

SUICIDE PREVENTION

A RESOURCE MANUAL FOR THE UNITED STATES ARMY

PREPARED BY

THE AMERICAN ASSOCIATION OF SUICIDOLOGY

AND

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



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Army Suicide Prevention

INTRODUCTION

On July 28, 1999, the Surgeon General of the United States, David Satcher, M.D., publicly declared suicide a serious public health threat, launching a national effort entitled a “Call to Action” to develop strategies to prevent suicide and the suffering it causes. This was an historic first, a recognition at the highest levels of government that this country could no longer ignore or deny the significant numbers of Americans who kill and harm themselves each year, and the trauma these events have on surviving loved ones and colleagues.

On average, more than 30,000 Americans die by suicide each year. An unknown and difficult to calculate number of others (some estimate these to be one hundred times as frequent as completions) make nonfatal attempts to suicide, about one-fourth of which require medical and psychological intervention to prevent further suicidal acts and possible death.

Military personnel are not exempt from this public health problem. Suicide is the third leading cause of death among active-duty personnel in peacetime U.S. armed forces, after accidents and homicides. Although the suicide rates in the military are lower than rates among comparable age, sex, and racial groups in the general population, military suicide rates are higher than one should expect, given that more seriously disturbed and maladjusted persons are weeded out through pre-induction screening (see chart, page 28 and the Office of the Chief of Staff, Personnel (ODCSPER) Website: <http://www.odcsper.army.mil/default.asp?pageid=66f>)

Prevention programming is intended to save lives and reduce the impact of self-harm behaviors. The Army Suicide Prevention Program (ASPP) involves the entire military community in a three-tiered approach to achieve the best-coordinated prevention possible. The first level, called **primary prevention** consists of those command programs designed to anticipate critical junctures in a person's career and make them less stressful. The second level, called **secondary prevention** includes those command programs of special support and crisis counseling needed when persons encounter times of crisis and may be helped by a caring professional. The third level is called **tertiary prevention**. When someone needs immediate care for a potentially life threatening crisis, they require care by a mental health professional.

The first aim of the Army Suicide Prevention Program (ASPP) is to prevent individuals from reaching the point where suicide is seriously contemplated. If these first efforts fail then the aim becomes one of early intervention. The ASPP strategy consists of **support, screen, spot, and secure**, as depicted in table 1. The goals of the support and screen components are primary prevention, that is, to identify and build *internal* or personal characteristics, and to build and increase awareness of and access to *external* support systems that can sustain individuals in times of distress. The **spot** component is secondary prevention and involves increasing the awareness of suicide and risk factors for suicidal behaviors among all levels of personnel and improving the

recognition and assessment of suicide risk by military caregivers. The **secure** component is tertiary prevention, providing guidelines for health care professionals to effectively assess for treatment those believed to be at risk.

Table 1

SUICIDE PREVENTION STRATEGY

SUPPORT	SCREEN	SPOT	SECURE
<ul style="list-style-type: none"> • Army structure & services • Individual skills • Accessible confidantes • Integrated into group • Sense of contribution 	<ul style="list-style-type: none"> • MEPS initial assessment & history • Periodic & milestone screening • Suicide Risk Assessment 	<ul style="list-style-type: none"> • Gatekeeper Training <ul style="list-style-type: none"> ◦ Myths ◦ Warning Signs ◦ Risk Factors ◦ Initial Response 	<ul style="list-style-type: none"> • Policies & Procedures • Help <ul style="list-style-type: none"> ◦ Accessible ◦ Coordinated ◦ Trained

Support continues throughout the strategy life-cycle as the Army structure & services, Individual skills, Accessible confidantes, Group integration and Sense of contribution permeate the Screen, Spot and Secure aspects of the Army Suicide Prevention Program.

Support is the most critical prevention strategy for any community or organization. It is mainly a primary prevention strategy in that it serves to reduce the incidence of suicidal thoughts and behaviors by moderating individuals' responses to stressful events or conditions. In public health terms, support involves the promotion of *protective factors* that consist of internal and external resources that can help an individual cope with challenges, changes, and feelings of stress. As such, **support is critical prior to the emergence of suicide. However, support is also an important part of the screen, spot, and secure prevention components, and therefore must be present prior to, during, and after a crisis.** The **Army Structure and Leadership** are the central components of this support.

Regardless of the level of available support, some individuals will become suicidal, usually due to disorders such as depression, alcohol abuse, and anxiety, or their particular response to stressors. **Screen** represents another primary prevention technique that attempts to identify individuals who have personal or situational factors that carry increased risk of suicide. Initial screening of recruits at the Military Entrance Processing Service (MEPS) Station can identify suicidal thoughts or previous attempts. Personnel who are currently or chronically suicidal may be denied entrance into the military. Annual well-being screening and subsequent periodic screening, particularly before deployments and during transitions, can identify troubled or at-risk individuals.

Increased risk for suicide may arise in *vulnerable* individuals for a variety of reasons that will be discussed as *risk* and *precipitating* factors. Therefore, the next line of defense is alert and

informed personnel who can **spot** an at-risk individual. This is called secondary suicide prevention because it involves identifying at-risk personnel.

In order to prepare *all* service members to **spot** and provide a supportive response for at-risk individuals, Gatekeeper Training must be widely disseminated. Different levels of knowledge and skills are required of individuals ranging from fellow soldiers to mental health professionals as will be described in the spot or gatekeeper section. All service members, including all new service members, should at least know how to refer troubled or at-risk individuals.

Once at-risk individuals have been spotted, there must be clear policies and procedures and accessible, coordinated resources to **secure** adequate help that will assess, manage, and intervene with suicidal individuals. This is tertiary suicide prevention because it involves assessment for treatment of suicidal behavior.

Each of these approaches will be addressed in detail in the sections that follow this general introduction. They are presented separately for training purposes, but they are interrelated and complementary. For example, familiarity with policies and procedures by all military personnel facilitates their responding to and obtaining help for troubled individuals in a timely and efficient manner. When individuals know what resources are available, how to access them, and how they will respond, this provides part of the structure that is a key element of the support that can prevent suicidal behavior. Also, as previously noted, the Army Structure provides an overarching framework for all suicide prevention efforts.

This manual provides guidelines for promoting protective factors and screening for individual well-being within the context of Army leadership and structure. The aim here is to prevent individuals from reaching the point where suicide is seriously contemplated. In addition, the manual provides lessons and materials that help to prepare Army personnel to respond to, assess, and obtain help for individuals who appear to be troubled, show warning signs for being at risk for suicide, or are making overt suicide threats or attempts.

The Suicide Prevention Task Force

Army Regulation 600-63, Army Health Promotion mandates that every Installation or Community Commander will establish and chair a Health Promotion Council (HPC). The council may establish a separate Suicide Prevention Task Force (SPTF) or the HPC may retain the suicide prevention mission. The SPTF at each installation is responsible for training, reporting and maintaining data, and conducting psychological autopsies when there is a confirmed or suspected suicide. The SPTF could best monitor, regulate, and compile training and other statistics.

SUPPORT

As in other walks of life, there are stressful aspects to Army life. However, in contrast to much of civilian life, the Army provides an overarching structure that can serve as a protective factor. That is, the **Army Structure**, consisting of Army **leadership** and a wide array of helping **services and programs** can serve as an enabling framework within which all aspects of suicide prevention in this manual can take place.

When a soldier, family member or Department of Defense civilian encounters an event that affects their day-to-day well-being, the Army helping agencies may help them through their difficult times. However, Army programs and services are only beneficial when they are available and can be readily accessed when needed. It is the duty of leaders throughout the chain of command to ensure that these programs are well publicized and available. They must afford personnel who encounter troubled times every opportunity to participate in these programs and services.

Primary and secondary suicide prevention programs are often more cost effective, and usually return an individual to a more normal lifestyle more quickly and effectively than tertiary treatment programs. The supportive structure of the Army facilitates primary prevention in ways that other aspects of our society cannot.

This training session provides a framework for Army leadership to carry out its responsibility to promote protective factors and provides information about available helping resources.

SUPPORT: THE ARMY STRUCTURE

LESSON PLAN ADVANCE SHEET

Title: Suicide Prevention: Support in the Army (Primary Suicide Prevention; First portion of "all personnel" training)

Time: 20 minutes

Target Audience: All Army personnel from top commanders to privates. The material in this lesson should be disseminated through the "cascade training" approach. That is, one iteration for the most senior rank possible would provide training to Major Command (MACOM) Commanders and their staff officers would in turn endorse training to all other levels of command. Those commanders would provide training to their units until all personnel are trained. The actual appropriate and efficient step-down procedure would be developed by MACOM and passed down through channels to the lowest level of command. The guiding principles would be to convey that a) this message comes from the top commanders of the Army, b) this process is considered critical, c) leaders will be held accountable for the safety of all personnel in regard to the prevention of suicide, and d) leaders will promote a culture in which *everyone* feels appropriate responsibility for the safety and support of all personnel.

Terminal Individual Objective

Task: Understand the Army Suicide Prevention Program (ASPP) structure and promote cohesion and mutual support among all personnel.

Enabling Learning Objectives (OH 1 a, b)*

Participants will be able to:

1. Describe primary, secondary and tertiary suicide prevention
2. Identify personal and environmental protective factors.
3. Know about support resources and programs.
4. Promote cohesion and a sense of belonging.
5. Destigmatize and encourage help seeking.

Soldier Preparation

None

Instructional Procedures

Conference

*OH = Overhead

HO = Handout

Instructor's Notes

Instructor Note: 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 friends and neighbors. Another task for the instructor is to encourage an attitude of hope and renewal.

Instructor Note: When a question is asked, take time to field answers from the class before proceeding.

The Army Suicide Prevention Program

The Army Suicide Prevention Program consists of three stages or tiers of prevention initiatives. The first level is the foundation on which the entire structure rests. This is called primary suicide prevention and it incorporates all personnel cooperating in a command directed community-wide effort to eliminate feelings of helplessness and hopelessness before they begin. Community programs and supportive counseling by chaplains, social workers and other professionals reduce incidents of suicidal thought and behavior by pre-empting potential crises. Secondary suicide prevention takes place when someone identifies a potentially suicidal person and knows how to respond in helpful ways. Again, professional counselors assist in providing supportive counseling and personal, face-to-face risk assessment for potentially suicidal personnel. Tertiary suicide prevention takes place when an individual is actively suicidal and must undergo professional, psychiatric treatment to return to their previous healthy lifestyle.

The Army Suicide Prevention Program (OH 2)

- Primary prevention: anticipating potential times of crisis and structuring pre-emptive support systems
- Secondary prevention: recognizing times of crisis and providing caring support.
- Tertiary prevention: Recognizing signs of acute suicidal behavior and responding with appropriate professional psychiatric treatment.

Training Strategy

At the foundation level, all personnel cooperate with the Commander's program of community **support**. The second stage employs caring professionals to **screen** for personnel who are encountering distress. These are primary suicide prevention efforts. Next comes gatekeeper training which enables all personnel to **spot** those who are exhibiting signs of self-destructive behavior. Then, formal gatekeepers (chaplains, other professional counselors) are trained to individually screen at-risk personnel for further mental health assessment. Finally, mental health professionals are trained in policies and procedures to **secure** and treat actively suicidal personnel.

ASPP Training Strategy (OH 3)

- Support

- Screen
- Spot
- Secure

Protective Factors

Ultimately the prevention of suicide will best be accomplished by enhancing supports and strengths. Not all risks can be identified or reliably associated with suicide in individual cases. Nor can all stresses be avoided. Research is beginning to identify resilience or **protective factors** that can moderate the impact of stress or psychological dysfunction. The presence of these factors can prevent a variety of ineffective behaviors including violence, substance abuse, and suicide, even in the presence of stressful events or environments.

There are two categories of protective factors: personal protective factors and environmental protective factors.

Personal Protective Factors (OH 4 a, b)

- Easy temperament.
- Previous experience with self-mastery, problem solving, crisis resolution.
- Optimistic outlook.
- Social/emotional competence.
- High self esteem, self worth.
- Decision-making, problem solving skills.
- Sense of personal control, self-efficacy.
- Sense of belonging to a group and/or organization.
- High and realistic expectations.
- High spiritual resiliency.

Environmental Protective Factors (OH 5 a, b)

- Strong family relationships.
- Models of healthy coping.
- Encouragement of participation.
- Opportunities to make significant contributions.
- Available social supports.
- Available helping resources.
- Healthy Spiritual/religious affiliation.
- Cultural and religious beliefs against suicide and in support of self-preservation.

Reasons for Living

Marsha Linehan, a prominent researcher in suicidology, developed a 48-item scale, the Reasons for Living Inventory, (OH 6) which differentiates suicidal from nonsuicidal individuals. As such, the items represent categories of protective factors that may moderate suicidality during stressful situations. The inventory categories are Survival & Coping Beliefs (e.g., “I believe I can find other solutions to my problems”); Responsibility to Family; Child-Related Concerns; Fear of Suicide; Fear of Social Disapproval; Moral Objections. When assessing for suicidal feelings one should also assess reasons for living. See pg. 69 for reference to this scale.

Spiritual Resiliency

Spiritual resiliency is another important aspect that strengthens one's resolve to live. Jarred Kass, Ph.D., LMHC and his wife Lynn Kass, M.A., M.A.T., LMHC developed the Spirituality and Resilience Assessment Packet to help people strengthen their inner resources. The packet inventories the strength of the person's positive worldview and their sense of connection with the spirit of life. The presence of a resilient worldview is empowering. It helps people mobilize their energies, relax their body and mind, think for themselves and trust in others and in life itself. This spiritual connectedness, characterized by confidence in life and self offers hope, a key protective factor. See page 69 for references to this scale.

Support in the Military

During World War II, Army personnel made significant contributions to the development of the field of crisis intervention and the promotion of effective coping. Among these were the discovery that, more than personal characteristics, an individual's *sense of belonging and integration into his/her particular unit* influenced how he (she) would stand up to the stresses of combat. Thus, promoting cohesion and being alert for withdrawal or isolation are important strategies for the prevention of suicide and other destructive behaviors. Whether we are addressing deaths by combat or suicide, the same principle applies: **connections save lives (OH 7)**.

Of course, the development and promotion of many of these personal and environmental protective factors can be recognized as essential elements of effective leadership. Moreover, the goal of Army training is to develop many of these skills and characteristics in order to promote effective functioning under stressful conditions.

(Instructor note) The extent to which these characteristics are selected for or developed is a military decision. There are measures that assess many of these characteristics, such as the BarOn Emotional Quotient Inventory (Eq-I), which is described at the end of this section on Structure.

Army leadership, assisted by a network of helping agencies constitutes primary suicide prevention through effective external supports. The Consideration of Others Program fosters a caring atmosphere for workers to support one another within their work group. Functions performed by the Army Community Services and the Army Chaplaincy provide support during times of transitional stress. Combat Stress Control Teams, Family Support Groups, Community Counseling Centers, Family Life Centers, the Family Advocacy Program, Army Emergency Relief, the Exceptional Family Member Program, and Community Mental Health, provide support in special need situations. Child Development Centers and Morale Welfare and Recreation programs provide relational services for single soldiers as well as family members. Chapel programs offer spiritual, religious and relational support to soldiers and family members. Medical Treatment Facilities, Dental Clinics and Community Health Nurses provide medical support. Reenlistment Counselors, Education Centers and leaders at all levels should assist soldiers to achieve their full potential within the Army system. (Trainer should obtain **handouts** that contain information about local resources).

From primary through tertiary prevention, the Army Structure affords a network of multidisciplinary agencies and caregivers unequalled in civilian life. It is extremely important for

leaders to be aware of and readily share information about the array of programs and services available in the Army.

In addition, it is important to ensure that services are temporally, culturally, and psychologically accessible to troubled individuals. Suicidal thought and behavior is often a symptom of a very treatable mental and/or spiritual illness. However, seeking help for such concerns is often very difficult, particularly for males. The Army leadership must systematically destigmatize mental illness and help-seeking behavior in response to stress, mental illness, and suicidal feelings by modeling and promoting seeking help as a sign of effectively dealing with problems, and of strength rather than weakness (**OH 8**). The remainder of this training focuses on preparing peers, leaders, and mental health professionals to respond effectively to at-risk individuals. Without systematic efforts to reduce the stigma of turning to them for help, their expertise and preparation may be wasted.

Leadership

The role of Army leadership in suicide prevention cannot be overemphasized. This strong leadership is the advantage that the military structure affords, and is the reason why protective factors can be more effectively promoted and sustained in the military than in civilian settings. Ever since the first military system was devised, a prominent characteristic of an effective leader has been the ability to protect those under his/her command. A good leader does not expose those under his/her command to unnecessary risk (**OH 9**). This applies to death by suicide just like it does to other senseless injury or death. Thus, it is the responsibility of Army leadership from the top commander down to platoon and squad leaders to promote the safety of all military personnel. This can be done in the following ways: (**OH 10 a-e**)

- Promote a norm of mutual support among all military personnel: *we are our brother's keepers!*
- Pay attention to warning signs and respond to those who need help. If anyone suspects or knows that a fellow soldier, family member, or anyone else is troubled, provide or get help for them.
- Be aware that heightened stress, relationship problems, and impending holidays can trigger inappropriate coping behaviors in vulnerable individuals. Pay close attention to the personal needs of your people, and be on the lookout for signs of stress.
- Communicate in your words and actions that it is not only acceptable, but a sign of strength, to recognize life problems and get help to deal with them constructively.
- Support and protect to the fullest extent possible those courageous people who seek help early, before a crisis develops.
- Create a responsive, caring, and responsible community where individuals are motivated to seek help with personal struggles without fear of stigmatization.
- Create and promote opportunities for social interactions that are important in defining a unit's supportive structure. These range from group and battalion/squadron events to

private gatherings. Make sure that you foster a social climate in your unit that communicates to everyone, 'you belong here'.

Conclusion

Efforts to foster a supportive environment and to destigmatize help-seeking may be the most potent form of suicide prevention currently available. However, they take time to develop and cannot be 100% effective in preventing suicidal behavior. Therefore, it is important that the Army has the capability to screen and identify those at-risk for suicide. This is addressed in the next training sessions.

SCREEN

Screening for suicidal ideation (the thoughts and constructs that people who are feeling helpless and hopeless often have) can be harmful if not administered by professionals who are trained to respond to a person who admits suicidal thoughts or intent. Additionally, suicide scales have proved less than successful when used with groups who are not accessible to the screener for more evaluation. Because of these difficulties, screening has not been used successfully in the civilian realm. The military, however, do to its unique structure and support base, is well equipped to effectively screen its personnel for well-being. The Army has caring professionals to administer screening questionnaires and has access to the personnel for future follow-up. Never-the-less, screening that asks questions regarding current suicidal thoughts and past attempts may stigmatize the respondent and hinder subsequent screening and help-seeking behavior. Therefore, the screening presented in this section is gated, that is to say, it does not begin with suicidal ideation, but with well-being. If personnel self-report difficulties in their perceived level of well-being, then subsequent screening is indicated.

Formal gatekeepers may wish to purchase and use one or more of the secondary screening instruments included in this manual. These tools may prove very helpful for the counseling process. However, they are never a substitute for face-to-face interviews using the screening questions provided in the "formal gatekeeper" section of this manual (see pages 50-55).

This section is a brief overview of the possibilities for well-being screening that exist in the Army. Screening procedures are a matter for consideration by the MACOM, Installation and Unit Commanders. This manual presents a review of available resources.

GATED SCREENING

LESSON PLAN ADVANCE SHEET

Title: Suicide Prevention: Gated Screening in the Army (Second portion of "all personnel" training)

Time: 10 minutes

Target Audience: All Army personnel from top command to privates. Screening by caring professionals for well-being can enhance early detection and lowest level intervention by community counseling professionals to support and assist personnel in times of distress.

Terminal Individual Objective

Task: Be knowledgeable of and willing to participate in general well-being screening.

Enabling Learning Objectives (OH 1)*

Participants will be able to:

1. Understand the benefits of gated screening.
2. Be informed about confidentiality of screening results.
3. Be informed of secondary screening instruments.

Soldier Preparation

None

Instructional Procedures

Conference

*OH = Overhead

HO = Handout

Instructor's Notes

Instructor Note: 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 friends and neighbors. Another task for the instructor is to encourage an attitude of hope and renewal.

Instructor Note: When a question is asked, take time to field answers from the class before proceeding.

The Army Structure

The Army structure offers an opportune atmosphere for screening that exists nowhere in the civilian realm. Because the military is a rather closed society, access to personnel is much less limited and therefore, screening for well-being and subsequently for suicidal ideation is a much more viable option.

The Army Structure and screening (OH 2)

- The Army structure makes screening viable.
- Screening must be gated.
- The Suicide Prevention Task Force collects and reports anonymous data.

Gated Screening

The philosophy behind gated screening (screening which begins at a broad level for personal well-being and steps up in levels of specificity) is to afford treatment to the individual at the first sign of distress and save them from multiplied problems stemming from lack of early intervention. Gated screening begins with the small unit. Well-being screening can tell the screener the relative level of well-being of individuals within the unit as well as reveal trends of felt well-being to the commander. The Goldberg Well-being Scale should be offered to the individual as a tool to assess his or her personal well-being. It gives permission to the individual to self refer if they identify areas of distress in their lives. The individual may be asked to provide an anonymous number score from unit level screening for the HPC to provide a database large enough to insure anonymity for the small unit and protect the accurate flow of information to the database.

This screening does not mention the word "suicide" and is meant to bring those who feel distressed to self-refer to the screener who then screens them further and/or refers them to the appropriate secondary level counselor for further screening and counseling as appropriate. The secondary level counselor can choose to use a more in-depth screening tool or, if time and resources permit, personally screen the individual with the questions printed in this manual in the "gatekeeper" section.

The instruments that follow are resources for the screener to use. The first instrument is included in its entirety and can be used to screen small units for well-being. This instrument is a primary

or first level tool. The other three instruments are optional for more intensive follow-up screening and must be locally purchased if used.

The Goldberg Well-being Scale (1972) (OH 3) (HO 1, page 20)

David P. Goldberg, M.A., D.M., M.R.C.P. (London & Edinburgh), D.P.M.

Purpose: Monitor Personal Well-being

Administration: Individual or group

Time: 2-5 minutes

The Goldberg Well-being Scale consists of twelve questions, the best of 140 questions from the General Health Questionnaire (GHQ). This tool can be invaluable to the commander to enhance the quality of life in the command and secure early intervention for at-risk personnel for behavioral health problems

The Goldberg Well-being Scale asks questions which will alert counselors at the secondary prevention level (e.g., Social Workers, Family Life Chaplains, as well as unit level chaplains, ACS counselors, Family Advocacy and Community Counseling Center counselors.) They will then be able to address the well-being needs of soldiers, family members and civilians. Well-being screening can help reduce stress and puts counselors in position to further screen personnel for suicidal/homicidal and abusive behaviors/ideation. Early intervention through well-being screening and treatment at a secondary or crisis intervention level reduces the demand for tertiary or professional psychiatric level intervention and treatment.

The Goldberg Scale does not ask direct suicide questions but asks questions that indicate the degree of well-being the respondent feels. This method of screening at a lower level can reduce false positives at the tertiary or treatment level, thus enhancing counseling at the secondary level and reducing the screening duties of mental health professionals. The use of this low-level screening device allows Community Mental Health to concentrate more on treating those who need high-level interventions.

Goldberg's instrument is scored by assigning a zero value to the first two responses of "Not at all" and "No more than usual" and a value of one to the second two responses of "Rather more than usual" and "Much more than usual," thus making the scale appear to be a Likert Scale, but in reality, a "Yes" or "No" scale. This method of scoring is the author's method and is named GHQ after the name of the 140-question instrument. The GHQ method is very simple to do, requiring only simple addition and is statistically as accurate as a Likert scale method of scoring.

A secondary prevention level counselor should administer the instrument annually at the small unit level. It will screen the command for any soldier who needs supportive and/or crisis counseling for personal, family and job related situations that may be causing excessive strain on the soldier and unit. Additionally, the instrument can be used prior to deployment and other high-stress events to reduce the incidence of Operational Stress Reactions. (OH 4).

A follow-on screening for those personnel who show a low level of well-being from the Goldberg Scale can give a more comprehensive picture. Standardized instruments are available such as the Multidimensional Health Profile (MHP), which contains a Psychosocial Functioning subscale that covers life stress, coping skills, social resources, and mental health. Following is a description of this scale from the website of Psychological Assessment Resources (www.parinc.com), Inc., as well as a description of another standardized scale available from PAR, Inc., the Life Stressors and Social Resources Inventory.

Multidimensional Health Profile (MHP) (OH 5)

Linda S. Ruehlman, PhD, Richard I. Lanyon, PhD, Paul Karoly, PhD, and PAR Staff

Purpose: Assess psychosocial and health risks in primary health care settings

For: Ages 18 to 90 years

Administration: Self-administered; individual or groups

Time: Approximately 15 minutes for each booklet

The MHP is a comprehensive screening instrument designed for general use in health-related settings:

- Detects areas of clinical concern and targets areas for follow-up evaluation.
- Developed and standardized for use with individuals ages 18 years and older.
- Consists of two 4-page carbonless, hand-scorable test booklets for use together or separately.

This is the first instrument to provide comprehensive information about psychosocial and health functioning. National representative norms based on a sample of 2,411 participants are available by gender for three age groups (18-32 years, 33-50 years, and 51-90 years).

The MHP materials consist of a Professional Manual and two test booklets written at a fourth-grade reading level:

- The MHP-Psychosocial Functioning (MHP-P) booklet contains 58 items that cover four major areas of concern: life stress, coping skills, social resources, and mental health.
- The MHP-Health Functioning (MHP-H) booklet consists of 69 items that provide information in five major areas of concern: response to illness, health habits, adult health history, health care utilization, and health beliefs and attitudes.

Once the respondent has completed the booklet, the health professional peels back the top page to reveal the scoring page. Scale scores are plotted on the profile grid provided in the booklet. The scores are used to interpret the respondent's level of psychosocial and health functioning.

The MHP Professional Manual provides information on the development of the instrument; guidelines for administration, scoring, and interpretation; normative data; and data bearing on the reliability and validity of the scales.

Qualification Level: B

WW-3994-KT MHP Introductory Kit (includes MHP Professional Manual, 25 MHP-P Test Booklets and 25 MHP-H Test Booklets).

Life Stressors and Social Resources Inventory (LISRES-Adult)

Rudolf H. Moos, PhD

Purpose: Monitor ongoing life stressors and social resources

Administration: Individual or group

Time: 30-60 minutes

The LISRES provides a unified framework to measure ongoing life stressors and social resources and their changes over time. Integrating these 2 domains in 1 assessment tool provides a comprehensive picture of an individual's overall life context. This inventory identifies the level of current stressors and their sources as well as the available social resources.

The LISRES-A may be used with healthy adults, psychiatric, substance abuse, or medical patients:

- It covers 8 major areas of life experience: Physical Health, Spouse/Partner, Finances, Work, Home/Neighborhood, Children, Friends & Social Activities, and Extended Family.
- The LISRES can be administered and scored by those with no formal training in clinical or counseling psychology.

The respondent answers the 200 (LISRES-A) items contained in the 8-page reusable item booklet. Responses are marked on the 2-part carbonless answer/profile form.

Qualification Level: B

WVV-2806-KT LISRES-A Introductory Kit (includes Manual, 10 Reusable Item Booklets, and 25 Hand-Scorable Answer/Profile Forms).

BarOn Emotional Quotient Inventory (EQitm)

Based on seventeen years of research by Dr. Reuven BarOn and tested on over 19,000 individuals worldwide, the BarOn Emotional Quotient Inventory is designed to measure a number of constructs related to emotional intelligence. A growing body of research suggests that emotional intelligence is a better predictor of "success" than the more traditional measures of cognitive intelligence (IQ).

The BarOn EQi consists of 133 items and takes approximately 30 minutes to complete. It gives an overall EQ score as well as scores for the following subscales:

Intrapersonal Scales <ul style="list-style-type: none"> • Self-Regard • Emotional Self Awareness • Assertiveness • Independence • Self-Actualization 	Interpersonal Scales <ul style="list-style-type: none"> • Adaptability • Reality Testing • Flexibility • Problem Solving 	Stress Management Scales <ul style="list-style-type: none"> • Stress Tolerance • Impulse Control General Mood Scales <ul style="list-style-type: none"> • Optimism • Happiness
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These areas of emotional intelligence are measured with the aid of 4 validity indices and a correction factor.

Available from: MHS Organizational Effectiveness Group, 908 Niagara Falls Blvd. North Tonawanda, NY 14120, 1-800-456-3003.

Conclusion

This "gated" screening process provides a comprehensive general health/mental health profile of the soldier that benefits the individual, as well as the commander. When respondents who report concerns on the initial scale (such as the Goldberg Well-being Scale) are assessed in a follow up screen using a suicide scale and an interview for a possible referral for mental health care, there are less false positives than with a one step suicide screening. (see Gatekeeper Lessons 2 & 3, pages 41-70). Suicide screening instruments are presented on pg. 69 of this manual.

Handout 1**The Goldberg Well-being Scale (1972)***Please circle the appropriate response:*

<i>In the last two weeks have you:</i>	Not At all	No more than usual	A little more than usual	A lot more than usual
1. Been able to concentrate on whatever you're doing?	1	2	3	4
2. Lost much sleep over worry?	1	2	3	4
3. Felt that you are playing a useful part in things?	1	2	3	4
4. Felt capable in making decisions about things?	1	2	3	4
5. Felt constantly under strain?	1	2	3	4
6. Felt that you couldn't overcome your difficulties?	1	2	3	4
7. Been able to enjoy your normal day-to-day activities?	1	2	3	4
8. Been able to face up to your problems?	1	2	3	4
9. Been feeling unhappy and depressed?	1	2	3	4
10. Been losing confidence in yourself?	1	2	3	4
11. Been thinking of yourself as a useless person?	1	2	3	4
12. Been feeling reasonably happy, all things considered?	1	2	3	4

Scoring Chart: Copy your answers in the spaces below each question number: Score a "1" or "2" response as "no" and score a "3" or "4" response as "yes." Record totals below.

1	3	4	7	8	12

Question Number:

My Answer:

Yes Responses: ____

Question Number:

My Answer:

2	5	6	9	10	11

No Responses: ____**Total Responses:** ____

The number of total responses (0-12) reflects your perceived level of well-being

SPOT (GATEKEEPER TRAINING)

“**Gatekeeper**” usually refers to responsible individuals in the community who supervise or provide services to community members. The term can be expanded to include *all* members of the Army, as well as their families and friends, in the sense that all can share in the effort to assist or get help for at-risk individuals.

The **goal** of this prevention approach is to increase the chance that at-risk individuals will receive help before they engage in self-destructive behavior by enhancing the knowledge and responsiveness of everyone with whom at-risk individuals come in contact.

Everyone does not share the same level of responsibility, thus the knowledge, attitudes, and behaviors necessary for taking appropriate action at different levels are depicted in Table 2, page 22. At the first level, all personnel can report through the chain of command individuals they suspect as being at risk for suicide. Those at each successive level thereafter must know the procedure for reporting at-risk individuals, must be able to recognize these individuals, and know exactly where to take them for help.

Gatekeeper level I applies to all service personnel. Everyone should be prepared to more readily identify or spot suicidal individuals through knowledge of warning signs, common precipitants, and symptoms of depression. They should also be familiar with the myths about suicide that prevent taking appropriate action.

Gatekeeper level II or leaders to whom soldiers may come or refer others to for help must be able to inquire about suicide, and obtain formal help for at-risk individuals.

Gatekeeper level III or Formal Gatekeepers should be able to conduct a basic risk assessment and decide whether to refer to psychological/medical personnel.

Personnel at Gatekeeper level IV must be able to conduct risk assessment screening and provide treatment to resolve the suicidal crisis.

The next sections provide lessons to prepare individuals to **spot**, respond to, and obtain help for at-risk individuals. Referral sources and policies and procedures are covered in a subsequent section of this manual. The Office of the Chief of Chaplains offers train-the-trainer sessions at the Menninger Clinic, Topeka Kansas. There are also established, comprehensive, gatekeeper training programs that the Army can contract or bring in. Overviews and information about these programs, The Menninger Clinic, LivingWorks, and QPR, are located at the end of the Gatekeeper Training section.

Table 2

GATEKEEPER RESPONSIBILITIES

	KNOWLEDGE	ATTITUDE	BEHAVIOR
I. All Service Members	<ul style="list-style-type: none"> • Myths & Facts • Warning Signs • Referral Sources (“buddy system”) 	<ul style="list-style-type: none"> • Take Signs Seriously • Accept Help Seeking 	<ul style="list-style-type: none"> • Obtain Help
II. Officers/Non-commissioned Officers	<ul style="list-style-type: none"> • Myths & Facts • Warning Signs • Protective Factors • Referral Sources • Policies & Procedures 	<ul style="list-style-type: none"> • Take Signs Seriously • Accept Help Seeking 	<ul style="list-style-type: none"> • Supportive Response • Obtain Help • Promote help seeking
III. Formal Gatekeepers (Chaplains; All Medical Personnel)	<ul style="list-style-type: none"> • Myths & Facts • Warning Signs • Risk Factors • Referral Sources • Policies & Procedures 	<ul style="list-style-type: none"> • Take Signs Seriously • Accept Help Seeking 	<ul style="list-style-type: none"> • Supportive Response • Obtain Help • Crisis Management • Promote help seeking
IV. Health Care Professionals	<ul style="list-style-type: none"> • Myths & Facts • Warning Signs • Risk factors • Protective Factors • Policies & Procedures • Risk Assessment • Risk Management • Brief Interventions & Treatment 	<ul style="list-style-type: none"> • Take Signs Seriously • Accept Help Seeking • Working With Suicidal Individuals 	<ul style="list-style-type: none"> • Assess Risk • Manage Risk • Resolve Crisis

GATEKEEPER LESSON 1

Lesson Plan Advance Sheet

Title: Suicide Prevention: Spotting Suicidal Individuals (Final portion of "all Personnel Training)

Time: 30 minutes

Target Audience: All personnel (OH 1) *

Terminal Individual Objective

Task: Assist in identifying a suicidal service member and to take appropriate action, and make proper referrals. Encourage positive action.

Enabling Learning Objectives (OH 2)

Participants will be able to:

1. Understand the Suicide Model.
2. Answer general questions about suicide.
3. Identify common precipitants of suicide.
4. Identify symptoms of depression.
5. Identify myths about suicide.
6. Identify warning signs of suicide.
7. Take appropriate action in response to at-risk individuals.

Soldier Preparation

None

Instructional Procedures

Conference

*OH = Overhead

HO = Handout

Instructor's Notes

Instructor Note: 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 friends and neighbors. Another task for the instructor is to encourage an attitude of hope and renewal.

Instructor Note: When a question is asked, take time to field answers from the class before proceeding.

Preview Main Points (OH 3 a, b)

During this block of instruction, we will address the following areas:

- The Suicide Model.
- What is suicide?
- Why should we know about suicide?
- Why do people commit suicide?
- Some stressful situations that can trigger suicidal feelings in the Army.
- Who commits suicide?
- Groups with special problems that can cause suicidal feelings.
- Misconceptions about suicide.
- How can you tell if someone is thinking about committing suicide?
- Common symptoms of depression and hopelessness.
- Referral Procedures.

Suicide is not a pleasant topic. It is the denial of a human being's basic need: self-preservation and contradicts the evaluation of human life that is implicit in our democratic and social ethics. It strikes at the heart of our underlying moral and ethical principles.

People generally feel a certain fear, hostility and revulsion when they think of suicide. Those who end their lives may be thought of as terribly abnormal or deranged. We are conditioned to see suicide as more shocking, more revolting, and more unacceptable than any other cause of death.

One consequence of these reactions is the tendency to ignore suicide threats and behaviors, assuming that the person is "merely trying to manipulate the system." Most suicidal people in the military convey the message that the solution to their problems is to get out of the service. So making a suicidal threat sometimes appears to be a way to manipulate the system and get out of the military. However, it is very difficult to discern whether such a threat is a manipulative statement or a statement of intent. Certain people might label a suicidal person "lazy"; even more specifically, a segment of people might interpret suicidal behavior as violating the soldier's mission to serve as a warrior. One military view values courage in the face of the enemy above all else, even when the enemy is within us.

The helping person must bear in mind that even if the suicidal communication is a manipulation, it may be the last resort in a series of efforts to find a way out of the emotional pain the person has been experiencing.

It becomes absolutely necessary for the helping person to look beyond the possibility of manipulation and try to gain an understanding of the person's struggle to control his circumstances.

Suicide Model (OH 4)

In order to understand the responsibilities of a gatekeeper (*a concerned person who is in the position to **spot** suicidal behavior and render "first aid"*), a basic orientation to suicidal progression is essential. The previous lesson covered the primary suicide prevention aspects of **structure** and **screen**. When personal and environmental protective factors fail to inhibit self-destructive thoughts and behavior, then the gatekeepers' role intensifies. Dr. David Shaffer of Columbia University developed a model for understanding the progression of suicidal behavior and the critical points of intervention. The sequence of events in this model may progress very rapidly because suicide is usually an impulsive act. Note that any stress event, however small, may "trigger" a mood change. This "mood change" area is the critical intervention point. The presence of gatekeeper support and the denial of access to a method of suicide are key to avoiding death by suicide. If a gatekeeper can **spot** the critical mood change and a mental health professional can **secure** the individual, a life will be saved. The following general questions and answers about suicide will help in identifying those critical intervention points.

General Questions about Suicide

1. WHAT IS SUICIDE?

We could say that it is the deliberate ending of one's own life. The problem of suicide includes (OH 5):

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

2. WHY SHOULD WE KNOW ABOUT SUICIDE?

Anyone may be in a position to stop a person who is considering suicide. Most suicides and suicide attempts are reactions to intense feelings of loneliness, worthlessness, helplessness, and depression. People who threaten or attempt suicide are often trying to express these feelings to communicate and ask for help.

With the help that is available to people who experience these feelings, many suicide attempts can be prevented.

3. WHY DO PEOPLE COMMIT SUICIDE?

Why do people kill themselves? Psychological pain is a basic ingredient of suicide. Suicide is seldom a result of joy or happiness. Rather, negative emotions lead to suicide. Suicidal death, in other words, can often be thought of as an escape from pain.

Psychological pain is the hurt or ache that takes hold in the mind; the pain of excessively felt shame, guilt, fear, anxiety, loneliness, and the pain of growing old or dying badly.

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

The primary source of severe psychological pain is frustrated psychological needs. The need to succeed, to achieve, to affiliate, to avoid harm, to be loved and be appreciated; to understand what is going on.

When an individual completes suicide, that person is trying to blot out psychological pain that comes from defeated or frustrated psychological needs "vital" to that person. For practical purposes, most suicides tend to fall into one of four categories of thwarted psychological needs. They reflect different kinds of psychological pain, such as defeated love experiences, acceptance and belonging (OH 6a, b).

- Lack of control related to the needs for achievement, order and understanding.
- Problems with self-image related to frustrated needs for affiliation.
- Problems with key relationships related to grief and loss in life.
- Excessive anger, rage, and hostility.

4. WHAT ARE SOME STRESSFUL SITUATIONS (PRECIPITANTS) THAT CAN TRIGGER SUICIDAL FEELINGS IN THE MILITARY? (HO 2, page 34)

Certain events have been found to precipitate suicide in vulnerable individuals. These are not causes of suicide. Rather, they are events that occur just before an attempt or completion of suicide. Like straws that break the camel's back, they are stresses that push someone who is already vulnerable due to a psychiatric condition, personal coping style, or accumulation of stressful events to take self-destructive action. These include:

- A bad evaluation for an enlisted soldier or officer
- The break up of a close relationship.
- Drug or alcohol abuse.
- Renewal of bonding with family on return from long field training or an isolated tour.
- Leaving old friends.
- Being alone with concerns about self and family.
- Financial stressors.
- New military assignments.
- Recent interpersonal losses.
- Loss of self-esteem/status.
- Humiliation.

- Rejection (e.g., job, promotion, boy/girlfriend).
- Disciplinary or legal difficulty.
- Exposure to suicide of friend or family member.
- Discharge from treatment or from service.
- Retirement.

Depression and Hopelessness

Depression 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. Depressed people see things in a very negative way and have a difficult time generating effective ways of dealing with problems. Hopelessness is a spiritual/relational issue. It stems from feeling disconnected from God and/or others. This manual addresses support from others under the section entitled Support. The connection people have with a higher power or God 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 worldview and may enable that person to rebound from the most severe disappointments of life. Spirituality may or may not be religious in nature. The key issue is whether or not that spirituality is heartfelt or intrinsic in nature. Religious or spiritual affiliation/ideation without heartfelt experience offers little to personal resiliency, and may even add to the feelings of hopelessness. On the other hand, when spiritually connected, one may relinquish control to a power beyond themselves, bringing perspective and stability to otherwise overwhelming circumstances. There is a close relationship between depression, hopelessness, and suicide, so let's take a look at some of the symptoms of hopelessness and depression.

5. WHAT ARE COMMON SYMPTOMS OF HOPELESSNESS AND DEPRESSION (HO 3, page 35)

Hopelessness:

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

Depression:

1. Difficulty concentrating or remembering. Decreased attention, concentration or ability to think clearly such as indecisiveness.
2. Loss of interest in or enjoyment of usually pleasurable activities.
3. Loss of energy, or chronic fatigue, slow speech and muscle movement.
4. Decreased effectiveness or productivity.
5. Feelings of inadequacy or worthlessness, loss of self-esteem.
6. Change in sleep habits-- the inability to sleep or the desire to sleep all the time.
7. Pessimistic attitude about the future--negative thinking about the past.

8. The inability to respond with apparent pleasure to praise or reward.
9. Tearfulness or crying.
10. Change in weight-- poor appetite with weight loss or weight gain.
11. Recurrent thoughts of death or suicide.
12. Decreased sex drive.
13. Anxiety

6. WHO COMMITS SUICIDE?

All kinds of people commit suicide. Of completed suicides in the U.S., more men than women actually kill themselves. Sixty-seven of the sixty-eight suicides in the Army in 1998 were males. In 1999, nine percent (3) of the 65 completed suicides were females. Men are most likely to use quick violent means of suicide such as a gun, hanging, etc. In the U.S., the highest suicide rates are among people age 25-34 and people age 65 and over. In the U.S. Army in 1998, those between the ages of 20 and 34 actually had lower suicide rates than those aged 17-19, 35-39, and 45+. However, anyone, at any age, can complete suicide.

The rate (incidence) of suicide in the military over the past 10 years has essentially held steady. When only civilians aged 15-44 are considered, the rate of suicide in the civilian community was about 20 per 100,000 compared with 15.5 per 100,000 in the military in 1993.

According to Department of the Army statistics, the most recent peak year for all military suicides was 1990 when 250 took their own lives. In 1991 during Desert Storm and its aftermath, the number fell slightly to 232. In 1992, the number dipped to 218 but went up in 1993 to 239. In 1994, the number was close to 200.

Studies over the past 10 years indicate more than two-thirds of military suicides can be attributed to relationship problems with spouses or significant others, legal problems, financial problems, or substance abuse.

Military statistics indicate more suicides occur on installations in the U.S. than at deployment sites. More service members are assigned to U.S. installations than are deployed at any given time.

The numbers of suicides and rates per 100,000 of completed suicides for Army personnel from 1990 through 1999 are on this chart (OH 7).

1990 -102 (13.5)	1991 -102 (13.1)	1992 -87 (13.5)	1993 -90 (15.5)
1994 -80 (14.5)	1995 -78 (14.2)	1996 -68 (13.8)	1997 -56 (11.5)
1998 -68 (14.4)	1999 -65 (13.8)		

The number of nonfatal attempts is, of course, much higher. These attempts and completions have left their mark on thousands of fellow soldiers, friends and family members. See the Office Of The Deputy Chief of Staff, Personnel (ODCSPER) Website for current rates:

<http://www.odcspcr.army.mil/default.asp?pageid=66f>

Myths & Facts (HO 4, pages 36-38)

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

MYTH: Most suicides occur with little or no warning.

Rationalization: If you can't see suicide coming, there's nothing anybody can do.

FACT: Most people communicate warning signs of how they are reacting to or feeling about the events that are drawing them toward suicide. These warning signs--or invitations for others to offer help--come in the form of direct statements, physical signs, emotional reactions, or behavioral cues. They telegraph the possibility that suicide might be considered as a means to escape pain, relieve tension, maintain control, or cope with a loss.

MYTH: You shouldn't talk about suicide with someone who you think might be at risk because you may give that person the idea.

Rationalization: It is best just to avoid it altogether.

FACT: Talking about suicide does not create nor increase risk. It reduces the risk. The best way to identify the intention of suicide is to ask directly. Open talk and genuine concern about someone's thoughts of suicide is a source of relief and often one of the key elements in preventing the immediate danger of suicide. Avoiding the subject of suicide can actually contribute to suicide. Avoidance leaves the person at risk feeling more alone and perhaps with even less energy to risk finding someone else to be helpful.

MYTH: People who talk about suicide don't do it.

Rationalization: There is no need to get involved with people who talk about suicide.

FACT: People who attempt suicide usually talk about their intentions, directly or indirectly, before they act. Four out of five people who commit suicide talk about it in some way with another person before they die. Failing to take this talk seriously is suspected of being a contributing cause in many deaths by suicide.

MYTH: Non-fatal acts are only attention-getting behaviors.

Rationalization: These behaviors can either be ignored or punished.

FACT: For some people, suicidal behaviors or “gestures” are serious invitations to others to help them live. If help is not forthcoming, there is an all too easy transition between a desperate invitation to receive help and a conclusion that help will never come-- between little or no intent to die and a higher intent to die. Punishing suicidal thoughts or actions as if they were an improper way to invite help from others can be very dangerous. Punishment often has the opposite effect to that which is desired. Help with problems, as well as help in finding other ways to ask for that help, is far more likely to be effective in reducing suicidal behaviors.

MYTH: A suicidal person clearly wants to die.

Rationalization: There's no point in helping. They will just keep trying until they complete suicide.

FACT: Most suicidal people are ambivalent about their intentions right up to the point of dying. Very few are absolutely determined or completely decided about ending their life. Most people are open to a helpful intervention, sometimes even a forced one. The vast majority of those who are suicidal at some time in their life find a way to continue living.

MYTH: Once a person attempts suicide, he (she) won't do it again.

Rationalization: I don't need to be concerned now; the attempt will be cure enough.

FACT: Although it is true that most people who attempt do not go on to kill themselves, many do attempt again. The rate of suicide for those who have attempted before is 50 times higher than that of the general population: 50 % of completers have attempted before.

MYTH: A suicidal person's need is so great that I can't possibly make a difference..

Rationalization: They need more than I can provide, so only a specialist can help.

FACT: There are as many reasons for suicidal behaviors as there are people who engage in them. In terms of finding general rules that apply to all people, suicide is very complex. However, understanding and responding to suicidal behavior in a particular person does not require deep understanding of the motivation or circumstances of the suicidal feelings. All that is required is paying attention to what the person is saying, taking it seriously, offering support, and getting help. Many persons are lost to suicide because this type of emergency first aid and immediate support wasn't offered or available.

MYTH: If a person has been depressed (e.g., withdrawn and lacking motivation) and suddenly seems to feel better, the danger of suicide is over.

Rationalization: They're better. I won't have to talk to them about suicide or keep my eye on them.

FACT: The outcome of feeling better can go two ways: 1) full recovery as one would hope, 2) or *increased* risk because the emotional conflict over living or dying has been resolved in favor of death. Also, a person who is severely depressed may not have the energy to kill him/herself: a lifting depression may provide the needed energy or give clarity to the perceived hopelessness of continuing with life. Or, resources may withdraw prematurely and not provide the support necessary for continued progress. Open and direct discussion of suicide is the only way to determine which of these directions applies.

MYTH: Improvement following a suicidal crisis means that the suicidal risk is over.

Rationalization: Again, everyone can relax and not have to deal with the issue of suicide again.

FACT: Many suicides occur following 'improvement'. Suicidal feelings can return. For at least three months following a suicide crisis, be particularly attentive to the individual. Professionals should see patients frequently during this time, and assessment for depression, hopelessness, or anxiety should be made.

MYTH: Once suicidal, a person is suicidal forever.

Rationalization: There is no way to help eliminate suicidal feelings or hope the person can return to regular duties after a suicidal episode.

FACT: Most suicidal crises are limited in terms of time, and will pass if help is provided. However, if emotional distress continues without relief, and help is not provided, the risk remains for further suicidal behavior. Professional help should be obtained after which the individual can usually resume normal activities.

Warning Signs

How can you tell if someone is thinking about suicide?

Research tells us that most people who complete suicide give clues to their intentions. Be alert for these particular danger signals:

- Previous Attempts - this may mean that the person is at a high risk to try again.

- Threats - these are often followed by suicide attempts. Take all threats seriously.
- Depression and hopelessness- be aware of the symptoms of depression and hopelessness that were presented earlier (HO 3, page 35).
- Changes In Personality or Behavior - such as sleeplessness; lost weight, or a tendency to withdraw.
- Preparations For Death - such as quickly putting affairs in order, giving away personal possessions, acquiring a means to commit suicide such as a gun, rope or knife.

A complete list of warning signs is presented in **Handout 4, pages 38-40**.

Initial Response for All Personnel

If you suspect that someone is at risk for suicidal behavior because you have seen some of the warning signs mentioned above, or because the person has confided suicidal thoughts or plans to you, your job is to obtain help for them. You do not have to conduct a risk assessment or be certain at this point.

You and/or the suicidal person may be concerned about his/her getting into trouble or having a negative mark on their record. You may be concerned about their being angry with you. But these concerns don't compare to the consequences of failure to take action when it is called for (i.e. their possible death). It is better to overreact than under react.

If you can, talk about your concerns about his/her possible suicide or self-harm with the person and then get help. If you do not feel that you can confront the person, bring your concerns to the most immediately available proper authority such as the Company Commander, platoon leader, or chaplain.

REFERRAL PROCEDURES (HO 5, page 39)

1. PREPARATION

- A. Identify helping resources available on post.
- battalion aid station
 - unit Chaplain
 - unit headquarters
 - military police
 - family life center
 - post hospital

2. FOLLOW THROUGH

- Stay with the individual or get someone else to stay with them until you can get the person seen by medical personnel.
- Accompany the individual to Community Mental Health or the local MTF Emergency Room. If you can not accompany them, have someone else personally accompany the individual
- Notify the Chain of Command when applicable.
- Notify military or civilian police as appropriate (i.e. in emergency immediate life-threatening situations).

3. WHAT NOT TO DO

- Don't assume the person isn't the suicidal "type".

- Don't keep a deadly secret. Tell someone what you suspect.
- When speaking with them:
 - Don't act shocked at what the person tells you.
 - Don't argue or try to reason. Don't debate the morality of self-destruction or talk about how it might hurt others. This may induce more guilt.
 - Don't analyze the person's motives. "You just feel bad because..."
 - Don't try to shock or challenge the person. "Go ahead and do it." (This only works in the movies!)

Instructor Note: It is recommended that the appropriate local referral procedures and explicit contact persons be provided as a **handout** here. This lesson provides guidelines for the most basic response by a fellow soldier. More detailed guidelines for the next level of service personnel such as officers are provided in the next lesson.

Handout 2

Some Stressful Situations (Precipitants) That Can Trigger Suicidal Feelings in The Military?

Certain events have been found to precipitate suicide in vulnerable individuals. These are not causes of suicide. Rather, they are events that occur just before an attempt or completion of suicide. Like straws that break the camel's back, they are stresses that push someone who is already vulnerable due to a psychiatric condition, personal coping style, or accumulation of stressful events to take self-destructive action. These include:

- A bad evaluation for an enlisted soldier or officer.
- The break up of a close relationship.
- Drug or alcohol abuse.
- Renewal of bonding with family on return from long field training or an isolated tour.
- Leaving old friends.
- Being alone with concerns about self and family.
- Financial stressors.
- New military assignments.
- Recent interpersonal losses.
- Loss of self-esteem/status.
- Humiliation.
- Rejection (e.g., job, promotion, boy/girlfriend).
- Disciplinary or legal difficulty.
- Exposure to suicide of friend or family member.
- Discharge from treatment or from service.
- Retirement.

Handout 3

What Are Common Symptoms Of Hopelessness and Depression

Hopelessness:

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

Depression:

1. Difficulty concentrating or remembering. Decreased attention, concentration or ability to think clearly such as indecisiveness.
2. Loss of interest in or enjoyment of usually pleasurable activities.
3. Loss of energy, or chronic fatigue, slow speech and muscle movement.
4. Decreased effectiveness or productivity.
5. Feelings of inadequacy or worthlessness, loss of self-esteem.
6. Change in sleep habits-- the inability to sleep or the desire to sleep all the time.
7. Pessimistic attitude about the future--negative thinking about the past.
8. The inability to respond with apparent pleasure to praise or reward.
9. Tearfulness or crying.
10. Change in weight--poor appetite with weight loss or weight gain.
11. Recurrent thoughts of death or suicide.
12. Decreased sex drive.
13. Anxiety.

Handout 4

Myths and Facts

MYTH: Most suicides occur with little or no warning.

Rationalization: If you can't see suicide coming, there's nothing anybody can do.

FACT: Most people communicate warning signs of how they are reacting to or feeling about the events that are drawing them toward suicide. These warning signs-or invitations for others to offer help-come in the form of direct statements, physical signs, emotional reactions, or behavioral cues. They telegraph the possibility that suicide might be considered as a means to escape pain, relieve tension, maintain control, or cope with a loss.

MYTH: You shouldn't talk about suicide with someone who you think might be at risk because you may give that person the idea.

Rationalization: It is best just to avoid it altogether.

FACT: Talking about suicide does not create nor increase risk. It reduces the risk. The best way to identify the intention of suicide is to ask directly. Open talk and genuine concern about someone's thoughts of suicide is a source of relief and often one of the key elements in preventing the immediate danger of suicide. Avoiding the subject of suicide can be a contributory cause of suicide. Avoidance leaves the person at risk feeling more alone and perhaps with even less energy to risk finding someone else to be helpful.

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FACT: People who attempt suicide usually talk about their intentions, directly or indirectly, before they act. Four out of five people who commit suicide talk about it in some way with another person before they die. Failing to take this talk seriously is suspected of being a contributing cause in many deaths by suicide.

MYTH: Non-fatal acts are only attention-getting behaviors.

Rationalization: These behaviors can either be ignored or punished.

Handout 4, con't.

FACT: For some people, suicidal behaviors or “gestures” are serious invitations to others to help them live. If help is not forthcoming, there is an all too easy transition between a desperate invitation to receive help and a conclusion that help will never come-between little or no intent to die and a higher intent to die. Punishing suicidal thoughts or actions as if they were an improper way to invite help from others can be very dangerous. Punishment often has the opposite effect to that which is desired. Help with problems, as well as help in finding other ways to ask for that help, is far more likely to be effective in reducing suicidal behaviors.

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Rationalization: There's no point in helping, they will just keep trying until they complete suicide.

FACT: Most suicidal people are ambivalent about their intentions right up to the point of dying. Very few are absolutely determined or completely decided about ending their life. Most people are open to a helpful intervention, sometimes even a forced one. The vast majority of those who are suicidal at some time in their life find a way to continue living.

MYTH: Once a person attempts suicide, he (she) won't do it again.

Rationalization: I don't need to be concerned now; the attempt will be cure enough.

FACT: Although it is true that most people who attempt do not go on to kill themselves, many who attempt do attempt again. The rate of suicide for those who have attempted before is 40 times higher than that of the general population.

MYTH: A suicidal person's need is so great that I can't possibly make a difference.

Rationalization: They need more than I can provide, so only a specialist can help.

FACT: There are as many reasons for suicidal behaviors as there are people who engage in them. In terms of finding general rules that apply to all people, suicide is very complex. However, understanding and responding to suicidal behavior in a particular person does not require deep understanding of the motivation or circumstances of the suicidal feelings. All that is required is paying attention to what the person is saying, taking it seriously, offering support, and getting help. Many persons are lost to suicide because this type of emergency first aid and immediate support wasn't offered or available.

Handout 4, con't.

MYTH: If a person has been depressed (e.g., withdrawn and lacking motivation) and suddenly seems to feel better, the danger of suicide is over.

Rationalization: They're better. I won't have to talk to them about suicide or keep my eye on them.

FACT: The outcome of feeling better can go two ways: full recovery as one would hope, or *increased* risk because the emotional conflict over living or dying has been resolved in favor of death. Also, a person who is severely depressed may not have the energy to kill him/herself: a lifting depression may provide the needed energy or give clarity to the perceived hopelessness of continuing with life. Or, resources may withdraw prematurely and not provide the support necessary for continued progress. Open and direct discussion of suicide is the only way to determine which of these directions applies.

MYTH: Improvement following a suicidal crisis means that the suicidal risk is over.

Rationalization: Again, everyone can relax and not have to deal with the issue of suicide again.

FACT: Many suicides occur following 'improvement'. Suicidal feelings can return. For at least three months following a suicide crisis, be particularly attentive to the individual. Professionals should see patients frequently during this time, and assessment for depression, hopelessness, or anxiety should be made.

MYTH: Once suicidal, a person is suicidal forever.

Rationalization: There is no way to help eliminate suicidal feelings or hope the person can return to regular duties after a suicidal episode.

FACT: Most suicidal crises are limited in terms of time, and will pass if help is provided. However, if emotional distress continues without relief, and help is not provided, the risk remains for further suicidal behavior. Professional help should be obtained after which the individual can often resume normal activities.

Handout 5

Warning Signs

Warning signs are observable changes, behaviors, or statements that indicate directly or indirectly that an individual is contemplating suicide. These can be organized using the word, FACT as an acronym:

Feelings:

- Hopeless-“Things will never get better” “There’s no point in trying”; can’t see a future.
- Helpless-“There’s nothing I can do about it” “I can’t do anything right”.
- Worthless-“Everyone would be better off without me” “I’m not worth your effort”.
- Guilt, shame, self hatred-“What I did was unforgivable”.
- Pervasive sadness.
- Persistent anxiety.
- Persistent agitation.
- Persistent, uncharacteristic anger, hostility, or irritability.
- Confusion-- can’t think straight or make decisions.

Actions

- Uncharacteristic aggression.
- Risk taking.
- Obtaining weapon.
- Withdraw from friends/activities.
- Becoming accident-prone.
- Unauthorized absence.
- Getting into trouble, discipline problems.

Change

- Personality-more withdrawn, low energy, apathetic, *or* more boisterous, talkative, outgoing.
- Increased use of alcohol/drugs.
- Loss of interest in personal appearance, hygiene, neatness of personal items, space.
- Loss of interest in hobbies, work, sex.
- Marked decrease in work performance.
- Sleep, appetite increase or decrease.

Threats

- Statements--talking about suicide directly or indirectly, e.g., “How long does it take to bleed to death”, written themes of death, preoccupation with subject of death.
- Threats-“I won’t be around much longer”, writing suicide note, making direct threat.
- Plans-Give away prized possessions, making final arrangements-putting affairs (e.g., finances) in order.
- Sub lethal gestures or attempts, e.g., overdose, wrist cutting.

Aside from threats, none of these signs is a definite indication that the person is going to attempt or commit suicide. Many people experience depression, losses, or changes in behavior or demeanor without considering suicide. However, these signs do indicate that a person is troubled, and a concerned friend or supervisor should inquire as to what is going on and offer help. If a number of these signs occur, they may be important clues.

Handout 6

Referral Procedures

1. PREPARATION

A. Identify helping resources available on post.

- battalion aid station
- unit Chaplain
- unit headquarters
- military police
- family life center
- post hospital

2. FOLLOW THROUGH

- Stay with the individual or get someone else to stay with them until you can get the person seen by medical personnel.
- Accompany the individual or have someone else personally accompany the individual to a professional mental health provider.
- Notify the Chain of Command when applicable.
- Notify military or civilian police as appropriate (i.e. in emergency immediate life-threatening situations).

3. WHAT NOT TO DO

- Don't assume the person isn't the suicidal "type".
- Don't keep a deadly secret. Tell someone what you suspect.
- When speaking with them:
 - Don't act shocked at what the person tells you.
 - Don't argue or try to reason. Don't debate the morality of self-destruction or talk about how it might hurt others. This may induce more guilt.
 - Don't analyze the person's motives. "You just feel bad because..."
 - Don't try to shock or challenge the person. "Go ahead and do it." (This only works in the movies!)

GATEKEEPER LESSON 2

Lesson Plan Advance Sheet

Title: Suicide Prevention: Taking Appropriate Action

Time: 1 hour

Target Audience: Officers/NCOs (OH 1)

Terminal Individual Objective

Task: Provide supportive initial response to suicidal individual.

Enabling Learning Objectives (OH 2)

Participants will be able to:

1. Inquire about suicide
2. Respond to phone callers
3. Obtain help for suicidal individuals

Soldier Preparation

Gatekeeper Lesson 1

Instructional Procedures

Conference, role-plays.

INSTRUCTOR NOTES

Instructor Note: 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 friends and neighbors. Another task for the instructor is to encourage an attitude of hope and renewal.

Instructor Note: When a question is asked, take time to field answers from the class before proceeding.

INITIAL RESPONSE

The initial response is what *a leader (level II in table 2, page 22)* can do in response to someone who is either openly threatening or talking about suicide, or to someone who is showing warning signs, or is known to have risk factors or to have experienced precipitating events. It can be thought of as emotional first aid, and does not require expertise beyond knowing the guidelines outlined here *and* knowing who the person(s) are to whom the at-risk individual should be taken. The most basic goal here is to engage the person, and stay with them until help arrives or until you can hand them off to a professional. Such encounters all start in one of two ways: either *they* bring up suicide, or *you* bring it up in response to the distress/warning signs that you are seeing or because someone has brought the individual to your attention.

They bring up suicide: Direct Statements or Threats (OH 3 a-c). If someone is talking directly about suicide:

- Stay calm: look at them directly and speak in a calm but clear and concerned tone.
- If possible, send someone for help. **Note:** If there is a weapon involved, **CALL THE POLICE** and let them handle the situation.
- Do not leave the person alone, even to go to the bathroom. Let them know that you are not going anywhere.
- Buy time: encourage the person to talk and let him/her know you are hearing him/her. It almost doesn't matter what you talk about, because the more the two of you talk, the harder it is for them to maintain the arousal necessary to take action.
- Acknowledge what you are hearing and convey that you are taking it seriously. Acknowledgement always precedes alternatives, directives:
 - “*I’m hearing that this feels hopeless to you and I’m thinking that there may be a way to deal with this that we haven’t thought of yet.*”
 - “*I can see that you are very upset and I’d like you to put the gun down so we can talk.*”
- Listen to what the person is saying and let him/her know that you are hearing him/her by reflecting back what you are hearing.
 - “*It sounds like you are having some very rough times and you don’t see any way to deal with this.*”
- Convey that you hear they see suicide as an only option and let them know that you believe with help other possible options can be discovered.
 - “*I hear that you are thinking of (planning to) killing (or harming) yourself. Something must have gotten you very upset to reach this point. I’m concerned and I would like to*

help you find another way of handling this” or “I want to help you get to someone who can help you.”

- Secure any weapon or pills: be directive:
“Let me take those pills for now.”
- Note the time any pills were taken so you can provide this information to the person(s) you will be handing them over to for help.
- Take action: send for help or take the person to someone or call someone in. A good rule of thumb is to *never* try to respond to this situation alone.

You bring up suicide: Responding to Warning Signs or a Referral

If you spot warning signs or have some other reason for concern, you may have to share your concerns with the person. *If there is time*, and you do not wish to talk to the person, you may raise your concerns with the chaplain or a mental health professional. Here is one way to inquire about suicide (**OH 4 a, b**):

- Review your evidence- what is happening, what is the person doing that causes your concern?
“Tom, I’ve (or, other people have) noticed that since you didn’t get your promotion, you haven’t been going out with the guys, you haven’t been eating much, and you’ve been drinking a lot more.”
- Inquire about feelings or state what you have seen or heard:
“It would be normal to be upset about the promotion- it seems as if you have been taking it pretty hard, is that right?”
- If you get denial, persist:
“Well, you really have been down (or acting differently) – again, that’s understandable, but I wonder (or I’m concerned about) how bad this has been for you.”
- Use the “sometimes” approach:
“Tom, sometimes when people feel as bad as you do they have thoughts of harming or killing themselves.”
- Ask directly:
“Have you had thoughts of harming or killing yourself?”
- Get help:
“There are people who can help you at times like this- help you come up with ways of handling this without hurting yourself.”
- Convey Concern
If you get denial and do not feel convinced, let them know:
“Tom, you say you haven’t thought about killing yourself, but I’m still concerned. Let’s go talk with_____.”

Things to Avoid:

- Don't leave the person alone or send the person away.
- Don't overreact-don't be shocked by anything he (she) says. You don't have to explore all of the details. Leave that up to the professional. Get enough information to show your care, concern, and willingness to listen non-judgmentally.
- Don't rush-remember, you are just trying to establish contact and get the person to someone who can help; you are not trying to completely resolve the crisis.
- Don't minimize the person's concerns: *"This is not worth killing yourself over"*. Remember to acknowledge: *"I see this is very upsetting to you and I want to get help for you"*.
- Don't discount or make light of the suicidal threat: *"You don't really want to kill yourself"*.
- Don't argue whether suicide is right or wrong.
- Don't preach or moralize-*"You have everything to live for."* The issue is the problem or bind the person feels he (she) is in, not life and death per se.
- Don't challenge or get into a power struggle. You will do everything you can to get help right now, but ultimately he (she) has control over his decision.
- Don't think the person just needs reassurance. You can reassure that you will get help.
- Don't promise to keep the conversation confidential. There is limited confidentiality in life-threatening situations.
- Remember that all persons who are at risk for suicide need help. It is always better to overreact (in terms of taking action) than to fail to take action. It is better to have someone angry with you or embarrassed than dead.
- Take care of yourself by asking for a debriefing session. Professionals recommend and practice this regularly.

After the initial response, the person should always be seen by a professional who will conduct a formal risk assessment. The guidelines for risk assessment and the initial interview are presented in the next section entitled **Secure**.

HANDLING TELEPHONE CALLS (HO 7, PAGE 48)

Take appropriate action when faced with a potential suicide on the phone.

1. Establish a relationship with the person:
 - Quickly reinforce the person for having called or confided in you.
 - Be accepting, non-judgmental, warm, friendly, and supportive.
 - Although you may be feeling nervous, exude confidence and concern.
 - Let the person know you are willing to help, that you care for them as a person.
2. Gather information:
 - Get as much information as possible and find out specifically where the person is.

- If someone else is there, get him or her to make the other calls. Get an address and call the military or civilian police first.
- Always call the military or civilian police in a situation where danger of suicide is high and the person is not in a controlled situation, such as in the company of friends or loved ones.
- You may be the only person available to help. In order to make other calls to gather and mobilize the suicidal person's resources, you may have to end your conversation with him or her.
- If so, be certain they understand why you need to end the telephone call. Tell them that you will call them back shortly after you have obtained the required assistance.
- You may call a chaplain, clergy person or obtain the help of paramedics, police, military police, or others. Let the person know who you have obtained help from.

ROLE PLAYS

NOTE TO INSTRUCTOR: Present the Scenarios and allow time for class discussion. You may choose to record class answers/responses on overhead, blackboard easel. The first scenario has many "red flags" for discussion purposes. Don't expect suicidal behavior to be so easily recognized.

At this time, we are going to look at some situations of people who have considered attempting suicide.

SCENARIO #1 (HO 8, page 49)

PROBLEM:

A friend tells you about a fellow soldier who is away at a major field exercise, deployment, or other reason for the first time. The friend becomes very anxious over his failure to be successful. He breaks up with his girlfriend and begins drinking and using drugs. He talks about being a burden to his friends and a disappointment to his family and unit. You know he recently tried to buy a pistol, saying it was a gift for his father. What do these signs suggest and what would you do about them?

ALLOW TIME FOR DISCUSSION (about 10-15 minutes)

DISCUSSION LEADER'S CHECK LIST:

- The problem is one of serious suicidal risk.
- The exaggerated sense of failure.
- The changes in behavior.
- The breaking up of relationships.
- The feeling of being a burden; the veiled suicidal thinking.
- The attempt to buy a pistol shows there is no time to waste.

WHAT TO DO:

- Notify your first line supervisor, chaplain, or senior NCO. Ensure they understand the seriousness of the problem and are prepared to act immediately. If you are not satisfied that they are taking the situation seriously enough, call the Company Commander or first sergeant to alert them to your concern for this fellow soldier.
- If the service member is married, notify the family member.
- Find out who the soldier trusts. Go to that person and ask their assistance in talking directly with the soldier.

SCENARIO #2 (HO 8, page 49)

PROBLEM:

A soldier who has recently been passed over for promotion to the grade of staff sergeant is showing signs of erratic behavior at his (weekend drill, formations, on the job, or other situation). He has recently changed his attitude and performance level. In fact, he has recently changed his beneficiary on his life insurance. His depression has been heightened by increased smoking, late for formation, and signs of increased consumption of alcohol.

He has talked with his fellow soldiers about quitting and how disappointing his failure to make promotion was to his family. What do you think these signs suggest and what would you do about them?

ALLOW TIME FOR DISCUSSION (about 10-15 minutes)

DISCUSSION LEADER'S CHECKLIST

The soldier appears to have a severe, possible suicidal depression. The change in his behavior as a result of not being selected to the rank of staff sergeant has manifested itself in his personal actions:

- erratic behavior at his (weekend drills, formations, etc.).
- his behavior has altered on-the-job performance, changing his beneficiary on his SGLI life insurance, increased smoking and possibly drinking.

These signs are particularly suggestive of suicidal depression.

WHAT TO DO

- Open lines of communication with the soldier.
- Don't play down the significance of his situation as being unimportant.
- If risk seems imminent, don't leave him/her alone.
- Suggest professional help from (chaplain, medical facility or other).
- If he/she refuses help, take the initiative. Get the chain of command involved.

SCENARIO #3 (HO 8, page 49)

PROBLEM:

A friend you have known well for several years confides that he is very disturbed by thoughts of suicide. He/she is frightened about some things and would like help, but he/she is worried that if people find out about this problem, it will damage his/her career and home life. What do you do: What would you avoid doing.

ALLOW TIME FOR DISCUSSION (about 10-15 minutes)

DISCUSSION LEADER'S CHECKLIST:

- The problem is one of serious suicidal risk.
- The service member has a feeling of being "trapped" by his thoughts and circumstances.
- The individual may have signs of long-term depression.
- The service member's conversation clearly points in the direction of suicidal thoughts.
- The service member is willing to talk about his problems(s).

WHAT TO DO:

- Don't be judgmental.
- Don't act appalled or offended.
- Talk freely; show a willingness to discuss it.
- Ask questions, both generally about the way the person feels and specifically about suicide. Don't play it down by telling the person to be grateful for how lucky they are, or by assuring them that everything is going to be all right.
- If risk seems imminent, don't leave him/her alone.
- Suggest professional help.
- If he/she refuses to get help, take the initiative by talking with your supervisor, senior NCO, Chaplain or Company Commander.

IN CLOSING, REMEMBER-The only thing that will save a human life is a human relationship.
(OH 5)

Handout 7,**HANDLING TELEPHONE CALLS**

Take appropriate action when faced with a potential suicide on the phone.

1. Establish a relationship with the person:

- Quickly reinforce the person for having called or confided in you.
- Be accepting, non-judgmental, warm, friendly, and supportive.
- Although you may be feeling nervous, exude confidence and concern.
- Let the person know you are willing to help, that you care for them as a person.

2. Gather information:

- Get as much information as possible and find out specifically where the person is.
- If someone else is there, get him or her to make the other calls. Get an address and call the military or civilian police first.
- Always call the military or civilian police in a situation where danger of suicide is high and the person is not in a controlled situation, such as in the company of friends or loved ones.
- You may be the only person available to help. In order to make other calls to gather and mobilize the suicidal person's resources, you may have to end your conversation with him or her.
- If so, be certain they understand why you need to end the telephone call. Tell them that you will call them back shortly after you have obtained the required assistance.
- You may call a chaplain, clergy person or obtain the help of paramedics, police, military police, or others. Let the person know who you have obtained help from.

Handout 8

SCENARIO #1

PROBLEM:

A friend tells you about a fellow soldier who is away at a major field exercise, deployment, or other reason for the first time. The friend becomes very anxious over his failure to be successful. He breaks up with his girlfriend and begins drinking and using drugs. He talks about being a burden to his friends and a disappointment to his family and unit. You know he recently tried to buy a pistol, saying it was a gift for his father. What do these signs suggest and what would you do about them?

SCENARIO #2

PROBLEM:

A soldier who has recently been passed over for promotion to the grade of staff sergeant is showing signs of erratic behavior at his (weekend drill, formations, on the job, or other situation). He has recently changed his attitude and performance level. In fact, he has recently changed his beneficiary on his life insurance. His depression has been heightened by increased smoking, late for formation, and signs of increased consumption of alcohol.

He has talked with his fellow soldiers about quitting and how disappointing his failure to make promotion was to his family. What do you think these signs suggest and what would you do about them?

SCENARIO #3

PROBLEM:

A friend you have known well for several years confides that he is very disturbed by thoughts of suicide. He/she is frightened about some things and would like help, but he/she is worried that if people find out about this problem, it will damage his/her career and home life. What do you do? What would you avoid doing?

GATEKEEPER LESSON 3

Lesson Plan Advance Sheet

Title: Suicide Prevention: Assessing Risk

Time: 2 hours

Target Audience: Formal Gatekeepers (OH 1)

Terminal Individual Objective

Task: Assess Risk for Suicide

Enabling Learning Objectives (OH 2)

Participants will be able to:

1. Identify Risk Factors for Suicide
2. Conduct Basic Risk Assessment

Soldier Preparation

Gatekeeper Lessons 1 & 2

Instructional Procedures

Conference.

Instructor Note: This lesson contains materials that supplement those of Gatekeeper Lessons 1 & 2, pages 23-49. These reflect the additional responsibilities of individuals at level III of table 2, page 22. In summary, it is proposed that:

Gatekeeper Lesson 1: All service personnel should be prepared to more readily identify or spot suicidal individuals through knowledge of warning signs, common precipitants, and symptoms of depression. They should also be familiar with the myths about suicide that prevent taking appropriate action.

Gatekeeper Lesson 2: Leaders to whom soldiers may come or refer others to for help must be able to inquire about suicide, and obtain formal help for at-risk individuals.

Gatekeeper Lesson 3: Formal Gatekeepers should be able to conduct a basic risk assessment and decide whether to refer to psychological/medical personnel.

Risk assessment is best carried out within the context of a helping interview. Therefore, this lesson assumes that Gatekeepers possess basic interviewing skills, which include establishing rapport, exploring affect, clarifying problems, exploring alternatives, and arriving at an action plan. More extensive training, including practice sessions, is available through the LivingWorks and QPRT resources identified at the end of this Gatekeeper section.

Following is current information as to risk factors and an outline of questions for assessing suicide risk.

Instructor's Notes

Instructor Note: 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 friends and neighbors. Another task for the instructor is to encourage an attitude of hope and renewal.

Instructor Note: When a question is asked, take time to field answers from the class before proceeding.

Risk Factors

A risk factor is a characteristic (e.g., personality trait or attribute such as gender, age) or context (e.g., family environment, unit morale) associated with an individual. People who share that characteristic or context have a higher probability for suicidal behavior than those who do not. Those who possess a number of risk factors may be more *vulnerable* to acting more suicidal in response to the stressors or precipitants that were reviewed in Lesson 1.

A wide variety of characteristics, ways one responds to difficulties, and negative events have been proposed as associated with suicidal behavior. The problem with using risk factors to assess the probability of suicide is that they all produce *high false positives*. That is, the majority of individuals who possess or experience them do not attempt or commit suicide. However, it is preferable to react than to not react (i.e., to gamble that this person is not at-risk, when they really are - a *false negative*). Combined factors increase risk.

The following risk factors should prompt protective responses (HO 9, page 55):

- Previous attempt(s)
- Lethal, available, specific suicide plan.
- Family history of suicide.
- Psychiatric disorder
- History of violent behavior.
- Medical illness.
- Single: separated, divorced, widowed.
- Rigid cognitive problem appraisal-problem solving style: problem is intolerable, inescapable, interminable; desire for a quick fix, trouble finding alternatives, looks for passive solutions, favorable evaluation of suicide.
- Emotional functioning: over-arousal, cannot regulate affect (perturbation); low tolerance for pain/distress; impulsive (act versus think) *or* think (obsess, ruminate) versus act.
- Lack of future plans.
- Lack of social supports: isolated, alienated from peers, family.
- Access to firearms.
- Negative attitudes toward help seeking.

Risk Assessment

Assessing the potential for suicide requires that the leader identify the probability of an attempt. You should view the process as interviewing someone who is about to take a trip. The purpose of the questions is to draw out how the person interprets his or her situation, their self-talk about the crisis they see themselves in.

The goals for the leader in the assessment process are to:

- Determine the seriousness of the danger that the person will attempt.
- Determine how much time there is to prevent a death or serious injury.
- Find a way to break the suicidal thought process of the person and defer the decision to take their life.

As a leader, you should calmly and with a matter-of-fact approach ask the following questions. Again, these questions occur in the context of an interview and can be asked when it makes sense in the context of the interview. In particular, you do not need to “pop” the suicide question. Rather, as outlined in Gatekeeper Lesson 2, asking about suicide usually begins with reviewing your evidence. This is usually some statement on the interviewee’s part about his or her pain or conflict. Acknowledging this pain or conflict can serve as a “doorway” into questions about suicide.

Risk Assessment Questions (OH 3 a-c):

QUESTION #1 Have you been thinking of killing yourself?

The best way to find out if a person is contemplating self-destruction is to ask them. Always use harsh terms for death with the suicidal person. Use "kill yourself" instead of "do yourself in." Use "death," not "pass away." The purpose is to try to sober a suicidal person with the ugly, unseemly aspect of what he/she is contemplating. Determine how active (i.e., a wish to kill self) vs. passive (i.e., a wish to be dead) are the reported thoughts.

QUESTION #2 What has happened that makes life not worth living?

With this question, the leader begins to investigate the *events* that have hastened so much stress in the person's life; so much of the *feelings* of depression, helplessness, and hopelessness that are overwhelming. Look for losses in the individual's life and try to identify the sources of stress. Remember, find out what is stressful for *him/her*, not what *you* think is stressful. Find out what has interfered with the individual's ability to cope better with the particular stressor.

QUESTION #3 How will you do it?

In this question, the leader needs to listen for a specific plan of suicide and the availability of a lethal means of doing it. If the person has a specific plan and has the means available to carry out the plan, the leader should stop the counseling process and get the person to the medical chain of command immediately. If the plan is vague or there is no plan, the risk is lower and the leader should continue asking questions, unless, of course, there are clear indications that the person lacks control over impulsive action (e.g., they have been drinking to excess).

QUESTION #4 How much do you want to die?

Ask the person to place their wish to die on a 3-point scale

Little Wish to die (1) Some Desire to Die (2) Great Desire to Die (3)

QUESTION #5 How much do you want to live?

This question helps evaluate whether the suicidal person is thinking of suicide occasionally, which would put the person at a low risk, or are they constantly thinking about it, which would put the person at a high risk.

Little Wish to die (1) Some Desire to Die (2) Great Desire to Die (3)

QUESTION #6 How often do you have these thoughts?

The leader needs to know whether the person rarely thinks of suicide (low risk) or constantly thinks about it (high risk).

QUESTION #7 When you think of suicide, how long do the thoughts stay with you?

This question helps the leader to know whether the thoughts of the service member are under control. Are these thoughts actually preoccupations? Is the person obsessing about suicide? Do they express a fear of losing control (i.e., of not controlling the impulse to act self-destructively; again, an indication of high risk)? Further inquiry includes whether the person can turn off the thoughts, switch to other less threatening ones, or counter these with thoughts of reasons for living. Do these thoughts take the form of “command hallucinations;” (i.e., voices telling the person to harm self)?

QUESTION #8 Have you ever attempted suicide?

A previous attempt may have been a dry run for a more lethal try. Once the barrier is broken, subsequent attempts will become easier for the person. A history of suicidal thinking, gestures, or attempts increases risk for subsequent attempts or completion. If there is a recent history of prior attempt, further questions are called for to understand the context for that attempt and the consequences of that attempt (e.g., Exactly how did they attempt? Did they make more than one attempt? Did they get into treatment? Was the problem resolved? Is the current context similar/dissimilar?).

QUESTION #9 Have you been drinking heavily lately or taking drugs?

Quite often the reason people abuse alcohol/drugs is to escape from pain or stress. Drug and alcohol abuse are some major warning signs that suicide is being contemplated. The leader should evaluate the risk of suicide as higher if the answer to this question is yes.

QUESTION #10 Has anyone in your family committed or attempted suicide?

If a significant person in the individual's life has used suicide to manage a crisis, then the person may believe suicide is a valid option for him/her. If the answer to the question is yes, then the risk is greater.

QUESTION #11 Is there anyone or anything to stop you?

A no answer to this question means that a person is at a high risk for suicide and an immediate referral must be made.

QUESTION #12 On a scale of 1 to 10, what is the probability that you will kill yourself?

The person's answer to this question will offer a clear signal about his/her control or compulsion to act self-destructively. Any answer that expresses the person's belief that he (she) cannot maintain control commands immediate intervention to safeguard that person from himself/herself, then take appropriate steps to refer the service member through appropriate channels for further evaluation.

Instructor: Recall the referral steps reviewed in Lesson 2. Here you should identify *specific persons* as referral sources for the particular participants in this class. The scenarios from Gatekeeper Lesson 2, pages 41-49 (Handout 8, page 49) can be expanded to provide practice for inquiring about risks.

Handout 9

Risk Factors

- Previous attempt(s)
- Lethal, available, specific suicide plan
- Family history of suicide
- Psychiatric disorder
- History of violent behavior
- Medical illness
- Single: separated, divorced, widowed
- Rigid cognitive
- Emotional over-arousal, perturbation (on edge or very confused)
- Low tolerance for pain/distress
- Impulsive *or* obsessive
- Lack of future plans
- Lack of social support
- Access to firearms
- Negative attitudes toward help-seeking
- Unprepared gatekeepers
- Inaccessible services
- Uncoordinated services

SECURE**IMPLEMENTING POLICIES AND ASSESSING RISK****Lesson Plan Advance Sheet**

Title: Suicide Prevention: Implementing Policies and Assessing Risk

Hours: 2 hours

Target Audience: Health Care Professionals (OH 1)

Terminal Individual Objective

Tasks: Implement Policies and Assess Risk for Suicide

Enabling Learning Objectives (OH 2)

Participants will be able to:

1. Become knowledgeable about Army suicide policies and procedures
2. Conduct Advanced Risk Assessment

Soldier Preparation

Gatekeeper Lessons 1-3 or equivalent

Instructional Procedures

Conference.

Instructor Note: This lesson provides a framework for Army policies and procedures needed to address suicidal behavior. It also contains an overview of advanced screening techniques for professional gatekeepers. This is intended as a refresher and an update for trained individuals. If some individuals have not received prior training in suicide screening, a skills training program that includes practice and feedback is recommended.

Instructor's Notes

Instructor Note: 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 friends and neighbors. Another task for the instructor is to encourage an attitude of hope and renewal.

Instructor Note: When a question is asked, take time to field answers from the class before proceeding.

Policies and Procedures

The first part of the secure procedure is the *wide dissemination* of clear **policies and procedures** that ensure a coordinated rapid response to referrals of suicidal persons. Everyone should at least know whom to turn to if he (she) encounters an at-risk or actively suicidal individual. In turn, those designated referral sources should know exactly what steps to take to provide or ensure an initial supportive contact and brief assessment, and how to obtain a comprehensive professional assessment.

Instructor note: Different commands may require different procedures and this manual cannot provide specific Army procedures. The Suicide Prevention Task Force (see page 5) provides ASPP administrative guidance to the local commander for implementing policy. What is provided here are guidelines to be used as a reference point for your specific command. When providing this training, copies of the appropriate policies should be handed out or referred to.

Policies and Procedures are needed that spell out the steps to be taken and the referral sources to be contacted in response to **(OH 3 a, b)**:

- An individual suspected of being at risk for suicide
- An individual who is talking about/threatening suicide.
- An individual who attempts suicide.
- A completed suicide.

The chaplain is the primary unhindered referral source. Service members can go directly to the chaplain, Community Mental Health, the local MTF emergency room or consult the chain of command to receive information on available help on Post.

In general, then, during the day, suicidal individuals or individuals showing warning signs can be brought directly to Company Commanders and/or chaplains or unit aid stations. From there, they may be referred to the post hospital if there is a clear risk for suicide. After hours, at-risk service members can be brought to the attention of duty officers or duty chaplains who can decide if a referral to the post hospital is called for. Again, specific procedures must be worked out locally and made known to all service members.

General Assessment Guidelines

These assessment guidelines are meant for mental health professionals.

The second part of the secure procedure consists of the assessment and initial crisis interview with the suicidal individual. This section provides an overview of the basics of assessing and conducting an initial interview with a suicidal person. It in no way is a substitute for the comprehensive training that is required to assess and manage suicidal persons. In order to develop the *skills* (as opposed to simply knowledge) necessary to conduct interviews, skill practice and feedback is necessary. This section outlines the basic strategies that must be learned through further skills training. Resources are listed at the end of this section for more detailed information on the assessment and management of suicidal persons.

Steps in Suicide Assessment (OH 4)

A suicide risk assessment can be completed by performing the following steps.

- *Set the stage for the interview.*
- *Assess for risk factors and warning signs for suicide.*
- *Inquire about suicidal ideation.*
- *Determine the level of suicide risk.*

Set the stage for the interview.

Certain steps should be completed for successful communication and assessment. This is called “setting the stage for the interview”. The following steps are suggested:

- Ensure privacy. The trust of persons may be forfeited if they are not given private time to speak with you.
- Ensure confidentiality and explain situations in which confidentiality cannot be maintained. Confidentiality does not hold if a person is suicidal, homicidal, or abused. You must make this clear.
- Establish trust. Before asking any private questions, you must establish trust with the person. This involves the helping interview approach that was referred to in Gatekeeper Lesson 3, pages 50-55.

Assess for risk factors and warning signs for suicide.

This is covered in Gatekeeper Lesson 3, pages 50-55.

Inquire about suicidal ideation.

This was covered in Gatekeeper Lesson 2, pages 41-49. This section expands on that material by focusing on characteristics of the individual’s current state that can enhance the degree of risk. These characteristics are: perturbation, cognitive constriction, intentionality, and lethality of the plan (**OH 5**).

Perturbation is “the degree of upset, disturbance, tension, anguish, turmoil, discomfort, dread, hopelessness, or other excessive psychological pain.” It can reach a point at which it is no longer tolerable. At this point, a person becomes motivated to do something about it. To assess someone’s feelings about suicide, ask questions such as the following:

“How bad is the hurt?”

“Is it bearable?”

“Is the feeling of unhappiness so strong that sometimes you wish you were dead?”

Cognitive constriction “can be defined generally as dichotomous thinking, tunnel vision, or a narrowing of the range of options to two and ultimately one.” As a gatekeeper, you need to

determine: (1) if suicide is an option for the person you are assessing, and (2) if suicide is now seen as the only option. Perturbation often contributes to cognitive constriction. That is, anguish or anxiety causes a narrowing of cognitive processes called “tunnel thinking”. Edwin Shneidman, a pioneer in the field of suicide prevention, said that “only” is the four-letter word in suicide.

Cognitive constriction may be assessed by asking the “sometimes” question:

“Sometimes when people feel this way, they think about hurting themselves or killing themselves. Have you ever thought about hurting yourself or killing yourself?” “Is this your only option?”

Intentionality refers to the conscious aim, goal, or purpose in seeing suicide as a viable option and eventually the only option in alleviating perturbation.” Intentionality includes both of the following: (1) the insight or thought that cessation of consciousness is the solution for unbearable psychological pain, and (2) “the decision for action”. Most people who complete suicide deliberately plan to do so. In the case of younger people, however, a suicide plan is a less important sign of risk, given their history of, or tendency toward impulsive behavior.

Lethality is the dangerousness of a planned or likely action, [e.g., if one puts a loaded gun to my head and pulls the trigger, death is the likely result (high lethality)]; if one ingests six aspirin with intent to kill oneself, one would have low lethality. To assess lethality, you must assess the how, when, what, and where of a person’s plan for suicide.

A suicide plan can only be discovered through **direct questioning**. The counselor must assess three areas: specificity, lethality and availability (**OH 6**):

Specificity of the Plan:

A person who has a well thought-out suicide plan, including time, place, and circumstances, as well as a highly lethal method, is at very high risk. Ask the following type of direct question:

“Do you have a plan worked out for killing yourself?”

When assessing for a plan, you also need to determine if it includes any rescue possibilities. Persons who contemplate a plan likely to end in discovery may be more attached to people and/or more ambivalent than other people who plan for their suicide to occur in an isolated setting, one where there is a low likelihood of being rescued. You must determine the place and time. Asking the following types of questions:

- *“What time of day do you plan to do this?”*
- *“Where do you plan to do this?”*
- *“Is there likely to be anyone else around at that time?”*

Also important in understanding the suicide plan (and its underlying intent) is an understanding of fantasies and death wishes, (e.g., *“What do you hope to accomplish?”*) There may be a wish for reunion or rebirth, for joining a deceased loved one, etc. Death may also have a positive

meaning or a person may have a particular view of death. Many people who become suicidal do not really wish to die; instead, they want to bring about a change that will help make life more livable.

Method:

Methods vary in their lethality. High lethal methods include the use of a gun; large doses of sleeping pills, barbiturates, acetaminophen, antidepressants, particularly tri-cyclic antidepressants (TCAs), taken under conditions of the low possibility of rescue; hanging; jumping; from significant height, drowning; and vehicular crashes at high speed.

Low lethal methods include those where there is a high degree of possibility of rescue, (i.e., where there will be an amount of time sufficient for intervention to occur before death might result; or where the agent, (e.g., drugs), are of insufficient quantity and dosage to be lethal, (e.g., many over-the-counter drugs). [An excellent resource for evaluating lethality is: Smith, K., Conroy, R. W., & Ehler, B. D. (1984). Lethality of suicide attempt rating scale. *Suicide and Life-Threatening Behavior*, 14 (4), 215-242; although the table referring to lethal dosages of medications needs to be updated].

You must ask a suicidal person about his or her method for completing suicide. You may ask the following question:

“What are you thinking of doing?”

Availability and Accessibility of Means:

Ask the following types of questions to determine the availability and accessibility of means:

- *“Do you have pills?” or “How do you plan to get the pills?”*
- *“Do you have a gun?” or “How do you plan to get the gun?”*
- *“Do you know how to use a gun?” and “Do you have ammunition?”*

You may ask questions by following the (TIPM) (OH 7) assessment (Rosenberg, 1997):

T = Thoughts

I = Intent

P = Plan

M = Means

The “Assessment of Risk level for Suicide” can be used as a tool for gathering data related to risk factors and warning signs. See Table 3 (HO 10, page 62

Additional guidelines for risk assessment are provided for your information in handout 11, pages 63-66. These are not meant as a burdensome set of questions that must be covered step by step. They basically serve as reminders of areas that may need to be covered in your inquiry. The material contained in them, this lesson, and the additional references provided should be organized to fit an approach and protocol that you are comfortable with on a case-by-case basis. For example, you may obtain sufficient information to make a clinical decision as to the necessary action after inquiring about the individual’s current plan and resolve. Your clinical

sense of the interaction and how the patient is responding in the interview are also important data for making your decision.

The Use of Suicide Scales

There are a variety of suicide scales that have been developed to aid in the assessment of suicidal risk. These scales are *not* a substitute for a careful clinical interview. Getting well acquainted with an individual through an *interaction* can provide better understanding of his or her suicidality than adding up “risk factors” presented as a scale for suicidal risk (Motto, 1999). Nevertheless, scales can help to organize and keep track of appropriate areas of inquiry. Portions of the Los Angeles Suicide Prevention Center Scale are presented below as an example of a scale that can serve as a guideline for a suicide assessment interview.

Los Angeles Suicide Prevention Center Scale (HO 12, pages 67-68)

The Los Angeles Suicide Prevention Center Suicide Potential Scale is designed to serve principally as a clinical aid in the evaluation of a client (e.g., an office patient or a caller to a telephone crisis service) who has identified himself or herself as suicidal. The pressing need at this point is to evaluate how seriously suicidal is the person. The answer to that question determines whether the process is continued in the office or the phone, whether emergency procedures are initiated to hospitalize, whether other resources such as family, relatives, neighbors, etc. are enlisted, or other resources and actions are considered.

The LASPC Scale is aimed at providing the assessor with a ready reference list of significant factors in estimating the current suicidal risk. Although numbers are used to arrive at a final score, the score does not imply a rigidly defined level of self-destructive status, but rather a general level which may guide appropriate and adequate response.

Scoring of the Suicide Potential Scale is clinically oriented. Ten categories are listed containing varied numbers of items in each. After each item, numbers are given suggesting the usual range of score for each item. Scoring Instructions and guidelines are available from:

The Prediction of Suicide (pp. 74-79) edited by A. T. Beck, H. L. P. Resnik, and D. J. Lettieri, 1986. Philadelphia, PA The Charles Press Publishers. Copyright 1974 by Dr. Norman Farberow.

Other commonly used standardized scales are presented in handout 13, page 69. When working with suicidal individuals, it is important for you and for the patient to make these reasons explicit and discuss them as part of your assessment of the risk of imminent suicidal behavior.

Additional resources for screening and management of suicidal individuals are provided in handout 12, pages 67-68.

Handout 10: Table 3

Assessment of Risk Level for Suicide

<i>Immediate Risk of Suicide</i>	<i>Indicators of Risk</i>
No Predictable Risk	<ul style="list-style-type: none"> • no history of a suicide attempt • no suicidal ideation • close contact with significant others • social support system is satisfactory
Low Risk	<ul style="list-style-type: none"> • suicidal ideation • low lethal suicide methods • no history of suicide attempts • no recent serious loss • personal or social resources are present but problematic • risk of an attempt, repeat attempt, and eventual suicide is high, depending on what occurs after the threat or attempt • risk is increased if drugs or alcohol are abused
Moderate Risk	<ul style="list-style-type: none"> • suicidal ideation • high lethal suicide method with no specific threats or plan; <i>or</i> • low lethal suicide method with a suicide plan • includes attempts in which the chance of rescue is precarious • ambivalence is strong-life and death are seen as equally favorable • risk for a repeat attempt and eventual suicide is higher than low risk if no life changes occur
High Risk	<ul style="list-style-type: none"> • current high lethal suicide plan • obtainable means to complete suicide • history of previous suicide attempts • not able to communicate with a significant other • lean more in the direction of death than life • immediate and long-range risk of suicide is very high • attempt would probably be fatal without rescue unless help is available and accepted immediately • chronic self-destructive behavior increases risk even further
Very High Risk	<ul style="list-style-type: none"> • current high lethal suicide plan • available means to complete suicide • history of previous suicide attempts • cut off from resources • attempt would probably be fatal without rescue • lean more in the direction of death than life • immediate and long-range risk of suicide is very high unless help is available and accepted immediately • chronic self destructive behavior increases risk even further

Following are sections from Risk Management Foundation of the Harvard Medical Institutions. (D. G. Jacobs (Ed). Guide to Suicide Assessment and Intervention, 1999, San Francisco: Jossey-Bass).

Purposes

- To provide a model for the assessment of suicidality in all clinical settings.
- To provide information to be incorporated into institution-specific protocols.

These guidelines are not to be construed or to serve as a standard of care. Standards of medical care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advance and patterns evolve. This model should be considered only as a guideline. Adherence to it will not ensure a successful outcome in every case. It should not be construed as including all proper methods aimed at the same results. The ultimate judgment of suicidality regarding a particular patient must be made by the clinician in light of the clinical data presented by the patient and other available information (adapted from Practice guidelines for major depressive disorder in adults. Am J Psychiatry 1993; 150[suppl4]).

When to Use These Guidelines

Assessment and documentation of suicidality are integral components of any psychiatric evaluation and become primary concerns in that evaluation at the following times:

1. During initial interview or on admission to a facility or program.
2. With the occurrence of any suicidal/self-destructive behavior or ideation.
3. On the occasion of any noteworthy clinical change (e.g., significant new symptoms, mental status changes, stressors).
4. For inpatients who have been assessed to be suicidal, the following situations may prompt any additional assessment:
 - a. On progression to a less restrictive level of precautions or privileges (including therapeutic passes).
 - b. At time of discharge from hospital.

The assessment of suicidality is an active process during which clinicians evaluate:

- Suicidal intent and lethality.
- Dynamic meanings and motivation for suicide.
- Presence of a suicidal plan.
- Presence of overt suicidal/self-destructive behavior.
- The patient's physiological, cognitive, and affective states.
- The patient's coping potential.
- The patient's epidemiologic risk factors.

Many of these observations are made during the general psychiatric evaluation and mental status examination. However, a number of suicide specific questions may be included in this process.

Suicidal Intent and Lethality

1. Are suicidal thoughts/feelings present?
 - a. What are they?
 - b. Are they active/volitional or passive/non-volitional?
 - c. When did they begin?
 - d. How frequent are they?
 - e. How persistent are they?
 - f. Are they obsessive?
 - g. Can the patient control them?
 - h. What motivates the patient to die or to continue living?
2. Dynamic meanings and motivation for suicide.
3. What form does the patient's wish for suicide take?
Is there a wish to die, to hurt someone else, to escape, to punish self?
4. What does suicide mean to the patient?
 - a. Is there a wish for rebirth or reunion?
 - b. Is there an identification with a significant other?
 - c. What is the person's view of death and relationship to it?
 - d. Does death have a positive meaning for the patient?
5. Has the patient lost an essential sustaining relationship?
6. Has the patient lost his/her main reason for living? (These losses can be threatened.)

Presence of a Suicidal Plan

1. How far has the suicide planning process proceeded?
2. Specific method, place, time?
 - a. Available means?
 - b. Planned sequence of events?
 - c. Intended goal? (e.g., death, self-injury, or another outcome)
3. Feasibility of plan? Access to weapons (Document any conversation about access to guns or other lethal weapons. Consider the possibility of misinformation.)
4. Lethality of planned actions?
 - a. Objectively assess danger to life.
 - b. Objectively question patient's conception of lethality.
 - c. Avoid terms such as gesture or manipulation, because they imply a motive that may be absent or irrelevant to lethality.
 - d. Bizarre methods have less predictable results and may therefore carry greater risk.
 - e. Pay attention to violent, irreversible methods such as shooting or jumping.
5. Likelihood of rescue? Patients who contemplate a plan likely to end in discovery may be more ambivalent and/or attached to people than others who plan their suicidal behavior to occur in an isolated setting.
6. What preparation has the patient made (e.g., obtaining pills, suicide note, making financial arrangements)?
7. Has the patient rehearsed for suicide (e.g., rigging a noose, putting gun to head, driving near a bridge)?

Handout 11, con't.

History of Overt Suicidal/Self-Destructive Behavior

1. Have suicidal behaviors occurred in the past?

2. It is useful to explore the circumstances of any past suicide attempts. If the patient can describe the past event, this may provide the best window into the current state of mind. Absence of previous suicidality, however, does not eliminate the risk of current or future attempts.
3. Statistical relationships of suicide attempts to suicide completion are:
 - a. Attempters are at increased risk for suicide over the general population by 7-10 percent.
 - b. 18-38 percent of those who died by suicide have made a prior attempt.
 - c. 90 percent of attempters do not go on to complete suicide.
 - d. 1 percent of past attempters kill themselves each year.
4. Has the patient engaged in self-mutilating behaviors?
 - a. Wrist-cutting or other self-mutilation suggests consideration of the diagnoses of Post Traumatic Stress Disorder (PTSD) or dissociative disorders among others.
 - b. Although self-mutilation is frequently an act of self-soothing rather than an attempt to die, patients who self-mutilate do sometimes commit suicide.
 - c. In assessing risk of further self-mutilation, one useful question is, "How do you calm yourself down?"

The Patient's Physiological, Cognitive, and Affective States

1. Does the patient's mental state increase the potential for suicide?
 - a. Does the patient have the capacity to act?
 - (1) Suicide requires both the ability to organize and the energy to implement a plan.
 - (2) Suicide potential may be heightened when there is greater energy (as in early recovery from depression) or lowered inhibition (as during intoxication or rage).
 - b. Is the patient hopeless?
 - (1) Hopelessness is a key psychological factor in suicidal intent and behavior.
 - (2) It is often accompanied by pervasive negative expectations.
2. Are depression and/or despair present? Depression is a mood state or syndromal disorder associated with vegetative symptoms. Despair is a cognitive state that features a sense of futility about alternatives, no personal sense of a future role, and a lack of human connections that might offer support.
3. Is a diagnosable psychiatric disorder present that is correlated with suicidality or poor treatment compliance?
4. Does the patient's physiologic state increase the potential for suicide? (illness, intoxication, pain)
 - a. Are intoxicants present?
 - (1) Acute intoxication or withdrawal can lead to an acute increase in suicide risk.
 - a. State dependent: decreased inhibition, poor judgment, denial
 - b. Importance of precipitants such as interpersonal loss
 - (2) Thorough evaluation difficult when patient is intoxicated.
 - a. Provide safe place until sober
 - b. Reassess suicide risk when sober

Handout 11, con't.

- (3) Chronic abuse or dependence leads to a chronic risk.
 - a. Trait dependent self-destruction and decreased self-care
 - b. Suicide risk can be elevated when a relapse occurs
5. Is the patient vulnerable to painful affects such as aloneness, self-contempt, murderous rage, shame or panic?

The Patient's Coping Potential

1. Are there recent stressors in the patient's life?
 - a. Is the patient facing a real or imagined loss, disappointment, humiliation or failure?
 - b. Has there been a disruption in the patient's support system (including treatment)?
2. What are the patient's capacities for self-regulation?
 - a. Does the patient have a history of impulsive behavior?
 - b. Does the patient need, and can he or she use external sustaining resources to regulate self-esteem?
3. Is the patient able to participate in treatment?
 - a. Does the patient verbalize a willingness to comply with treatment plan?
 - b. Does the patient possess the capacity for making an alliance?

Handout 12**Los Angeles Suicide Prevention Center Scale**

Note: This is not the complete scale.

AGE AND SEX (1-9)	Rating for Category
MALE	
50 plus (7-9)	()
35-49 (4-6)	()
5-34 (1-3)	()
Female	
50 plus (5-7)	()
35-49 (3-5)	()
15-34 (1-3)	()
Symptoms (1-9)	
Severe depression: sleep disorder, anorexia, weight loss, withdrawal, despondency, loss of interest apathy (7-9)	()
Feelings of hopelessness, helplessness, exhaustion (7-9)	()
Delusions, hallucinations, loss of contact, disorientation (6-8)	()
Compulsive gambling (6-8)	()
Disorganization, confusion, chaos (5-7)	()
Alcoholism, drug addiction, homosexuality (4-7)	()
Agitation, tension, anxiety (4-6)	()
Guilt, shame, embarrassment (4-6)	()
Feelings of rage, anger, hostility, revenge (4-6)	()
Poor impulse control, poor judgment (4-6)	()
Other (describe):	
Stress (1-9)	
Loss of loved person by death, divorce, or separation (5-9)	()
Loss of job, money, prestige, status (4-8)	()
Sickness, serious illness, surgery, accident-loss of limb (3-7)	()
Threat of prosecution, criminal involvement, exposure (4-6)	()
Change(s) in life, environment, setting (4-6)	()
Success, promotion, increased responsibilities (2-5)	()
No significant stress (1-3)	()
Other (describe):	
Acute Versus Chronic (1-9)	
Sharp, noticeable and-sudden onset of specific symptoms (1-9)	()
Recurrent outbreak of similar symptoms (4-9)	()
No specific recent change (1-4)	()
Other (describe)	
Suicidal Plan (1-9)	
Lethality of proposed method-gun, jumping, hanging, drowning, knife, pills, poison, aspirin (1-9)	()
Specific detail and clarity in organization of plan (1-9)	()
Specificity in time planned (1-9)	()
Bizarre plan (1-9)	()
Rating of previous suicide attempt(s) (1-9)	()
No plans (1-3)	()
Handout 12, con't.	

Other (describe):

	Rating for Category
Resources (1-9)	
No sources of support (family, friends, agencies, employment) (7-9)	()
Family and friends available, unwilling to help (4-7)	()
Financial problems (4-7)	()
Available professional help, agency or therapist (2-4)	()
Family and/or friends willing to help (1-3)	()
Stable life history (1-3)	()
Physician or clergy available (1-3)	()
Employed (1-3)	()
Finances no problem (1-3)	()
Other (describe):	
Prior Suicidal Behavior (1-7)	
One or more prior attempts of high lethality (6-7)	()
One or more prior attempts of low lethality (4-5)	()
History of repealed threats and depression (3-5)	()
No prior suicidal or depressed history (1-3)	()
Other (describe):	
Medical Status (1-7)	
Chronic debilitating illness (5-7)	()
Pattern of failure in previous therapy (4-6)	()
Many repealed unsuccessful experiences with doctors (4-6)	()
Psychosomatic illness, e.g., asthma, ulcer, hypochondria (1-3)	()
No medical problems (1-2)	()
Other (describe):	
Communication Aspects (1-7)	
Communication broken with rejection of efforts to reestablish by both patient and others (5-7)	()
Communications have internalized goal, e.g., declaration of guilt, feelings of worthlessness, blame, shame (4-7)	()
Communications have interpersonalized goal, e.g., to cause guilt in others to force behavior, etc. (2-4)	()
Communications directed toward world and people in general (3-5)	()
Communications directed toward one or more specific persons (1-3)	()
Other (describe):	
Reaction of Significant Others (1-7)	
Defensive, paranoid, rejected, punishing attitude (5-7)	()
Denial of own or patient's need for help (5-7)	()
No feelings of concern about the patient; does not understand the patient (4-6)	()
Indecisiveness, feelings of helplessness (3-5)	()
Alternation between feelings of anger and rejection and feelings of responsibility and desire to help (2-4)	()
Sympathy and concern plus admission of need for help (1-3)	()

Handout 13

The Scale for Suicide Ideation. Beck, A. T., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intent: The Scale for Suicide Ideation. Journal of Consulting and Clinical Psychology, 47, 342-352.

The Hopelessness Scale. Beck, A. T., Weissman, A., Lester, D., & Trexler, L., (1974). The measure of pessimism: The Hopelessness Scale. Journal of Consulting and Clinical Psychology, 42, 861-865.

The Suicidal Ideation Questionnaire. Reynolds, W. M. (1987). Odessa, FLA: Psychological Assessment Resources (PAR, Inc.).

The Reasons for Living Inventory. Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. K. (1983). Reasons for staying alive when you are thinking of killing yourself: The Reasons for Living Inventory. Journal of Consulting and Clinical Psychology, 51, 276-286.

Spirituality and Resilience Assessment Packet Version 4.2. Kass, Jared D. & Lynn (2000) Greenhouse Inc. 46 Pearl Street, Cambridge Massachusetts 02139 Ph. (617) 492-0050
Military contracted source: <http://chppm-www.apgea.army.mil/dhpw/default.htm>

Note: These scales are copyrighted and cannot be reproduced here. They can be obtained from the above sources. Updated reviews from the National Institute of Mental Health and other sources of currently available suicide scales are on track to be published in the spring or summer of 2000.

Handout 14

Additional Reference Materials

Additional material on prevention and the assessment and management of suicidal persons is available from the following sources.

Bongar, B. (1991). The suicidal patient: Clinical and legal standards of care. Washington, DC: American Psychological Association. *Very good treatment of assessment. One of the most thorough overview of assessment and outpatient management issues available.*

Chiles, J. A., & Strosahl, K. D. (1995). The suicidal patient: Principles of assessment, treatment, and case management. Washington, DC: American Psychiatric Press. *Clearly written practical strategies and the philosophical issues involved in working with acute and chronic suicidal cases.*

Hoff, L. A. (1995). People in crisis: Understanding and helping. San Francisco: Jossey-Bass. *This, along with Kleespies, is one of the better general texts on crisis intervention.*

Jacobs, D. G. (Ed.). (1999). Guide to suicide assessment and intervention. San Francisco: Jossey-Bass. *The most current and thorough treatment of this topic.*

Kleespies, P. M. (Ed.). (1998). Emergencies in mental health practice. NY: Guilford.

Maris, R. W., Berman, A. L., Maltzberger, J. T., Yufit, R. I. (1992). Assessment and prediction of suicide. NY: Guilford. *A comprehensive and detailed resource on assessment by leading authorities in the field.*

Mitchell, J. T., & Everly, G. S. (1995). Critical incidence stress debriefing: Cisd: An operations manual for the prevention of traumatic stress among emergency and disaster workers. Baltimore: Chevron Publishing. *Mitchell is the founder of CISD, and this is one of a number of practical step-by-step books available from Mitchell's group through Chevron.*

Shea, S. C. (1999). The practice of suicide assessment: A guide for mental health professionals and substance abuse counselors. New York: John Wiley & Sons. *This is an excellent practical source that contains detailed guidelines and verbatim examples for assessing suicide risk.*

Switzter, David K. (1986). The minister as crisis counselor. Nashville, TN: Abington Press. *This is a classic source for basic crisis counseling with special considerations for clergy.*

Worden, J. W. (1991). Grief counseling and grief therapy. NY: Springer Publishing. *The best practical guide in this area.*

Menninger Suicide Prevention Training sponsored by The Office of the Chief of Chaplains

Background Information

In 1993 the Office of the Chief Of Chaplains began sponsoring Basic Suicide Prevention Training and Advanced Suicide Prevention Training at the Menninger Clinic. The training is the standard for training chaplains in Suicide Prevention Training for their units.

Point of Contact:

Office of the Chief of Chaplains, ATTN: Soldier and Family Ministries (DACH-PPF)
2511 Jefferson Davis Highway, Crystal City
Arlington VA 22202-3907
DSN 329-1182 CML (703) 601-1182

LivingWorks

Education

ASIST: Applied Suicide Intervention Skills Training

Background Information

1. Origins: Four human service professionals, from psychiatry, psychology and social work, collaborated with the provincial and state governments of Alberta and California, and the Alberta Division of the Canadian Mental Health Association in Alberta to develop suicide intervention training programs for front-line caregivers/gatekeepers of all disciplines and occupational groups. Founded as a partnership in 1983, LivingWorks Education is a public service corporation.

One of the original four principals died in 1997. New principals have been added and LivingWorks has reorganized to ensure its long-term survival and commitment to public service.

LivingWorks programs are delivered through an extensive network of community-based registered trainers in Canada, the United States, Australia and several other countries. LivingWorks is dedicated to enhancing suicide intervention skills at the community level, and committed to making its suicide prevention training programs widely available, cost effective, interactive and easy to learn, with practical applications designed for all types of caregivers. The LivingWorks objective is to register qualified trainers in local communities, who in turn can prepare front-line gatekeepers with the confidence and competence to apply first-aid suicide intervention in times of individual and family crises.

2. Beneficiaries: Customers of LivingWorks' suicide intervention training workshops (Applied Suicide Intervention Skills Training - ASIST, formerly the Suicide Intervention Workshop, and before that the Foundation Workshop) include provincial, state, and federal government departments and agencies involved in alcohol and drug abuse, family and children, mental health, military, police and corrections services; public school boards, hospital departments,

native communities, and nongovernmental community mental health and crisis intervention organizations.

LivingWorks' Training for Trainers Courses have trained and certified more than 1,400 locally based suicide intervention workshop instructors since 1983. They, in turn, have given first aid suicide intervention training to more than 130,000 community participants from all walks of life. An average of over 10,000 participants annually attend ASIST. ASIST is by far the most widely used, acclaimed and researched program of its kind in the world.

Training for Trainers Courses and local ASIST workshops are user-financed through institutional sponsorships and individual registration fees. The specific benefits to caregivers are reductions in the fears and taboos associated with the word "suicide" and increases in the knowledge and skills, which empower them to effectively deal with almost any suicidal situation. Participants come away knowing that suicide is a preventable problem.

Evidence from properly integrated and coordinated suicide prevention program with other community prevention and health promotion programs has shown reduced rates of suicide in prison populations, public school regions, and in Native American communities. Apart from formal evaluations, anecdotal feedback from individuals and their families frequently describe life-saving benefits in specific situations.

3. Dissemination and Impact: A program originally developed to reduce the problem of suicide for individuals and families in Alberta has spread far beyond its original mandate. In addition to its widespread use in Canada, Washington, California Australia and Norway, there are resident certified trainers in Singapore, Denmark, and Sweden, and several other states - Georgia, Louisiana, New Mexico, Oregon, Tennessee, Texas, and Washington.

The U. S. Army (5th Corps) in Germany implemented the program in 1990. Successful demonstrations have been made in Australia, India and Russia. The programs have been successfully presented in a wide range of settings: family and child welfare services, school systems, correctional institutions, northern communities, hospital departments, police programs, mental health agencies, peer group programs, employee assistance programs, college and university settings, etc.

In 1993, LivingWorks Education was a co-sponsor of the United Nation's first inter regional experts meeting on suicide prevention and continues to work with the UN Department of Policy Coordination & Sustainable Development on the dissemination of national strategy guidelines for the prevention of suicide to member countries and interested NGOs around the world. In the United States, a grass roots movement, SPAN (Suicide Prevention Action Network) is actively lobbying the federal government to develop a national strategy plan.

The impact on workshop participants has been considerable. Individual caregivers consistently report increased competence and confidence in first-aid skills, provide frequent anecdotal reports of lifesaving interventions, and 99% recommend the program for others. Public users in the form of community agencies report increased grant support from charitable foundations; large correctional services have improved their community service image by providing trainers free-of-charge for community workshops; and the U. S. Army was sufficiently impacted that they had the developers provide critical incident stress debriefing and bereavement service training during the Gulf War.

#208,1615-10th Ave. SW, Calgary, AB, Canada, T3C OJ7.

- Ph: 403 209 0242
- fax: 403 209 0259
- email: living@nucleus.com • web: www.livingworks.com

QPR Gatekeeper Instructor Certification Course

For any person or organization interested in preventing suicide in their community

Course Description:

This certification course trains instructors to teach QPR, CPR for Suicide Prevention to their community. Participants first learn about the nature of suicidal communications, what forms these communications take and how they may be used as the stimulus for a QPR intervention. To gain perspective, participants are introduced to the history of suicide, suicide prevention and the spectrum of modern day public health suicide prevention education efforts. The history, background and research support for QPR are reviewed. Participants then learn to market QPR, target potential gatekeepers, and how to teach the QPR curriculum. Participants also learn to deal with pent-up audience demand to talk about suicide, survivor issues and how to make immediate interventions and referrals. Each participant has the opportunity for individual rehearsal and practice.

Course Objectives:

- To understand the nature, range and importance of suicidal communications and their importance in preventing suicide.
- To review and understand the groups at greatest risk of suicide and why QPR can work for them. To train participants to teach QPR, CPR for Suicide Prevention.
- To gain a historical perspective about suicide prevention and how QPR fits into national efforts.
- To acquire specific knowledge about how audiences may respond to the QPR message and how to react in a helpful manner.
- To learn how to effectively market suicide prevention in their own communities.
- To gain the competence and confidence to teach others how to save lives and help prevent suicidal behaviors.

Course Content:

- Suicidal communications: video vignettes and discussion
- Suicide and suicide prevention in history
- Gatekeeper training; how, why and the research
- New and promising approaches to suicide prevention. Targeting prevention education efforts
- Review of the QPR video
- Teaching QPR
- Facilitating role plays
- Handling questions from audiences
- National and local resources and how to use them
- Expanding QPR to other community prevention efforts
- Completion of evaluations of training
- Orientation to the national QPR network and Greentree
- Awarding of three-year Instructor Certificates

Certification Program includes:

- A full-day training course
- A QPR Instructors Manual complete with:
 - QPR training video hosted by Carrie Fisher
 - Detailed teaching information
 - 35mm slides
 - Overhead masters for transparencies
 - Audiotape of a QPR Gatekeeper training
 - Two QPR booklets and QPR wallet cards
 - A copy of *Tender Leaves of Hope* booklet
 - Tool kit (continuously updated) with information on issues related to suicide
 - Two of Dr Quinnett's books: *Suicide: The Forever Decision & Suicide: Intervention and Therapy*
 - Access to Greentree's 800 number for consultations on QPR training
 - *QPR Times*: a newsletter created for QPR
 - Certified Gatekeeper Instructors

QPRT is an acronym for Question, Persuade, Refer or Treat

QPRT Training is one of the many programs offered by **Greentree Behavioral Health**. Greentree Behavioral Health, a nonprofit organization, is a division of:

Spokane Mental Health
524 West Sixth Avenue
Spokane, Washington 99204
509 458-7471 800 256-6996

Further information about QPRT can be obtained from the **QPR Institute (888-726-7926)**

QPRT

Suicide Risk Detection, Risk Assessment and Risk Management

For Counselors, Case Managers and Health Care Providers

Course Description:

This course introduces counselors and care providers to suicide risk detection, risk assessment, and risk management from a medical, psychological and legal perspective. The course is both didactic and interactive, and provides practice with the QPRT Suicide Risk Management Inventory. At the conclusion of the course, participants will be able to conduct a suicide risk assessment, complete the QPRT Suicide Risk Management Inventory, and engage an at-risk client and/or family in a no suicide contract and a shared risk management plan.

Course Objectives:

- Identify at least ten major risk factors for suicide.
- Describe current suicide risk assessment methods, their contributions and limitations.
- Make informed risk assessment judgments, based on actual experience in estimating suicide risk from clinical vignettes.
- Describe the rationale and components of the *QPRT Suicide Risk Management Inventory*.
- Be able to engage an at-risk patient in a frank discussion of suicidal thoughts, feelings and plans, including taking a pertinent suicide history.
- Be able to conduct and complete a risk assessment interview, complete the QPRT, and document a risk management plan, including a no-suicide contract.
- Be familiar with the QPR: CPR for Suicide Prevention public health education program.

Course Content:

- Suicide risk factors in clinical settings, epidemiology and overview.
- Detecting suicidal thoughts and feelings; understanding the problem of dissimulation.
- Risk factors and their assessment (practice in risk rating clinical cases).
- Completing the QPRT Suicide Risk Management Inventory (interview and practice\with form).
- Understanding para suicidal behavior.
- Managing the at-risk patient over time; risk windows and opportunities.
- Treatment considerations for depressive illness and co-morbid substance abuse.
- Avoiding bad outcomes: clinical and legal considerations.

QPRT POSTVENTION

In the Aftermath of Suicide

Course Description:

Trauma can occur at any time in an individual's life. Rarely is the impact greater than the death of a loved one to suicide. This training provides participants with the basic information and skills to assist survivors of suicide in processing their initial grief reactions and to assist them in the early phases of healing. Utilizing both didactic and interactive methods of presentation, participants will explore personal perspectives associated with death and suicide, characteristics of acute and/or posttraumatic stress reactions, a model for conducting a quality postvention interview, as well as concerns of contagion and strategies for contagion control. By learning effective intervention strategies, participants will be in the position to promote a healthy grief response in their clients or, in some circumstances, to intervene in the suicidal journey of a surviving family member or friend.

Course Objectives:

- Explore personal attitudes associated with death and suicide.
- Facilitate the awareness of trauma in general, and the impact of suicide in particular.
- Identify the major symptoms and characteristics of acute stress reactions and posttraumatic stress disorder.
- Describe the differences in grief and recovery related to anticipated versus unanticipated death.
- Be able to utilize a step-by-step format for conducting a postvention interview.
- Awareness of the prevalence of contagion and procedures for contagion control.
- To decrease the self-destructive acting out and/or number of suicides by a friend or loved one following a suicide.
- Explore the bereavement crisis associated with the clinician as survivor.
- To practice through role-playing, the application of postvention interview skills.

Course Content:

- Review of symptoms associated with acute and/or posttraumatic stress reactions.
- Exploration of differences in grief associated with anticipated versus unanticipated death.
- Overview of basic therapeutic intervention strategies.
- Identification of benefits associated with postvention efforts.
- A step-by-step format for conducting a postvention interview.
- Definition of contagion and its prevalence following a suicide.
- Policies and procedures for contagion control.
- Address factors that are present when clinicians are the survivors of suicide.
- Treatment and referral considerations.

CRITICAL INCIDENT STRESS DEBRIEFING

This section describes Critical Incident Stress Debriefing. This is a procedure that should be implemented for all caregivers who have worked with an individual who completes suicide or makes a seriously injurious attempt. This is just an overview. Formal training is required to provide this procedure. See resources listed at the end of this section.

Support Strategies for the Professional: Critical Incident Stress Debriefing

Assisting an individual who is considering or threatening suicide can be a highly stressful endeavor. On one hand, such stress can actually enhance the professional's ability to assess and intervene in the situation by sharpening attention to detail and creating the concern to thoroughly follow through with prevention plans. Some aspects of this stress are not quite as productive. In fact, fear or nervousness about the client's safety may be somewhat overwhelming and become an obstacle to thorough assessment and intervention. One type of stress associated with "high-consequence activities (HCA's), such as suicide prevention, is almost always negative and disturbing -- that is Critical Incident Stress.

"High-consequence activities" are defined as those tasks, such as suicide assessment, in which small oversights or omissions may result in serious, or perhaps tragic outcomes. This, of course, results in a great deal of both real and perceived pressure and responsibility on the professional involved in the suicide assessment or other "high-consequence activity". It is not unusual for the professional to express feelings of self-doubt or anxiety about the thoroughness of the evaluation or intervention plan when working with a client at risk of suicide. It is also not unusual for the same professional to be completely overwhelmed in those instances when a client may actually go on to hurt or kill themselves in the hours, days, or weeks following assessment, intervention and treatment.

While the prevalence of attempted and completed suicides is alarming, it would be unusual for any one practitioner to encounter such an emotionally difficult situation with any frequency. Such a powerful event as the death of a current or past client by suicide, would hopefully be a rare and isolated event. It is an unusual event, and the resulting reaction experienced by the professional who has worked closely with the client may vary in intensity and duration. This reaction or response to the news that a client has attempted or completed a suicide is known as Critical Incident Stress Reaction. *It is the normal reaction normal people have to an abnormal event.*

Critical Incidents have the power to overwhelm the normal coping abilities of even the most experienced professional. Typically, these rare, but overwhelming events, especially those which may end with a tragic outcome, often have the power to completely immobilize the professional or potentially an entire group of people. An example would be the client who begins to threaten suicide, and then actually injures or kills himself/herself while a "hotline" worker is still on the phone attempting to help them. It is not hard to imagine the emotional impact such an incident would have on the professional, but unless the worker has had prior experience with such incidents, they may feel as if they are very much out-of-control of their reaction.

By definition, "Critical Incidents are those events that overwhelm an individual's ability to cope. They are psychologically traumatic, causing emotional turmoil, cognitive problems and behavioral changes" (K. Johnson, 1989).

Typical Critical Incident Stress reactions affect each individual somewhat differently. This individual difference is influenced not only by prior life experience, but also by other personal factors, such as culture, pre-existing levels of stress and the professional's perception of their responsibility in the client's injury or death. There are also aspects of the client's behavior which may shape the professional's reaction. For example, a suicide completed in a very graphic or gory manner, may result in a more powerful response, as might a suicide completed during a time when the future appeared very bright for the client. Regardless of the multitude of variables specific to the client, the professional and the incident, there is a typical pattern of reaction impacting the professional in five different areas of functioning. The "typical" reactions, those which are considered the "normal reaction of normal people to an abnormal event" include:

Physical Reactions

Insomnia
Loss of appetite
Nausea
Headaches, light headedness
Muscle weakness
Elevated vital signs

Cognitive Reactions

Distractibility
Declining work performance
Recurrent intrusive images
Flashbacks, nightmares
Disorientation
Distortion of facts

Affective Reactions

Feeling sad or depressed
Feeling anxious or overwhelmed
A constricted or blunted affect
Feelings of guilt, anger, shame, fear
Global pessimism
Emotional numbness

Behavioral Reactions

Clinging to others
Isolation and distancing
Hypervigilance
Elevated startle reflex
Increased substance use
Possible phobic behaviors

Spiritual/Existential Reactions

Questioning one's faith
Questioning the purpose of life
Questioning one's competence
Questioning one's career choice
Question's concerning afterlife

Critical Incident Stress Debriefing (CISD)

Debriefing procedures have a long history in the military and have been adapted to serve many purposes and populations. A well-known and widely used variation of this procedure is Critical Incident Stress Debriefing (CISD), one of several debriefing formats, developed by Jeffrey Mitchell in the 1970's at the University of Maryland Emergency Health Services Program.

The Mitchell model of debriefing was initially developed to assist police, fire and Emergency Medical Service (EMS) personnel as a group method to help workers process and defuse their emotional reactions. The overall goal of CISD is to mitigate the likelihood of the development of posttraumatic stress disorder (PTSD). Therefore, it is often considered a form of "psychological first aid" to be used with individuals confronted with threatening or traumatic events, such as the suicide or sudden and shocking death of a client

The debriefing session, while therapeutic, is not psychotherapy per se. It is done by way of an educational, preventative and supportive process typically facilitated by a combination of CISD-trained peers and/or mental health professionals, for those persons directly connected to the powerful event. CISD and other popular debriefing formats generally employ a phase or stage model. Although the labels for the various stages may differ slightly, all models usually include:

1. Introductory Phase: to provide general guidelines for the session.
2. Fact Phase: Also known as the “reconstruction phase”, used to establish the facts related to the incident.
3. Thought Phase: May be referred to as the Cognitive Phase, involves discussion of the thoughts associated with the situation.
4. Reaction Phase: Used to discuss the emotions related to event.
5. Symptom Phase: A review of the signs and symptoms of distress.
6. Teaching Phase: Also known as the “psycho-educational” Phase, this segment is used to “normalize” the stress reaction by educating the participants about the “typical” response to critical incidents, and providing useful coping strategies.

While the Mitchell CISD model moves predictably from phase to phase, facilitators can conduct the debriefing process in a more flexible manner. In a small to medium-sized group (3-8 persons, not including at least a pair of trained debriefers), the entire process may last between 45 minutes and 1 hour. Participants are encouraged to share their stories, as well as their reactions, in a supportive dialogue with other group members and the facilitators, with a shared focus on “ventilation” of the powerful experience and “validation” of their reactions.

CISDs are thought to be most effective at stabilizing the immediate reaction to the powerful event and reducing the potential onset of PTSD when conducted within 12-72 hours following the event. Individuals may participate in debriefings up to 14 weeks after a critical incident with some positive affect, but the optimal benefit of the debriefing seems to be gained by using the debriefing format within the first few days.

In most cases, even when exposure to the traumatic event has been very direct and intense, the traumatic stress reaction begins to subside within 6 weeks to 3 months after the event. Debriefing is not a form of treatment; it is a proactive intervention, and when traumatic stress symptoms persist at a distressing level for several weeks or more following the incident, it is strongly recommended that the professional seek assistance from other qualified mental health providers.

Other Strategies for Recovery

For the caregiving professional who is trying to manage the emotional effects of client's injury or death, the symptoms often cannot dissipate quickly enough. Often confidence is shaken, belief systems shattered and career choices re-examined in the wake of such a devastating occurrence.

While participation in a structured debriefing following a serious suicide attempt or completed suicide is strongly recommended, and has become standard operating procedure in many organizations, it is not the only avenue of reducing the traumatic reaction of the professional. In addition to availing oneself to a debriefing, the following suggestions are also helpful in managing the effects of traumatic exposure:

For Yourself

Stay connected with others
 Try to resume a normal schedule
 Try to maintain your sleep habits
 Try to eat a little, even if not hungry at meal times

Talk openly with others, especially supervisors or coworkers about your thoughts and feelings

Don't be ashamed to ask for help or seek assistance for prolonged reactions
 Let loved ones know what you have experienced and what may be helpful for you
 Avoid caffeine, watch alcohol use

For Your Loved Ones

Allow space and quiet
 Encourage meals
 Don't personalize reactions
 Don't moralize or minimize
 Offer a sympathetic ear
 Protect private time and space
 Reduce noise levels in home
 Expect interrupted sleep
 Show your concern, don't smother

Summary

No one can prepare the professional for the sudden shock of learning that a client has attempted or committed suicide. Textbooks and classroom instruction seldom address the fact that in some instances a professional can do everything correctly and still face a tragic outcome. The emotional toll on the professional engaged in suicide prevention can be devastating in the wake of a suicide, and while the typical reaction to such a powerful event may be somewhat predictable, it is never pleasant. CISD is a highly recommended and widely used method of stabilizing and reducing the impact of the trauma. The secondary trauma experienced by the professional in the aftermath is an unfortunate but real hazard to the wellness of the professional. It must be recognized and attended to by anyone who intends to remain active professionally with "high-risk" clients.

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, February 27, 1998.

AR 600-63, Army Health Promotion, December 17 1987.

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.

Resources

The following organizations can provide additional information about Critical Incident Stress Management and self-care for the professional:

American Academy of Experts in Traumatic Stress

368 Veteran's Highway
Comack, NY 11725
(516) 543-2217
www.aaets.org

American Red Cross

11th Floor
1621 No. Kent St.
Arlington, VA 22209
(703) 248-4222
www.redcross.org

International Critical Incident Stress Foundation

10176 Baltimore National Pike
Unit 201
Ellicott City, MD 21042
(410) 750-9600
www.icisf.org

International Society for Traumatic Stress Studies

National Organization for Victim Assistance
1757 Park Road, N.W.
Washington, DC 20010
(202) 232-6682
<http://www.icisf.com/>

National Organization for Victim Assistance

1757 Park Road NW
Washington, DC 20010
(202) 232-6682
www.try-nova.org

National Center of PTSD

215 No. Main St.
White River Junction, VT 05009

(802) 296-5132

www.dartmouth.edu/dms/ptsd

United States Army Center for Health Promotion and Preventive Medicine (USACHPPM)

5158 Blackhawk Road

APG MD 21010-5403

(410) 436-4656

<http://chppm-www.apgea.army.mil/dhpw/default.htm>