility for the care of the soldier and state the need for suicide prevention:

AR 165-1, Chaplain Activities in the United States Army, 25 Mar 2004.

AR 600-63, Army Health Promotion, ?, 2007.

DA PAM 600-24, Suicide Prevention and Psychological Autopsy, September 30, 1988.

DA PAM 600-70, Guide to the Prevention of Suicide and Self-Destruction Behavior, November 1, 1985.