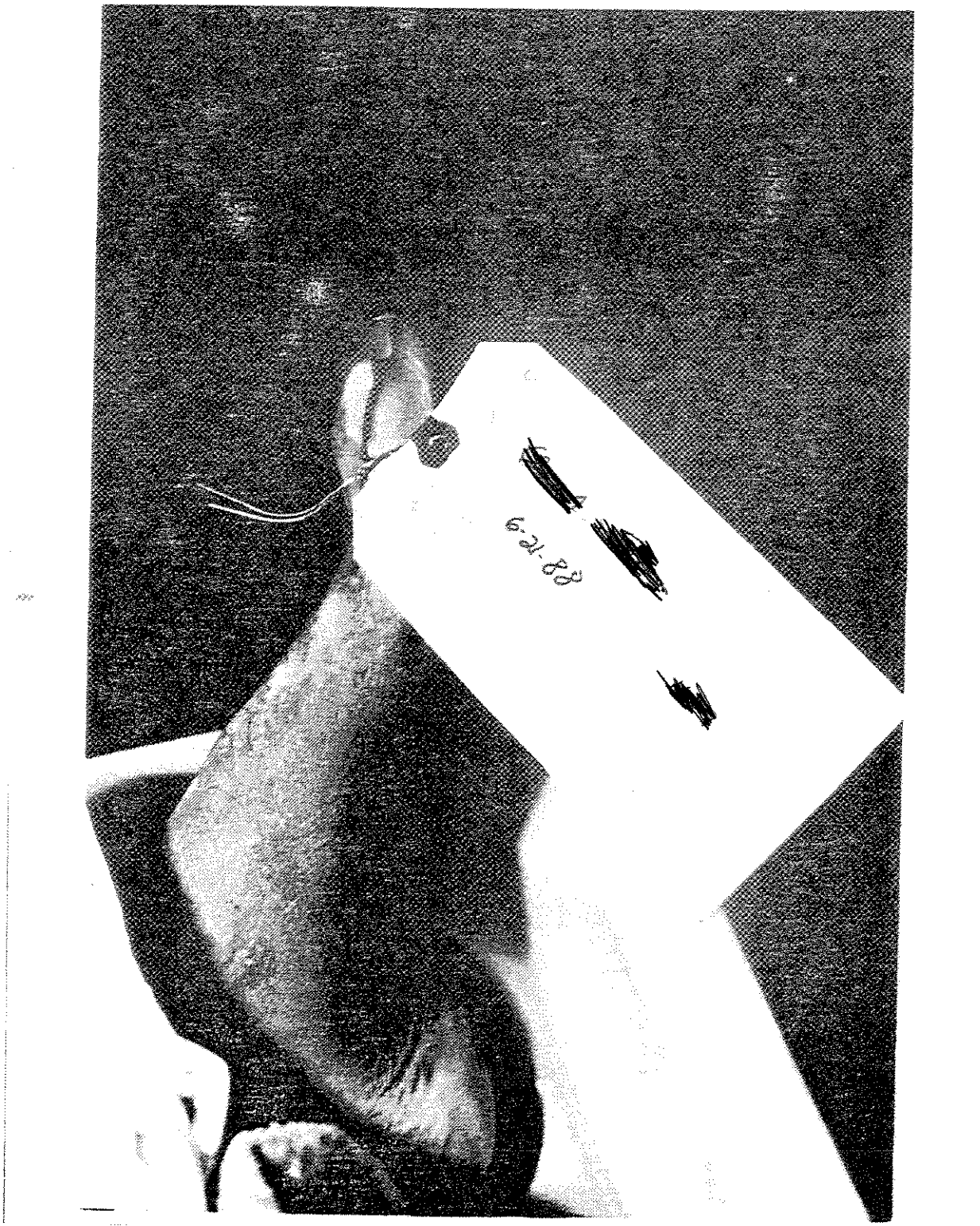


ABOVE: A 33-year old single white male E-6 asphyxiated himself in his off-base apartment. He was a loner who had nothing to do with his colleagues. He had not been seen for three days and when a co-worker was sent to check on him he discovered the body. The E-6 had a very low self-concept and was disappointed over his perceived failure to achieve the goals in life he had set for himself.

NOTES

Alighieri, Dante. *The Divine Comedy*, Part I: *Inferno*, translated by John D. Sinclair. London: John Lane The Bodley Head, 1939, pp. 167-178.

Beck, Aaron T., Resnick, Harvey L.P., and Dan J. Lettier. *The Prediction of Suicide*. Bowie, Maryland: The Charles Press, Inc., 1974.

Brent, David A., "The Psychological Autopsy: Methodological Considerations for the Study of Adolescent Suicide," *Suicide and Life-Threatening Behavior*, Vol. 19, No. 1 (Spring 1989): 43-57.

Centers for Disease Control. *Suicide Surveillance, 1970-1980*. Atlanta, Georgia: CDC, April 1985.

Coleman, Loren. *Suicide Clusters*. Boston: Faber and Faber, Inc., 1987.

Cowley, Geoffrey and Karen Springer, "The Promise of Prozac," *Newsweek* (March 26, 1990): 38-44.

Darbonne, Allen R., "Suicide and Age: A Suicide Note Analysis," *Journal of Consulting and Clinical Psychology*, 33 (1) (1969): 46-50.

Datel, William E., "The Reliability of Mortality Count and Suicide Count in the United States Army," *Military Medicine*, Vol. 44, No. 8 (August 1979): 509-512.

DiMaio, Vincent J.M. *Gunshot Wounds*. New York: Elsevier, 1985 (see especially pages 293-302).

Demaris, Ovid. *America the Violent*. Baltimore, Maryland: Penguin Books, 1970.

Eisele, J.W., Reay, D.J., and Ann Cook, "Sites of Suicidal Gunshot Wounds," *Journal of Forensic Sciences*, Vol. 26, No. 3 (July 1981): 480-485.

Farberow, Norman L. *The Many Faces of Suicide*. New York: McGraw-Hill Book Company, 1980.

Fishbain, David A., et al. "Relationship Between Russian Roulette Deaths and Risk-Taking Behavior: A Controlled Study," *American Journal of Psychiatry*, Vol. 144, No. 5 (May 1987): 563-567.

Gelman, David, et al. "Depression," *Newsweek* (May 4, 1987): 48-57.

Holding, T.A. and B.M. Barraclough, "Undetermined Deaths - Suicide or Accident?" *British Journal of Psychiatry*, 133 (1978): 542-549.

Kerkhoff, Alan C., "A Theory of Hysterical Contagion," in Tamotsu Shibutani, ed., *Human Nature and Collective Behavior*. Englwood Cliffs, New Jersy: Prentice-Hall, Inc., 1970.

Kleck, Gary, "Miscounting Suicides," *Suicide and Life-Threatening Behavior*, Vol. 18, No. 3 (Fall 1988): 219-236.

Leenars, Antoon A., "Brief Note on Latent Content in Suicide Notes," *Psychological Reports*, Vol. 59, No. 1 (October 1986): 640-642.

Lester, Gene and David Lester. *Suicide: The Gamble With Death*. Englewood Cliffs, New Jersey: Prentice-Hall, Inc., 1971.

McIntosh, John L. and Barbara L. Jewell, "Sex Differences in Completed Suicide," *Suicide and Life Threatening-Behavior*, Vol. 16, No. 1 (Spring 1986): 16-27.

McGinnis, J. Michael. "Suicide in America - Moving Up the Public Health Agenda," *Suicide and Life Threatening-Behavior*, Vol. 17, No. 1 (Spring 1987): 18-32.

Menninger, Karl. *Man Against Himself*. New York: Harcourt, Brace & World, Inc., 1938.

Monk, Mary, "Suicide," page 1386 in Last, John M., ed., *Public Health and Preventive Medicine*, 12 edition. Norwalk, Connecticut: Appleton-Century-Crofts, 1973.

Neuringer, Charles. *Psychological Assessment of Suicideal Risk*. Springfield, Illinois: Charles C. Thomas, 1974.

O'Carroll, Patrick W., "A Consideration of the Validity and Reliability of Suicide Mortality Data," *Suicide and Life-Threatening Behavior*, Vol. 19, No. 1 (Spring 1989): 1-15.

Rich, Charles L., Ricketts, Joanne E., Fowler, Richard C. and Deborah Young, "Some Differences Between Men and Women Who Commit Suicide," *American Journal of Psychiatry*, Vol. 145, No. 6 (June 1988): 718-722.

Robinson, Janet E., "How Accidental Are Accidents?" *The Levinson Letter*, 1984.

Rosen, George, "History in the Study of Suicide," *Psychological Medicine: A Journal for Research in Psychiatry and the Allied Sciences*, Vol. 1, No. 4 (August 1971): 4-29.

Rosenberg, Mark L., et al, "Operational Criteria for the Determination of Suicide," *Journal of Forensic Sciences*, Vol. 33, No. 6 (November 1988): 1445-1456.

Rothberg, Joseph M., Bartone, Paul T., and David H. Marlow, "Death and the Army I: Why Isn't the SMR = 100?" *Military Medicine*, in press.

Schlossberg, Nancy K. *Overwhelmed: Coping With Life's Ups and Downs*. Lexington Books, 1989.

Sheehy, Gail. *Passages*. New York: E.P. Dutton, 1976.

Shneidman, Edwin S. *Deaths of Man*. New York: Quadrangle/The New York Times Book Co., 1973.

Shneidman, Edwin S. *Definition of Suicide*. New York: John Wiley & Sons, 1985.

Shneidman, Edwin S., "Suicide Notes Reconsidered," *Psychiatry*, Vol. 36 (November 1973): 379-394.

Shneidman, Edwin S. and Norman L. Farberow. *Clues to Suicide*. New York: McGraw-Hill Book Company, Inc., 1957.

Shneidman, Edwin S., Farberow, Norman L., and Robert E. Litman. *The Psychology of Suicide*. New York: Jason Aronson, Inc., 1976.

Stone, Irving C., "Observations and Statistics Relating to Suicide Weapons," *Journal of Forensic Sciences*, Vol. 32, No. 3 (May 1987): 711-716.

Tabachnick, Norman, ed. *Accident or Suicide?* Springfield, Illinois: Charles C. Thomas, 1973.

Thomas, Chris, "First Suicide Note?" *British Medical Journa (1980): 284-285.*

U.S. Bureau of the Census, *Historical Statistics of the United States, Colonial Times to 1970*, Bicentennial Edition, Part 2. Washington, D.C.: Government Printing Office, 1975.

Vorkoper, Charles F. and Charles S. Petty, "Suicide Investigation," in Curran, William J., McGarry, Louis A., and Charles S. Petty, *Psychiatry and Forensic Science*. Philadelphia, Pennsylvania: F.F. Davis Company, 1982.

Welz, R. and H.J. Moeller, *Bestandsaufnahme der Suizidforschung*. Regensburg, Germany: S. Roderer Verlag, 1984.

Expert Outlines Approaches to Suicide Prevention

WASHINGTON — All Air Force major commands have people who are high-risk suicide candidates.

Whether or not they kill themselves may be influenced by the overall atmosphere in the command, Charles P. McDowell of the Air Force Office of Special Investigations believes.

McDowell, who works in the special studies division of AFOSI's directorate of investigative analysis, outlined some basic approaches to suicide prevention in his report, "Suicide Among Active-Duty USAF Members, 1981-1986." The report is based on an analysis of 380 active-duty suicides between Jan. 1, 1981, and Dec. 31, 1986.

"I believe that the military at the senior-command level basically has two responsibilities," McDowell said.

"One is to see to it that the mission is done. And there are times that you do the mission knowing that you're going to kill people — that's the military," he said. "The other responsibility is for the health, welfare and morale of your people.

"These two things, these two lines, intersect. It requires a lot of judgment, and I think that if you lose sight of either of those missions, then you run the risk of not being able to perform well."

Demanding high mission performance, he said, is not inconsistent with caring about the people who perform. You can do both.

"If you can generate a concept of a caring command — that's a term the Army uses — then you can open up a lot of vistas that are otherwise closed to you," he said. "I think the troops have got to believe that you care."

McDowell said major-command leaders must recognize that people, like automobiles, break down periodically.

"If you can accept that fact, and if you can accept that fact that they can be fixed, then you're on the way to a solution," he said.

"When the kid comes in and says, 'Hey boss, I'm broken,' the boss has got to say, 'I can't use broken people, plus I like you. So we're going to get you fixed. Go get fixed and come back.'"

Unfortunately, that scenario seldom happens in some Air Force commands, he said.

"You look at the SPs, which have one of the highest numbers of suicides in the Air Force. A lot of

See SUICIDE, Page 18

From Page 6

these kids are on PRP (personal reliability program) because they're out there guarding airplanes and nuclear weapons," he said.

"If you show up and say, 'I'm suffering from depression,' or, 'I'm extremely unhappy,' or 'I'm contemplating suicide,' what do they do? They pull your PRP.

"So if you basically like your job, but you need help and say, 'I need help,' you wind up losing your status. Then you've created a real professional problem for yourself.

"And how do these kids — two-, three- and four-stripers — how are they suposed to work their way through that kind of issue? They can't."

McDowell conceded that the price a command pays for a compassionate atmosphere may be that malingerers and malcontents take advantage of it. He insists, however, that the cost is well worth paying.

There is nothing sadder than seeing some 18- or 19-year-old person who is in a temporary depression kill himself, he said.

"It's sort of funny in the military," he said. "We place a premium on performance and we reward success. But when people begin to malperform and they do things that are unsuccessful, we get angry at them.

"We wonder if these folks really need to be around. But sometimes they're telling you something. The bad performance doesn't mean they don't like the Air Force. It means they're becoming unraveled."

There are several initiatives that can be taken at the major-command level to support the caring-command concept, he said.

For example, the study shows that many individuals who eventually took their own lives told coworkers or first-echelon supervisors — usually NCOs — of their problems, yet their cries for help went unheeded.

People who do not recognize a potential suicide crisis, or do not know how to react to one, probably will not be able to give effective help, McDowell said. He suggests suicide awareness be made a topic at all NCO academies.

The subject now is being taught at several NCO leadership schools, he said.

McDowell also thinks commands should encourage use of off-base family support programs. That is because many high-risk suicide candidates have disturbed or even chaotic family lives. As a result, they have no safe haven — nowhere to go where they can relax and escape from their problems.

"Every community of any size at all has family support groups, and they deal with everything from child abuse to alcoholism," he said. "I think what the Air Force should do is identify those existing resources that support military communities . . . and encourage their use."

A base family action information board, he said, can be established to disseminate data on various outreach services, hotlines and marriage encounter programs.

Commands also can help prevent suicides by exercising care in reporting them when they happen, McDowell said.

He explained that high-risk suicide candidates often indulge in what psycholgists call "magical thinking."

"They kind of lose the ability to be objective in assessing their own lives, so they look for clues — 'the Lord gave me a sign' kind of stuff," he said.

"I think a lot of people who contemplate suicide kind of scan their environment. They're looking for something that will either say, 'Yeah, go do it,' or, 'No, don't do it.'"

Therefore, reports — in newspapers and official command communications — of suicides by others sometimes convince those at risk that taking their lives is a viable solution to their problems, he said.

"There is a clustering of suicides (and) I think the clustering is — at least in part — a function of how the news of it travels," McDowell said.

"For example, we had three deaths at one base two years ago when a person died of accidental causes — a hibachi in a truck."

A man was cooking steak by the roadside when a rainstorm forced him to put the hibachi in his van. When the door to the van was closed, the fire consumed the oxygen in the air, accidentally killing the man.

Following that incident, McDowell said, "two people at the same unit at the same base, within a very short period of time, committed suicide by putting hibachis in their cars. What are the odds of that happening by chance alone?"

— Pat Dalton

DEPARTMENT OF THE AIR FORCE
AIR EDUCATION AND TRAINING COMMAND

HQ AETC/PAM
100 H. Street Ste 3
Randolph AFB, TX 78150-4330

Meyer Moldeven
P.O. Box 71
Del Mar CA 92014-0071

Dear Mr Moldeven

Enclosed are several products produced within the Air Education and Training Command on suicide prevention which you may find useful.

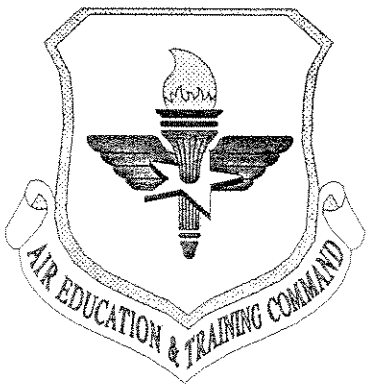
A short video tape entitled "Suicide Prevention in ATC" (Air Training Command), was also produced a couple years ago for showing throughout the command. I have not included a copy of this tape, but if you would like one, please let me know. A short reference to the video may be all you need. If this is the case the PIN number is 611361. The tape runs about 10 minutes.

If we can be of any further assistance, please do not hesitate to write.

Sincerely

JIM SANDEFUR
Deputy Chief, Media Relations Division

Page 3-73 withdrawn (covered elsewhere)



SUICIDE:

We Can Make a Difference

OPR: AETC/SG

SUICIDE: We Can Make a Difference

Over the past three years, suicide has been the leading cause of death in ATC's enlisted force. Suicide is a tragic personal loss and leaves survivors, especially loved ones, with a lifetime of bitterness, anger and guilt. For the Air Training Command, suicide disrupts unit cohesiveness and can critically affect our Force mission. Suicide takes trained, productive members from us and wastes our most valuable resource; our people.

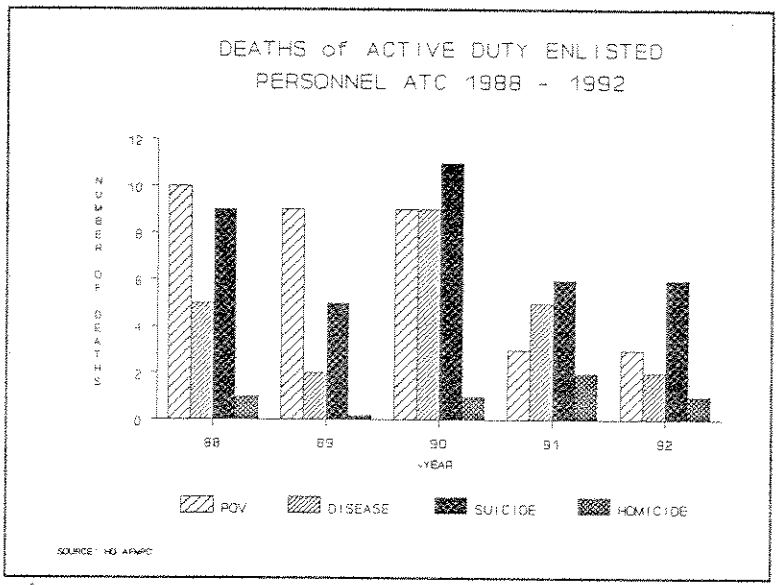


Figure 1

Historically, ATC has averaged eight suicides per year over the past twelve years. The number of active duty suicides has ranged from a high of 12, in 1988, to a low of five in 1983, 1986, and 1989. Our experience with the number of suicides is displayed in Figure 2.

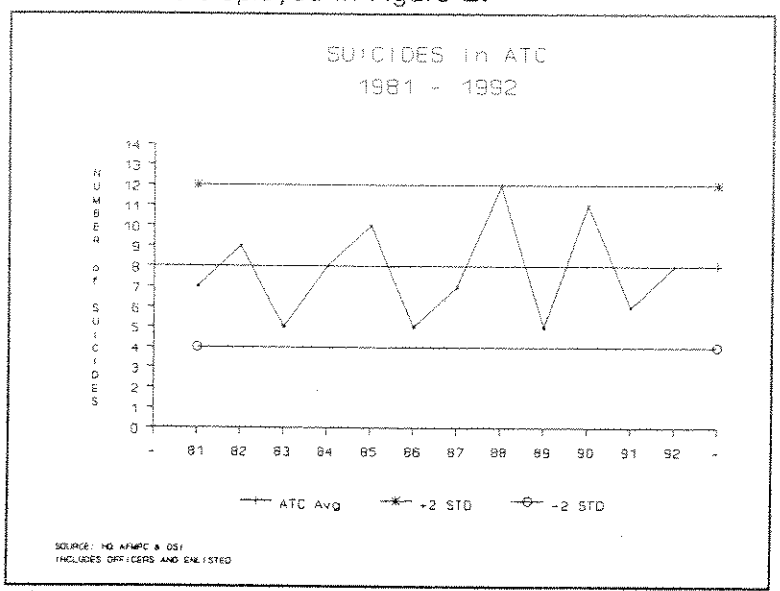


Figure 2

Figure 3 displays our rate per 100,000 (100K) over the past five years. Our rate has varied from a high of 20.84 to 8.34 per 100K. Our rate in 1992 was 15.36/100K and compares to the most recent (1989) civilian rate of 14.28/100K in persons age 15 - 39. Although there appears to be a downward trend, remember that suicide is still our leading cause of death in our enlisted personnel.

Dr Charles McDowell, HQ AFOSI, cautions that it is difficult to calculate meaningful annual rates for specific bases. In his opinion, when a small number of incidents is divided by the base population and multiplied by 100K the result is an artificially high product.

However, suicide in active duty members does seem to distribute non-randomly by base. That is, some bases appear to have "many" suicides while others have "few." Why?

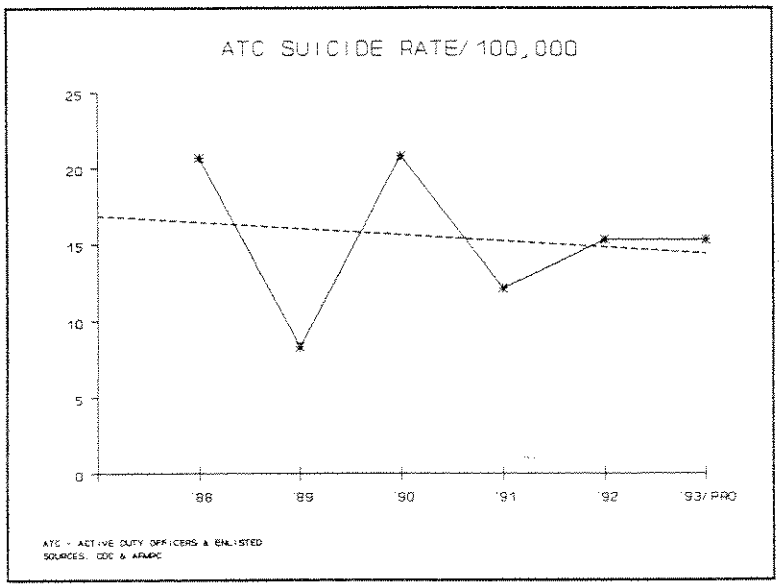


Figure 3

One explanation is called "clustering." There are occasions when one suicide may precipitate others. This is sometimes called the cluster or contagion effect. Although not a well understood phenomena in suicides, these clusters may have a very reasonable explanation. Assume for a moment that every base has a population at risk consisting of people who are actively considering suicide. These people will range from high to low risk depending on their personal commitment to self-destruction. Nearly all of them will have a strong desire to be "out of their misery," but few will have a genuine wish to be dead. Depending on the size of the population, a certain proportion will be in a state of ambiguity: unwilling to kill themselves but also unable to set aside the desire to do so. Under these circumstances they will "look for a sign" to guide their decision. The suicide of one person may therefore act as a trigger to others at high risk, leading to a clustering of suicides. For that reason, our consultants caution against "over responding" to a suicide event. The consultants advise that we support and help the family, friends and co-workers through the adjustment period. Highly advertising the event may be more harmful than helpful.

Those at greatest risk of suicide have historically displayed remarkable consistency in the signals they gave prior to their deaths. Most had troubled relationships with intimates (i.e., separations, divorces, and dysfunctional relationships). Many had work-related and financial problems, and most were depressed prior to taking their lives. In most cases the decision to commit suicide was reached after careful deliberation. Frequently, those who seriously intend suicide leave clues. Sometimes they are obvious and direct; sometimes they're very subtle. For some, it was almost as if they were seeking an opportunity to cry out and to be heard. About half the victims told someone of their suicidal intention but were either ignored or received ineffective responses.

According to our consultants, the key is for commanders and first echelon supervisors to recognize the signs or signals.

(1) The surest sign of intent is the suicide attempt. It is considered by many to be the most dramatic cry for help. All too often, people do not recognize its significance and respond with frustrated or critical comments like, "He was just trying to get attention." Any gesture or attempt must be treated seriously. Historically, twelve percent of those who attempt suicide make a second try and succeed within two years. Four out of five people who do kill themselves have made at least one previous attempt.

(2) Another signal is a person's talking about committing suicide. The verbal threat should be viewed with great concern. Remember the old myth that "those who talk about it never do it?" It is just that -- a dangerous untrue myth. The following may indicate that a person is contemplating suicide:

- A declaration that "I'm going to kill myself."
- Asking friends what they think about suicide
- The "goodbye" message (victim tells friends good-bye)
- The victim giving prized possessions away
- Statements such as:
  "I really enjoyed knowing you."
  "I'm thinking about suicide."
  "You would be better off without me."
  "Life has lost its meaning."

(3) Sometimes thoughts of suicide are triggered by situations. However, it is the situation (external) acting in concert with something from within that creates the motivation for self-destruction. In short, the person no longer has the tools to cope with alarming prospects for the future. For example, financial difficulties hit more than just the pocketbook. There are crucial problems of food, clothing. rent, utilities, car payments, etc. The perceived hopelessness of the situation calls into question ones competence and self esteem which generates feelings of inadequacy and failure.

Divorce, domestic difficulties and problems with intimate associates also rank very high on the list of stress provoking situations and often prove to be more difficult to handle than the death of a loved one. When a person dies, we can explain the death in terms of physiological ("he had cancer") or theological ("the Lord giveth, the Lord taketh away") reasoning. Divorce is not as easy to explain because its grief is compounded by practical, on-going issues like child custody, dependent support, alimony, feelings of grief, guilt, failure, anger, loneliness, etc. It's easy to see how stressful situations like these can overwhelm a person's ability to cope.

(4) Emotional symptoms provide some of the best signals. Any sudden change in personality is a warning because people under stress typically show signs that are readily seen by family, friends and co-workers. The majority of potential suicides suffer from depression which is a condition of emotional dejection and withdrawal characterized by intense and prolonged sadness. Feeling low or sad are normal reactions to the stress of everyday life. For most, depression may last a few hours, days or weeks. However, as part of living, depression does not totally disrupt life nor involve the totality of an individuals thoughts and actions. This kind of severe, all consuming depression is referred to as clinical depression. Some of the warning signs of clinical depression include:

- Ordinary tasks become difficult to perform; concentration is lacking; difficulty in making even the simplest decisions is not uncommon; there is a marked decline in job performance.

- Physical complaints such as severe insomnia, early awakening and inability to get back to sleep, poor appetite, weight loss, headache, palpitations and blurred vision.

- Social functioning is impaired; depressed individuals prefer more and more to be alone, speak less frequently and withdraw from family and friends.

- There is a loss of sense of humor, antagonism toward those normally near and dear plus frequent crying for trivial reasons.

Of course, not everyone reacts the same way. There are those who do not look depressed and may even state how happy they are. They never complain and are prideful about the immense, inner burdens they bear without a whimper. They fail to realize that its easier to share a burden than carry it alone. Be cautious when depressed people "recover" suddenly without obvious reasons. It can be the calm before the storm - they may have reached a decision.

(5) Our consultants tell us that in about 45% of cases, the victims were involved in some type of substance (alcohol or other drugs) abuse. While substance abuse is a problem by itself, it may also indicate deeper problems. Substance abuse can easily become the catalyst to an untimely end.

Some of the FABLES and FACTS about suicide:

FABLE: People who talk about suicide rarely take their own life.
FACT: Of any ten persons who kill themselves, eight have given definite warnings.

FABLE: Suicide happens without warning.
FACT: Studies reveal that the suicidal person gives many clues and warnings regarding their intentions.

FABLE: Suicidal people are fully intent on dying.
FACT: Most suicidal people are undecided about living or dying and "gamble with death" and leave it to others to save them. Remember, those who commit suicide frequently let others know how they are feeling.

FABLE: Once a person is suicidal, he is suicidal forever.
FACT: Most individuals are suicidal for a limited amount of time.

FABLE: When the suicidal patient shows improvement, the danger is over.
FACT: Patients discharged from the hospital, or those who stop therapy, continue to be at some risk. Some suicides occur within three months of this time when the individual has the energy to put his morbid thoughts and feelings into effect.

FABLE: Only the poor and the rich commit suicide.
FACT: Persons in every income bracket and social bracket kill themselves.

FABLE: The tendency toward suicide is inherited or "runs in the family."
FACT: There is no evidence that suicide has a hereditary basis. It is an individual pattern.

FABLE: All suicidal people are depressed, mentally ill or insane.
FACT: Although more suicides occur among those diagnosed as psychologically depressed, the potential for self destruction is present in persons with any mental disorder as well as persons in an apparently rational state of mind.

FABLE: Suicide has simple causes that are easily established and dealt with.
FACT: The surface cause/explanation often has complex underlying causes imbedded in a complex motivational system reflecting individual value systems.

If you are concerned about an individual who you feel may be considering suicide, get them to professional help. If you encounter a suicide in progress, get professional help via emergency room personnel or by crisis lines (911). On the other hand, if no one else is there to assist and there is no way to contact professional help, you are it. Do your best to remain calm. Panic is contagious. One other caution, if you come upon a suicide attempt in progress that involves a dangerous weapon or firearm; don't be a hero. Remember the suicidal person is emotionally out of control and in these situations your life may also be in danger.

"Since even the strongest death wish is filled with uncertainty, suicide is more preventable than any other cause of death. The suicidal person holds two desires -- one wanting to die, the other wanting to live. The strength and relationship of these two simultaneous desires will vary. Most suicidal people don't want death as much as they want some way out of the terrible situation they perceive themselves to be caught up in. They seek reassurance that life is worth living."

Resources:

Suicide -
- Mental Health Professionals
- Chaplains
- "911"
- Videotape "Suicide Prevention in ATC"
  SAVPIN 611361 (10 Min.)

Stress Management -
- Mental Health Clinic's Stress Management Class
- Morale, Welfare, Recreation & Services

Acknowledgements:

David Kentsmith, Col, MC, USAF (Ret)
Dr Charles McDowell, HQ AFOSI, Bolling AFB, DC
The Centers for Disease Control, Atlanta, GA
HQ ATC/DPXM, Randolph AFB, TX

SUICIDES BY ACTIVE DUTY USAF MEMBERS
ON AIR EDUCATION AND TRAINING COMMAND BASES
(1 JAN 85 TO 31 DEC 92)

Previous studies of active duty suicides (focusing on both the Air Force as a whole and on specific major air commands) consistently revealed that the population at greatest risk consists of white male enlisted members. In addition, this high-risk population has historically displayed remarkable consistency in the symptoms its victims exhibited prior to their deaths. Most had troubled relationships with intimates (i.e., separations, divorces and dating problems). Many had work related and financial problems, and most were depressed prior to taking their lives. The decision to commit suicide was usually (but not always) reached after some period of deliberation. About half the victims told someone of their goal to commit suicide but were either ignored or received an ineffective response.

Active duty suicides seem to distribute non-randomly by base. That is, some bases appear to have disproportionately more suicides than others. This observation is puzzling because location by base would seem to have little relationship to the epidemiology of suicide. There are two possible explanations:

First, one suicide may precipitate others. This is sometimes known as the cluster or contagion effect. Although not well understood, these clusters may have a reasonable explanation. Assume for the moment that every base has a population at risk consisting of those who are actively considering suicide. These people will range from high to low risk depending on their personal commitment to self destruction. All of them will have a strong desire to be "out of their misery," but few will have a genuine wish to be dead. Depending on the size of this population, a certain proportion will be in a state of ambiguity: wanting to kill themselves but not quite able to do so. Under these circumstances they will look for some kind of external sign to guide their decision. The suicide of another person may act as such a sign and therefore trigger others at high risk, leading to a clustering of suicides at the same base. A cluster is deemed to occur on an Air Force base when three or more people take their lives within a twelve month period with no more than six months between any two suicides.

Second, an unusually high incidence of suicide may be related to failures in either leadership or mental health (or a combination of both). In the former, a non-supportive or hostile climate may increase an individual's feelings of helplessness and hopelessness, thereby constricting his or her perception of possible solutions. In the latter case, individuals at risk are either not identified as such or if identified, do not receive effective mental health treatment. In the latter case, they are identified and referred to mental health but their problem is inadequately diagnosed or dealt with.

The key to reducing suicide at the base level lies in identifying whether or not there is a problem in the first place; and if there is, identifying whether it is more closely related to leadership or mental health issues. It is possible to determine if there is a problem with a given major air command by comparing its suicide rate with that of the entire Air Force (rates are based on the number of active duty suicides per 100K). It is difficult to calculate meaningful annual rates for specific bases because the small number of incidents, when divided by the base population (and multiplied by 100K), typically results in an artificially high product. To identify bases that have a problem, perhaps the best approach is to look for suicide clusters.

If there is a problem, it is more difficult to determine whether it is a function of leadership or mental health. One would suspect a leadership problem if the proportion of "communicators" is high; that is, if an excessive number of victims previously communicated their intentions to commit suicide but were ignored. One might suspect a mental health failure if the proportion of victims being seen by mental health (or having recently been seen by them) is higher than would be expected.

The information that follows identifies each AETC base where one or more active duty suicides took place and provides the following:

Number: The number of active duty members who committed suicide at that base. This number includes military members who are not assigned to AETC but who are assigned to the base (They are indicated by a + sign after the case number). NOTE: Individuals who "belong" to AETC but who committed suicide at a non-AETC base are not included because they would be reported under the MAJCOM of the base where they are stationed.

Age: This is the average age of all the active duty military members who committed suicide at the base.

By way of background, AETC has had an average annual suicide rate of 15.9 per hundred thousand over the past five years. The AETC rate for 1992 was 11.9 while the 1992 active duty suicide rate for the Air Force was as a whole was 12.5 This would indicate that AETC does not have a suicide rate higher than would be expected by chance alone; or phrased another way, its overall rate is within normal limits.

WHY SUICIDE?

It is one thing to tabulate statistics on suicide, but to understand why an individual decides to take his or her life is another matter. The heart of the problem lies in the fact that suicide is a choice. Clearly, many of the victims in this study gave the matter considerable thought before they opted for self-destruction. Perhaps they believed the decision to commit suicide was their best choice. Perhaps they saw it as their only choice. Our best clues to this decision-making process come from analysis of the victim's behavior; what he or she had to say prior to the suicide, and the content of suicide notes. Understanding why people kill themselves is critically important because effective suicide prevention must try to influence the potential victim's decision-making process before he or she finally selects suicide.

Behavior is driven by purpose: people do things for a reason. There is no such thing as random behavior. Even so, people are not always consciously aware of why they behave the way they do. A great deal of human behavior has to do with "protecting" the individual from physical and psychological harm or stress. To do this, people have complex personalities which employ psychological defense mechanisms to protect the sense of well-being. This is not always easy, as the realities of life sometimes exert enormous pressure. Perhaps it helps to look at personality as a tool box and the psychological defense mechanisms as tools. Depending on the kind of "work" that needs to be done to protect the individual, he or she intuitively selects the best tools for the job and tries to fix what's broken. If some of the tools are missing or if the individual doesn't know how to use them, efficiency is diminished. Sometimes people use the right tools the wrong way, other times they use the wrong tools. Worse yet, sometimes they deny the fact that anything is broken and make no effort to fix what needs to be repaired. In some cases, the individual even breaks things that are working just fine. They do this for what seems to them to be very gook reasons, although to the rest of us it looks crazy.

Although they normally serve us very well, when these tools are misused the individual's behavior becomes maladaptive and the results show up as problems that are reflected in how the person talks and behaves. When one's behavior and communications are completely out of touch with reality, we consider him to be psychiatrically incapacitated. If he or she is able to function adequately, friends are much less likely to recognize the existence of serious psychological problems and may even make allowances for the person's poor or otherwise questionable behavior. In a great many cases the person is not psychiatrically impaired at all but may be simply overwhelmed by situational factors and lack the resources to cope. The vast majority of the active duty suicides fell in this category.

Even though mental health intervention is important, its major shortcoming lies in the fact that the health care system can only act if it is aware of a problem. This means that individuals at risk must either seek help on their own or be brought into the health care systems by others. This results in an obvious shortfall, as two-thirds of the victims in this study had not come into contact with the health care system. Thus, although the health care system has an important role to play in suicide prevention, it does not (and should not) "own" the problem.

Another problem with the mental health system is the belief that if a person tells a mental heath worker about his or her suicidal thoughts, that information will be provided to the individual's commander. There is a widespread fear that reporting to mental health will have a negative impact on the person's career. In fact, AFOSI has documented numerous cases in which troubled people sought mental health care off base through private resources rather than use the Air Force system.

It is tempting to identify specialists and give them responsibility for the problem; however, suicide does not lend itself to this kind of approach. Instead, it meeds a carefully integrated approach that takes a systems orientation by identifying, diagnosing, and treating those at risk. The cornerstone of this approach rests on a bedrock so important and so obvious that it is often overlooked: leadership.

The military is a unique community governed by procedures and customs unlike those found in most civilian communities. An important element of leadership includes responsibility to and for subordinates along with a commitment to the mission. The military is one of the few communities that has the authority to compel behavior by force of law. However, just as military commanders have the authority to compel behavior, they also have a corresponding responsibility for the health, well-being and morale of their subordinates. This requirement applies all the way from the four-star generals down the lowest level of enlisted supervision. Leaders in the military are supposed to know their people and have a major moral and legal obligation for "managing" them.

More importantly, the obligations of leadership cannot be transferred up the chain or across organizational lines to such specialists as psychiatrists, psychologists, or chaplains. To the contrary, these specialists provide their services in support of command responsibility. This means the initial process of suicide prevention (risk identification) rests with the potential victim's most immediate associates and his or her first-echelon supervisor. The first echelon supervisor is <u>the</u> key player in suicide prevention. He or she not only supervises the individual's work but is also in a position to see any changes in behavior or performance that might signal a problem. In fact, a large part of supervision is nothing more than managing human resources.

People at risk for suicide are beset with feelings of internal conflict and profound anxiety. Their failures in love, work, and finances lead to an unacceptable loss of self-esteem, frustrations, and finally, aggression. The first major stage for a potential suicide victim is a feeling of great emotional pain based on a subjective perception of personal failure. The second phase evolves from an inability to deal with this pain. This is usually accompanied by increasing social isolation and a gradual increase in the aggression the victim feels toward himself. When problems appear overwhelming and the person feels unable to change things for the better, an attitude of hopelessness develops. This is usually accompanied by a constriction of perception that blossoms into depression. A "wish to die" emerges when death is seen as a viable means of escape, and it is at this point that thoughts of suicide become a seductive siren call. At this point the victim becomes ambivalent and uncertain. He or she is likely to make suicide threats that others are equally likely to disregard, even thought they are a legitimate cry for help.

At this point the potential victim is at great risk. Fortunately, because of the ambivalence they feel, most of them do not necessarily want to die. They want to escape from their problems and death is seen as a means to that end rather than as a goal in its own right. These people then do a strange thing: they engage in a process of magical thinking in which they look for "sings" that committing suicide is (or isn't) the right thing to do. It is almost as if they know it's a bad idea and need a nudge one way or another to make up their mind. If found, certain of these sighs are taken as confirmation that the situation is hopeless and suicide is the correct course. The victim's feeling of ambivalence then turns to commitment to a fatal course of action.

What are these signs? The person may discuss suicide to judge the reaction of others. Some suicidal comments are vague and quite difficult to recognize ("I won't have to put up with this crap much longer" or "things would be a lot better if I wasn't around"). In other cases the victim is quite blunt; so much so, in fact, that those who hear their comments simply don't believe them. AFOSI has documented numerous cases in which victims explicitly told friends and co-workers they were going to commit suicide and even told them when and how they were going do it. When the victim makes these comments or starts giving away prized possessions, he or she wants someone to recognize the situation for what it is and tell them suicide is an unacceptable solution to their problems. The failure to do so becomes a justification in the victim's mind. This is, of course, extremely unfair because those who are supposed to recognize the crisis are often ill-equipped to do so and don't know they are caught up in a psychological game in which true meanings are masked.

Another sign appears to be the occurrence of another suicide. We believe suicide is a kind of proximity bomb that triggers other suicides. Analysis of active duty suicides clearly points to a "clustering" phenomenon: suicides are more likely to take place in military communities where there have been other, recent suicides. Although it is only a matter of speculation at this point, we believe that all communities (military and civilian) have a "population at risk" consisting of people who are at more than casual risk for suicide. Most of these people are ambivalent about taking their lives and although they may think about suicide a great deal, they have not fully committed themselves to self-destruction. However, if another person (especially one who is "like" them) commits suicide that act may have special significance to those at risk. It says, in effect, "Yes: suicide is an option. Look at so-and-so. He was in your shoes just a few days ago and now his problems are over. Go for it!" If the community has a significant number of people at risk, then a completed act is very likely to be followed by several others until those at greatest risk have self-eliminated through suicide.

If this is true, it would go a long way toward explaining the cyclical variation in the annual number of suicides and also offers a powerful incentive to be especially mindful of the need for preventive interventions in the wake of a completed suicide. It also suggests a powerful connection between the internal, subjective thoughts of those at risk and external factors within the community.

For many suicide victims the final stage is the "calm before the storm" After making up their mind to commit suicide, they often become tranquil. Others are likely to correctly interpret this as the victim having solved his or her problems, but incorrectly assuming that the solution is wholesome.

SUICIDE PREVENTION: WHO SHOULD DO WHAT?

Although suicide is an Air Force wide concern, who is in the best position to exercise authority over the problem? In the Army suicide prevention falls under health promotion. In the Air Force it has generally been viewed as a health-related issue and to the extent that it has been dealt with at all, it has fallen under the domain of the Surgeon General (more specifically under mental health). This is only natural, as potential suicide victims are normally referred to mental health for evaluation and treatment. Depression and suicidal ideation are clinical issues for which there are effective remedies, and these remedies are applied by mental health professionals.

DEPARTMENT OF THE AIR FORCE
PACIFIC AIR FORCES

AUG 26 1993

REPLY TO ATTN OF: HQ, 3d Medical Group/MGMMM
24800 Hospital Drive
Elmendorf AFB AK 99506-3700

SUBJECT: Suicide Intervention/Prevention

TO: Mr Meyer Moldeven
P.O. Box 71
Del Mar CA 92014-0071

1. The 3d Medical Group, Mental Health Services, approach to suicide is predominatly threefold: suicide awareness, customer service/program coordination, and incident response. As per your request, the remainder of this letter will briefly outline our strategy for suicide intervention/prevention and lists suggested resources.

2. The professional staff of Mental Health Services has consciously chosen to focus on suicide awareness for commanders and helping agencies rather than suicide prevention for the base community. Studies of suicide prevention programs, especially for adolescents, have indicated that they can paradoxically increase suicide risk as they often appear to normalize suicide as an option. Our focus is on giving commanders, first sergeants, and helping agencies information that supports their intervention and referral efforts. At least two, military specific, documents exist to aid our presentations. One document developed by Dr Charles F. McDowell, Headquarters, USAF Office of Special Investigations, Bolling AFB, D. C., contains background reports and demographics. The other document developed by Dr Frank Budd, Chief, Mental Health Clinic, Scott AFB, Il 62225, serves to supplement awareness and intervention strategies. Feel free to contact either one of these two gentlemen for further information.

3. The second pillar of our approach revolves around efforts to ameliorate external stressors, to the extent possible, as a means of preventing suicidal behavior. Underlying issues and causes receive the brunt of our prevention energy. A myriad of base programs and resources are available to the base community. The following is a partial list of those services:

a. Family Support Center

(1) Family life education on a number of subjects (e.g., parenting, couples communication, step-family living, family life cycle, elder care, single parenting, self-esteem, family stress management)

(2) Personal Financial Management Programs

(3) Information and referral on financial issues

(4) Transition assistance

(5) Relocation assistance

(6) Employment assistance

(7) Support during duty separation

b. Chaplains

(1) Worship, several denominations

(2) Religious education

(3) Pastoral counseling for personal or family problems

(4) Unit chaplain for visitation, liaison with each unit

(5) Duty chaplain (24 hours) for crisis services

(6) Youth groups

c. Social Actions

(1) Substance abuse prevention education for various groups

(2) Substance abuse counseling/reorientation

(3) Equal opportunity counseling/reorientation

(4) Referral services

(5) Base climate assessment

d. Health Promotions

(1) Stress management videotapes

(2) Stress management handouts

e. Mental Health Services

(1) Suicide Awareness briefings for command and key personnel

(2) Expects to develop, provide, collaborate on stress management briefings and programs

(3) Evaluation and therapy for individuals, couples, families

(4) Change management briefings

(5) Seasonal Affective Disorder briefings

(6) Outreach services to remote sites

f. Family Advocacy Program

(1) Awareness and prevention activities for the general public; prevention programs for at-risk groups/families

(a) Includes briefings, classes, one-day events and media campaigns

(b) Target groups include: single parents, pregnant teenagers, first-time parents, adoptive parents, families of special needs family members, etc.

(2) Evaluation and treatment where there are concerns about child or spouse maltreatment within a family

(3) Exceptional Family Member Program, assists families with special medical or educational needs of child family members, and special medical needs of nonactive duty adults

Community members are encouraged to use helping agencies and seek assistance during newcomer orientation, periodic briefings, and agency activities.

4. The third pillar of our strategy relates to responding to suicide gestures, attempts, and completions. Services include: lethality assessments, crisis intervention, on-call providers, outpatient therapy, inpatient treatment and Critical Incident Stress Debriefings (CISD). The first five services are self-explanatory. Our sixth service, CISD, assists individuals to deal with their reactions to traumatic events such as suicide attempts and completions. Dr Jeffrey Mitchell, a civilian provider and author, is the originator of the CISD model. For additional information, refer to his book entitled, "Emergency Services Stress." The CISD model is an important component of our treatment approach and can be valuable in diminishing adverse effects. The Mental Health Service has six existing CISD Teams.

5. Concerns about suicide and about continued stress associated with system changes, downsizing, and taskings will most likely increase attention to stress management issues at the base level. Mental Health Services, with the help of the aforementioned agencies, will continue to heighten sensitivity to the impact of systemic stressors. Awareness seminars, etiological sensitivity, customer service, and treatment approaches are currently the mainstays to the Elmendorf AFB suicide intervention/prevention strategy.

JURGEN R. RASCHMANN, Major, USAF, BSC
Mental Health Services

DEPARTMENT OF THE AIR FORCE
MALCOLM GROW USAF MEDICAL CENTER (AMC)

23 August 1993

Meyer Moldeven
P.O. Box 71
Del Mar, CA 92014-0071

Dear Mr. Moleven:

Your 9 August 1993 letter to the Commander, Air Force Medical Operations Agency was forwarded to me for response. Suicide prevention efforts in the Air Force have been undertaken by the Major Commands rather than by Headquarters initiatives. As with other preventive efforts, it is felt that each command has a unique population which would be best served by an individual approach.

For example, the Air Education and Training Command has a young population under academic stress whereas Air Mobility Command has members with different phase of life stressors. Air Combat Command, on the other hand, can expect deployment to be an important stressor, and would thus be expected to devote some energy to addressing this issue in its suicide prevention efforts.

I do not have a complete set of the materials used by each of the commands in this endeavor, but would suggest you correspond directly with them for additional information.

Sincerely,

M. Richard Fragala
Colonel, USAF, MC, FS
Consultant for Psychiatry
Office of the Surgeon General

DEPARTMENT OF THE AIR FORCE
60TH MEDICAL GROUP (AMC)
101 BODIN CIRCLE
TRAVIS AIR FORCE BASE, CALIFORNIA 94535-1800

FROM: SGHAS (Major Steffey, 5168) 21 September 1993

SUBJ: Response to Request for Records, Your Ltr, 9 August 1993

TO: Mr. Meyer Moldeven
PO Box 71
Del Mar, CA 92014-0071

1. I appreciate your interest in compiling a book to discuss suicide prevention measures. Here at Travis Air Force Base, we have recently became involved in developing a more structured suicide prevention program. The program is being coordinated by different specialties and involves coordination among different base agencies.

2. Because this program is an Air Mobility Command (AMC) initiative, it is more appropriate for the mental health consultant at AMC to discuss this initiative than it is for me to do so. Major Carla Monroe-Posey, the AMC Mental Health Consultant, will be a good reference point for you. Her address is:

Major Carla Monroe-Posey
HQ AMC/SGPS
502 Scott Avenue
Scott AFB, IL 622225-5319

3. Thank you for your interest in the tape of suicide prevention. I think it is very relevant to today's military.

CYNTHIA A. STEFFEY, Major, USAF, BSC
Director, Family Advocacy Model Program.

WILLIAM R. BANAS, Colonel, USAF, MC, FS
Chairman, Department of Mental Health

DEPARTMENT OF THE AIR FORCE
45TH SPACE WING (AFSPACECOM)

45 SPW/CV
1201 Minuteman St
Patrick AFB FL 32925-3299

[illegible] 1993

Meyer (Mike) Moldeven
P.O. Box 71
Del Mar, CA 92013-0071

Dear Sir

My staff has reviewed your request for information and we feel that we do not have any documents which would be useful to your work. While we are engaged in suicide prevention, this work does not fall into the written type of information you are seeking.

Our suicide prevention work focuses on two areas: education and intervention. Our educational efforts include briefings to units and other interested groups. Our efforts toward intervention include actions to help suicidal individuals and outreach workshops to units following a suicide.

Unfortunately, these efforts do not lend themselves to a written format but are a part of our normal workload in the Mental Health Clinic.

Sincerely

William A. Sample

WILLIAM A. SAMPLE
Colonel, USAF
Vice Commander

Memoir: Participation in grass roots suicide prevention volunteer work at U. S. A. F. McClellan Air Force Base, California and at the civilian community's Suicide Prevention Service during the 'Viet Nam' Years, and hassling the bureaucracy post-retirement.

Meyer Moldeven

(Caution: This memoir does not constitute guidance or advice, in any form or manner whatsoever, to persons who may be experiencing suicide ideation or intent. If you feel suicidal seek professional help immediately.)

Mental health experts have come to accept paraprofessional-level crisis intervention and suicide prevention workers as among those in the forefront of primary resources. The view is that their intervention might reduce the lethality of a person contemplating suicide, and even influence someone to who has actually initiated the act of suicide to draw back from it. In this regard, some years ago, Dr. Calvin Frederick, a past President of the American Association of Suicidology wrote: (quoting):

"Dealing with suicidal behavior, that is, suicide prevention] differs from more classical diagnostic and treatment procedures in the following respects:

1) suicidal behavior covers a broad range of disturbances and personalities and is, therefore, not a unitary concept;

2) it possesses a unique life or death quality;

3) intervention does not utilize traditional therapy methods;

4) the problem is multidimensional and multidisciplinary, often involving social and cultural attitudes, the law, medical intervention, and innovative psychological approaches;

5) the use of indigenous volunteers as stable and sensitive crisis workers is greater than that found in most aspects of therapeutic endeavor. (unquote)

Before I retired from the federal civil service in 1974 I was the civilian deputy to the Inspector General (IG) at McClellan Air Force Base, a major military installation near Sacramento, California. The base had about 25,000 permanent personnel (military and civil service) at the time. In addition to its local operations and worldwide logistics functions McClellan AFB was a major hub in the pipeline for military personnel and materiel to and from Southeast Asia and the Pacific Area generally.

I was and remain a lay person in all mental health disciplines. My involvement in 'suicide prevention' as it applied to the U. S. Armed Forces is based on circumstances of the 'Viet Nam War.' The bulk of active duty military mental health professionals and

trained support staff were serving in Southeast Asia and at en route stations for military personnel on their way to or from SEA. Military mental health professionals and staff were also concentrated at medical and other facilities in the U. S. where Armed Forces wounded received care. This resulted in a general and often critical shortage of mental health specialists and support staff at stateside military installations. It was not unusual for Civil Service employees working in other than the mental health fields to be temporarily assigned 'additional duties' to fill priority requirements and gaps in staffing.

Among my routine IG duties was to hear and try to resolve grievances and complaints of permanent and transient military and civil service personnel, military dependents, and the general public. It was not unusual in my interviews with a desperate military or dependent grievant to hear him or her hint at suicide ideation or contemplating a self-destructive act if a "reasonable" solution was not reached to his/her problem. As one whose career background was in logistics and related administrative functions, such complaints and potential self-destructiveness was new to me.

In 1969, the McClellan Air Force Base senior Commander (General Officer) requested me to represent him on the Sacramento County Mental Health Council. At the time, the Council was considering the establishment of a county Suicide Prevention Service (SPS). The SPS was quickly approved, and I became involved as a volunteer SPS 'planner' during my non-duty working hours. As the SPS functions and workloads became clear, I joined its paraprofessional training to certification, and when the Service became operational took my turn on the 'hotline,' especially on calls related to my McClellan responsibilities.

In time, because of the number and sources of incoming calls, I extended my involvement to SPS liaison with several military bases in the Sacramento area (Mather and Travis Air Force Bases, the Army Signal Depot, etc.). At that time, central California and Nevada had military installations where active duty personnel of all Services were in transit or stationed for training and operations. In effect, the Sacramento-San Francisco corridor and its communities in the late 1960s-mid 1970s filled with active duty military, returnees from Southeast Asia, and military dependents and retirees.

One viewpoint expressed among those engaged in the suicide prevention field is that official statistics on the number of suicides and suicide attempts in any given population are like the tips of icebergs. They do not reveal to the casual analyst the reality of how many in that population succeeded in killing themselves, intentionally, and how many tried and failed, and did or might try again - intentionally.

Experts' estimates occasionally appear in both professional and popular media that, conservatively, there are about eight to ten successful suicides for each one certified as 'completed' for the official record. Also, that there is about fifteen unsuccessful, often hidden, suicide attempts for each one that is formally classified as successful, again, for the record.

Among my Inspector General's office responsibilities was to organize and operate

McClellan AFB's support to the 'Air Force Inspector General Complaints System'. The basic principle of the System holds that, as a last resort within their organization, military and civilian personnel, members of military families, and military retirees have the right to address a grievance or appeal to an installation's Inspector General. The Inspector General represents the installation's senior Commander. An appeal to the IG may be for information and explanations concerning status and duties; perceived unreasonable conditions under which a person works, inadequate support to self or dependents, or for other reasons relief from what is believed to be an intolerable and unjustifiable situation.

As noted above, there were occasions when a complainant hinted at an act of desperation as the only remaining recourse should he or she be denied what they considered reasonable resolution of the issue they presented. In the IG function a potential 'act of desperation' to self, others or 'things' was not granted 'confidentiality.'

The SPS policy, on the other hand, was to not disclose a caller's identity: protecting a hotline caller's identity is (or was at the time) generally practiced by most suicide prevention centers unless the caller or another person in the episode was in an imminent life-death crisis. It was not unusual for such calls to require information or actions from staff at a military or other government entity.

Organized, volunteer-staffed, suicide prevention 'hotline' services were beginning to operate in the larger cities throughout the U.S. In the late '60s, about a hundred 24/7 centers were active across the country. To help me understand the 'suicide' phenomenon and to perform my duties in support of the USAF IG Complaints System, I became a regular volunteer at the SPS, attended their ongoing paraprofessional and upgrade training, and worked a shift and 'on call' with the hotline. I served with the SPS Speakers Bureau, Executive Board and other committees and gave talks about the base and community programs at staff, non-commissioned officers', military dependents', civilian community, and other meetings.

I compiled an information kit on suicide 'myths' versus 'facts,' and on visible signs that might suggest a friend or family member was experiencing suicide ideation. I acquired copies of handouts and other literature from the SPS and the National Institute of Mental Health (NIMH) and sent them to my counterparts at other military bases. The USAF Inspector General printed an article about the information kits in the USAF TIG BRIEF (The Inspector General Brief [TIG Brief]) an IG administrative newsletter distributed to U. S. Air Force organizations worldwide and to the headquarters of other Services. The newsletter was also distributed in Viet Nam. The item resulted in more than 150 requests to my office from Southeast Asia and elsewhere.

During talks I gave to military personnel and civilian community I was occasionally asked for examples of a 'hotline' interview and follow up with a distressed caller. Two of the three following summaries relate to the Viet Nam conflict. The third is a problem all too common, regardless of the times; it happened and continues to happen as often in the civilian world as it does in the military. I've screened my recollections so as to honor my commitments to confidentiality. The narration reflects a tiny sample of the effects of

stress in military life and is not intended to represent major emotional, behavioral, or physical indicators of suicide ideation. My regular work shift at the SPS usually brought me as much of a military-civilian mix of callers as the other hotline workers, so I've seen both sides.

The contacts were by telephone, and in two of the three cases led to a number of quick calls to several parties on and off McClellan. Each caller had the potential for violence, either to self or another. If intervention, at a high point in the interaction failed, the situation might well have deteriorated, possibly with tragic results.

Draftee

While on the job in the McClellan IG office, a phone call came in from the SPS Director who told me he needed my help right then. A young Army draftee was on the SPS hotline, threatening to kill himself. He was supposed to be on his way to Viet Nam but had gone AWOL instead. He was far from home and felt lost and confused. He said he had one question before deciding whether to kill himself:

'What'll they do to me if I turn myself in?'

He wouldn't give his name or say where he was.

The SPS Director said that he didn't have the answer. He told the soldier he had a contact at a nearby military base that could check it out. Holding the caller on one line he called me on another and gave me the facts. I immediately called the Base Staff Judge Advocate - who was part of my on-base network - and had him phone the SPS Director immediately to review the ramifications of military justice as it might apply. The SPS Director passed the information to the soldier and then talked to him for about an hour. The guidance provided by the Staff Judge Advocate gave the soldier options that might reduce potential charges he faced, not ruling out desertion. We never found out what the soldier decided; he never called back.

This call, and how it was handled, demonstrated teamwork between a community suicide prevention resource and military and civil service administrators on a military base. Comparable groundbreaking was going on in other military-civilian communities and contexts.

Family Problem

The Base Chaplain called me at home late one Sunday night and said he'd had a phone call from a hotline worker at the county SPS. The SPS worker had asked for his help in a call that had come in from an airman's wife. She had phoned the SPS from her home off base and threatened to kill her husband and then commit suicide.

The caller to the SPS had impulsively terminated the call after a few minutes, but in her responses to questions at the outset of the interview, had given her phone number to

the hotline worker. After she hung up, the SPS worker concluded the woman was more than moderately lethal, and also that she might listen to a military Chaplain. That brought on the call to the Base Chaplain.

The Chaplain phoned the woman and talked to her for about 10 minutes before she hung up on him too. His conclusion, also, was that she was highly lethal for both homicide and suicide. He phoned the Base Security Police and then the Director of Personnel. The Chaplain was to leave that day for Viet Nam, so the Director of Personnel suggested he call me.

The Chaplain asked me to follow up. I called the woman. The conversation was heavy, and lasted for more than 2 hours. The problem was in marital relations, finances, and spouse abuse. We finally got around to talking about on-base resources that might ease the load she was carrying: the Staff Judge Advocate, Family Services and Medics. Just listening, and then talking about potential on-base resources helped to lower the pressure. She finally agreed to wait until morning, now only a couple of hours distant, in order that specialists at the activities we discussed could be consulted.

First thing that morning, I invited the base Family Services people into the act. They moved in fast, took control, got the airman's wife around to talk to the right people, and did a lot themselves. I checked back later. Family Services had her under their wing. She wasn't talking about murder-suicide any more. It was going to be one day at a time for her for a while. She now had somewhere on base where she felt she could turn, and people in whom she had some confidence.

Why hadn't the woman tried Family Services on her own? I don't know. She chose the civilian community's suicide prevention resource. She had other options, and she might have tried them too. What's my point? Another instance in which military and civilian community resources collaborated and made the system work.

Returnee

At about 11 PM one night I was in my shift at the SPS hotline desk. The phone rang; it was the switchboard supervisor at the area telephone service. She said she had a soldier on-line, that he was in a fury and she couldn't handle him. Would I take him? I told her to let me have him and he was on.

It took a while to get him down to where he could speak coherently. He was an enlisted man, he said, just in from Southeast Asia and making his way to the East Coast. His problem wasn't suicidal -- at least at this point -- but from the way he talked, homicidal. He was in a barroom, drinking and minding his own business. Another patron at the bar had ridiculed his uniform and his Service. He had a weapon in his bag, he said, and had an almost overwhelming urge to use it.

A stranger in town, just passing through, he realized that he'd better talk to someone. Searching for some means to vent his rage against the insult -- other than

committing an assault -- he had, on impulse, picked up the barroom phone and dialed the operator. He must have come down real heavy on her and her supervisor, because he found himself, all of a sudden, switched to a hotline worker at the local SPS.

We talked for more than three hours. At the outset he was openly hostile, demanded to know who I was, and how the hell I had been loaded on to him. When I told him, he said he didn't know what "suicide prevention" was all about and, anyhow, wanted no part of it. But he didn't hang up on me, and we never hung up on anyone.

When he realized that he was talking to someone who had more than a passing knowledge of the military, who could respond in his jargon and relate to his lifestyle and to his feelings, his hostility eased. He talked, I listened. As I said, this went on for about three hours. Other feelings began to surface.

He admitted that he had been deeply shaken and enraged by his experiences during border crossings into Cambodia and other missions, and he still carried the same, almost overwhelming anger. Without my bringing it up, he confided that he'd had intense thoughts about self-injury, even suicide, and that the feelings had been strongest before starting off on missions. His rage, remorse and thoughts of suicide were still with him and, looking back at them in calmer moments, he said he was alarmed at their intensity. After a while, he admitted, reluctantly, that he might need help. He said he would think about seeking it out when he got to his permanent station.

At the close, he was much calmer. He phoned back a few hours later and told the hotline worker on duty that he was at the bus depot, and would soon leave for the east. He said to pass the word to me that he was OK.

Beyond 'Viet Nam'

Collaboration

It was clear to me from my IG and SPS experiences, that much could be accomplished through a carefully designed system for collaboration between military installations - or other federal entities - in any given geographic area and the crisis intervention/suicide prevention (ci/sp) resources of adjacent civilian communities. The potential for good was enormous, not only for and within the military community, but to the nation. I learned in time that I was not alone; many others, professionals and lay, in and out of government, were actively advocating along similar lines.

I was convinced that the time was long past for both military and civilian managers and supervisors, in both the public and private sectors to acquire basic indoctrination in ci/sp as it pertained to the people that they commanded or supervised. I wrote numerous letters on the issue, recommending specific actions, and continued doing so after I retired in 1974. My appeals went to the Federal Executive, Congress, and the media. I stressed the urgent need for proactive command or agency-wide training and motivational programs to confront the suicide phenomenon, and to get organized to reduce suicide

overcome barriers among middle year adults (parents of school age children) as well as the elderly.

An article I wrote in 1984 Suicide Prevention Must Be Everybody's Business was published in the January 14, 1985 supplement to the Army, Navy and Air Force Times. I posed the following questions for Commanders:

'a. Does your base have a program whereby supervisors and co-workers who might be confronted with suicidal people are trained to recognize the warning signs and refer potential suicides to professionals?

'b. Are any base personnel, especially security police, social actions or family support workers, trained in crisis intervention techniques? Are any of them volunteer workers in the local community's suicide prevention program?

'c. Does your base have any sort of arrangement with local suicide prevention centers or hotlines so that a civilian crisis worker can contact the base for information or assistance? Do civilian volunteers know exactly whom to call for help when a military person or dependent threatens suicide?

'd. Do your base officials routinely check with local crisis clinics to find out the number and types of distress calls being received from military people? Is this information analyzed to determine trends or patterns?

'e. Do your base mental health workers give talks to active duty and dependents' groups on this subject? Are civilian experts in suicide prevention brought on base to explain their services?'

The following month (February 22, 1985), the Secretary of the Army and the Chief of Staff issued a Memorandum for Major Commands and Staff Agencies which stated in part, "The Department of the Army has developed a Suicide Prevention Strategy designed to help commanders deal with this problem. Commanders must use this plan and complement it with initiatives tailored to specific needs."

During the following months the Department of the Army issued implementing directives, programs, and guides.

I secured copies of studies, plans, directives, guides and other documents published by NIMH, the American Association of Suicidology (AAS), and the Army on their in-house suicide prevention programs. In late 1985 I compiled and published them in book form, title: 'Military-Civilian Teamwork in Suicide Prevention,' sold them through bookstores and donated two thousand copies in response to orders and requests from military installations, other government activities, schools, and the private sector. Another update in 1988 'Suicide Prevention Programs in the Department of Defense', and the last update in 1994, 'Military-Civilian Teamwork in Suicide Prevention' also received a wide distribution.

My intent, in collecting and disseminating information on suicide prevention programs and practices of the Armed Forces, NIMH, and other contributors was to join with the many lay persons, like myself, who had become 'advocates.' I felt that wide distribution might also promote cross feed and thereby focusing on conflicting policies and procedures. The process, itself would encourage collaboration among professionals, paraprofessionals, and administrators and directors of suicide prevention entities in neighboring civilian communities. Further, I hoped that publicizing the Armed Forces' plans and procedures for ci/sp would encourage other government entities to explore their needs for comparable programs, and that potentially beneficial ideas and methodologies might spin off to the private sector.

My continuing interest in proactive and organized suicide prevention efforts in the Armed Forces led me to write to then Secretary of Defense Les Aspin, and to Senator Sam Nunn and Congressman Ronald Dellums in their roles as Senate and House chairmen, respectively, of committees charged with the oversight of military affairs. A copy of my letter to, and the response from the Office of the Secretary of Defense is included further along in this memoir.

Programs

A monumental medical and societal advance was made in suicide prevention by the original U S Army Suicide Prevention Plan, (Feb 1985) prepared by the Directorate of Human Resources, Office of the Deputy Chief of Staff for Personnel. The Plan called on each U S Army base to develop and publish an installation Suicide Prevention Plan. The plan was to provide for active duty units, Army families, the Army Community, and civilian employees of the Army. Among its many initiatives were several dealing with collaboration with civilian communities and other public and private sector mental health and crisis intervention resources.

The Navy issued its program in 1987, and the Air Force issued formal policy guidance in 1997 on implementing their suicide prevention program. Since the USAF 1997-policy statement follows my dated copies of the Army and Navy programs by about a decade, I assume that it conforms to more recent DoD medical policies on the subject and perhaps has been scrutinized and commented upon by the other Services. The following is from the USAF Policy Letter Digest December 1997 (Source: World Wide Web, search engine title: 'Air Force Policy Letter Digest').

QUOTE:

Building Healthy Communities - Intervention and Prevention

The global mission of the Air Force requires airmen who are fit, healthy and ready to deploy on a moment's notice.

To build healthy lifestyles and do it in the most cost-effective manner, the Air

Force is investing in capabilities that promote prevention and intervention. Put Prevention into Practice (PPIP) is a strategy developed by the U.S. Department of Health and Human Services, which the Air Force has implemented to organize and guide the preventive medicine efforts of medical providers.

The first step in PPIP is the health enrollment assessment review (HEAR), which is conducted with each patient as he or she enrolls... and (which is) then is updated annually. Data from the HEAR helps to identify the health status and prevention needs of patients. This data ... is used by major commands and the Air Staff to assure that resources are available to care for the populations assigned.

The second element of PPIP is the preventive health assessment (PHA), which in 1996 replaced the periodic physical examination program for all active-duty members. The PHA is a four-stage process that includes a prevention-oriented clinical screening, occupational examination, screening of military-unique medical requirements and counseling. The PHA will help ensure the highest rates of mission and mobility readiness by providing feedback to commanders on the health of their troops.

Air Force leadership is concerned about the ability of its members to cope with increasing levels of stress in the face of significant increases in operations tempo and force downsizing. As a result, the Air Force established an integrated product team (IPT) to evaluate suicides among active-duty members and to develop strategies for suicide prevention and intervention.

The IPT identified numerous factors as leading causes of suicide service wide. Chief among them were relationship difficulties, members facing adverse actions viewed as 'career ending,' financial difficulties, substance abuse and the perception that seeking help would have a negative impact on the individual's career. After evaluating this information, the team called in consultants from both the Air Force and public sector to develop a comprehensive approach to suicide prevention.

Since the inception of the suicide prevention IPT, the suicide rate for active-duty members has decreased by more than 35 percent. This has been strong senior leadership, awareness training for all Air Force members, training at all levels of professional military education, and the development of critical incident stress management teams at every installation. The bottom line in successful suicide prevention is self-aid and buddy care. Everyone must lead the culture shift in the way prevention services are delivered and remove the stigma of seeking help.

The Air Force established policies providing limited confidentiality protection to service members experiencing personal problems and greatly expanded the proactive role of mental health service providers. Various helping agencies in the Air Force - such as family services, chaplains, mental health services, substance abuse and health and wellness centers - now work together to provide comprehensive prevention services that enhance both individual and organizational resilience. In fact, a civilian consultant hired by DoD to evaluate the military services' suicide prevention programs praised the Air

Force's program as one that is 'as advanced and enlightened as any I have heard of.'

Commanders, first sergeants, first-line supervisors and co-workers must be aware of danger signs and encourage members to seek help. Leaders should become familiar with Air Force Instruction (AFI) 44-154, 'Suicide Prevention Education and Community Training,' and AFI 44-153, 'Critical Incident Stress Management.'

Base helping agencies are now working closely together under an integrated delivery system, or IDS. The IDS is designed to link base helping agencies to address risk factors, reduce stress and improve the coping skills and general well- being of individuals and families in the Air Force community. Wing commanders received guidance on implementing this system for their units earlier this year. Commanders at all levels can now work closely with the various agencies to offer a more comprehensive range of prevention services, increase the protective factors and decrease the behavioral risk factors in the community.

As base agencies join ranks, potential problems can be identified earlier and efforts taken more quickly to prevent tragic trends.

AIR FORCE INSTRUCTION 44 -154 1 MARCH 1997

(text)

SUICIDE PREVENTION EDUCATION AND COMMUNITY TRAINING

This instruction implements AFPD 44 -1, Medical Operations, concerning suicide prevention education and community training. It establishes requirements and procedures for the conduct of general suicide prevention education and community training. This instruction applies to all active duty Air Force, Air National Guard, and Air Force Reserve, as well as Air Force civilian employees, except for Title 32 U. S. C National Guard Technicians (IAW Technician Personnel Regulation 100 (172)).

1. Community Training Requirements.

1.1. The Secretary of the Air Force will ensure that all Air Force personnel, to include active duty, guard and reserve, as well as civilian employees receive training in general suicide prevention education at least on an annual basis including awareness of basic suicide risk factors and referral procedures for potentially at risk personnel. Training programs will be designed to destigmatize help seeking behavior among Air Force personnel and not destigmatize the act or attempt of suicide itself.

1.2. The Air Force Surgeon General will be the primary Air Force OPR for this training, and will ensure that this training is conducted as detailed throughout each MAJCOM, as well as in the Air National Guard and Air Force Reserve.

1.3. Each MAJCOM will ensure that all squadron commanders receive training in

basic suicide risk factor identification and referral procedures for at risk personnel as part of the new squadron commander's course. Additionally, each MAJCOM will ensure that the following training is conducted at each base, with base mental health serving as the primary OPR for this training.

COMPLIANCE WITH THIS PUBLICATION IS MANDATORY

UNQUOTE

The following is quoted from the Institute of Medicine's (IOM) Healthy People 2000 Report - Citizens Chart the Course, a separate volume of Healthy People 2000 which records the testimony and suggestions of citizens interviewed by the Public Health Service in the development of year 2000 national health objectives. The quote is from the section: Violent and Abusive Behavior, page 137): (quote) 'Meyer (Mike) Moldeven of California, says that volunteer training is an important component of successful suicide intervention for all ages: 'A community's suicide intervention and prevention resources - of which the suicide prevention center, crisis center, and hotline are elements - depend to an enormous degree on local paraprofessionals and trained volunteers. In the workplace, employers already provide programs for stress management, as well as cardiopulmonary resuscitation and first-aid training. Thus , 'why not a lay worker on the job site who is trained to function in an emergency suicide situation?' asks Moldeven. 'The United States [Armed Forces] have established formal suicide prevention programs, and the groundwork laid can be used to tailor comparable programs for other employers.'(unquote)

The largest single federal department, formally recognizing suicide as a critical challenge to the good and welfare of their personnel, took a great leap forward by formalizing 'suicide prevention.' With the foresight and efforts of advocates and caring managers, comparable initiatives, both formal and ad hoc, can be expected from other government entities. When top-management-directed - and supported - suicide intervention and prevention policies do take root throughout the federal system, as they inevitably will, they will merge or interact with adjacent Regional, State and community programs. The United States Armed Forces 'everybody's business' approach to crisis intervention and suicide prevention for their military and civilian populations has great potential toward the public good.

Public and private sector employers and schools benefit from their awareness of policies, resources, and standard operating procedures for suicide intervention and prevention practiced by institutions and other employers in their area. Where such cross feed and mutuality does not prevail, employer-community initiatives can explore them and apply worthy results. Such efforts contribute to the well being of employees and their families, parents, teachers, counselors and students, encourage and improve industrial and community safety, and generally enhance esteem and mutual respect among employers and the community of which they are a part.

In order that ci/sp policies, practices, and training can move forward, information

that will help the ultimate recipient of crisis intervention services needs to be disseminated to all levels and throughout all functions of the military and civilian communities: the line and the staff and their families; the civil services, academic and business communities, the domain of the elderly, and the general public. Readily accessible in public, institutional, and industry's libraries, adapted to and ingrained within the system, the procedures and delineation of who-does-what in crisis intervention/suicide prevention will help to coordinate and improve plans, methods, and collaboration across the board. The news media and the Internet can alert employers that do not as yet have their own programs, and keep them informed of opportunities to participate.

Following is an excerpt from my correspondence with the Office of the U S Secretary of Defense concerning 'confidentiality' in suicide prevention in the Armed Forces:

April 26, 1993
To:
Secretary of Defense
The Pentagon
Washington, DC 20301
Honorable Secretary:

[The opening paragraph in the original letter cited a number of suicides at a military installation. Identification of the activities involved is not relevant to the text of this excerpt.]

There is one aspect of organizing around (suicide intervention and prevention) all-services-wide - that deserves review at command level and, if a covering policy or management system exists, that it be publicized throughout the services and in civilian communities adjacent military installations.

Normally, a military person with an intolerable personal problem tries to get relief from within the system of which he or she is part, e.g., a buddy, family support services, chain-of-command, personnel staff, the IG, etc. Many personal problems are not job related, but because of the victim's inability to cope, spill over and affect "job." When the person is in a suicidal crisis, realizes that help is urgently needed, and wants such help, he or she will not hesitate to contact whomever can provide it, if not from within the system, then from outside.

Unless the military administrative system has changed on this point, a suicidal military person, or a suicidal member of his or her family who seeks help from within the system, believes that a record of the contact will be made. The "record" transforms to stigma and a potential threat to present job and future career.

"Records," more often than not, compel the person in a suicidal crisis to look elsewhere. Elsewhere includes the adjacent civilian community's crisis intervention resources, specifically, the suicide prevention telephone hotline where callers need not provide identification - they're as safe from being identified as anywhere they can be under their circumstances. The hotline worker does what can be accomplished quickly to keep the caller from slipping deeper into crisis and acting out a threat to suicide. They listen, offer nonjudgmental feedback, and together with the caller, explore options.

Almost invariably, when a civilian community crisis worker (telephone hotline or face-to-face) needs information on options unique to military life to help a suicidal military member or someone in his or her immediate family, the source is the nearest base's health care, personnel or other administrative functions. Very often, when contacts with base officials occur and the worker has the name of a suicidal caller, confidentiality is literally vital; being tagged in the base's records as someone who phoned an off-base crisis center carries almost certain exposure to military authority, and might well add the final straw.

If it's accepted that the military base and its adjacent civilian community should cooperate in suicide intervention, then the civilian and military agencies need mutually accepted procedures to do the job. If a community's crisis resource has one set of procedures for cooperation from the Navy, another for the Marine Corps, and still others for the Army and the Air Force, confusion mounts and collaboration suffers. This is especially true when the situation is tight and there isn't much time to keep a suicide threat from becoming an act. To the telephone hotline worker in a suicide prevention center it makes no difference whatsoever if the person on the other end of the line is a soldier, sailor, airman, marine - or civilian. On the other side of the scale, however, is the we-take-care-of-our-own turf, and that, to the suicidal person, is meaningless.

I hoped that, by now, military bases would have been further along in collaborating with adjacent civilian suicide prevention resources and that such teamwork would be reflected in base and community media. How else would a military person or a member of his or her family on the edge of a life-death decision for themselves know where to go or whom to phone, especially where their privacy and confidentiality would be respected - if they decided to take a chance and continue living? Is a city telephone directory listing for the local crisis center enough?

Agreements, procedures and contact points for military-civilian teamwork in suicide prevention deserve to begin on a county, metropolitan, or other regional basis, rather than in single-base to community understandings, especially where the area has installations that represent different services. When all the services in an area have maximum understanding among themselves about collaborating with community suicide intervention resources, it will optimize the support that they and their people as individuals can ask for from that resource, and the help that the hotline worker can offer to them. In effect, when a civilian suicide hotline has been appealed to for help by a military member/family member the crisis line worker will have clearly written, mutually agreed upon procedures for communications and actions with each base in the area. All

concerned will have been trained, tested, and know to the greatest degree possible who is going to do what. With present computer networking capabilities the resources indices in such guides can be readily maintained current and widely disseminated throughout a region and on and among military installations.

The opinions in this letter are my own, and are based on my experiences as a civilian IG-type and suicide prevention hotline volunteer in the late '60s/early 70s (and hassling the bureaucracy on this subject into the mid-80s.) I am not now associated with any mental health profession or military organization - strictly a private citizen. It may be that what I've suggested already exists or, conversely, that it isn't justified; I don't know, but I would be remiss not to present my views for your consideration.

Respectfully,
s/Moldeven

Reply
(From) Office of the Secretary of Defense
Washington D. C. 20301
(Force Management and Personnel)
Dear Mr. Moldeven:

Thank you for your letter of April 26, 1993 to Mr. Les Aspin, regarding suicide prevention programs in the Department of Defense.

Your letter prompted a review of policy in the Department of Defense on suicide prevention. The Department of Defense does not address suicide prevention in its directive on Health Promotion. That directive was published March 11, 1986, and is in need of revision. The Department is reviewing and revising that directive and a suicide prevention section will be added. We will address in the development of that section the issues you raised in your letter to Mr. Aspin.

Thank you for your interest and continued concern in this important mental health area.

S/Principal Director
(Military Manpower and Personnel Policy)
[added, hand-written: 'Thanks!']
cc: OASD(HA)

##########END##########