28 SUICIDE PREVENTION

CORE CONCEPTS

- Explain the historical issues that led to today's Army Suicide Prevention Program.
- Describe suicide prevention, intervention, and postvention.
- Identify suicide risk factors.
- Recognize suicide myths versus facts.
- Identify immediate warning signals of impending suicide.
- Outline appropriate actions to take when confronted with a suicidal individual.

INTRODUCTION

Suicide prevention is a continuum of prevention, intervention, and postvention to save lives. The Army Suicide Prevention Program has a commitment to reduce suicidal behavior across the Army enterprise. The goal of prevention is to develop healthy, resilient soldiers who do not view suicide as an option. You must be aware of your role in preventing suicide, ensuring you properly respond to individuals who may be in danger of attempting suicide, and safeguarding those who express suicidal thoughts.

HISTORICAL ISSUES REGARDING SUICIDE AND SUICIDE PREVENTION

Suicide among those who serve in our armed forces and among our veterans is a matter of national concern that calls for action and commitment. The Department of Defense (DOD) tracks and compiles all statistics annually, with regard to suicide activity throughout the armed forces. The DOD publishes all information that it tallies throughout the calendar year in an annual report titled "Department of Defense Suicide Event Report" (Figure 28-1), implemented in 2008. The reports showed the following suicide rates among soldiers for consecutive calendar years:

- 2013–300 soldiers (121 active duty, rate: 22.7 per 100,000 soldiers)[1]
- 2014–245 soldiers (126 active duty, rate: 24.6 per 100,000 soldiers)[2]

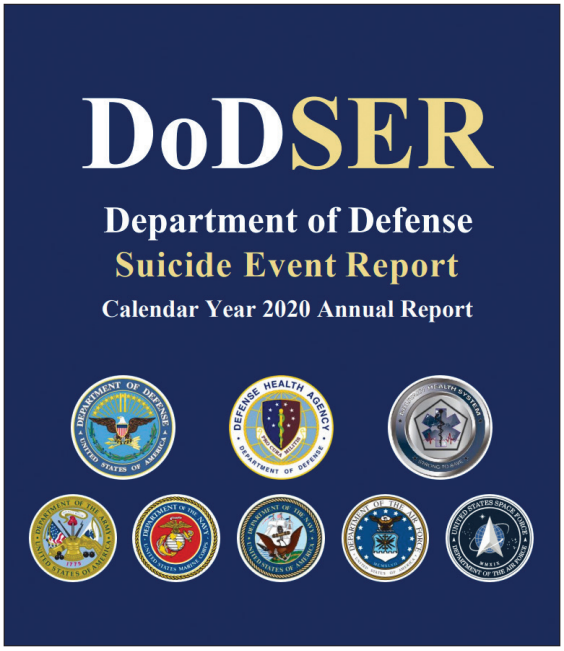

Figure 28-1. The Department of Defense Suicide Event Report is an annual publication that provides rates of suicide for each of the components (active duty, reserves, National Guard) and each of the services (Army, Marine Corps, Navy, Air Force). The report also provides the annual totals of suicide deaths and attempts recorded for the military, the mechanisms of injury for those events, and descriptive summaries of risk and contextual factors present among service members who engaged in suicidal behaviors that year. Reproduced from https://health.mil/Military-Health-Topics/Centers-of-Excellence/Psychological-Health-Center-of-Excellence/Department-of-Defense-Suicide-Event-Report

- 2015–279 soldiers (120 active duty soldiers, rate: 24.4 per 100,000 soldiers)[2]
- 2016–280 soldiers (130 active duty, rate: 27.4 per 100,000 soldiers)[3]
- 2017–295 soldiers (114 active duty, rate: 24.3 per 100,000 soldiers)[3]
- 2018–305 soldiers (139 active duty, rate: 29.5 per 100,000 soldiers[4]

From 2013 to 2018, the suicide rate for the Active Component across all services increased from 18.5 to 24.8 suicides per 100,000 service members. This increase reflected small increases in the number of suicide deaths across all services.

There is one important caveat to the reported data, according to the 2018 DOD report. After controlling for differences in age and sex between military and civilian populations, military suicide rates are comparable to civilian suicide rates.[4] While this information adds perspective, it does not lessen the urgency with which the DOD is addressing suicide among the armed forces.

For many years, suicide prevention training focused on stress management; however, this is only one available tool. The military has a proactive annual mandatory training program that provides soldiers with alternatives to suicide. The biggest push has been toward removing the stigma attached to reporting suicidal thoughts or seeking mental health care. The stigma suggests that soldiers who have thoughts of suicide are weak or could face negative career impacts.

Admiral Jeremy M. Boorda (Figure 28-2) was the Chief of Naval Operations and the first American sailor who started his career as an enlisted man and progressed through the ranks to Admiral and Chief of Naval Operations. Admiral Boorda was investigated by the media for wearing two "V" devices, which he was not authorized to wear, on two of his military ribbons. The year before the media started its investigation, the Navy informed Admiral Boorda that he was not authorized to wear the devices, and he immediately removed them. However, when the investigation began, Admiral Boorda committed suicide because he felt that his good-faith uniform error had tarnished the reputation of the Navy.

Figure 28-2. Admiral Jeremy M. Boorda (November 26, 1939–May 16, 1996). Reproduced from Naval History and Heritage website. https://www.history.navy.mil/browse-by-topic/people/chiefs-of-naval-operations/admiral-jeremy-m-boorda.html

In 1996, following Admiral Boorda's suicide, the Assistant Secretary of Defense for Health Affairs called for an analysis of the DOD suicide prevention programs. This study showed that suicide within the military was not primarily associated with current stress in an individual's life; rather, it frequently appeared to be associated with a diagnosable psychiatric disorder, such as depression or substance abuse. Of the 277 soldiers who committed suicide in 2016, 71 (25.6%) had been diagnosed with a mental health issue, and of the 586 soldiers who attempted suicide, 366 (62.5%) were also diagnosed with a mental health issue.[2] These data show a higher percentage of attempted (but not completed) suicides among soldiers diagnosed with a mental health issue. This difference shows how prevention efforts may be affected by complex suicidal motivations and potential underlying causes.

Another study showed that a person who experienced adverse events as a child has up to a fivefold increased risk of attempting suicide.[5] Adverse events may include mental, physical, or sexual abuse; neglect; witnessed domestic violence; having a family member with mental illness; having a family member who attempted or completed suicide; substance abuse in the family; incarceration of a family member; and divorce or separation of parents or guardians. As a result, affected individuals may come from homes that have not adequately prepared them to cope with crises in a positive way.

Check on Learning

1. In the DOD, who has the duty of suicide prevention?
2. Select the statement about suicide in the Army that is NOT correct.
   a. In 2018, the Army suicide rate dropped significantly due to effective prevention.
   b. The suicide rate in the Army has increased over the past several years.
   c. Adverse events in childhood may increase a soldier's suicide attempt risk.
   d. Suicide prevention efforts are complicated by complex suicidal motivations and underlying causes.

THE UNITED STATES ARMY SUICIDE PREVENTION PROGRAM

Many suicides are preventable. This is why Army leadership took an aggressive stance on developing a suicide prevention program, making it an essential part of wellness. Comprehensive programs train both leaders and individuals in recognizing and appropriately responding to troubled soldiers or their family members to discover alternatives to suicide. The Army Suicide Prevention Program is based on command policy and action, positive leadership, deep concern by supervisors, and risk reduction. Even under the best circumstances, individuals may still commit suicide. Therefore, the Army recognizes the importance of suicide risk reduction, which consists of reasonable steps taken to lower the odds of an individual engaging in self-destructive behavior.

FACTORS THAT MITIGATE SUICIDE RISKS AND IMPACTS

Prevention

Prevention focuses on preventing normal life stressors from turning into life crises. Prevention concentrates on equipping soldiers, army civilians, and family members with coping skills to handle overwhelming life circumstances. Prevention refers to all efforts that build resilience, reduce stigma, and build awareness of suicide and related behaviors. Prevention includes early screening to establish baseline behavioral health and to offer specific remedial programs before dysfunctional behavior occurs.

Prevention is dependent on caring and proactive unit leaders and managers who make the effort to know their personnel. These leaders will more adequately be able to estimate how their subordinates handle stress and will be in a better position to offer a positive, cohesive environment that nurtures and develops coping skills. These "gatekeepers" serve as the first line of defense to mitigate risk.

Suicide prevention was once recognized as a leadership responsibility. Now it is everyone's duty, including leaders, supervisors, soldiers, and civilian employees. Your role in suicide prevention includes the following:

- identify high-risk individuals,
- be proactive and care for individuals,
- encourage help-seeking behavior,
- promote positive life coping skills to deal with life crises,
- be aware of suicidal thoughts and behavior in individuals,
- know the community-wide and operational resources for referring individuals demonstrating self-destructive behavior, and
- ensure that an individual's problems are properly addressed (be an advocate for the individual).

Intervention

Intervention includes addressing the conditions that produced the current crisis, treating underlying psychiatric disorders that may have contributed to suicidal thoughts, and providing follow-up care. This includes ensuring the individual at risk of suicide is safe, through the use of a buddy system or Unit Watch. Commanders play an integral part during this phase, as it is their responsibility to ensure access to appropriate health care and ensure the safety of assigned personnel.

Postvention

Postvention is required when an individual has attempted or completed a suicide. After an attempt, commanders, noncommissioned officers (NCOs), and installation gatekeepers should take steps to secure and protect such individuals before they can cause additional harm to themselves or others. After a completed suicide, postvention activities also include unit-level interventions to minimize psychological reactions to the event, prevent or minimize potential for suicide contagion, strengthen unit cohesion, and promote continued mission readiness.

IDENTIFY RISK FACTORS ASSOCIATED WITH SUICIDE

Suicide is an equal opportunity destroyer—it cuts across rank, race, and gender. Soldiers must be able to recognize service members who display behaviors that might identify them as high risk for attempting suicide. It is important that you know your soldiers so that you can better recognize those with past or present adverse events, emotional pain, or a psychiatric disorder. These factors may interfere with adequate coping skills and may increase suicide risk.

Individuals who have difficulty coping with intense feelings or emotions may consider taking drastic measures as a solution to their problem. Intense feelings that may lead to suicide include loneliness,

worthlessness, hopelessness, helplessness, and guilt. Strategies to address suicide risk should include mitigating the negative effects of intense emotions and addressing the circumstances provoking these emotions.

Life coping skills can mitigate the negative effects of strong emotions. Some people, however, have genetic predispositions that may influence the effectiveness of their coping skills. These include a vulnerability to develop alcohol or substance abuse and/or a psychiatric illness (eg, depression). Developmental history (eg, childhood trauma, abuse, neglect, parental abandonment) and/or the current environment (eg, work and home conditions) are also factors that may affect an individual's ability to cope with adversity.

Only a small percentage of those affected pursue medical treatment or assistance for psychological issues, and many deny an issue exists. It is vital that you know the signs and symptoms of depression and understand risk factors leading to contemplation of suicide. Using knowledge of signs, symptoms, and risk factors to identify soldiers who may be at risk is only the first step in combating this issue. You must also be aware of appropriate steps in ensuring the individual's immediate safety, and procedures to establish care and effective treatment.

MYTHS AND FACTS ABOUT SUICIDE

It is unclear why some people contemplate suicide and others do not. As previously discussed, psychiatric disorders and substance abuse do play a large role in the number of suicides in the DOD, but they may not be the sole determinants. In the Army in 2017, 56% of those who completed suicide had been diagnosed with a mental health disorder, including substance abuse and adjustment, mood, and anxiety disorders.[3] However, other simultaneous contributing factors may complicate analysis of the reasons for suicide.

Suicidal people tend to feel a tremendous sense of loneliness and isolation. They feel helpless, hopeless, and worthless. Often, they believe that it does not matter if they live or die and that no one would miss them if they were gone.

Younger soldiers may tend to resort to suicide if they lack effective coping skills and are faced with relationship problems, financial problems, pending civilian legal action, or Uniform Code of Military Justice disciplinary action. Poor coping skills combined with these types of external stressors may force them beyond their tolerance level. Older soldiers tend to resort to suicide when facing negative life transitions, such as divorce or being passed over for promotion. Some individuals may suffer from chronic substance abuse or mood disorders. Isolation and loneliness are common feelings among all ages.

A review of cases in the Army in 2017 revealed that failed or failing relationships topped the list of adverse events correlated with completed suicides (35.1%).[3] Other adverse events associated with completed suicide included the following[3]:

- pending, completed, or adjudicated administrative or legal problems (26.1%);
- workplace issues (23.1%); and
- financial difficulties (9%).

Other specific events that may be associated with suicide include:

- a bad evaluation for an enlisted soldier or officer,
- the breakup of a close relationship,
- the anniversary of the suicide of a close friend or family member,
- leaving old friends,
- being alone with concerns about self or family,
- a new military assignment (but being deployed is not associated with suicide risk[4]),
- death (including suicide) of a loved one (spouse, child, parent, sibling, friend, or pet),
- loss of esteem or status,
- humiliation,
- rejection (job loss, failed promotion, discharged), and
- retirement.

At times, a person's misconceptions about addressing people who may be suicidal or their thoughts about discussing suicide may become a barrier to overtly reaching out to people who may be in danger. Several common myths contribute to misconceptions about suicide:

Myth: People who talk about suicide rarely attempt or commit suicide.

Fact: Nearly 19.3% of service members who commit suicide attempted to communicate their intentions prior to the act. For those who attempted but failed to commit suicide, 25.3% gave some warning of their intentions. When people talk about committing suicide, they may be giving a warning that should not be ignored.[2]

Myth: Talking to people about their suicidal feelings will cause them to commit suicide.
Fact: Talking to people about their suicidal feelings usually makes them feel relieved that someone finally recognizes their emotional pain, and they feel safer talking about it.[4]

Myth: All suicidal people want to die, and there is nothing that can be done about it.
Fact: Most suicidal people are undecided about living or dying. They may gamble with death, leaving it to others to rescue them. Often, they call for help before and after a suicide attempt.[4]

Myth: Suicide is an impulsive act with no prior planning.
Fact: With regard to completed suicides, 40.5% are carefully planned and thought about for weeks.[4]

Myth: A person who attempts suicide will not try again.
Fact: Most people who commit suicide have made previous attempts (80%).[7]

Myth: Improvement in a suicidal person means the danger is over.
Fact: Most suicides occur within about 3 months following the beginning of improvement, when the individual has the energy to act on suicidal thoughts and feelings. More than 62% had seen or had been treated by a medical professional within 90 days prior to completing suicide.[2]

Myth: Suicidal individuals suffer from a mental health condition.
Fact: Many people who complete suicide have not been diagnosed with a mental health condition, and many people who have been diagnosed with a mental health condition do not commit suicide.[8]

Myth: Because it includes the holiday season, December has the highest number of suicides.
Fact: Nationally, December has the lowest suicide rate of any month. During the holiday season, depressed individuals may feel a sense of belonging and believe things will get better. Statistics show that the majority of suicides tend to occur in spring and fall.[9]

Check on Learning

3. What is one genetic vulnerability that could increase suicide risk in an individual?
4. Myth or fact? December is the most common month for suicide due to the holiday season.

DANGER SIGNALS AND ACTIONS

Signals of Imminent Suicide Attempt

When one or more of the following signs are observed in a person, suicidal behavior may be imminent:

- talking about one's own death or hinting at suicide;
- giving away important possessions or making a will in connection with disposal of personal property;
- obsession with death, sad music, or sad poetry; themes of death in letters or artwork;
- uncharacteristic behaviors or withdrawal from social activities;
- significant change in performance;
- access to lethal means and specific plans to commit suicide; and
- buying a firearm in connection with any of the above signs.

If a person demonstrates imminent behavior and has experienced some life stress events associated with suicide, appears to be depressed, or has a history known to cause an increased suicide risk, the chances of suicide increase even more.

APPROPRIATE ACTIONS WHEN CONFRONTED WITH A SUICIDAL INDIVIDUAL

When confronted with what you believe to be an imminently suicidal person, the Army recommends following the Ask, Care, Escort (ACE) suicide prevention model. First, remove any potential means of self-harm (eg, firearms, knives, pills). Ask directly if they are thinking about suicide or taking their life. If they answer yes, follow up by asking what has happened to lead to that decision and how they plan to accomplish it. If you suspect a person is suicidal, begin asking open-ended questions such as "How are you doing?" Getting the individual to talk about it is a positive step; be a good listener.

Take all suicide threats seriously. The warning signs can be subtle; you must trust your suspicions. Don't

be afraid to discuss suicide with the person; doing so will not encourage the individual to commit suicide. In fact, confronting these feelings may deter the person from attempting suicide by demonstrating that someone cares. Express concerns about the impact of the person's decision on their significant others.

Individuals who attempt suicide most often feel alone, worthless, and unloved. You or any soldier can help a suicidal person by letting them know they are not alone and you are there to talk. By assuring them help is available, you are offering hope and throwing them a lifeline. Remember, although individuals may think they want to die, most have an innate will to live and are more than likely hoping to be rescued.

Get help and help the suicidal individual understand you are seeking help because you are concerned about them. The most useful thing that can be done for a suicidal person is to get them professional help. The battalion aid station, emergency department of any medical treatment facility, community mental health service, social work services, chaplain, Army Community Service, and the chain of command are some possible agencies and places that can assist with a suicidal individual. Getting help for someone involves respect for their welfare and dignity. Be compassionate toward the needs of others. Accompany the person to a behavioral health expert or assign them an escort.

Always keep a suicidal individual safe; do not leave the person alone if you believe the risk for suicide is imminent. Have a capable soldier stay with the individual at all times. Do not assume a person is not the suicidal "type." Take every threat and suspicion seriously and refrain from making moral judgments, acting shocked, or making light of the situation. This only adds to the guilt, humiliation, shame, and isolation the individual may feel. Offering advice such as "be grateful for what you have" or "you're so much better off than most people" may only deepen a sense of guilt the person may already feel. Don't keep your suspicions secret (deadly secret); tell a commander, mental health provider, or other members of the military support system what you suspect.

Check on Learning

5. Which of the following is not an imminent sign of possible suicide attempt?
   a. Initiating a personal life insurance policy.
   b. Obsession with death, sad music, or sad poetry; themes of death in letters or artwork.
   c. Talking about one's own death or hinting at suicide.
   d. Giving away important possessions or making a will in connection with the disposal of personal property.

PROTECTIVE FACTORS

In addition to suicide risk reduction strategies, there are numerous protective factors that may be enhanced by DOD efforts. Protective factors function like insulators, and they are an important component in the complex interplay of suicide risk factors. You should be familiar with factors that fortify at-risk individuals. They include the following[10]:

- effective clinical care for mental health and substance abuse issues;
- easy access to support for those seeking help;
- strong bonds with family, social groups, and community;
- effective problem solving and conflict resolution skills; and
- embrace of cultural or religious beliefs that support self-preservation.

SUMMARY

The Army Suicide Prevention Program is based on prevention, intervention, and integration of installation and community resources. Preventing suicide is always the goal of the program.

Intervention attempts to prevent a life crisis or behavioral disorder from leading to suicidal behavior, and it includes managing suicidal thoughts that may arise. At its most basic level, intervention may simply include listening, showing empathy, and escorting a person to a helping agency. This is something that can be done at the unit level by any soldier, civilian, or family member with minimal training. Army-approved training for this level includes suicide prevention training programs for soldiers, leaders, DOD civilians, and families.

CHECK ON LEARNING ANSWERS

1. In the DOD, who has the duty of suicide prevention?

   Everyone, including leaders, supervisors, soldiers, and civilian employees.

2. Select the statement about suicide in the Army that is NOT correct.
   a. In 2018, the Army suicide rate dropped significantly due to effective prevention.
   b. The suicide rate in the Army has increased over the past several years.
   c. Adverse events in childhood may increase a soldier's suicide attempt risk.
   d. Suicide prevention efforts are complicated by complex suicidal motivations and underlying causes.

   a. In 2018, the Army suicide rate dropped significantly due to effective prevention.

3. What is one genetic vulnerability that could increase suicide risk in an individual?

   Alcoholism or psychiatric illness.

4. Myth or fact? December is the most common month for suicide due to the holiday season.

   Myth—spring and fall have the highest incidences of suicide.

5. Which of the following is not an imminent sign of possible suicide attempt?
   a. Initiating a personal life insurance policy.
   b. Obsession with death, sad music, or sad poetry; themes of death in letters or artwork.
   c. Talking about one's own death or hinting at suicide.
   d. Giving away important possessions or making a will in connection with disposal of personal property.

   a. Initiating a personal life insurance policy.

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